Co-constructing The Self: A Phenomenological-dialogal Case Study Of A Patient's Journey To Healing

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DEDICATION

This work is dedicated to Rachel. I am privileged and humbled to have walked the path to healing with you. I salute your courage and your strength.

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ABSTRACT

The purpose of this study is to explore the value of the psychotherapeutic meeting between the patient and therapist in the healing process of the patient. The argument is that the phenomenological and dialogal approaches provide a solid foundation for grounding the healing process in the **relationship** formed between the therapist and the patient which is a very different stance from the traditional approaches to dealing with psychosis. A six year case study of a psychologically fragmented woman who experienced psychotic episodes from an early age is explored. The growth to a more cohesive sense of self and integration and the lessening of psychotic symptoms is shown to be primarily due to the psychotherapeutic relationship.

The main objective is to argue that profound psychological damage, and even psychosis, may be healed to some degree through a deeply meaningful and containing interpersonal relationship. Whilst the author's belief is that the team approach to healing is valuable and sometimes crucial, this study implies that it is not always necessary to medicate and hospitalise.

This case also highlights how it is possible to work with other theories within the framework of the dialogal approach of 'healing through meeting'. Donald Winnicott's perspective of object relations theory and phenomenology were the base from which the therapist began this psychotherapeutic journey. The question was raised at a relatively early stage as to why this psychotherapy was succeeding in holding this fragmented and depressed woman sufficiently without medication or hospitalisation. This led the therapist into an exploration of the ability therapists have to use themselves within the psychotherapeutic relationship to hold the chaos effectively. More important was the discovery that the psychotherapeutic relationship was providing the foundation from which such severe damage and psychotic behaviour could be healed sufficiently for the patient to live more effectively in her world.

IN THIS TEXT THE MASCULINE GENDER IS INTENDED TO INDICATE BOTH GENDERS OTHER THAN WHEN SPECIFICALLY DEALING WITH THE PATIENT IN THE STUDY. IT IS ONLY USED FOR EASE OF EDITORIAL STYLE.

DIE GESAMENTLIK OPBOUING VAN DIE SELF: 'N FENOMENOLOGIESE/DIALOGIESE STUDIE VAN 'N PASIËNT SE PAD NA GENESING

ABSTRAK

Die doel van hierdie studie is om die waarde van die psigoterapeutiese verhouding tussen pasiënt en terapeut op die pad na genesing van die pasiënt te ondersoek. Die betoog is dat die fenomenologiese en dialogiese benadering 'n soliede basis vorm vir genesing deur die **verhouding** wat tussen die terapeut en die pasiënt ontwikkel wat heeltemal verskil van die tradisionele benaderings wanneer met 'n psigotiese pasiënt gewerk word. Oor 'n tydperk van ses jaar is 'n studie gemaak van 'n sielkundig gefragmenteerde vrou wat van 'n baie vroeë ouderdom, psigotiese episodes ondervind het. Die groei na 'n meer samehangende self, integrasie en die vermindering van psigotiese simptome wat waargeneem is, is bewys van hierdie psigoterapeutiese verhouding.

Die hoofdoel is om aan te dui dat diepgaande psigologiese skade en selfs die psigose kan tot 'n mate genees word deur hierdie baie betekenisvolle en interpersoonlike verhouding. Terwyl die skrywer glo dat 'n spanpoging waardevol en partykeer noodsaaklik is vir genesing, dui hierdie studie aan dat dit nie altyd nodig is vir medikasie en hospitalisasie nie.

Hierdie geval bring die moontlikheid na vore van "genesing deur verhouding" saam met ander teorieë binne die raamwerk van die dialogiese benadering. Donald Winnicott se perspektief van objekt verhoudingsteorie en fenomenologie vorm die basis waarop die terapeut hierdie psigoterapeutiese studie gefundeer het. Die vraag wat in 'n baie vroeë stadium gevra moet word is waarom hierdie psigoterapie geslaag het om hierdie gefragmenteerde en depressiewe vrou genoegsaam aanmekaar te hou sonder medikasie of hospitalisasie. Dit het die terapeut gelei na die ontdekking van die vermoeëns wat terapeute het om hulself te gebruik binne die psigoterapeutiese verhouding om die chaos effektief teen te werk. Meer belangrik was die ontdekking dat die psigoterapeutiese verhouding die basis was om hierdie ernstige skade en psigotiese gedrag genoegsaam te genees vir die pasiënt om meer effektief in haar wêreld te leef.

IN HIERDIE DOKUMENT VERWYS DIE MANLIKE GESLAG NA BEIDE GESLAGTE BEHALWE WAAR DAAR SPESIFIEK NA DIE PASIENT IN HIERDIE STUDIE VERWYS WORD. DIT WORD SLEGS GEBRUIK VIR 'N GEMAKLIKE SKRYFSTYL.

ORIENTATION, AIM AND METHOD

The aim of psychotherapy, in any form, is the healing of the patient in order that he may function more adequately in the world in which he lives, works and plays. Most psychotherapeutic studies have investigated how a particular psychological theory or aspect thereof is of value in assisting personality growth or changing the behaviour of the patient. This study explores how the psychotherapeutic relationship can provide a framework for the healing of the patient. It is based on the philosophical principles of phenomenology and dialogal therapy. These views focus on how man lives and interacts in his world rather than being a preconceived set of theoretical beliefs. There is a vast quantity of philosophical and theoretical literature available on dialogue and dialogal therapy. However, there is little literature on the application and concrete experience of how the dialogal principles function in practice. This thesis aims to provide some substantial examples to fill this gap and argues that dialogal therapy is a viable way to work with disturbed patients.

A case study of a psychologically fragmented woman with little sense of a cohesive self who has experienced psychotic episodes since childhood is examined. The thesis aims to indicate how even psychosis may be healed to varying degrees when the patient is simply met and heard in a climate of respect and trust. It emphasises that the therapist does not always have to provide rational and logical explanations for certain behaviour, beliefs and thoughts but can simply allow the experience to reign free and speak for itself. Much of the information obtained about fragmented and deeply disturbed people has come from studies on schizophrenia. Unfortunately, many of these patients are unable to provide much useful information on their own experiences and perceptions of the world and their psychotherapy. The patient in this case, Rachel, is sufficiently stable and articulate to have been able to gain insight and clearly describe her psychotic episodes, psychotherapeutic experience and growth. This provides valuable information for theorists and clinicians working in the field with severely disturbed patients.

Generally, psychotic symptomatology has been treated by medication and/or hospitalisation and the person's experiences have been firmly placed in the context of an abnormal reality. The person is usually required to recognise and understand this sickness in order to regain mental health. This attitude results in a negation of the person's sense of experiencing and sense of self. The negation often comes from all the people involved within the patient's world, including the family, community, society and mental health professionals. Being labelled sick and abnormal increases the sense of isolation and encourages withdrawal and an entrenchment of pathological patterns of behaviour. A history of the traditional and current views of the approach towards psychosis is provided in chapter one.

If one is exploring the hypothesis that psychopathology may be healed within the psychotherapeutic relationship, it is necessary to explore the different facets (variables) that make up that relationship. The qualities of the patient, the therapist and the situation all contribute to the relationship formed between the therapist and patient. The combination of these factors results in the unique creation of a relationship which is

greater than, and different from, the initial, individual facets. These variables are explored in chapters two, three, four and five.

The author and therapist in this case is a clinical psychologist trained in the psychodynamic approach. When psychotherapy began with this patient, I had not heard of dialogal therapy. I was working from the phenomenological premise that man lives in the world and Winnicott's approach and certain aspects of the object relations theory's views of fragmentation made good sense of the patient's world for me. After eighteen months of psychotherapy, the question arose as to why, despite an initial presentation of severe depression and psychosis, I had not referred the patient to a medical practitioner or psychiatrist for medication and/or hospitalisation. It seemed as if respecting and sharing her experiences had provided a safe space for the beginning of an integration of the self. It was felt that the relationship established between the patient and therapist was providing a strong holding environment in which exploration, discovery and integration were occurring - and that medication was not a necessary route. Subsequently, I learned about dialogal therapy during the doctoral course at the University of Pretoria, South Africa. This further enlightened me as to how the psychotherapeutic relationship provided a solid foundation for healing.

The theoretical base for understanding the fragmentation is based on Donald Winnicott's views of object relations theory. The Winnicottian view of the True and False Self is a useful concept as it aptly describes the unintegrated sense of self in deeply pathologised states. It has provided a solid framework for understanding the patient in this study. However, the movement from fragmentation and despair to a sense of a cohesive self will be explored primarily from the phenomenological and dialogal perspectives. These viewpoints provide a deeper understanding of the value and meaning of the symptoms as well as how the 'healing through meeting' (Buber, 1958) occurs. It also shifts the focus from techniques to shedding light on the patient as a unique individual in his own world.
The phenomenological approach views the patient's perceptions and reality as constituting a reality that needs to be understood on its own terms and does not attempt to make it fit the categories of any specific school of thought. Phenomenology stresses the need to recognise and respect the validity and value of the experience for the patient. The patient's experience is reality for him because that is how the event is perceived and lived by the patient. The emphasis is on how the patient has changed, and with him his world, even though the world of the so-called normal person has not. Moss (1989) states that man is never separate from the world and partly shapes and is shaped by the world. Man and the world together create the individual's personal world of experiences. Due to this constant interaction, the relationship between the self and objects, the self and the body, and the self and the world is explored to understand the unique world of each person. How the subjective interpretation of objective, shared reality affects these relationships is of prime importance and, likewise, the meaning this has for the patient. This perception, interpretation and experiencing is always contextualised in the patient's world. The aim is to explore the patient in his world as a whole unit and not presume that the patient can be understood without referring to the meaning his world has for him. These views are explored in depth in chapters six and seven.

During the First World War the Jewish philosopher, Martin Buber, became aware of the breakdown of relationships and connections between people which resulted in the dehumanisation, objectification, alienation and isolation 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. His belief that this split can only be healed through a healthy relationship with another human being, led to the development of the dialogal therapy approach.

Dialogal means relational. The core of the dialogal therapy approach is that of viewing the patient as a whole human being in a world of relationships. Pathology and psychosis are viewed as a disturbance of man's entire existence. The therapist explores the entire context as well as the dialectics existing between the major dimensions of the patient's whole world. Buber (1958) believes that the underlying basis of all psychopathology is the absence of confirmation and states that man is never sick alone but always in relationship. Pathological behaviour and psychosis protect the most vulnerable part of the self so it is critical to explore the symptoms and their meaning for the patient.

Dialogal psychotherapy is thus an approach where psychotherapy is centred on the meeting between the therapist and patient/ family as the key to the healing mode. The stress is on meeting the patient in his world of reality and respecting his experiences which confirms the patient and encourages the integration of the self. The patient's psychological damage is healed in the psychotherapeutic relationship. This approach is explored in chapter eight.

The case study (chapter nine) provides an example of how the psychotherapeutic relationship forms a solid foundation for the healing through meeting. It highlights the patient's journey from fragmentation and internal chaos to a sense of being a separate, unique and whole human being. It also provides the reader with a sense of what the patient's experiences in the world were like for her on a daily basis. The meaning of these experiences for her highlights the value of focusing on the patient's understanding of her world.

The psychotherapeutic journey is followed by a theoretical discussion of the relevant issues. As stated, one of the primary aims of this study is to show that, in some cases, even psychosis may be reduced and growth attained by providing a healing environment and understanding the patient's experiences within the context of his own world. Chapter ten is dedicated to exploring the patient's psychotic experiences and the meaning and use they had for her survival in her world.

Chapter eleven explores the general growth and integration that occurred within the patient. It deals with the major themes that have been dominant and relevant in her life and psychotherapy. This exploration is based on the phenomenological and dialogal approaches as the significance of these principles is clearly highlighted in her journey to healing. Her path to integration, a more cohesive sense of self and the beginning of relating to the world in a healthy manner are the major foci.

Having explored the healing through meeting throughout her case study and the following chapters, the conclusions (chapter twelve) highlight which of the variables of the patient, therapist, situation and psychotherapeutic relationship have had value in this specific case. Further variables, which have received little attention in the past, are discussed in order to broaden the understanding of the qualities necessary to form a sound and healthy relationship between the patient and therapist. This therapist's specific characteristics and contribution are also explored to discover what qualities promoted the healing to be effective in this particular instance. Although the focus is on a specific case study, the goal of this work is to highlight and emphasise a powerful way of working with people in general. It is hoped that the stress on specific characteristics and the highlighting of previously under-rated factors will provide valuable information for both learning therapists as well as those already experienced within the field. A healthy debate on these issues can only further increase understanding and knowledge of the factors which contribute to the healing of patients.

Another aim of this work is to indicate how searching for definitive answers is not the goal and how one should make an attempt to understand the uniqueness of the individual within the context of human beings in general. Hycner (1991) states that it is "not the therapist's theoretical orientation that is as crucial in the healing process as is the wholeness and availability of the self of the therapist" (p. 15). The genuineness of human meeting provides the core for the healing which means the therapist must leave the security of knowledge and theory and enter the patient's world. This stresses the importance of meeting each patient as a unique and valuable human being.

Overall then, the aim is to indicate that the provision of a sound, accepting, confirming psychotherapeutic relationship can be sufficient to heal psychological damage even at very deep levels.

RESEARCH METHOD:

In the field of psychotherapy, quantitative measures are frequently ineffective in gaining a deeper understanding of the concepts involved. Quantitative, statistical methods may be too restrictive and are, therefore, in certain instances, of little value to the researcher. Kruger (1988) states that research is a cautious inquiry involving critical and exhaustive investigation but not necessarily experimentation. It is extremely difficult to scientifically measure and prove that a particular school of thought or philosophy is better than another. To attempt to do so involves objectifying the person which is the antithesis of what this study is about. This does not mean that quantitative studies are not of value or always reduce the people involved to objects to be studied. However, this thesis sets out to explore the human qualities involved in healing through meeting. It would thus be inappropriate to reduce the patient and her experiences to definable and measurable, scientific entities. The therapist gains an understanding of the patient's experiences by entering the patient's world and experience and not by making inferences on the basis of abstract principles. There is a back-and-forth movement between the search for the constituents that make up the whole and a precise description of the facts of the person's existence. Thus, a qualitative research method is necessary in this case which can explore the unique experiences of the patient.

Case studies describe psychological phenomena and highlight their value with more

depth and meaning than a quantitative method could. Since Freud, the case study has been regarded as a legitimate method for advancing theoretical and therapeutic understanding. Bromley (1986) maintains that the case study plays a key role in the development of theory. The researcher aims to open up the essential qualities of the case being studied which includes making assumptions about constructs and the relationships between them. Any principles or assumptions gained from one case study can be tested against further case studies.

As the current case is an individual case study, a combination of the Case Study Research Method (CSRM) and the Duquesne Phenomenological Research Method (DPRM) was deemed to be the best method (Edwards, 1991). The CSRM focuses on a single case which is examined in depth. The DPRM is based on the work of Giorgi who states that phenomenological research begins with information about the direct experience of the individual. Attempts are then made to describe the experiences and meaning they have for that person in order to understand the central themes of the phenomena in question. This method usually involves interviewing several subjects. Edwards (1991) reports on the major differences that Giorgi mentions between DPRM and other methods of analysing data. In DPRM the focus is on the events experienced in everyday life. Following phenomenology principles, researchers aim to provide an accurate description of the phenomenon as it is lived and perceived by the subject. Information on the key concepts and themes is obtained from the case study or interview rather than from the theory. The research goal is to highlight the relationships between the various aspects of the subject's experiences by dialoguing with the subject and/or his description of the events. Good phenomenological research provides a sound data base for the development and testing of theory.

The focus in the current study is on a single case study that explores the phenomena as the DPRM does. The study may be defined as a descriptive-dialogic case study where the emphasis is on fully describing the phenomena as well as embodying general principles of existing theory (Edwards, 1991). The case study has been written up from the comprehensive notes taken during the six year period of psychotherapy. The patient was requested, during her psychotherapy, to write a description of her psychotic episodes so that the researcher might have a deeper understanding of how she perceived and experienced these events as well as the meaning the experiences had for her (Appendix A). During the course of psychotherapy, her permission was gained to write the thesis on her life and her experiences of psychotherapy. Over the next two years she was requested to write of her experiences, both positive and negative, in psychotherapy (Appendix B) and a few interviews were conducted in order to clarify certain aspects of her experiencing and understanding. The patient also provided the researcher with some of the religious writings she had completed in the years before psychotherapy. From these it is possible to glean further knowledge of how she viewed life and what it meant for her. In November, 1999, she wrote a brief description of what she believed she had gained in psychotherapy. Armed with the above information, it was possible to explore the general themes in relation to the phenomenological and dialogal therapy approaches. The patient's specific experience of psychotherapy provides substantiation and argument for the healing through meeting hypothesis.

In any research the questions of generalizability, reliability and validity arise. Although

the specifics of experiencing are unique to each individual, it is possible to extract general themes which are applicable to and useful in understanding other peoples' experiences. Kvale (1996) states that the postmodern approach to generalizability results in an emphasis on the heterogeneity and contextuality of knowledge with a shift from generalization to contextualisation. Kvale writes that analytical generalization involves "a reasoned judgment about the extent to which the findings from one study can be used as a guide to what might occur in another situation" (p. 233).

"Reliability pertains to the consistency of the research findings" (Kvale, 1996, p. 235). In some ways the only reliable information that can be gained about the phenomena is from the person who is experiencing the events.

Validity involves ascertaining the truth and correctness of the phenomena being studied. Kvale (1996) believes this involves the credibility of the researcher as well as the methods used. To ensure valid results the researcher must adopt a critical outlook on the analysis of the subject matter studied. Glaser and Strauss (Kvale, 1996) state that validation is not some final verification but consists of continual checks on the credibility, plausibility and trustworthiness of the findings. This involves analysing the potential bias that may occur in qualitative observation and interpretation.

In this case, information was clarified in discussion with the patient to ensure that the understanding of her experiences was correct. Discussion in psychotherapy sessions around issues and interpretation also guaranteed that the validity of statements was addressed. By asking the patient to write specifically about her psychotic episodes, experiences in psychotherapy and the growth she believes she has attained, the attempt was made to ensure that the meaning of her experiences was clearly illustrated. Thus, the description and understanding of the meaning of the events for her was not simply the researcher's interpretation. The process and interventions made were queried and the therapist's mistakes are also discussed.

A common criticism of interviews and case studies is that the findings are not reliable and valid because the information supplied by the subject may be false. As the phenomenological and dialogal therapy approach is that the importance of an event is how it is experienced, perceived, felt and interpreted by the subject, this objection is not relevant. The truth is how the subject perceives and lives it and not whether this can be concretely and objectively proved as fact. Kvale (1996) points out that validity is not only an issue of method as pursuing the validation of methodology raises theoretical questions about the nature of the phenomena being investigated. House (Kvale, 1996) emphasises that research does not primarily predict events but presents material in such a way that readers can see new relationships between phenomena and answer new but relevant questions. Cronbach (Kvale, 1996) maintains that interpretation should remain open and unsettled in order to invite sensible discussion. Kvale supports this with his belief that, if there is too much focus on validation, it can be counter-productive. "Rather than let the product, the knowledge claim, speak for itself, validation can involve a legitimation mania that may further a corrosion of validity -the more one validates, the greater the need for further validation" (p. 252). He advocates that the research findings should be convincing and powerful enough to provide their own validation. If the research procedures are clear and the results evident, the

conclusions of a study will carry their own weight and be credible.

A brief explanation of phenomenological and dialogal research methods is necessary for a clear understanding of what was involved in this study. Polkinghorne (1989) states that phenomenological research is descriptive and qualitative. He agrees with Husserl's belief that knowledge is grounded in human experience. Husserl's view of phenomenological reduction means suspending any or all reality judgements concerning the patient's description in order to concentrate on the meaning of the experience for the patient. The focus is on how the experience is lived by the patient. Husserl states that one does not question the world as it actually is but the specific world which is valid for the person as it appears to him (Jaspers, 1963).

Phenomenological and dialogal research describe the structure of the experience rather than the characteristics of the person who has the experience. The aim is to understand the experience by asking the question "what ?" rather than the question "why ?". Phenomenology and dialogal therapy make the critical distinction between what the patient perceives as his own reality and what may exist for most others as reality. Descriptive findings shed light on actual human functioning in the context of certain real life situations and can provide empirical evidence. The aim is not to prove in a scientific sense that the dialogal therapy approach is more effective than some alternative, but to demonstrate how this approach works in practice and how one can justify its use clinically and philosophically in the healing of the patient.

Phenomenological description can never be exact. If one interprets more, one understands less so it is important to remain true to the facts as they are happening or have happened. Interpretation can be contaminated due to the therapist's own world-view and ideological views, so verifying interpretation within the hermeneutic principles allows us to remain "within the locus of the text" (Corin & Lauzon, 1994). The aim is to understand and find the deeper meaning underlying the story. To achieve this in a phenomenological and dialogal way, one must examine the patient's interpersonal sphere, network of social relationships, significant others, social support links, the sense of integration into family life and the relationship to social norms. Corin and Lauzon state that there is usually damage in all these areas. In other words, the therapist is required to explore how the individual negotiates or arranges relationships within his world. For example, the use of religious ideas to rearticulate the personal history can provide greater coherence in the patient's present life. It can provide a supportive environment and resolve past family problems on a symbolic stage.

Many proponents of the dialogal therapy approach see the dialogue as critical for understanding the patient's reality. It is thus far more a process than a procedurally oriented approach. Strasser stresses the importance of relating to the other in dialogue and not losing sight of this when exploring and evaluating (Halling & Leifer, 1991). "The ethical ideal is the absolute respect for the other person" (Halling, Kunz & Rowe, 1994, p. 117). The experience must be the central focus but it is important to contextualise this within the patient's world. One allows the phenomenon to come alive and speak for itself so that interpretations are grounded in the data. If the interpretation fits with multiple aspects of the patient's life, then it is a valid and valuable interpretation. Halling and Leifer stress the need to be faithful to the data and the lived experience and to see

beyond to what is implicit rather than readily observed. Thus, one makes the phenomenon a partner in the dialogue.

It is critical to make the phenomenon a partner in the dialogue as the patient's descriptions of his experiences are the only entry we have into the patient's world. Jaspers (1963) believes that the psychotic's self-descriptions are unique but reliable and through them man has discovered many of the basic concepts of psychotic experience and meaning.

The above explanation provides a clear rationale as to the reasoning behind why a single case study was deemed to be the most satisfactory method for this dissertation.

CHAPTER 1 - TRADITIONAL AND CURRENT VIEWS ON PSYCHOSIS

This study explores the growth and healing of a patient who has suffered from psychotic episodes since her early childhood. It is argued that the phenomenological and dialogal approaches provide a solid foundation for grounding the healing process in the **relationship** formed between the therapist and the patient which is a very different stance from the traditional approach to working with psychosis. The study aims to indicate that psychosis may be healed to varying degrees when the patient is simply met and heard in a climate of respect and trust. The growth to a more cohesive sense of self and integration and the lessening of psychotic symptomatology is shown to be primarily due to the psychotherapeutic relationship. An overview of the traditional and current views of the mentally ill and psychosis is provided in this chapter.

ATTITUDES AND APPROACHES TO THE MENTALLY ILL IN THE WEST THROUGH THE AGES:

Psychosis has been an element of human existence since time immemorial. Various attitudes and approaches to psychopathology and treatment, or the lack thereof, have differed according to society's prevalent beliefs and philosophical views. Cushman (1992) states that psychotherapeutic theory and practice are "social artifacts and as such both reflect and shape the configuration of the self and the illnesses of their era" (p. 34).

The stages discussed below do not end abruptly but overlap and blend into each other.

1. The Middle Ages.

The truth of Cushman's statement has been clearly demonstrated across the centuries. There are varying reports of how disturbed people were treated in the Middle Ages in Western Europe. Ellenberger (1974) states that there were institutions for the mentally sick but there is little information as to what the conditions of these institutions were like. There are some descriptions indicating that the mentally ill led a marginal life, living off charity, being ridiculed but also being allowed to tell the truth to anyone. In the thirteenth to fifteenth centuries, the Islamic world treated the mentally ill with more consideration and some luxurious hospitals were built. Spain followed the example by creating better facilities and laws for the treatment of the insane. However, the contrast of other mental institutions, where people were chained to the walls and barely fed, highlighted that society was still uncertain as to how to treat those who did not conform to social norms.

2. The Renaissance.

The Renaissance began in Italy in the fourteenth century but only spread through Western Europe in the sixteenth to seventeenth centuries. Michelet (Microsoft Encyclopedia, 1993 - 1996) refers to this period as the time when there was a discovery of the world and of man. The great Swiss historian, Jakob Burckhardt, characterised the Renaissance as nothing less than the birth of modern humanity and consciousness after a long period of decay. The contrasts displayed in the Middle Ages were also to be seen during this period. It was a time of great suffering for the mentally ill and non-conformists. For example, slavery was re-established and witch hunts increased. The

number of asylums built in Spain were few. However, in the sixteenth century, Juan Duarte, who had been hospitalised for an acute psychotic episode, founded an organisation that was to build many institutions where people were treated humanely. These institutions were built in Spain, Italy, France and other countries. Ellenberger (1974) states that a negative feature of the Renaissance was its "contempt for the vulgar, the illiterate, and the fool" (p. 15).

Dreyfus and Rabinow (1983) analyse Foucault's views in their article "Michel Foucault: Beyond Structuralism and Hermeneutics". In Madness and Civilisation (1965), Foucault portrays the mental asylums of the seventeenth century as grim and gruesome places. Originating in the middle ages as institutions for the confinement and care of lepers, these structures were subsequently used to house many social misfits in the years that followed. Foucault attributes the mass incarceration of that time to changes in how mental illness was defined by society. Luchins (1993) states that Foucault believes society was threatened by unreasonable people in an Age of Reason. In that time period, in Paris, all socially deviant and unacceptable people were confined to keep them off the streets. Thus, the mentally ill, criminals, the poor and unemployed were all incarcerated in the same institutions. Previously the poor had been banned from the cities but now they were confined within them. Dreyfus and Rabinow report that, in 1656, one percent of the Parisian population was housed in mental institutions and Foucault queries the social control factors involved in this marked increase of the socially deviant. He speaks of the contrast between madness and reason, that is the dialectic between labelling people as social deviants requiring incarceration and the religious call to care for them. Foucault submits that this social incarceration resulted in the isolation and observation of whole categories of people and was the first sign of the modern medical, psychiatric and human sciences approaches. He highlights that this was a form of social control. These type of institutions spread throughout France and Western Europe and were utilised for the above purposes until the French Revolution.

Foucault believes that it was after the revolution that society's current approach to madness emerged. At the beginning of the nineteenth century, many people were enraged that the mentally ill had been confined with criminals. This was not necessarily a humane response but rather a social response of the upper class criminal element who reacted negatively to being confined with people they perceived as their social inferiors. Foucault states that the second reason was that the poor were viewed as a powerful social resource and thus an economic factor because they could be made to work for nothing or very little. Dreyfus and Rabinow (1983) allege that if the greater sector of society, the poor and unemployed, were a potential source of the nation's wealth, then, as Foucault says, "confinement was a gross error, and an economic mistake" (p. 8). Thus, Foucault alleges that the rehabilitation and treatment of the mentally ill was a myth. These reasons highlight that society was still unable to understand and respect the world of disturbed people. The tragedy is that, as patients were deemed to be responsible for their illness, they were punished for their behaviour. Foucault says this was to make the patient aware of the responsibility of his own actions. That these occurrences were a result of societal influence is reinforced by Pinel's view that the mentally ill "must be brought back to an affirmation of social standards by a series of techniques of retraining, consciousness alteration, and

discipline of both the body and the psyche" (Dreyfus & Rabinow, 1983, p. 9).

3. The Age of Enlightenment.

In the Age of Enlightenment, in the late seventeenth and eighteenth centuries, laws were based more on the belief that good order is intrinsic to the development of greater truth, rationality and humanity. The number of mental hospitals in Western Europe increased. These were based on the models of either the prison or the monastery and Ellenberger (1974) states that the systems based on the monastery treated the mentally ill more humanely. Burckhardt's "birth of humanity" had thus not enlightened society to a deeper understanding of mental illness or mankind. Descartes and the prevalent thought in the early seventeenth century was unfortunately to set the tone for the centuries that followed. He attempted to apply the rational, inductive methods of science and mathematics to philosophy. It is hardly surprising that the objectification of human beings was further entrenched as a tenet due to this approach to philosophy. Descartes states: "In our search for the direct road to truth, we should busy ourselves with no object about which we cannot attain a certitude equal to that of the demonstration of arithmetic and geometry" (Microsoft Encyclopedia, 1993 - 1996). Apart from his desire to understand life based on a scientific approach, Descartes introduced the concept of a duality between the mind and body and man and the world. This resulted in man perceiving mind-body and man-world as separate entities and not as an indivisible whole.

In the eighteenth century, mental illness was regarded as a disease to be treated by the medical practitioner rather than the priest. The Cartesian influence and the medical model resulted in an approach in which the aim was to subdue and/or obliterate any signs of psychosis without any attempt at understanding. Within this approach, mental patients were viewed as objects to be medicated and/or hospitalised in settings which recognised little individuality and showed no respect for human dignity.

However, the Moral Treatment approach which arose towards the end of the eighteenth century offered some hope for the mentally ill. In the United States of America, Benjamin Rush introduced the concept of moral treatment at the Pennsylvania Hospital in Philadelphia and other institutions were opened based on similar principles. Rees (1957), who has been a medical superintendent at various mental hospitals in the U.S.A., describes this as a time when there was more focus on social and environmental factors as being the causes of mental illness. This was a positive change as the mentally ill were now regarded as normal people who had lost their reason due to severe psychological and social stress. Rees states that these stresses were called the "moral causes of insanity, and moral treatment aimed at relieving the patient by friendly association, internal discussion of his difficulties and the daily pursuit of purposeful activity; in other words, social therapy, individual therapy and occupational therapy" (p. 306).

The peak of Moral Treatment was reached during the years 1820 - 1860 and this approach achieved excellent results. Where there had been little or no improvement with archaic and cruel treatment, many patients improved with moral treatment. For example, in the Worcester State Hospital in the United States of America, seventy

percent of patients admitted within one year of the onset of their illness, were discharged some years later. A follow-up of these discharged patients indicated that only fifty percent had had a relapse. This figure indicates a fairly high rate of success (Bockhoven, 1963).

Rees (1957) writes that it is generally agreed that Moral Treatment declined towards the end of the nineteenth century and was at its ebb during the first two decades of the twentieth century. Rees states that this has been attributed to a number of varying developments. For example, the Industrial Revolution and mass production which led to growing materialism, the influence of Darwin as well as that of Virchow's cellular pathology. Virchow states that insanity was due to irreversible cellular changes and heredity. This is a depressing view as it removes the hope that the mentally ill can be healed by the interventions prescribed by the Moral Treatment approach. This resulted in the incarceration of many people to avoid them reproducing children who would also be mentally ill.

4. The Industrial Revolution.

The Industrial Revolution which began in Britain at the end of the eighteenth century further dehumanised and depersonalised man (Microsoft Encyclopedia, 1993 - 1996). As this industrialisation continued worldwide into the early twentieth century, technology resulted in the more efficient organisation of society, business and life, but rendered the individual man less important and merely a number in a system.

5. The nineteenth century.

Kierkegaard states that the major problem of his age was a "contempt for the individual man" (Chessik, 1986, p. 83). This attitude resulted in man becoming more isolated from his fellow man and detached from himself. Personality was viewed as consisting of fragmented aspects of the person and this carried into the twentieth century where Victorian man saw himself as separate pieces involving reason, emotion and will. This attitude was congruent with the development of industrialisation. The broader concept of reason in mental illness had become limited to techniques, specific problems, separated from emotion and will (May, 1958). For example, Beard theorised that symptoms were a result of exhaustion and a lack of "natural body electricity" (Cushman, 1992, p. 33). His treatment involved removing people from their everyday environment to reduce stress and recharging their "natural emotional energy by direct doses of electricity" (p. 33). This further entrenched the Cartesian split between mind-body and man-world.

Despite the growth of industrialisation and the attitudes of people like Beard, there were some positive moves in the nineteenth century. William Tuke allowed patients to express their agitation which resulted in the reduction of symptomatology. Pioneers such as Johann Langermann, Johann Heinroth and Karl Wilhelm Ideler, shared the belief that mental illness had emotional causes and that psychotherapy could possibly help even severe psychotics. This provided some glimmer of hope for the disturbed (Ellenberger, 1974).

6. The twentieth century.

Cushman (1992) describes man, at the turn of the century, as being "confused,

faceless ... beset by feelings of derealisation, moral confusion, and a lack of a sense of meaning and a place in society" (p. 36). This trend continued into the new century. For example, in the early part of the twentieth century John Watson and Luther Holt advocated that one did not need to meet children's emotional needs. The Holt feeding schedule, which was to set feeding patterns for babies for decades to come, was based on methods originally planned for feeding cattle. Watson advised that babies and children should never be shown physical affection. The pervasive influence of finance as a measure of power and success in Western cultures in the twentieth century has further deepened the split in man who defines himself according to his position and wealth in society rather than himself as a human being. The connectedness of self, both within and with the outside world that exists in many Eastern cultures, indicates the authenticity of living as a whole human being within the context of a family, community and society. Something that has been little understood within Western scientific thinking, especially in the increasingly materialistic twentieth century.

By the mid-twentieth century, the United States had approximately 600,000 patients in psychiatric hospitals, nearly all of them diagnosed as psychotic and over half as schizophrenic. The number of mentally ill people, including those not hospitalised, was estimated at around a million (Cameron, 1947). Accounts from various individuals in the first half of this century support the fact that attitudes to mental illness and the mind-body/man-world split were still alive and strong. Boisen (1962) describes his period in a mental institution in the early 1920's as extremely negating. The typical approach of the times is highlighted by his mention of the "organistic" approach doctors had in which illness and symptoms were simply not discussed with patients. In his first edition published in 1936, Boisen was advocating that the difficulty for many lay, not in an organic defect, but in "the disorganisation of the patient's world" (p.11). He stresses the failure of the individual to live up to society's standards and how this accepted social judgement results in a loss of self-respect and creates a sense of alienation.

Kaplan (1964) has collated a number of psychotic patients' descriptions of their experiences of mental illness. Lara Jefferson, who was hospitalised in the 1940's due to her psychosis, powerfully describes the chaotic, constrictive, objectifying and uncaring atmosphere in the mental asylum as she strove to maintain some small semblance of sanity. In speaking of the societal pressures to conform, she relates how she undoubtedly would have been accepted into society at another time and place where she would have been recognised and accepted for who she was. As she could not conform to the current societal demands, she was declared insane. The treatment, including the use of straight-jackets, led to her insight that she could "see a new place to apply the abhorrence we feel for the Chinese custom of foot binding" (p. 11). She portrays the psychiatrists as men who have "endless ideas and theories" (p. 5) and "have got us all analyzed and psycho-analyzed down to insignificant daubs of protoplasm" (p. 14). She feels that patients were not allowed to take any responsibility for themselves and that their attempts to cope with the world in a manner that suited them was completely ignored by the psychiatrists. The end result for the psychiatrists of not recognising the meaning of the insane world was the inability to make "an insane person sane" which rendered them "helpless" (p. 5) to treat effectively. Francis Farmer's (1942) shocking description of eight years in a mental asylum in the U.S.A. also highlights the dehumanisation of the mentally ill human being in that period. It is

an amazing account of the nightmare and terror which she survived before she was able to function in the world again. Cameron (1947) points out that society dooms many curable patients to a lifetime of despair and loneliness because of its inability to recognise mental illness as a natural and understandable form of illness.

The Phoenix Conference, held in the United States of America in 1985, highlights the two dominant themes present as the twentieth century drew to a close. Firstly, that "the only valid knowledge is scientific knowledge; hence human life is predictable, explainable and controllable". The second is that man must be "set free from the stunting effects of civilisation to realize itself and to actualise its highest potentials" (O'Hara, 1993, as cited in Stubbs & Bozarth, 1994, p. 109). This indicates that the scientific approach which stresses that man is an object to be studied and controlled still has a powerful influence over modern day thinking about man. Although the second theme recognises the more positive belief that man is an individual who should be allowed to be a unique person in a community or society, the dangers of objectification are still very real.

Tragically, Cushman's words about the confusion of human beings at the beginning of the twentieth century, as stated above, remain remarkably true for man as he begins the new millennium. Although we might appear to have moved far from those lunatic asylums with people in straight-jackets, subdued and controlled with medication, their influence is still strong today. With the growth in technology connecting mankind worldwide, the trend to objectify man seems even more powerful. Man's individual rights and needs are ignored in the search for greater control and management of life on this planet. Individual isolation is further heightened by this approach.

SOCIAL FACTORS:

The course and outcome of treatment for dysfunctional behaviour may differ significantly depending on sociocultural and political contexts. In some non-Western, non-industrialised societies, people recover fairly quickly and are reintegrated back into community with little, if any, residual damage to their sense of self and belonging. In the Western world people suffer from more chronic and progressive problems, often with a poorer prognosis. Corin (1990) found that re-hospitalisation was often associated with a need to be normal and fit societal norms and values. Her examples show how "contemporary Western capitalism may be as responsible for the nature of psychotic experience as for the loss of sense of self and functioning" (Davidson, 1994, p. 123). Kaplan (1964) believes that abnormal behaviour indicates a negative response to societal norms - "perhaps the most extreme and complete form of negation that is possible" (p. xi). In a workshop presented in South Africa in February 1999 by a well-known American psychologist, a cartoon was displayed which summed up Western society's current attitude. The slide depicts a doctor coming to meet the patient in a consultation room with a thick file, saying "Nice to put a face on a disease." This cartoon is a sad indictment exemplifying the lack of human interaction and caring in today's medical fields.

As indicated above, individuals who do not conform to society's norms are labelled as deviant and/or abnormal. They are harshly judged against the cultural norms of acceptable behaviour and the ability to have social relations. The need to assist human

beings to function in a world of interpersonal-relationship becomes a necessity in society, not only in psychopathology. This is emphasised by Pande (1968) when he examines the differences between the Western and Eastern cultural approaches. Western society is an individual-oriented society where work, productivity and reaching individual goals are of prime importance. Eastern cultures are more relationship-oriented and thus tend not to need psychotherapy in the same way Westerners do. Pande makes the valid statement that Western man needs to constantly be making progress towards some goal whilst daily life becomes more fragmented and split. The result is a failure to find real value and meaning in human relationships. This accentuates the isolation and withdrawal that occurs in Western society as the lack of support systems and healthy relationships create alienation and an inability to live with ambivalence.

Ironically, the Cartesian influence and the medical model created a need for psychotherapy and yet psychology remained firmly entrenched in the very concepts which had created the problem in the first place. Many schools of thought in the psychological field adhere to objectifying the patient thus looking for solutions within the framework that created the scientific, objectifying, negating approach. Basing exploration of the patient's experiencing on a scientific approach results in a narrow, limited framework which will offer few alternatives and never allow the richness of the experience to emerge. Romanyshyn (1991) describes how the scientific approach with its need for order and linear, simplistic answers, results in less meeting of man in his complexity and his soul. He believes we need to "remain twisted, soulful, in a linear world ... If, individually and culturally, we are to make myths instead of symptoms, we need to preserve the complex character of our ensouled involvement with the world" (pp. 27 - 28).

Contemporary treatment usually involves drugs and/or hospitalisation to control unwanted and unacceptable behaviour. In a world where pharmaceutical companies form major conglomerates and are a source of high income, the influence and power they yield is enormous and this both encourages easy solutions and can result in drug abuse. Ciompi, 1991 (as cited in Prouty, 1994), reports "good to satisfactory results in about two-thirds of cases" (p. xvii) where schizophrenics were treated with psychotherapy and very low dosages of neuroleptics. This suggests that medication is not always necessary and, even when it is, it does not have to be used to blunt or obliterate the patient's feelings and experiencing.

Parloff alleges that government officials, courts, insurance companies, managed health care workers and the like demand definitive answers to queries around solutions that will meet society's needs in a cost-effective and timely manner (Goldfried, 1980). The quick fix mentality of modern society also encourages supposedly instant, easy solutions and effective short-term control methods. The vast number of people requiring assistance in the mental health field adds weight and impetus to this approach. The decline in the supportive, extended family network has contributed to increasing isolation of the individual and the inability of some to cope effectively with their problems. The media, who highlight important information, can also create fads where it becomes fashionable to be on certain drugs. A good example is Prozac which is viewed in the media as the popular "personality drug". Overall the so-called quick and

easy solution approach ensures more control over socially unacceptable behaviour generally. It reduces and even negates the importance of the time and effort taken to understand and improve the patient's communication and interaction within the larger framework of society.

TRADITIONAL AND CURRENT APPROACHES TO PSYCHOPATHOLOGY:
In the psychiatric framework the meaning and function of any experience that does not conform to society is usually brushed aside or viewed with a judgemental and jaundiced eye.

Admittedly, psychological literature abounds with examples of scientific studies and this can provide one with a general overview of psychopathology and knowledge on the particular profiles which emerge. This can increase one's understanding of psychopathology but the trap is that it can also result in objectifying man and failing to view the person's individual experiencing and world thus eliminating the most basically human aspect of existence.

Psychopathology acknowledges that there can be severe disturbances in man's behaviour, thought patterns and consciousness. What is seldom recognised is that this so-called abnormal behaviour is an "exaggerated or unbalanced expression of the normal" (Noyes, 1963, p. 80). It is always possible to link the abnormal person to who he was before the need for a mental illness arose. When defences are no longer able to provide stability the adaptive abilities of the person become ineffective and disorganised. A mental disorder serves the functional purpose of protecting the individual and allowing some sense of control in an altered and isolated world. When man is labelled according to whether he is normal/abnormal or healthy/sick it immediately separates him from the everyday world. In this process symptoms are viewed as something to be removed, medicated away. This prevents one from understanding the value and role of the symptom and the need to face and respect the real experience of the patient.

CONCEPTIONS OF PSYCHOSIS:
Much of the literature on psychosis focuses on schizophrenia. Although the current study is not about someone diagnosed with schizophrenia, the patient has experienced psychotic episodes since she was a child. It is thus important to understand the prevailing views on psychosis in general.

What is perceived as concrete reality depends to a large degree on societal beliefs. We have to live with others in mutual relationship, whilst preserving some sense of self. This can result in conflict, confusion and a "flight into illness in order to escape from reality and relieve oneself of responsibility" (Jaspers, 1963, p. 387). Psychosis allows one to experience as real what "reality refuses" (p. 387) to believe.

The narrowest definition of psychosis is restricted to the presence of delusions and prominent hallucinations. The psychiatric definition of psychosis (Kaplan & Sadock, 1991) is an "inability to distinguish reality from fantasy; impaired reality testing, with creation of a new reality" (p. 218). The DSM-IV (1994) offers a broad range of definitions based on the characteristic features of the disorder to which the psychosis

is linked. For example, it provides the features and diagnostic criteria present in Brief Psychotic Disorder, Shared Psychotic Disorder as well as those disorders characterised by having psychotic symptoms as the defining feature.

Whilst definitions may provide us with broad guidelines of the concepts involved, the danger lies in the simplistic approach of accepting these as concrete facts and failing to deepen the understanding of the broader implications. Likewise, definitions provide us with superficial descriptions of behaviour without any explanation as to what it means to the individual in his context. Thus, in the psychiatric sense, the meaning of the symptom is largely ignored and simply treated to alter or eliminate it.

Two aspects of psychosis are briefly discussed as the patient in this study has experienced both these alterations of reality.

1. Hallucinations.

This is defined by Kaplan and Sadock (1991) as a "false sensory perception not associated with real external stimuli; there may or may not be a delusional interpretation of the hallucinatory experience; hallucinations indicate a psychotic disturbance only when associated with impairment in reality testing" (p. 220). The DSM-IV (1994) adds that the hallucination "has the compelling sense of reality of a true perception" (p. 767). Jaspers (1963) defines true hallucinations as "false perceptions which are not in any way distortions of real perceptions but spring up on their own as something quite new and occur simultaneously with and alongside real perceptions" (p. 66).

There are variations of hallucinatory experience such as hypnagogic and pseudo-hallucinations as well as true hallucinations as described above. Hallucinations can appear when there is disturbed consciousness due to organic reasons. For example, in head injury after motor vehicle accidents, epileptic seizures, sedation, cerebral illness/insult but, in psychosis, consciousness is considered to be clear. Auditory hallucinations are more common and result in less confusion and fear than visual hallucinations which are a greater distortion of reality (Noyes, 1963).

1.1 Pseudo-hallucinations. Sedman (1966) defines pseudo-hallucinations as false sensory perceptions which occur when a person is fully awake. They are usually fully projected into external space and are experienced as if through the sense organs. Pseudo-hallucinations are usually of human figures which are psychologically meaningful to the individual and are recognised as visions of people rather than real. It is as if they were experienced in the mind's eye. Jaspers (1963) states that the only way they differ from true hallucinations is that they are figurative, occurring in inner subjective space and not in concrete, external, objective space. They frequently have definite contours and are fully detailed but may also manifest in the form of pale, vague images. Jaspers states that there can be a transition where pseudo-hallucinations can change into true hallucinations or a state where they combine. Like the true hallucination, pseudo-hallucinations cannot be deliberately altered or evoked.

2. Delusions.

A delusion is defined by Kaplan and Sadock (1991) as a "false belief, based on incorrect inference about external reality; not consistent with patient's intelligence and

cultural background, that cannot be corrected by reasoning" (p. 219). The DSM-IV (1994) adds that the inference is "firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary" (p. 765).

One of the strongest features of delusions is that they are incapable of being altered by logic or argument which is why they can be so firmly entrenched and intractable. They then lead to errors of judgement of reality. Cameron (1947) adds to his definition on delusions stating that they "usually lead to behaviour that is socially detrimental, inappropriate or inept" (p. 390).

THE MEANING OF PSYCHOTIC BEHAVIOUR:
Van Werde states that psychotic behaviour is pre-expressive behaviour. This means that "we see such behaviour as a way of expressing meanings that are there, but not yet fully in process, nor available to the person" (Prouty, 1994, p. 96). That is, these meanings are implicit or unconscious.

In many psychological approaches psychosis is understood to be meaningful within the framework of the patient's experiencing of his world. Psychosis is related to the patient's attempt to make sense and create order out of the unmanageable aspects of his life and self. This is similar to the manner in which the child uses fantasy to control and master his universe. Fantasy is a major adaptive response for coping with reality in the life of a child. The intensity of the symptoms points to the patient's desperate need to gain some mastery over a chaotic world. In children, the role of fantasy becomes important as a way of magically mastering danger. With no effective or adaptive defences to manage the daily environment, the child can gain control by splitting and fantasising. Fantasy becomes a powerful tool as the child can people his fantasy world with the omnipotent, protective, need-satisfying characters he seeks. Winnicott (1977), in his case study of Piggle, agrees and stresses how the child can play with the fantasies that most disturb her. That is, enjoyable play allows anxiety to be mastered and contained within the total experience.

Jaspers (1963) describes reality as generally being formed within the context of its societal meaning and common understanding. Man does not have a direct, objective contact with reality and experiencing is always influenced by his subjective perceptions, emotions, hopes and fears (Noyes, 1963). Individual experiencing must therefore be tested against the general, shared reality. This becomes a difficult task when the individual's need for an altered reality arises. If the pressures and stress of life become unmanageable, the adult may revert to an extreme form of fantasy as a means of coping and distancing. Another of man's earliest defences is the ability to remove himself from reality by distancing and blanking out experience. This distancing occurs in order to avoid feeling the pain and emotional disturbance of the current experience. However, if the individual's way of life and experiencing constitutes severe or ongoing crisis and trauma, physically and/or psychically, dissociation and depersonalisation are insufficient defences. Psychosis is the most extreme manner of escaping reality.

Kruger (1988) describes how schizophrenia is an attempt to "bring a halt to the disorder of inconsistency" (p. 173). Eigen (1993) states that the sense of catastrophe

experienced in psychosis is a basic and often central fact of psychosis. In the process of disintegration the individual experiences a state of nothingness which Winnicott ascribes to a break in continuity in his experiencing of the world. For example, in this connection, Nuechterlein et al's. 1922 longitudinal study on vulnerability and stress in schizophrenia is very relevant (Prouty, 1994). It was discovered that there were a "disproportionately high frequency" of stressful, uncontrollable life events outside the client's life "in the months before psychotic exacerbations and relapses" (p. xvi). Ciompi describes acute episodes with visible psychotic symptoms as a "critical overtaxing of a vulnerable information-processing system" whereby "pathological new states of equilibrium" (p. xiii - xiv) are attained.

Schwartz, Wiggins and Spitzer (1997) detail two differences between normal and psychotic experience. The first is that the psychotic's experiences include an "expanded horizon of meaning" and secondly, that implicit meaning becomes "explicit and covert" (p. 178). These differences are viewed in the phenomenological sense of meaning and horizon which incorporates both implicit and explicit meaning in their broadest sense. Well adjusted people have a relatively defined understanding of objects whilst psychotics have an infinite number of meanings for objects and experience. Thus, one meaning is changed to another and broadened until there is a generalisation of the initial meaning into the psychotic's whole world. Dorr-Zegers, 1988, states that "normals" have a profound difficulty in understanding this expanded horizon (Schwartz et al., 1997). Hence, the lack of understanding and inability to connect with the psychotic's world by society, the medical profession and even many mental health professionals. The only person who can provide an adequate, but not full, account of the experience and its meaning is the patient. Kaplan (1964) relates how the patient is the one intimately connected with the experience. He has a special interest in the process as it is his life so he may be able to provide some valid insight into the meaning of the experience.

The meanings that emerge in psychotic states are more "forceful, explicit and graphic" (Schwartz et al., 1997, p. 180). This expanded horizon and explicit meaning makes the psychotic's world more unmanageable and complex. When there are an overwhelming number of possibilities and interpretations for experiences available, there is a need to reduce this complexity. The psychotic will automatically select a particular, relevant meaning which is conditioned by his past beliefs and experiences. To regain control, the psychotic focuses on this meaning and behaves according to the meaning it has for him in his world. This is still not, however, shared by others and the individual remains disconnected and isolated. Schwartz et al. believe that the original, shared meaning thus recedes to the background as the psychotic reality takes precedence due to its relevance. If the psychotic does not achieve any control over his world, there is chaos and disorder, resulting in "a fragmenting of experience" (p. 181). Contrary to Jaspers (1963), however, the authors believe that these experiences can be understood by responding to the expanded horizon and its meaning for the psychotic.

There is a narrowing of experience in all psychosis when the focus is on the current meaning and experiencing and the broader perspective is lost. Eigen (1993) describes hallucinations as bringing "experience to a standstill, and one small portion of experience is heightened to an extreme degree. The subject is hypersensitive in a

highly selective way. Everything seems to gain its meaning from this small portion of experience" (p. 125). Thus, the emotional quality involved in hallucinations and delusions and the desperate need to have a sense of balance results in a lowering of the critical ability to judge. Sass (1994) describes the world of psychosis as "a place not of darkness but of relentless light, which is the natural metaphor for conscious awareness" (p. 94). This increases the intensity of the experience and narrows the field of experiencing.

The above description highlights the difference between normal and psychotic experience. Jaspers (1963) states that common reality is identifiable and accessible to all and "not merely a private and subjective matter" (p. 95). However, psychotic reality is not easily identifiable and comprehensible. Sass (1994) agrees that delusions are not always in the shared world but "rather, it is in the mind's-eye world where emotions, other people, and even the patient's own body exist as purely subjective phenomena, figments of an abstract imagination" (p. 92). The patient is always the centre of his delusion and this results in psychotic patients having severe boundary problems. They have no possibility of distancing and creating boundaries as they are "obsessed by the compactness of their being" (Corin & Lauzon, 1994, p. 44). The sense of where the self ends and the other begins is blurred and this openness to the world and experience can result in a frightening feeling of the loss of the self, or invasion and a threat of annihilation. The patient struggles to maintain a sense of mental space to allow the internal ordering of experience to occur efficiently (Eigen, 1993). Likewise, there can be a confusion in relation to body issues where a split is experienced between the self and the body. A sense of 'I' is lost or heightened and one is incapable of experiencing a common, shared reality. Thus, there are extremes of rigidity and fluctuation in symptomatology (Eigen, 1993).

Jaspers (1963) defines delusion as "a transformation in our total awareness of reality" which "can only arise in the process of thinking and judging" (p. 95). He stresses how there is no self-reflection in psychotic experience as there is in normal, everyday life. Instead there is a great deal of self-deception in the urge to escape reality. Kruger (1988) gives an account of Fischer's, 1985, views on the concept of self-deception from a phenomenological perspective. Fischer describes how the possibility of self-deception arises when three inter-related conditions are present. Firstly, the individual already has a firm belief in his understanding of a particular situation or aspect of his life. Secondly, that firm conviction may suddenly become ambiguous and uncertain due to additional information becoming available. Finally, when the ambiguity creates anxiety, not only in the person's view of the specific situation, but in the whole view of his life and world, his understanding of the phenomena will be perceived as threatening. If these conditions occur, the individual will deceive himself in order to reduce anxiety and deny the uncertainty and ambiguity. To achieve this he will realign his understanding of the experience in relation to the new information in order to maintain the status quo.

So, although the delusion provides the individual with a sense of safety, the belief is still not a reality in the eyes of the shared world and there is still some anxiety present due to avoiding the normal fears of everyday life. Sass (1994) argues that the need for a delusion may arise precisely because it is experienced as unreal rather than because

it is felt as real. He refers to Sartre's, 1966, belief that the delusion is an attempt to escape the form of life. That is, the uncertainty and the need to respond which creates anxiety, rather than its content. Fischer agrees, stating that it is easier to try and reduce anxiety than confront it. Should the person query the presence and meaning of the anxiety, he may come to the realisation that he is deceiving himself. If this is the case, the person will need to alter his current reality, attitude or understanding which may feel more anxiety-provoking. Fischer states that, if the individual listens to the anxiety he may come to recognise that the belief is fallacious. The danger of ignoring the messages received in the process of retaining the delusional belief is that the individual reaffirms that he is the person he believes himself to be or that the situation is really as he perceives it. When this occurs there is no healthy change in the belief structure to modify understanding. The experience will uncompromisingly affirm his current dysfunctional views and beliefs.

Many authors have a similar outlook on the reasons for the appearance of hallucinations. Eigen (1993) states that hallucinations may be viewed as images which could function symbolically but are taken literally. They make the abstract concrete and vice versa and recreate the meaning of reality. As stated, when the real, inner core of the self is not heard and responded to in a caring manner and healthy contact is denied, the individual seeks to provide a reality in which these basic needs can be fulfilled in some other way. So, the very lack of satisfactory interpersonal relationships forces the individual to create an alternative reality where he may control his world or be the victim, but to accept that the self is too inadequate to engage in healthy interaction is unbearable. Symbols assist us in understanding by creating an analogy which dominates reality (Jaspers, 1963). Cameron (1947) states that hallucinatory experiences, especially visual ones, often occur due to extreme feelings of personal need, anxiety or frustration and depend on the supporting delusional beliefs.

When someone experiences an hallucination there is a powerful need for that experience to be grounded in reality. Delusions are thus often associated with hallucinations in an attempt to support and make sense of that reality. Like the child who uses fantasy to conquer fears and anxieties and gain mastery over his world, delusions provide what life has denied (Noyes, 1963). Thus, delusions can be viewed as simply an exaggeration of the normal beliefs people use to bolster their perceptions of themselves and reality. When there is a large discrepancy between a person's experiencing and what appears to be the norm, the need to make the experience congruent with the personality becomes a high priority. So, the patient's reality is not necessarily a disorganisation but a "choice that has a superior claim to reality" (p. x) from the patient's perspective (Kaplan, 1964). The delusion assists in providing a meaning to the event or hallucination.

The meaning of an event is not a theoretical issue but a personal experience. Meaning changes once one addresses that particular experience and one can feel and be different. That is, there is a constant movement in awareness and perception as the meaning of the phenomenon shifts. As hallucinations are understood to be perceptions without an external stimulus, the content of the hallucination provides valuable information about the individual's perceptions and ways of interacting with the world (Noyes, 1963). Noyes views hallucinations as being projections of the individual's

psychological difficulties onto the outer world. Thus, the hallucination provides valuable clues as to what those difficulties are.

There is a "kernel of truth" (Eigen, 1993, p. 9) in psychosis. This truth allows one to recognise the common ground upon which the therapist can work with the patient to understand the value and role of the psychosis in relation to his past experiencing and how it is being acted upon in the present. To medicate away the psychosis is to obliterate the kernel of truth/reality and thus not to discover the deep roots and meaning for the individual. It becomes important to build on that kernel to heal and grow the self so that hallucinations and delusions are no longer needed. Thus, the key to the psychosis lies within the psychosis itself and how the specific meaning is linked in with the patient's world.

Prouty (1994) views hallucination as a "fragment of the self" and the "successful treatment of hallucinations is a restoration of the self" in order to restore a "communicative human self that was lost in madness or retardation" (p. xxii). Eigen (1993) describes how Jung amplified, rather than reduced, the psychosis in order to understand its meaning for the individual. By amplifying the phenomenon, the patient is allowed to leave reality for the moment to explore and play with the full meaning of the psychotic symptom. Eigen also highlights Perry's view that the psychotic's inner self is deeply wounded which results in feelings of worthlessness, inferiority and self-deprecation. He supports the need to get in touch with the core of the psychosis and self in order to truly grow.

The psychiatric labelling that so frequently occurs, results in the patient feeling "totally trapped within the psychiatric world" which is "colored by an important sense of suffering" (Corin & Lauzon, 1994, p. 23). Psychoses need not always be viewed in a negative light. Freud, Bion and Jung believe that hallucinations play a role in beginning or destroying psychic life (Eigen, 1993). Jaspers (1963) supports this belief by stating that hallucinations can be sources of human potential and possibility, not only deviations from the norm. May (1958) cautions us not to project our theories onto the patient but to ensure we are knowing him in his own reality. The thrust of questions must be about the patient's world and his experiencing. Of importance is that one does not always attempt to totally eliminate a person's defences as they may be providing a sense of stability.

Phenomenology is interested in man, not the mentally ill man, but simply man in his world. The emphasis is on meeting, hearing and understanding the unique individual and not defining him according to definitions and theory. With the growth of phenomenology and the dialogal approaches there has been a shift to understanding the patient within his context and as someone inter-relating with others in the world. Corin and Lauzon (1994) mention many authors (Giorgi, 1976, 1988, 1990; Hoeller, 1988; Messer, Sass & Woolfolk, 1988) who are challenging the objectivistic approaches. This is a healthy shift towards viewing man as a whole human being interacting and living in the world. The phenomenological viewpoint offers an alternative approach to working with psychosis other than the usual first-line treatment of neuroleptic medication.

However, these approaches to psychology are not recognised sufficiently in the psychiatric field and many schools of thought which objectify man are still prevalent in psychotherapeutic work today. Corin and Lauzon (1994) stress that the patient's individual experiences are still largely ignored. A recent study by Norcross and Freedheim (1992) affirms their position. These authors conducted a study on their predictions of the future of psychotherapy with 40 of the major contributors to a History of Psychotherapy - A Century of Change (1992). All 40 respondents held a doctorate and had an average of 27 years of postdoctoral experience. The respondents predicted that "present-centred, structured, and directive techniques would increase markedly" (p. 882). These included audio/video feedback, problem-solving techniques, cognitive restructuring, self-change techniques, behavioural contracting, social skills training and computerised therapies amongst others. This clearly indicates that the quick-fix solution mentality is firmly in place at the start of the new millennium. A warning to be heeded.

Eigen (1993) wisely comments: "Wherever madness comes from, it is with us. We must learn to live and work with it. We must find ways of letting it speak to us. We must listen to and digest its voices, visions, and enactments. We must learn to absorb and evolve with its impact" (p. 370).

As we further isolate and dehumanise people, so we increase the likelihood that they will manifest with dysfunctional behaviour in a desperate attempt to have some meaning in their chaotic, depersonalised lives.

VARIABLES IN THE PSYCHOTHERAPEUTIC RELATIONSHIP

CHAPTER 2 - THE PATIENT AS A VARIABLE IN THE PSYCHOTHERAPEUTIC RELATIONSHIP

There are many variables which contribute to the development of the psychotherapeutic relationship and the outcome of psychotherapy. A wealth of literature exists which explores the contributing aspects of the patient, the therapist, the situation and the psychotherapeutic relationship. The current chapter deals with what successful outcome means in psychotherapeutic terms and the factors that the patient contributes to the psychotherapeutic relationship and healing. The following two chapters explore the variables of the therapist and the situation and are followed by a discussion of the psychotherapeutic relationship itself.

THE OUTCOME OF PSYCHOTHERAPY:

There has been much written about successful outcome in psychotherapy. Possibly one of the most well-known articles is "The Effects of Psychotherapy, an Evaluation" written by Eysenck (1952). Causing considerable controversy, he states that two thirds of neurotic patients improve no matter how they are treated or whether they are treated at all and he reinforces this view in subsequent articles in 1960 and 1965 (Malan, 1973). In the ongoing argument about these findings many authors question these results and Malan (1973) refers to Bergin's 1966 paper which he regards as one of the most important papers to have emerged in the past twenty years. Bergin (1966) discusses Rogers, Gendlin and Truax's Wisconsin four-year study of 16 schizophrenics which concludes that psychotherapy can make patients either better or worse. This is supported by Bergin and Garfield (1971) who evaluate the outcome of many studies including those of Eysenck, 1952; Rogers and Dymond, 1954; Cartwright and Vogel, 1960; Truax and Carkhuff, 1965 and Volsky, 1965. These studies were all empirically based, Rogers and Dymond assessing the effects of psychotherapy, Cartwright and Vogel administering the TAT to assess whether there was any deterioration in patients when in psychotherapy with inexperienced therapists and Truax and Carkhuff conducting repeated empirical studies of psychotherapy in different settings. These authors found that what happens in psychotherapy is powerful and this can have either beneficial or harmful effects.

Eysenck has also raised the question of how spontaneous remission plays an important role in the improvement of patients in psychotherapy. Bergin and Garfield (1971) found, in their review of Eysenck's studies and their own follow-up of 52 outcome studies, that the spontaneous remission rate is lower than expected and improvement is linked to therapeutic procedures of many different types. Meltzoff (Malan, 1973), concludes that there is little doubt that some patients will improve over time without psychotherapy but clearly many patients benefit from the psychotherapeutic experience. This conclusion is based on Meltzhoff's research of over 100 controlled outcome studies, most of which yielded positive results. Bergin (1966) supports this finding and adds that psychotherapy is more likely to be successful under the right conditions. Lambert and Bergin (1992) discuss how numerous authors have come to the same conclusion that "psychotherapy is effective at helping people achieve their goals and overcome their

psychopathology at a rate that is faster and more substantial than changes that result from the client's natural healing processes and supportive elements in the environment" (p. 363).

Smith, Glass and Miller, 1980, in a study with 475 patients, found that the "average psychotherapy patient is better off than 80% of the untreated sample" (Lambert & Bergin, 1992, p. 364). Smith and Glass (1977) found that the average patient receiving psychotherapy fared better than 75% of the untreated control group. Seligman (1995) studied the results of the 1995 Consumer Reports conducted in America. This questionnaire survey of patients in ongoing psychotherapy found that "of the 246 people who were feeling very poor when they began therapy, 87% were feeling very good, good or at least so-so" (p. 968) at the time of the survey. Overall the survey indicates that people had "fewer symptoms and a better life after therapy than they did before" (p. 974). Results generally support the fact that psychotherapy treatment is considerably more effective than no treatment at all (Luborsky, Singer & Luborsky, 1975; Smith & Glass, 1977; Smith, Glass & Miller, 1980; VandenBos, 1986; VandenBos & Pino, 1980). However, let it not be forgotten that a minority of patients do not improve and some do deteriorate.

Stubbs and Bozarth (1994), in a qualitative study of psychotherapeutic research over four decades (1950 - 1993), found enough evidence to reject Eysenck's findings that psychotherapy is no better than no psychotherapy. Subsequent research has led to an overall rejection of the Eysenck study. Bergin found value in Eysenck's study in that it was a "prime stimulant, if not irritant" (Stubbs & Bozarth, 1994, p. 111) pushing for further research in the field.

In psychotherapy certain specific questions need to be asked when evaluating success. For example, Strupp (1971) suggests that the following need to be explored: Has the patient changed demonstrably over the time in which psychotherapy was conducted ? What is the nature of any change ? Can this change be reasonably attributed to the therapist's interventions ? Is this change lasting so that the effect can be seen at a subsequent follow-up ? Or are changes due to the partnership created between therapist and patient ?

Successful psychotherapy does, therefore, involve change. Garfield (1989), in his research of empirical studies, found that this is not a unitary phenomenon with uniform change but a mixture of positive and negative, overt and covert changes. Patients come to psychotherapy in distress, with a more or less disorganised state of being, and we can assess whether what we have offered them has helped by the change or gain in their behaviour. Thus, successful psychotherapy implies a visible and significant change and not just a belief, on the patient's part, that he has changed (Carkhuff, 1966). Garfield (1989) suggests that successful outcome also means increased understanding about the self and personal difficulties. Good psychotherapy has a wholeness and a continuity that makes it a unique experience for each patient-therapist team. Successful resolution, according to Rice and Greenberg (1984), involves a sense of completion and relief and an implicit sense that something has changed. Rogers (1965), on the basis of his experience as a client-centred psychotherapist as well as empirical studies, views change as having occurred when the patient is able to perceive

himself as a more adequate and worthwhile person. This includes a more realistic appraisal of himself as a whole, his relationships and the environment as well as having learned to place the basis of standards within himself. For Buber (1958), confirmation of the person as a human being, is at the core of healing. This confirmation of self will allow the patient to finally move back into relationship in his whole world.

An important indicator of psychotherapeutic success is the symptomatic relief experienced by patients after the completion of psychotherapy. Battle et al. (1966) view psychotherapeutic success as the removal or relief of psychiatric complaints with no new ones taking their place.

Thus, successful psychotherapy is a change in personality organisation, structure and behaviour for the betterment of the patient, through insight, understanding and awareness, which includes improved functioning and some degree of symptom relief (Rogers, 1965). Hycner (1991) views the goal of dialogal psychotherapy to be "the enhanced relational ability of the client" (p. 4) which is achieved when some restoration of the "atrophied personal center" (Buber, 1958, p. 133) of the patient has been gained.

Many patients evaluate the effectiveness of psychotherapy by the degree of alleviation of the distress associated with their problems and this allows for systematic research of success in psychotherapy to be conducted. However, research into the components that make for successful psychotherapeutic outcome is confounded by the lack of clear definitions and shared fundamental beliefs amongst researchers and psychotherapists (Forsyth & Strong, 1986). The difficulty in applying the answers from efficacy studies to the actual practice of psychotherapy further complicates issues. Seligman (1995) states that experimental research under highly controlled conditions provides very different answers as to what actually occurs in the reality of a psychotherapeutic context and to what is successful in practice in the field.

Research findings must be extrapolated from the data to the real world to be of any use to clinicians in practice. Howard, Moras, Brill, Martinovitch and Lutz (1996) ask three fundamental questions: Does the treatment work under special, experimental conditions ? Does it work in practice, that is, how effective is it ? Is it working for this patient ? Jacobson and Christensen (1996) believe that "single-participant" (p. 1038) designs and qualitative research methods will play a more important role in providing relevant answers to practising clinicians. In order to gain some insight into what makes for successful psychotherapy, the following aspects are explored.

THE PATIENT AS A VARIABLE IN THE PSYCHOTHERAPEUTIC RELATIONSHIP:

As the psychotherapeutic relationship is created by an interaction between the patient and therapist, it is important to explore what factors have traditionally been viewed as positive contributors in terms of the patient. People react differently to the process of psychotherapy with some being able to change and resolve problems. Others may be unable to change and learn from the experience and, for some, their symptomatology may even worsen (Wolberg, 1977). It is, therefore, important to seek common denominators to enhance knowledge and understanding.

Whilst there has been little comparability from study to study and the research on patient variables has produced inconsistent results, some important factors have emerged. The following variables have been identified as being significant to the outcome of psychotherapy.

1. **Initial state of adjustment**.

Luborsky, Chandler, Auerbach, Cohen and Bachrach (1971) and Astrup and Noreik, 1966 (Luborsky et al., 1971), suggest that the patient's initial state of adjustment is the highest predictor of outcome. This is supported by a three to nine year follow-up study of 84 patients conducted by Clementel-Jones, Malan and 77Trauer (1990) where a clear, positive correlation was found between good initial adjustment and successful outcome. Cartwright, 1957, and Kirtner and Cartwright, 1958 (Bergin & Garfield, 1971), found that those patients who perceived themselves as fairly well adjusted at the start of psychotherapy and exhibited a higher level of personality integration tended to find psychotherapy more helpful. Several other empirical studies support this finding that patients who are better adjusted at the beginning of psychotherapy show the greatest improvement (Gelder, Marks & Wolff, 1967; Stone, Frank, Nash & Imber, 1961; Stephens & Astrup, 1965, in Strupp (1971); and Rogers, 1965). Luborksky (1992) avers that the more severe the problems, the more limitations and difficulties there will be in attaining a good outcome for the patient. Many clinicians comment that the most well-adjusted people are given the most intensive treatment whilst the more seriously disturbed are viewed as having a poor prognosis and receive less psychotherapeutic input (Garfield, 1992). So, this view holds that not only does the more seriously disturbed patient have more problems to deal with due to the deeper levels of damage, but he is also less likely to receive the best psychotherapeutic assistance from the therapist.

2. **Patient expectation**.

Carkhuff (1966) agrees that the patient's initial level of functioning is important but contends that his expectations are also critical. Fiske et al. (1970) found positive expectancy to be a necessary condition for psychotherapeutic effectiveness. Bergin and Garfield (1971) cite findings by Frank and his colleagues (Frank, 1959; Frank, Gliedman, Imber, Stone & Nash, 1959; Rosenthal & Frank, 1956) which all point to the fact that the greater the distress and need for help, the greater the expectancy or likelihood of that help being perceived as successful. Bergin and Garfield refer to the findings made by Lennard and Bernstein, 1960, Lipkin, 1954, Goldstein and Shipman, 1961, who all report a positive link between expectancy and perceived symptom reduction. However, this finding should be viewed cautiously as this relationship was curvilinear - patients with very high or very low expectancy showed the smallest symptom reduction.

Perhaps more important is that there is congruence between the patient's and therapist's expectations and this variable has been shown to be consistently related to psychotherapeutic progress (Lennard & Bernstein, 1960; Heine & Trosman 1960, in Strupp (1971); Heine, 1962, in Bergin & Garfield (1971)). But what is it that the patient is expecting from the therapist ? Rogers (1965) says that the patient could expect the therapist to be like a surgeon who will probe deeply, causing pain against his wishes resulting in the patient perceiving the therapist as threatening. Or he could view the

therapist as a father figure or psychotherapy as a place to solve problems and thus have a positive outlook. Clearly the perception and expectancy of the psychotherapy and therapist is of critical importance.

3. **Level of motivation**.

Malan (1973), conducted a study at the Tavistock Clinic in London, where he treated 20 patients with brief psychoanalytic psychotherapy. The study was later replicated with 30 patients and similar findings were made. He found that, of all the selection criteria studied, motivation and a desire for insight were the most important predictors of successful outcome. This finding is also reported by Sifneos (in Malan, 1973); Strupp (1971); Rogers and Dymond (1954); Truax and Carkhuff, 1967; White, Fichtenbaum and Dollard, 1964 (in Strupp, 1971). Sifneos stresses that the patient's motivation ought to be for change within the self rather than simply a motivation for symptom relief as he speculates that this is associated with a good prognosis. Malan (1963) found that a high proportion of patients who experienced psychotherapy as successful had a high level of motivation and those with low motivation had poorer results. Rogers, Gendlin, Kiester and Truax (1976) report finding that the more motivated a patient is, the easier it is for the therapist to become involved in and committed to the relationship. However, Rogers and Dymond (1954) did an extensive study on motivation as a factor in personality change and found that motivation alone is insufficient to bring about this change in the absence of psychotherapy.

4. **Patient involvement in psychotherapy.**

Rice & Greenberg (1984) report that Mathieu-Coughlan and Klein believe that the critical aspect in psychotherapy is what Gendlin describes as the patient's engagement in the process so that the patient has a bodily, felt sense of what is occurring. Without this, the authors state, subsequent steps of struggle, shift or resolution would be both meaningless and impossible. Truax and Carkhuff (1964) found that the greater the degree of patient involvement, the greater the constructive personality change. Involvement includes an ability to be open, rather than defensive. Involvement was found to be the most consistently positive correlate of psychotherapeutic outcome in the Orlinsky and Howard 1986 study of patient variables. Involvement also included the ability for "greater immediacy or affective expression" (Stubbs & Bozarth, 1994, p. 115).

5. **Referral**.

An important factor to consider, primarily because it is linked to motivation, is whether patients refer themselves for psychotherapy or come under duress. One could speculate that if an individual is motivated to seek help voluntarily the prognosis is better as it suggests that the symptoms are egodystonic. Bergin and Garfield (1971) point out that the more egodystonic the symptom, the higher the level of motivation to change.

6. **Age**.

Bergin and Garfield (1971) did not find age to be of any major significance and Seeman, 1954 (Cartwright, 1955), also found no significant association between the age of the patient and the rated success of psychotherapy. Likewise, in a study involving patients between the ages of 21 - 40, Rogers and Dymond (1954) found no correlation between age and movement in psychotherapy. In contrast, Casner (1950)

found a significant difference in improvement and success when patients were under the age of 30. Similarly, Truax and Carkhuff (1964) state that Stone, Frank, Nash and Imber's 1961 study found that younger patients changed more positively.

7. **Gender of patient.**

Rosenbaum, Friedlander and Kaplan (1956) found that a significantly higher number of women than men are in psychotherapy and suggest that this could be because women are more likely to accept the fact that they are suffering from emotional distress. Seeman, 1954 (Cartwright, 1955), and Casner (1950) report finding a significantly higher rate of women being more successful than men in psychotherapy. Rogers and Dymond (1954) also found women to make significantly more progress than men.

8. **Education and socioeconomic status.**

Most studies report a positive relationship between education and length of stay and success in psychotherapy. Bergin and Garfield (1971) point out that educational level is only part of a larger factor that may include verbal ability, sophistication about and interest in psychotherapy, and income. Angus (1992) conducted a retrospective research study with 18 patients on their experience of the effectiveness of psychotherapy with therapists-in-training. A very positive outcome on this factor was expected in this study as the entire sample consisted of students with a minimum of 12 years education. The result of an 89% success rate supported this.

Socioeconomic status is also linked to psychotherapeutic progress in that the Rosenbaum et al. (1956) study found that those patients who were "much improved" following psychotherapy were of a higher social strata. It can be speculated that a high socioeconomic status generally provides an individual with
more opportunities for a higher education level and the other qualities mentioned by Bergin and Garfield (1971) above.

9. **Severity of symptomatology.**

It is generally felt that the less severe the symptomatology and diagnosis, the more chance there is of psychotherapy being successful. Bergin and Garfield (1971) cite many authors to have found less-disturbed patients more likely to respond positively to psychotherapy. Truax and Carkhuff, in their 1967 study, offer the hypothesis that patients who perceive their symptoms as inwardly experienced and not mainly overtly displayed tend to be more in touch with themselves and show the greatest psychotherapeutic improvement. This suggests an ownership of and responsibility for problems by the patient which further enhances growth in psychotherapy. The more egodystonic the symptom the higher the motivation for change is likely to be and this hypothesis has found support from many authors (Bergin & Garfield, 1971). However, Stone et al.'s study found that the patients who evidenced the most difficulties and problems exhibited the greatest positive change after psychotherapy.

10. **Patient's perception of the therapist/perceived similarity to patient**.

The patient's experience of the therapist and his functions are critically important to the psychotherapeutic process. Rippee, Harvey and Parker, 1965, found that the patient's perception of the therapist is influenced directly by what the therapist does in the psychotherapeutic contact (Carkhuff, 1966). Robinson, Redlich and Myers' 1954 study

suggests that a similarity of culture and understanding facilitates psychotherapy and that patient-therapist differences may hamper the development of the psychotherapeutic relationship and thus the effectiveness of psychotherapy (Rosenbaum et al., 1956). This is supported by empirical research conducted by Halpern, 1955; Fiedler and Senior, 1952; Normal, 1953; Notcutt and Silva, 1951; Wolf and Murray, 1937 (in Lesser, 1961), who all note that similarity between the therapist and the patient does have a positive effect on psychotherapeutic outcome. Fiedler and Senior, 1952, point out that the perceived similarity is of more importance than reality as it suggests a positive attitude by the therapist towards the patient indicating that he has connected with and understood the patient's experience (Lesser, 1961). This results in an enhancement of the psychotherapeutic process and creates a deeper, richer understanding. Truax and Carkhuff (1964) state that Stoler, 1963, supports this with his finding that successful patients were those who were more liked by the therapist thus suggesting that this perceived similarity is reciprocal. However, Lesser (1961) cautions that the best results will not be obtained if this similarity is overestimated. Rogers (1965) comments that how the patient perceives the therapist has a significant and profound effect on how much the patient will reveal of himself and the rate of progress in psychotherapy. Lorr, 1965, found a significant relationship between patient improvement and patient perception of the therapist as accepting and understanding (Carkhuff, 1966).

Whilst patient-therapist similarity does seem to be positively correlated with outcome, Bergin and Garfield (1971) caution that no clear conclusions can yet be drawn as more definitive research needs to be done. The Angus (1992) study reveals that, despite 44% of the sample finding the therapist to be dissimilar in attitude, only one subject perceived psychotherapy as a failure. This suggests that, despite perceived dissimilarities, psychotherapy can and does have successful results if other critical variables are present.

11. **Patient satisfaction**.

How the patient perceives psychotherapy and the degree of symptom reduction is critical for rating success. Cartwright (1955) found that those patients who rated themselves as satisfied with psychotherapy had been viewed by the therapist as having achieved success in psychotherapy. Part of the experience of satisfaction is assumed to be the patient's perception of being heard and accepted by the therapist (Rogers, 1965). This experience allows the patient to accept those previously unacceptable aspects of the self.

With the Angus (1992) study revealing that 56% of the patients perceived their own characteristics as hampering the process and outcome of psychotherapy, it is clear that the patient himself is a critical factor in the psychotherapeutic equation. A difficulty in self-disclosure (6%), a fear of their own emotional reaction (11%), of taking risk or of being judged (11%) and of their own self-destructive behaviour and thoughts (11%) were perceived as being the most important patient factors hampering the process and outcome of psychotherapy. Despite this, results indicated that 89% of the subjects assessed psychotherapy as having been successful.

Based on the above findings some assumptions can be posited about the kind of

patient most likely to succeed in psychotherapy. Positive indicators on the part of the patient for successful outcome include: a relatively high level of adjustment, good expectation and motivation and thus involvement in the psychotherapeutic process, middle to upper-class socioeconomic status, at least twelve years of education, being female, self-referral, egodystonic symptoms and some perceived degree of similarity between patient and therapist.

VARIABLES IN THE PSYCHOTHERAPEUTIC RELATIONSHIP

CHAPTER 3 - THE THERAPIST AS A VARIABLE IN THE PSYCHOTHERAPEUTIC RELATIONSHIP

The therapist is an essential element of the psychotherapeutic process which attempts to change the patient for the better. Frank, 1961, states that the therapist is the most important, but least understood, part of the psychotherapeutic equation (Strupp, 1971). Any technique or type of psychotherapy used will necessarily be influenced by the personality of the therapist (Bergin & Garfield, 1971). Thus, it is important to consider what and how the therapist contributes towards the psychotherapeutic encounter, process and any change in the patient. Obviously this will differ for each patient with whom the therapist interacts.

Although the therapist can exert a positive influence on the psychotherapeutic relationship, one must realistically accept that the therapist may also cause harm. This is highlighted by Grunebaum's 1985 study in which 10% of mental health professionals reported being harmed in their own psychotherapy experiences (Lambert and Bergin, 1992). Lambert and Bergin accurately point out that some patients are worse after psychotherapy than before treatment started. However, this is not necessarily the result of a failure in the psychotherapeutic process or on the part of the therapist. The patient may be in the process of a general decline that few interventions could prevent. Other patients may experience external life traumas which exacerbate the current problems being explored. Lambert and Bergin report that research indicates a variety of reasons for negative outcomes in psychotherapy. These include external events, patient characteristics, therapy interventions and therapist attitudes. However, the therapist still has an enormous responsibility towards the patient which must never be under-estimated. There is an awareness of all who work in the field of the unprofessionality of certain colleagues who abuse their trust and harm patients. It is sadly a phenomenon that should be reported more often to protect both the patients in question as well as the name of the profession.

Despite the fact that a minority of patients experience the therapist in a negative manner, Luborsky found strong evidence that therapists contribute positively to successful outcome (Bordin, 1986). Strupp (1971) indicated that there are specific skills that the therapist has which enhance growth in the patient. Dialogal psychotherapy views the therapist as the "steward of the dialogal" (Hycner, 1991, p. 48) and a fully participating partner in the psychotherapeutic relationship. Despite the uniqueness of each therapist, it is possible to identify certain therapist variables which cut across theoretical approach and affect both the process and outcome of psychotherapy. These include both personality characteristics and skills.

1. **Accurate empathy, non-possessive warmth, genuineness/authenticity.**
Rogers (1954) contends that there are three essential behaviours necessary for the therapist to provide a climate in which the patient is able to explore, grow and change. These are: accurate empathy, non-possessive warmth and genuineness. He stated that these conditions were necessary and sufficient for successful outcome. Bergin and Garfield (1971) and Truax and Carkhuff (1964) aver that virtually all phenomenologically

oriented as well as most behaviouristically oriented therapists have agreed to the clinical importance of these three. Lambert and Bergin (1992), however, assert that there is a limit to how much these characteristics affect the process "casting doubt on the accuracy of Carl Roger's bold attempt at specifying the necessary and sufficient conditions for positive personality change" (p. 373). Stubbs and Bozarth (1994) found that despite four decades of research including these factors, Rogers' statement has not been adequately tested. Whether the conditions are sufficient remains a question but it appears that most authors would agree that they are important or at least facilitative. These three basic characteristics will be dealt with together.

Whitehorn and Betz, 1954, and Rogers, 1954, were the pioneers in the study of the role that these factors play in facilitating positive psychotherapeutic change (Bergin & Garfield, 1971). Whitehorn and Betz found a significant improvement of 75% compared to 27% in patients whose psychiatrists showed these qualities despite the fact that they had all had the same training. This is supported by findings made by Rogers, 1962; Truax, 1963; and Gendlin and Kiesler, 1967, in studies conducted over a 5 year period (1962 - 1967) and again in follow-up studies done in 1969 by Truax as well as Horowitz and Tausch and his colleagues (Bergin & Garfield, 1971). Truax and Carkhuff (1964) found that the absence of these factors tends to be followed by deterioration in the patient's psychological state.

1.1 **Accurate empathy**.

Greenson states that empathy is a "partial and temporary identification with the patient" (Friedman, 1985, p. 196) and it requires the therapist to become one with the person he is listening to. Empathy implies a willingness for the therapist to become emotionally involved by feeling "oneself in the client through giving up the ground of one's concreteness" (p. 197) but never losing one's own identity and experiencing of the moment. Wolberg (1954) suggests that an optimal amount of tension between being the therapist and being in the patient's world of experiencing is necessary for psychotherapy to progress successfully. Thus, the degree of empathy shown needs to be carefully balanced.

Despite the distinct and positive advantages of self-exploration and growth which may result when a psychotherapist is empathic, it has been found that too much direct expression of accurate empathy too early in the psychotherapeutic relationship may be deleterious (Truax & Carkhuff, 1964).

With deeply disturbed patients, Prouty (1994) believes that empathy should be focused on the patient's efforts to communicate and on the "lived experience of the psychosis itself" (p. 50). In order to enter the experienced world of the patient, the therapist needs to be empathic.

1.2 **Non-possessive warmth**.

Bergin and Garfield (1971) discuss two important studies on this factor conducted in 1969. Wyrick and Mitchell conducted an empirical study on the effectiveness of 40 undergraduate student counsellors. Wagner and Mitchell studied the effects of 316 students' perceptions of their 29 instructors' levels of accurate empathy, warmth and genuineness on the students final examination scores. These authors found a

significant correlation between therapist/instructor warmth and the patients'/students' perceptions of the therapist or instructor's effectiveness. In fact, patients seen by therapists who were low on these skills exhibited deterioration in personality and behavioural functioning. Whitehorn and Betz, 1954, conducted a retrospective study of seven psychiatrists who had achieved a 75% improvement rate in their schizophrenic patients (Truax & Carkhuff, 1964). The successful psychiatrists were perceived as warm people who attempted to understand the patient in a personal, immediate and individual way. Whitehorn and Betz thus found non-possessive warmth to be positively correlated with constructive personality change. These findings suggest that non-possessive warmth has a significant effect on the final outcome in psychotherapy.

1.3 **Genuineness/authenticity**.

In the dialogal approach, being genuine means meeting the other as oneself, as a whole human being, but not necessarily divulging personal information. Thus, one's therapeutic identity is defined by one's personal identity (Eckler-Hart, 1987). Eckler-Hart studied 15 doctoral students in clinical psychology who described their experiences of learning and the development of their identities as therapists. The therapists discovered that the professional identity or False Self they developed offered security, but limited their own sense of aliveness and genuineness in the psychotherapeutic encounter. It created a distance which led to an "undermining of intimacy" (p. 609) and trust. It was recognised that one needed an "emotional body sense of being with the client. And you have to use your whole self" (p. 690).

Truax and Carkhuff (1964) found that a lack of genuineness, on the therapist's part, actually limited self-exploration. Genuineness includes the ability to be open, real, spontaneous and involved as a whole human being in the relationship. Rogers et al. (1976) state that the realness of the therapist allows the patient to express his real feelings without fear which allows for exploration and growth. Buber (1958) believes a genuine meeting can only occur when the person (therapist) attempts to meet the other as a 'Thou'. That is, there must be a genuine interest in the patient as a valuable, separate and unique person. Without this attitude, the patient will only be viewed as an object or 'It', something to study and fix. Being genuine and authentic as a therapist allows the patient to reciprocate and be open in return. Buber views help without genuineness as being like an attempt to practice magic. There has to be a real meeting otherwise a "false dialogue" or "monologue disguised as a dialogue" is created (Friedman 1960, p. 123).

The above three qualities are important for a trusting and open rapport which is essential in allowing the patient to drop his defences, gain insight and move towards the freedom of being himself. Rogers et al. (1976), in an empirical study of schizophrenic patients in psychotherapy, found the group showing the "greatest openness to experience, the greatest spontaneity, the greatest capacity for communicating themselves" (p. 85) was the group which had been exposed to "the highest level of therapeutic conditions" (p. 85). These qualities profoundly affected the level to which the patient was able to explore and experience himself. This study thus supported the findings that these three qualities are positively associated with improved psychotherapeutic involvement and change in the patient but could not prove the hypothesis that these qualities were sufficient conditions for change.

2. **Gender of therapist**.

In the Wyrick and Mitchell study discussed above, gender differences were found to be of some importance. There was a significantly high correlation between accurate empathy and the female patients' perception of female therapist effectiveness suggesting that gender-similarity played a role there. Cartwright (1955) speculates though, that patients progress better in psychotherapy with a therapist of the opposite gender which implies that successful psychotherapy depends, to some extent, on the establishment of a satisfactory heterosexual relationship. In only one instance, in the Angus (1992) study, was the gender of the therapist viewed as negatively affecting disclosure but the final outcome was still viewed as a success and there was a statistically significant reduction in the client's symptomatology. This indicates that, although at times it is difficult for a client to disclose freely with an opposite-gender therapist, the overall result can be positive. One could speculate that the nature of the problem being dealt with plays a role and perceived therapist-patient congruence is more critical for self-disclosure and effective psychotherapy to occur.

3. **The therapist's experience**.

Garfield (1992) states that psychotherapy is "a complex, interpersonal process that requires both personal qualities and a high level of skill" (p. 344). Joslin, 1965, (in Carkhuff, 1966) and findings by Grigg (in Truax & Carkhuff, 1964), based on patient-assessment in a study of 249 patients, found no relationship between the level of the therapist's experience and positive outcome. In that particular setting, the therapists did not seem to have benefitted from the training thus far obtained. The patients found the inexperienced therapist to be more prone to being active and giving advice but this did not adversely affect the perceived success of the psychotherapeutic experience. In contrast, Bergin and Garfield (1971) found that more experienced therapists were more successful than inexperienced therapists. The study also indicates that many of the patients in psychotherapy with inexperienced therapists were making little progress or even deteriorating. Studies by Fiedler, 1950; Bradley and Stern, 1965 and Fretz, 1965 support the above findings that inexperienced therapists may be less effective (Carkhuff, 1966).

Strupp (1986) provides an excellent analogy to describe the skill of the therapist when he states that "it is largely meaningless to examine the surgeon's scalpel to discover why a particular operation is successful, but one may learn a great deal by focusing on the manner in which the surgeon ... employs it" (p. 125). Strupp considers the therapist's skill to include the ability to resist participating in the patient's dysfunctional ways of communicating and relating thus providing him with a new experience. The therapist provides role modelling of "reality and adult behaviour" (p. 126) which fosters exploration and deeper understanding of the dysfunctional thoughts and behaviour. Thus, the therapist's level of competence is important and is shown by the ability to foster a new way of being within the interpersonal relationship.

Fiedler, 1950, in studying the characteristics that make an ideal psychotherapeutic relationship, found that experts created relationships significantly closer to the ideal than non-experts and were better able to maintain an appropriate emotional distance (Rogers, 1965). However, both Malan (1963) and Strupp (1971) found that neophyte therapists are often more successful due to their energy and enthusiasm despite

missing valuable clues.

Although only 67% of the patient sample in the Angus (1992) study perceived the therapist as having sufficient experience, of the 22% who did not, only one subject perceived psychotherapy as having totally failed. Despite not being perceived as having sufficient experience 11% found the therapist to be very high on positive qualities and psychotherapy to be a success. The other 11% found the therapist critical, unaccepting, bored, withdrawn and insensitive. Notwithstanding this, one of these subjects still found a significant level of symptom relief despite not viewing psychotherapy as successful overall. This suggests that neophyte therapists are often capable of providing a sound and safe psychotherapeutic environment in which patients can heal.

Hycner (1991) points out the need for the therapist to be practical and philosophical, to deal with specific issues and yet retain a grasp of the bigger picture. He is also required to distinguish between pathological behaviour and what is a consequence of the personality characteristics which an individual is born with and the circumstances of life he is unable to avoid. This requires flexibility which can only be attained with experience. Friedman (1985) points out that the therapist "has no monopoly on reality" (p. 216) but he brings more experience to the relationship of "inclusion, in imagining the real, in experiencing the other side of the relationship as well as his own, in seeing through the other's eyes as well as through his own" (p. 216).

Overall, the literature supports the theory that the more experienced the therapist is, the better the psychotherapy will be and the more successful the outcome.

4. **Theory and knowledge**.

This is obviously important for the understanding of pathology and health. Theory is essential but can interfere with the genuine encounter between therapist and patient. What is most important is to view the patient as a person first with knowledge and theory in the background. Hycner (1991) suggests this delicate balance is critical for the quality of the relationship that is established.

Gendlin (1974) warns of the harmful uses of knowledge and theory when therapists use theory rigidly without viewing the individual as a whole, unique, feeling being. There is then a tendency "to turn the persons we work with into knowledge" (p. 270). Buber states that the therapist's task is to be "the watcher and healer of sick souls" and the therapist "again and again confronts the naked abyss of man, man's abysmal lability" (Hycner, 1991, p. 22). Buber understands the therapist's desire to use theory and objectification to control the situation but warns of the dangers of making the other into an 'It' in the process.

It is, therefore, extremely important to use knowledge and theory to provide guidelines and to deepen our understanding of the patient's world. Lawner (1981) is of the opinion that it is our "training and self-understanding" that are the "only things that keep us from often removing ourselves from the process of being overwhelmed" (p. 311) by the psychotherapeutic process. But, this must never result in a disruption of the story unfolding. And no method can teach the therapist to meet the other in a genuine, authentic encounter. Buber, 1976, states that theory is only an entry point and that the

therapist is always responding to the individual in that unique moment (Hycner, 1991).

5. **Therapist's ability to listen**.
Listening is a skill which requires attention and concentration to both the spoken and unspoken communication and is a basic component of psychotherapy (Garfield, 1989). The better the listening is, the greater the understanding of the problem will be which provides a more meaningful experience for the patient. Garfield believes that good listening allows the therapist to understand the patient's internal frame of reference with greater clarity. Mathieu-Coughlan and Klein, 1984, feel that good listening also facilitates focusing (Rice & Greenberg, 1984). This suggests that if the therapist is sensitive to what the patient is trying to communicate the chances of successful outcome are enhanced. Boelen (1963) defines authentic listening as being an openness where "only he who wonders can truly listen" (p. 93). Farber, 1976, describes Buber's approach to listening as "the ability to attend imaginatively to another's language" ((Friedman, 1985, p. 81). Chessik (1996) believes that this requires tolerance, flexibility and a certain maturity to achieve. Rogers (1973) recounts how he followed a patient's need in psychotherapy and simply listened rather than trying to fit a diagnosis. He describes the psychotherapeutic relationship as being a "far more personal relationship" (p. 9) which had good results.

Listening becomes more critical when the therapist is lost in the darkness of the unknown or what Van den Berg (1972) refers to as the "not-knowing" (p. 118). Shainberg (1983) advises the therapist to focus on "listening and attending to what he saw" (p. 166) in the psychotherapy thus encouraging the therapist to experience the felt-sense and be with the patient without the need to do something. Chessik (1995) supports the dialogal concept of the therapist bracketing his own ideas/ formulations to hear the patient. Chessik states that this is difficult as it contradicts the therapist's tendency to create a "neat, consistent, and holistic theoretical explanation ... even if it is wrong" (p. 597).

Rogers (1973) gives a pertinent quote from Lao-Tse which highlights this need to listen and hear to shift the process.
"It is as though he listened
and such listening as his enfolds us in a silence
in which at last we begin to hear
what we are meant to be" (p. 12).

6. **Therapist expectations**.
Generally, findings suggest that therapists prefer patients who are not too severely disturbed as the more emotionally balanced patient is usually more sensitive, intelligent and willing to talk about himself (Truax & Carkhuff, 1964; Bergin & Garfield, 1971). Truax and Carkhuff (1964) also found that therapists tend to regard symptomatic relief and improvement in social relationships as indicative of successful outcome whilst the patients assessed their own levels of self-understanding and confidence.

7. **Patient attractiveness**.
Strupp (1971) supports the belief that the therapist's personal reaction to the patient may influence the outcome of psychotherapy and Nash et al., 1965; Heller and

Goldstein, 1961, report outcomes favouring attractive patients (Strupp, 1971). Strupp and Williams, 1960 (Strupp, 1971), found that, despite contradictions, a favourable prognosis is generally predicted for more likeable patients. Barbara Sullivan (1989) believes that it is not possible to provide a healing environment for someone one does not like as it is the therapist's love/liking that allows the patient to achieve inner emotional healing.

8. **General personality characteristics**.
Holt and Luborsky, 1958, view a successful therapist as being one who is genuine, socially adjusted with his co-workers, free from status-mindedness, able to obtain self-objectification, has adequate emotional control and the ability to display warmth, acceptance, spontaneity and empathy (Strupp, 1971). Langs (1989) also stresses the importance of neutrality and relative anonymity. Truax and Mitchell's 1971 literature review confirms that the personality of the therapist is more important than his techniques (Stubbs & Bozarth, 1994).

9. **Therapist attitudes**.
Strupp (1986) stresses the importance of both the therapist's verbal and non-verbal behaviour which must be experienced as meaningful to the patient. Therapist attitudes include both attitudes towards the patient and towards the self. Ingham and Love (1954) state that the primary function of the therapist is to promote attitudes in the patient that are favourable to psychological progress. This can be done by encouraging the patient to approach his own difficulties with a healthy attitude of tolerance, objectivity and sincerity. To do this the therapist must display respect for the patient so that he perceives himself as an intrinsically likeable and worthwhile person (Ingham & Love, 1954; Rogers, 1965). This respect includes an honesty in dealing with the patient (Ingham & Love, 1954).

Another important dimension is the degree of authoritarianism shown by the therapist as the amount of control the therapist exercises has a powerful effect on the psychotherapeutic outcome. A healthy balance of control and permissiveness allows the patient to work at his own pace and in his own direction whilst still affording the therapist the chance to gain information and guide the patient. The exact balance is unique to each psychotherapeutic alliance.

Wolberg (1977) states that the therapist's attitude must inspire hope, faith, trust, liking and a freedom to respond in the patient. Ingham and Love (1954) believe that the therapist ought to maintain a sufficient degree of psychological comfort about his role and level of competence and have a tolerance for his own errors. This involves an optimum tension between complacency about his own competence and a feeling of adequacy to do the job. An openness to his own fallibility and the honesty to accept and learn from errors is critical. Winnicott (1977) stresses the need for the therapist to be receptive. In being an alive and perceptive presence, with the ability to play, the therapist offers a rich psychotherapeutic environment for exploration. In fact, Stone emphasises that failure to show a reasonable human response at appropriate times can invalidate the patient work done in good psychotherapy (Friedman, 1985).

Stubbs and Bozarth (1994) refer to Lambert, Shapiro and Bergin's 1986 study which

supports the findings that the therapist's attitudes form a vitally important part of the psychotherapeutic outcome. They add that techniques are not irrelevant but that their "power for change is limited when compared with personal influence" (p. 112). Sloane, Staples, Cristol, Yorkston and Whipple, 1975, found the following factors to be very important for the patient in successful outcome for 70% of their sample: the personality of the therapist, the therapist helping them to understand problems, encouragement from the therapist to gradually practice facing the issues that bothered them, being able to talk to an understanding person and the therapist's helping them to a greater self-understanding (Arkowitz, 1992).

The dialogal view is that the therapist must recognise that psychotherapy does involve paradox, conflict and opposing qualities and he should strive to integrate them. Hycner (1991) views health as an "ever elusive rhythmic balance of separateness and relatedness" (p. 9). This requires the therapist to become involved and fully present in the process and yet maintain an objectivity in order to understand the process unfolding. Buber (1965) describes this as a "detached presence" (p. 71). The therapist must have the ability to understand the patient's experience and yet also be aware of what this raises within himself. The therapist must also be alert to what is occurring in the psychotherapeutic space between himself and the patient and what and how each person is contributing to the process. Finally, the therapist must recognise that the relationship created is greater than the separate aspects which each has contributed. Thus, the therapist is required to flow with the patient in a never-ending dance of separateness and relatedness, providing a balance in the psychotherapeutic relationship. For example, if the patient is being too intellectual, the therapist needs to guide the patient gently into feeling emotions and being more connected with his body.

10. **The therapist's self**.

Eckler-Hart (1987) explores the therapist's sense of self in a study based on Winnicott's True and False Self concepts. In this article he describes how the training therapist forms a "psychotherapeutic false self" or "professional identity" (p. 683) in order to protect himself from the demands made on his own psyche. He stresses the importance of the therapist being open, creative, spontaneous and giving of his whole self in a deep relationship with the patient. Winnicott maintains that this can only occur when the real, authentic core of the self (True Self) is allowed to communicate with the patient. However, this very openness is threatening to the vulnerable core of the therapist who may then resort to the mask of the False Self or professional identity to protect himself. May (1958) comments that therapists can protect themselves by resorting to technique or give theoretical explanations to distance themselves from the vulnerable situation. It is critical for the therapist to attain and maintain a balance between being too exposed and vulnerable and yet being present in an authentic manner in the relationship.

This is of vital importance as Hycner (1991) states that the therapist's theoretical orientation is not the major factor in success or healing but the "wholeness and availability of the self of the therapist" (p. 15). Ultimately it is the therapist's whole self which must be fully present. By being fully present in the psychotherapy, the therapist is already providing the basis for a deep, respectful, sound and solid psychotherapeutic relationship in which to begin healing. Being fully present allows the therapist to

experience the patient's world more deeply and thus with more understanding. May (1958) in describing presence states that "the relationship of the therapist and patient is taken as a real one, the therapist being not merely a shadowy reflector but an alive human being who happens, at that hour, to be concerned not with his own problems but with understanding and experiencing so far as possible the being of the patient" (p. 80). So, presence is not simply a sentimental attitude but how the therapist views human beings. This means that the therapist does not impose his ideas and feelings on the patient but follows the patient's lead and feelings. One may be present even in silence.

It is difficult to create a balance between being a genuine and authentic human being in the encounter and not being drawn into the whirlpool of emotions and chaos that will result in the therapist becoming as chaotic as the patient. This does not, however, preclude the therapist from feeling lost in the unknown at times (Lawner, 1981). Lawner supports Eckler-Hart and May's views and affirms that when the anxiety and vulnerability of being in the unknown is strong, the tendency is for the therapist to allow the False Self to step in and protect - but this can be at a cost to the psychotherapeutic encounter. Lawner (1981) thus warns the therapist to "avoid trying to create light where none exists" (p. 307) but to learn the value of simply waiting and being with the patient.

Trüb, 1947/1964, speaks of the overall role of the therapist as embodying a real person and being an example of the broader relationships the patient will experience in his world (Hycner, 1991).

11. **Confidentiality**.

Langs (1989) stresses the importance of confidentiality. If a patient in any way feels that this factor is not very high on the list of the therapist's priorities there will be little trust and a psychotherapeutic alliance will be difficult, if not impossible to form.

Overall, Angus (1992) found that the positive qualities in the therapist as assessed by the patient, clearly indicated that the therapists provided a climate where the patient felt heard, liked, accepted and cared for. The therapists themselves were generally perceived as interested, empathic, genuine and sensitive. Factors which were perceived as leading to improvement in outcome were mainly qualities of the therapist which created a psychotherapeutic space, insight, attitude change and a belief in the self for the patient. Self-disclosure was inhibited, to some degree, for 33% of the subjects by the therapist. For example, the therapist's silence, non-involvement, lack of challenging, lack of focus on present issues and lack of self-disclosure inhibited the patient's self-disclosure. These reasons were seen as factors which hampered psychotherapy and it was felt that their presence would have facilitated progress. On the whole, successful outcome was largely attributed to therapist qualities. It can be concluded, therefore, that the personality characteristics and skills of the therapist are critically important and can positively or negatively affect outcome. Friedman (1985) wisely cautions us not to turn "healing through meeting into injury through mismeeting" (p. 191). Perhaps the dictum 'primum non nocere' is the most essential baseline for any therapist to adhere to.

Basically the therapist's personality is more important than any technique he uses. But, valuable techniques in the hands of an empathic, warm and genuine therapist, are of

inestimable value in assisting the patient to view himself more objectively and accept all those elements which make up the whole person.

In conclusion, despite divergent viewpoints, most authors agree that there are basic characteristics that are shared by effective therapists. Bergin and Garfield (1971) give the following breakdown: "(1) an effective therapist is nonphony, nondefensive and authentic or genuine in his therapeutic encounter; (2) an effective therapist is able to provide a nonthreatening, safe, trusting, or secure atmosphere through his own acceptance, positive regard, love, valuing or nonpossessive warmth, for the client; (3) an effective therapist is able to understand, 'be with', 'grasp the meaning of', or have a high degree of accurate empathic understanding of the client on a moment-by-moment basis" (p. 302).

CHAPTER 4 - THE SITUATION AS A VARIABLE IN THE PSYCHOTHERAPEUTIC RELATIONSHIP

There is considerably less literature available dealing with the importance of the contextual or situational variables which play a critical role in defining the psychotherapeutic milieu. Patients respond not only to the therapist but to the physical and psychotherapeutic conditions surrounding them which have a definite effect on the outcome (Goldstein, 1971). Garfield (1992) stresses the importance of situational variables in affecting the patient's process in psychotherapy. Goldstein (1971) defines situational variables as "all those events occurring around an individual which are not a property of the individual himself" (p. 61).

1. **Length of psychotherapy**.

Seligman (1995) discusses the findings of the 1995 Consumer Reports study conducted in the United States of America. This study found that long-term psychotherapy resulted in more improvement than short-term therapy. The major general findings are that a moderate length of time is most productive, that is, approximately six months of weekly psychotherapy (Lambert & Bergin, 1992).

Kirtner, Cartwright, Robertson and Fiske (1961) found that the correlation between length of time in psychotherapy and measures of change in personal integration was not significant. However, Malan (1973), in his study of successful cases, comes to the conclusion that considerable change is generally obtained in 10 - 50 sessions and this is supported by the brief-term psychotherapy done by Sifneos, 1981, and Mann, 1981 (Ursano & Hales, 1986). Clementel-Jones et al. (1990) conducted a three to nine year follow-up study on 84 patients who had been treated with individual psychotherapy at the Tavistock Clinic. The findings reveal that people with poor adjustment, severe pathology and a disturbed childhood, gained some success in 40 sessions. The best results were seldom obtained in less than 60 sessions. Contrary to this, Muench, 1965, found that time-limited and short-term psychotherapy was more effective than long-term and Truax, Carkhuff and Kodman, 1965, support the fact that time-limited psychotherapy is effective (Carkhuff, 1966). McNair, Lorr, Young, Roth and Boyd's (1964) results indicate that the extent of improvement is linked to the length of psychotherapy which was a minimum of four months in that study. Rogers and Dymond (1954) support this with their view that, with more than 20 sessions, there is a considerable assurance of psychotherapeutic gain.

Perhaps it is impossible to view length of psychotherapy as a variable without taking into consideration the important factors of the initial degree of integration and level of symptom distress. Kirtner and Cartwright (1958) found a significant relationship between the personality structure of the patient at the beginning of psychotherapy and the effectiveness as measured by the length of psychotherapy. Malan, 1975; Mann, 1981; and Sifneos, 1981, all agree that a higher degree of integration and motivation is necessary for brief psychotherapy to be successful (Ursano & Hales, 1986). Cartwright (1955) also believes that the type of problem to be dealt with is important. He maintains that there is a difference between patients with mainly situational

problems and ones with personal adjustment problems. Longer-term psychotherapy is deemed to be necessary in the latter instances.

Kirtner and Cartwright (1958) and Cartwright (1955) speak of a "failure-zone" which falls roughly between 13 - 20 sessions and both found that outcome was more successful if the length of psychotherapy was on either side of these figures. This suggests that if it is not possible to solve the problem within the short-term period, it tends to require longer-term psychotherapy to resolve the issues.

There is little literature that specifically speculates about the success and power of long-term psychotherapy. Qualitative studies would be useful indicators in this respect. In the Angus (1992) study, the average number of sessions was 23. The 89% successful outcome rate supported the findings that short-term, in-depth psychotherapy can be extremely effective with relatively well-adjusted patients. However, 28% of the patients stated that they would have preferred more time in psychotherapy and felt that issues could have been explored in greater depth, more effectively, given a longer time span.

Spontaneous remission also confounds the issue. Rogers and Dymond (1954) state that spontaneous remission is so commonly observed that its existence can hardly be doubted. Fiske et al. (1970) argue that its effects can be considerable. However, Bergin and Garfield (1971) maintain that studies show that there is something unique about psychotherapy which causes improvement beyond the effects of spontaneous remission. Bergin and Garfield (1971), as stated earlier, found that the spontaneous remission rate is lower than expected. Although this may be a factor, it is evident that there can be deeper and more meaningful exploration and thus more possibility for growth in long-term psychotherapy.

2. **Type of psychotherapy.**

While it is safe to argue that each school of thought probably considers its own style of psychotherapy to be the most efficacious, studies suggest that there is little proof that any one method is the best. The proliferation of therapies available today confuses the issue. Arkowitz (1992) and, more recently, Kazdin, 1986 (Garfield, 1992), state that there are about 400 different techniques or therapies available today.

Much of the literature indicates that no specific type of psychotherapy is better than any other. Subsequent to Eysenck's 1952 study, much research has been conducted to test his findings. Most researchers have disagreed with his results. Strupp and Howard (1992) quote studies by Howard, Kupta, Krause and Orlinsky, 1986, and McNeilly and Howard, 1991, which reveal that Eysenck's study in fact showed that 67% of people who did seek psychotherapy improved within two months. This was a clear indication that psychotherapy did have some success. Bergin, 1971, in reviewing Eysenck's results found that if the number of patients who dropped out of psychotherapy were excluded from Eysenck's results, the improvement rate jumped to 91% (Wolberg, 1977). This suggests that motivation is a key to successful psychotherapy and that those who stay in psychotherapy have more chance of improving than those who drop out early, rather than indicating that any one type of psychotherapy is superior or more effective than any other. This statement is supported by the findings of Cartwright, 1966; Heine, 1953 (Luborsky et al., 1971); Wolberg (1977); Smith and Glass (1977) and

Bordin (1986). Bergin and Garfield (1971) further support this view with their findings of the outcome of 52 studies as a function of the nature of the psychotherapy. These authors found that the type of psychotherapy appeared unrelated to outcome. Bergin and Garfield also studied the reports of the results of psychotherapy on 8,053 patients from psychoanalytic and eclectic schools ranging over a 30 year period from 1920 - 1951. The findings highlight that each type of psychotherapy has both its successes and failures and no single type of psychotherapy was found to be more successful than any other. This is supported by Arkowitz (1992) who declares that there is little evidence that any of the over 400 different psychotherapy approaches is more effective than any other. One can rather ask whether the particular patient's condition will respond to a particular type of psychotherapy and assess whether it does work for that patient. And under what circumstances is a particular technique or particular kind of therapist suitable ?

One could speculate that the process determines the outcome and the type of problem being treated plays an important role in what type of psychotherapy would be most beneficial. Garfield (1992) asks the pertinent question of whether the psychotherapeutic approach is more important that the overall therapeutic skill of specific therapists. Although research on this question is limited, this paper argues that, regardless of the type of psychotherapy, healing is possible if the dialogal approach of 'healing through meeting' is provided by the therapist as a base within the context of the psychotherapeutic relationship.

Lazarus, 1977, wisely states that he would like to see "an advancement in psychological knowledge, an advancement in the understanding of human interaction, in the alleviation of suffering, in the know-how of therapeutic intervention" (p. 993) rather than further research of types of psychotherapy (Goldfried, 1980).

3. **Tape recorded sessions**.

Psychotherapy sessions can be tape-recorded by therapists to ensure an accurate chronicle of the session or for learning purposes in supervision. The question is whether the patient is adversely affected by being tape recorded or not. Roberts and Benzaglia, 1965, found that patients made more positive self-references when they knew they were being recorded and more unfavourable self-references when not being recorded (Carkhuff, 1966). An interesting factor here is that tape recording also affected the therapists who were less patient-centred when aware of being recorded. In the Angus (1992) study, 33% of the sample were inhibited by being tape-recorded. So, although there is value in having an accurate recording of a session, this factor can interfere with the psychotherapeutic process.

4. **Setting and atmosphere**.

Despite the importance of the physical setting in which psychotherapy takes place, little research has been conducted concerning this variable. The perceived comfort, atmosphere, noise level and privacy can either positively or negatively impact on the psychotherapeutic process and more research on the result of these factors is needed. Goldstein (1971) writes of the profound effect that these variables have on psychotherapeutic outcome but does little to identify specific factors. The Angus (1992) study revealed some of the negative effects of the setting. For example, the room was

experienced as uncomfortable or too noisy by 22% of the sample and this adversely affected self-disclosure. Langs (1989) believes that, unconsciously, the setting in which psychotherapy is conducted becomes part of the psychotherapeutic experience. He suggests that the setting should, ideally, be private, comfortable, soundproof, have a separate entrance and exit and be tastefully furnished.

An ideal setting combined with good initial interaction provides a secure frame for the psychotherapy to unfold in and defines the roles of both therapist and patient (Langs, 1989). Again, it is less the situation itself that is of importance than how it is perceived that affects outcome.

5. **Patient's cultural setting.**

An important facet of outcome is the existing cultural milieu from which the patient comes and will be returning to. Wolberg (1977) comments on how the patient's prevailing lifestyle can either neutralise any success gained in psychotherapy or encourage success by rewarding healthy behaviour. Phenomenology's whole approach to the patient is based on the fact that he exists as a human being in relationship to his world. Thus, the context of the patient's background, family and culture are critically important.

6. **Payment of fees**.

This is usually considered to be an important part of the psychotherapeutic process as it frequently reveals negative transference issues (Langs, 1989). For example, is the patient perceiving psychotherapy as a right for which he ought not to pay? Langs (1989) believes that paying a fee implies that both therapist and patient accept responsibility for being present at the sessions. If fees are paid by a third party this can introduce the third party into the psychotherapeutic alliance and have a negative effect. The ideal is for the patient to pay himself. The general consensus (Rosenbaum et al., 1956) is that paying patients are better motivated. In their study, Rosenbaum et al. found that there were a significantly higher proportion of paying patients in the group which showed greater improvement. They point out that fees were based on the patient's income so that the association may have been between financial security and successful outcome.

The above variables can have a subtle, yet profound effect on psychotherapy. Many of these factors are, however, largely ignored by therapists in the field. It is, therefore, important that therapists become more aware of these factors and incorporate the value gained from research into their practices on a daily basis.

CHAPTER 5 - THE PSYCHOTHERAPEUTIC RELATIONSHIP

Having discussed the variables which contribute to the psychotherapeutic relationship, this chapter explores the meaning and value of this relationship in the healing of the patient. This factor will be explored further in chapter 8.

The psychotherapeutic alliance is an interpersonal relationship involving two people with the aim of producing change in the one (the patient) through interaction with the other (the therapist) (Conrad, 1952). Any success or failure may be interpreted in the light of this mutual interaction. Each psychotherapeutic relationship is unique due to the inherent variability in both patient and therapist. Bugental, 1987, describes the psychotherapeutic relationship as "the powerful joining of forces which energizes and supports the long, difficult, and frequently painful work of life-changing psychotherapy" (Clarkson, 1990, p. 150).

The psychotherapeutic relationship is viewed as one whole unit. Jaspers (1963) stresses that the whole comes before its parts, it is not the sum of its parts but greater than and different from them. The whole cannot be grasped from its elements alone as the whole can exist even when parts are lost. The whole must rather be understood as a combination of its parts and the parts as being integral aspects of the whole. There is always a mutual interplay of parts and wholes which creates a constant movement in the ongoing process of psychotherapy. This is an important view as, although the characteristics that contribute to this relationship have been discussed as separate entities, the combination of these characteristics creates a new and unique entity. The psychotherapeutic relationship takes on a life of its own and is always in a state of growth and change. As the patient is affected and changes, so too is the therapist in a constant dance of creativity and growth.

Luborsky (1992) stresses the psychotherapeutic relationship as being an important factor in influencing outcome and Lambert and Bergin (1992) state that "relationship factors predict, if not cause, outcome" (p. 373). Glass and Arnkoff (1988), in a study of 76 patients' evaluations of change in psychotherapy, found that interpersonal and therapist interaction factors were very important. These authours cite Cross et al., 1982; Marcovitz and Smith, 1983, and Strupp et al., 1964/1969 as having similar findings. Stubbs and Bozarth (1994) state that Lambert's 1986 findings support the view that patients consider relationship variables as being closely related to successful outcome and that therapist variables are "fundamental in the formation of a working alliance" (p. 114). Lambert, Shapiro and Bergin, 1986, conclude that the psychotherapeutic relationship is "critical" (p. 113) as it provides a safe milieu in which the patient may heal (Stubbs & Bozarth, 1994). Thus, it is suggested that the most important factor in healing the patient is the psychotherapeutic relationship.

Prouty (1994) claims that certain pre-conditions are necessary in order to form a psychotherapeutic relationship. The basic one is "psychological contact" (p. 37) which requires the therapist to meet the patient at the most basic levels of his experiencing and give him respect, space and time to emerge and unfold his story. Clarkson (1990) reinforces this belief when he speaks of the fundamental importance of establishing a relationship with the patient who has lost his sense of inter-relatedness in order that he

may return to the world in relationship. This new relationship created between therapist and patient also assists him in correcting the problems experienced in his past and current relationships (Strupp, 1986). Brice (1984) describes how the patient has attempted to flee from the fears arising in the ambiguity and uncertainty of his world. The psychotherapeutic relationship aims at assisting the patient to view these problems from a different perspective in order to equip him to deal more effectively with the real world.

This is achieved by the therapist helping the patient to identify, understand and master the problems within the psychotherapeutic relationship (Strupp, 1986). Shainberg (1983) believes the therapist achieves more when he realises that his presence is the "healing environment in which the being is the doing" (p. 175). Change within a patient always occurs within the context of a personal relationship but May (1958) adds that "the essence of relationship is that in the encounter both persons are changed" (p. 63).

It is thus recognised that both the therapist and patient influence each other and the relationship. Rogers et al. (1976), in their study of "The Effects of the Therapist and the Patient on Each Other", comment that it is recognised that some patients are more difficult to work with and some patient-therapist combinations work better than others as each party has a strong influence on the other. In this study, the authors allowed chronic, hospitalised, schizophrenic patients to choose whichever therapists they wished to work with thus not limiting them to only one psychotherapeutic relationship. The patients in the control group were placed in a psychotherapeutic relationship that was low in empathy and congruence. The result provides evidence to support the hypothesis that the "levels of problem expression and immediacy of experiencing of the patient are a function of both the patient and the therapist ... and the particular patient-therapist combination" (pp. 357 - 358). Rogers et al. also found that the more meaningful the psychotherapeutic relationship, the more the schizophrenic patient developed the capacity to communicate with other people. The control group patients "showed no change or even regressive change" (p. 86).

Rogers et al. (1976) conclude overall that the relationship qualities are not supplied by either the patient or the therapist and that "high therapeutic conditions" (p. 90) are a product of the interaction between the patient and the therapist. The conclusion in the study is that there is substantial evidence that "relationships" high in genuineness and accurate empathy, as perceived by the patient were "associated with favourable personality changes and reductions in various forms of pathology, particularly in schizophrenic pathology" (p. 86). Results indicate that "the therapist and the patient influence each other's therapeutic behaviour as well as their own, and that the therapeutic behaviour of one is positively related to the therapeutic behaviour of the other" (pp. 355 - 356). The patient was found to have a greater effect on the relationship than the therapist. Rogers et al. infer that the more defensive, unmotivated and reluctant the patient is, the more difficult it is to deepen the relationship. The more positive conditions are present, the more likely it is that there will be positive outcome whether one is dealing with neurotics or schizophrenics. Hence, both patient and therapist are complexly interwoven in a cycle of dynamic interaction aimed at the patient's growth. The psychotherapeutic relationship is built on, but not totally limited

by, what each brings to the relationship. This stresses that the relationship between the therapist and patient is the most important element in growth and change in psychotherapy.
The dialogal view is that the "overall approach, the process, and the goal of psychotherapy" needs to be grounded in Buber's basic tenet that there is "healing through meeting" (Hycner, 1991, p. 4). Thus, the focus is not on the therapist or the patient but on the 'between' and the unique relationship created by the meeting of the therapist and patient. A basic dialogal principle states that "there are always two sides to an interaction" (p. 59). As there is tremendous risk involved with the deep exploration of issues and in genuine dialogue, either the therapist or the patient can set the limits as to what is explored and to what extent (Hycner, 1991). Usually the patient is the first to draw a boundary as it is his life and world that are being explored.

Buber (1953) stresses the importance of the relationship when he says "the inmost growth of the self is ... accomplished ... in the relations between the one and the other ... in the making present of another self and in the knowledge that one is made present in his own self by the other" (p. 249). In the relationship the therapist is called to enter "into the elementary situation between one who calls and one who is called" (pp. 94 - 95), that is, "the between" (Buber, 1957). Buber (1965) stresses that meaning "is to be found neither in one of the two partners nor in both together, but only their dialogue itself, in this 'between' which they live together" (p. 75). This requires the therapist to be a person first and a professional second. In genuine and open meeting the therapist can move into the world of the patient where "a soul is never sick alone, but always a betweenness also" (Buber, 1957, pp. 96 - 97).

Friedman (1985) points out that the responsibility of whether the psychotherapy works or not does not lie entirely with the therapist or the patient but in the 'between' of the relationship. Hycner (1991) describes this as the "rhythmic alternation between separateness and relatedness" (p. 48) which occurs in the space of the 'between'. It is only in the relationship that both therapist and patient can explore the depths of the psyche. Colm (as cited in Friedman, 1985) comments on the psychotherapeutic relationship stating that "healing does not result merely from greater knowledge of oneself but from experiencing oneself (as one is) in relation to another person" (p. 190). Trüb, 1952 (as cited in Hycner, 1991, pp. 67 - 68), maintains that "it is in the framework of this basic partnership relation that the psychic conflict tension .... arrives at a psychotherapeutic resolution."

Rogers (1965) reports Fiedler, 1950, as stating that almost all therapists agree that the relationship is a critical factor in facilitating psychotherapy. He found that the characteristics of this ideal relationship include, in order of significance: the therapist's ability to participate completely in the patient's communication; his ability to make comments that are always right in line with what the patient is trying to convey; viewing the patient as a co-worker on a common problem; treating the patient as an equal; understanding the patient's feelings; and always following the patient's line of thought and conveying, by tone of voice, the ability to share those feelings. Jaspers (1963) emphasises the need for the therapist to understand and question his own feelings, needs and motives in the psychotherapeutic relationship as well as the patient's.

Clarkson (1990) speaks of three authors' views on the psychotherapeutic relationship. Guntrip, 1961, claims that the genuine, personal relationship between the therapist and patient is the basic and major psychotherapeutic factor from which all other therapeutic factors and healing grow. Boss, 1979, believes that the importance of the psychotherapeutic relationship lies in the fact that each participant discloses himself as a human being. Anna Freud states that "two real people of equal adult status stand in a real personal relationship to each other" (p. 157) in the psychotherapeutic relationship.

Shainberg (1983) stresses the importance of the therapist understanding that work is always ongoing and that one can never fully know the patient's experience. It is only in the "mutual participation of discovering the essential quality of the patient that the healing can take place" (p. 164). This requires two people being together without theory and labels. Categorisation reinforces an objective approach to the patient preventing the therapist from seeing and relating to the individual. Thus, the therapist is required to allow the patient's experience to appear and simply be lived together in the psychotherapeutic space. However, patients are frequently dependent on others for a sense of direction and have little insight into their problems. They can then disrupt the psychotherapeutic relationship when they do not achieve the results they expect or are not treated the way they believe they should be. In those situations, the therapist can gently guide the patient back into the realisation that psychotherapy is a mutual process.

It is thus evident that a good psychotherapeutic alliance is critical for change and growth as it serves as a valuable relearning experience allowing the patient to take what he has learned in psychotherapy and generalise this corrective experience to relationships in the world (Wolberg, 1977). Norcross, 1986, states that successful psychotherapy is best predicted by three components, that is, the patient, the therapist and the psychotherapeutic relationship (Clarkson, 1990). Stubbs and Bozarth (1994) explored the question Paul posed in 1967 when he asked "what treatment by whom is most effective for this individual with that specific problem under what set of circumstances ?" (p. 115). It seems that this question cannot be adequately answered despite years of research. Certainly all the variables combine to provide a unique psychotherapeutic space for the patient and therapist to strive for the patient's healing and growth. The focus should not be on what the therapist does, but **how he is** with the patient. As long as one has respect for the patient and some form of relationship has been created, some level of success can be reached with even the most regressed, uncommunicative and fragmented patients.

CHAPTER 6 - THE PHENOMENOLOGICAL APPROACH

Having explored the variables which contribute to the psychotherapeutic relationship and the relationship itself, it is necessary to gain a general understanding of the basic phenomenological principles on which the case study is grounded. The phenomenological view is based on the premise that man lives in and relates to the world and is not an object in isolation. This approach emphasises the wholeness of man and grounds him within a context. This is vitally important as it highlights that man can only be understood in terms of his whole existence and not merely within the framework that makes a distinction between healthy and sick. This is essential for understanding and working with the patient in psychotherapy as it emphasises that the mentally ill are not alien beings. They are simply individuals with a different perception and view of the world from the average, shared reality of society. It is imperative to have an approach, such as phenomenology, that recognises this fundamental relatedness to avoid further isolating people who do not adhere to the socially acceptable norms of behaviour. This chapter discusses the principles of phenomenology and its approach to psychopathology. The following chapter deals with the validity and usefulness of this approach to the views of abnormal behaviour, psychosis and psychotherapy.

Phenomenology has its roots in the philosophy of Kierkegaard's existentialism of the nineteenth century and Husserl's philosophical views of the early twentieth century. Phenomenology is not a theory which is a preconceived system of beliefs based on general principles independent of the particular things to be explained. It is a philosophy which is a set of beliefs attained by the use of reason and argument in seeking the truth and knowledge of reality especially of the causes and nature of things and of the principles governing existence (Tulloch, 1993). Thus, phenomenology is a manner or style of thinking, a study of the "essences" or the perception of physical phenomena and human behaviour (Merleau-Ponty, 1967). It is a matter of describing life, behaviour and events rather than explaining or analysing them. Husserl (as cited in Merleau-Ponty, 1967) calls phenomenology a "descriptive psychology" or a "return to the things themselves" where the phenomena in the person's world are explored and described (p. viii). Thus, Kruger (1988) states that phenomenology attempts to clarify how man encounters other people in the world, how man relates to the world and how each individual finds meaning in his particular world. Polkinghorne (1989) reports that human behaviour is not simply a mechanical, learned response as Pavlov's canine experiment suggests, but a manifestation of meaningful experience. He states that Husserl's view is that "all knowledge is ultimately grounded in human experience" (p. 45) so phenomenology is focused on the actual phenomena of psychic experience and aims at connecting man with the events in his life as they are lived and experienced. With this view, theory is not a prerequisite as phenomenology does not attempt to find the causes of behaviour but simply to describe the meaning that each individual's behaviour has for him. Jaspers (1963) believes that it is only once one looks for an explanation in the underlying causes that one has a need for a theory to assist the therapist in discovering the facts.

THE WHOLENESS AND CONNECTEDNESS OF MAN:

Phenomenology totally rejects the Cartesian split between mind/body and man/world.

Its broader view is of man as a whole with a unity of body and mind, behaviour and the situation (Moss, 1989). Merleau-Ponty (1967) believes that "there is no inner man, man is in the world, and only in the world does he know himself" (p. xi). Friedman (1985) states that Boss views "the essence of existence" (p. 78) as living and sharing with other people. Kruger (1988) supports these views with his statement, "to be at all, to exist, is to be with fellow man and things" (p. 33). Heidegger's view of man 'being-in-the-world' (Dasein) places man's experiencing firmly in interaction and relationship. Dasein means 'to be there in the world' and being-in-the-world thus expresses how man always experiences, lives and is grounded in the context of his own personal world (Chessik, 1986). Jaspers (1963) describes living as "an encounter with a world which we all call concrete reality. To live involves struggle, impact, creation" (p. 325) and constant interaction with and feedback from the world. The existentialists hold that man and his world are a whole - one larger unit in which each is only understandable in relation to the other (May, 1958). Man is shaping and being shaped by the world (Moss, 1989) and is thus defined and understood in relation to his world and vice versa. The notion of being-in-the-world emphasises that connectedness, interaction and dialogue with the whole environment in which a person exists are fundamental to human life. The above statements stress that the phenomenological view is based on the premise that man lives in and relates to the world and is not an object in isolation.

Phenomenology does not separate subject from object. Man, as a whole, is in constant, dynamic interaction with the world. As Moss (1989) states, the question "Who am I ?" is inseparable from the question "What kind of world do I live in ?" (p. 80). How man experiences himself influences how he experiences others and himself in the world (Chessik, 1986). Heidegger describes man as being "thrown" into the world where there is no choice in terms of culture, history, language, gender and the like. This means that an individual is in relationship to a world which consists of a "meaningful set of relationships, practices, and language that we have by virtue of being born into a culture" (Leonard, 1989, p. 43). It thus becomes impossible to view man in isolation and everything that is lived is experienced in terms of the world. Insofar as one is living a connected and intentional existence of constant interaction within the world, man is able to make certain choices. So, although man does not have total free will due to the 'thrownness' of his life situation, the fact that he influences and is influenced by the world allows him to have some freedom within the specific situation where he is able to choose within his given context. Phenomenology stresses the importance for man to make his own choices because the selection from his own unique range of possible responses provides him with authenticity. Having made the unique choice of response, action and behaviour, man is responsible for that choice and the consequences that follow. This opens his experience to the possibility of guilt as man acknowledges his right to choose and bear the consequences of being real and authentic (Kruger, 1988).

In the nineteenth century, the development of bourgeois society emphasised respectability and conformity. During this period, both Kierkegaard and Nietzsche warned that man was losing his sense of being which results in a loss of his world and thus a sense of community (May, 1958). This possibility remains very much a danger in contemporary society. Boisen (1962) supports the importance of the need for a sense of community and living in a connected world of relationship when he states that the "primary evil lies in the realm of social relationships ... in a life situation involving the

sense of personal failure" (p. 28).

The view that the person is in constant dialogue with the world and is outwardly focused is critically important in shifting the focus away from viewing only particular aspects of a whole human being as if he were like a clock, made up of pieces that can be taken apart and put back together again. It becomes impossible to truly comprehend man and his behaviour without some understanding of the context of his being-in-the-world as "every entity in the world is grasped as an entity in terms of world, which is always already there" (Leonard, 1989, p. 43). The end result is understanding that one must always come back to viewing man's experience and perception within the context of his world.

Thus, phenomenology views man as living in and grounded by the world (Chessik, 1986). Previous theories, based on the Cartesian, scientific view, largely disregarded the reality that man lives in the world and is not an island. It becomes imperative to have an approach, such as phenomenology, that recognises this fundamental relatedness. The challenge in psychotherapy is to pull theory away from the narrow pathway of observing and working with only aspects of the individual, to always viewing him within his context - the broader perspective. With this perspective as the basis of the phenomenological approach, techniques may be used in psychotherapy to focus specifically at times, but one must remain solid in the basic belief of the unique individual living in his unique context in the world.

THE UNITY OF MIND AND BODY:

The scientific world views man as possessing a body rather than being a body, that is, a mind-body unity. Merleau-Ponty (1967) views man, his mind and body as being one with the world. He was one of the first to stress the subjectivity of the body when he stated that perception is a bodily event in that we perceive and find reality through our body in constant interaction with the world. This bodily experience is at a pre-reflective, pre-verbal level as the experience is lived in the body before it is known to the conscious or reflective mind. So, analytic reflection starts from our experience of the world and comes back to the body subject to be experienced and interpreted as unique for that person. The body is never merely an object in space, that is, it is not a thing enclosed within itself but a subject constantly interacting with the world.

Given the unity of mind and body, Merleau-Ponty speaks of a "lived body", far removed from the physiological one that can be dissected as some object (Moss, 1989). In phenomenology one **is** one's body rather than one **has** a body. Most of the time, people live without an explicit awareness of the body and take it for granted. Kruger (1988) states that man is usually only aware of his body when he is ill, in pain, being examined and focused on. Phenomenologists view the body as a living, experiential, active body dynamically involved in relationship with people and objects in the world. Man's perception through the body provides him with a personal meaning, point of view of and unique relationship to the world. The expressive body is thus the focus of inherent meanings. How man behaves is affected by his interactions and the responses made to him. This constant sharing and co-defining shapes and defines the person's sense of an I and mineness (Moss, 1989).

With the belief that man is always related to the world, comes the recognition that behaviour is directed towards objects in the world. Phenomenology views the body as already situated in the world, inhabiting space. Husserl's view is that consciousness is necessarily consciousness of something. This implies an intention and link towards an object with which man is in relationship. For example, man does not simply see but sees something, man loves or hates someone. The subject is always linked with the object. The body intentionally reaches out to the world that invites man, as a whole, to interact (Kruger, 1988). Moss (1989) states that how and why an individual behaves in a certain manner is determined by the specific nature and meaning that the object has to that individual. The body's objective position in space is not the only issue to consider. It is the task of the body, so to speak, in that situation that provides the meaning of that specific behaviour. As Merleau-Ponty (as cited in Kruger, 1988) states, "my body is there where it has something to do" (p. 62). All behaviour is both intentional and purposeful. That is, the aim of any behaviour is to complete the task that the person has set out to achieve. For example, the complete absorption of a student in the hours spent reading and studying for examinations, indicates the strong desire and need for that student to complete his studies successfully. Each individual interacts with and perceives objects differently according to his own history, beliefs, fears and desires. Thus, the same object may have different significance for different people but each unique meaning is what is real for each person.

How each man lives in the world as an embodied being expresses the personal meaning that any event or interaction has for him. For example, the differences in personal space allowed with a stranger, a friend or a lover provide an indication of the individual's personal relationship to those people. In order to inter-relate fully, Pirsig states that man must be completely attentive to the object with which he is interacting. This means an active rather than passive involvement of engaging with another person (Kruger, 1988).

Being-in-the-world emphasises the connectedness between the mind and body. Gendlin (1964) states that all experience is lived and felt through the body. Both Merleau-Ponty and Gendlin stress that the body experiences meaning at a pre-reflective level and it is only when we pay attention to the feelings in the body, that we can begin to gain a clearer sense of that meaning at a reflective level. This highlights that meaning is experienced in the body at a deep level that precedes any rational, reflective understanding and languaging. To gain understanding Gendlin suggests focusing on the sensations felt in the body. For example, the physical feeling experienced in the throat, solar plexus and abdomen (Halling & Goldfarb, 1991). It is only as one becomes attuned to the bodily sensations and brings them forth to a reflective level that the individual may gain an accurate sense of the meaning that particular experience has for him. This Gendlin describes as the 'felt-sense' of the experience. For example, a person may feel apprehensive when the boss confronts him on a particular issue. He will only truly comprehend what the meaning of that apprehension is about if he focuses on the felt-sense in the body. By bringing it to a more reflective level he may analyse that the apprehension links to confrontation with his father in the past.

Phenomenology focuses on what is currently being experienced in the interactions and

connectedness of the person and how this is being lived within his relationships in his world. The goal of phenomenology is, therefore, to understand the phenomena in their immediacy and not to explain, predict or control them (Moss, 1989). From this it is abundantly clear that the linear approach to causality has no place within phenomenology (Valle, King & Halling, 1989).

PERCEPTIONS OF REALITY:

Each individual's experience of reality is based on his interpretation of it. Merleau-Ponty (1967) claims that perception is a faith in the belief that there is a world to live in and interact with. However, as faith is not knowledge, there is always the threat of discovering that what one is experiencing is not reality. Merleau-Ponty views truth and untruth as two ways of existing on the same level of reality and states that one can only perceive correctly when the body has an accurate grasp of what is being observed. However, one's grasp can never be total and absolute, as reality cannot be verified, and one person's perception can be different from another's perception of the same phenomena. As perception is at a pre-reflective level and difficult to verbalise, Merleau-Ponty states that the individual is in a state of ambiguity where he may alternatively live in a world of illusion or reality. This uncertainty of what is illusion/false and reality/true can exist concurrently at a pre-reflective level. However, once this is brought into conscious awareness, these opposing realities create ambiguity and confusion. Hence there is a need to gain a balance and sense of congruence by accepting only one reality.

How man perceives is directly linked to the goal or task that the individual is aiming to reach (Wertz, 1989). For example, the meaning that the student attempting to finish his degree may attach to problems that arise, will depend on whether he is aiming to attain a distinction for his degree or not. If man can interpret reality and illusion according to his own perceptions and beliefs, the available possibilities of interpretation and experience are endless. Thus, Kruger (1988) describes the world as providing a "totality of meanings" (p. 36). However, there is always the question of what is "abstractly true and what is existentially real" (May, 1958, p. 13). The interpretation and meaning for each individual also lies in the interaction and dialogue with others who may confirm or deny the reality or meaning. For phenomenology, the value lies in the experience and its meaning for the patient and not in scientific proof. Kierkegaard and Nietzsche correctly warned that there was a "growing split between truth and reality in Western culture" (May, 1958, p. 14). Kierkegaard's philosophy opened up the possibility that subjective reality may be true even though it contradicts objective fact. This does not mean that objective reality is cast aside but that the meaning of the objective fact for the individual depends on his relation to it and the meaning it has for him. This is a critically important viewpoint when dealing with abnormal behaviour and psychosis.

THE PHENOMENOLOGICAL VIEW OF TIME:

Phenomenology thus works with man's primary experience of the world and not in the scientific realm. Phenomenology not only has a profoundly deeper and broader perspective of man in the world but also expands this concept to temporality. The focus in psychotherapy has traditionally been on the past as the crux in understanding behaviour without taking into consideration the present let alone the future. In the early

1920's psychoanalysis was "bogging down in ... the patient's past" (May, 1958, p. 7). For example, Freud spoke of the influence of past events on the present consciousness of the patient (Kruger, 1988). However, more importantly, the stress was that to heal the problem the "contents of the unconscious" (p. 15) had to be recovered and the past explored. Freud always tied the present symptom to an earlier event in life and retained the principle that the present could only be explained by the past. Kruger states that Freud "never gave any great significance to the present tense, nor was his meta-psychology able to accommodate the future as future" (p. 16).

Another school of thought focusing mainly on the past and present behaviour has been behaviourism. This approach has never looked at the future - for example, that anxiety and neurosis may be due to the fear of a future event or possibility. Behaviourists have only been interested in observable, objective phenomena. They are not interested in understanding behaviour from the point of view of the subjective, volitional human being but study the aspects of the environment that influence and shape behaviour (Skinner, 1953).

Fessler states that the traditional approaches have always begun by reducing the unity of the whole in the psychotherapeutic encounter, conceptualising various parts and then studying them separately (Smith, 1979). The phenomenological approach of Heidegger's being-in-the-world (Dasein) and of studying man in relation to his whole world of experiencing introduces the concept of a three-dimensional temporality. This alters the whole approach of working with man and assists in healing the split between man and body, and man and the world. The phenomenological view of temporality also highlights the approach's concept of wholeness and context.

The phenomenological approach is that "time is in man; it characterises his existence" (Kruger, 1988, p. 65). Dasein is historical - "one is one's whole life-history and one is one's lived time" (p. 71). That is, one's life-history includes one's past, present and future. Heidegger views human lived experience as temporal and argues that temporality is "directional and relational" and applies only to being, not physical objects (Leonard, 1989, p. 49). The life journey that man undertakes is an ongoing, continuous one which precludes the concept of splitting time into separate and delineated parts. Boss claims that a human being's relationship to time thus results in his "always ordering the past, the present and that which we anticipate in one or other way and thus we are timing our dwelling and journeying in the world" (Kruger, 1988, p. 66). Thus, time is not viewed as linear because the linear concept creates a problem in linking past, present and future. They cannot be viewed as separate concepts chronologically following each other but all belong to the current, lived moment in the present. As all three phases of past, present and future are constantly interchanging and interacting, time is seen as a transition, an activity and dynamic in nature.

In the phenomenological approach, the importance of the past is recognised. The past is set to some degree in that the situation into which we are born is out of our control. As stated, we are thrown into a world of culture, family, relationships, practices, rituals and language which determines, to some degree, our attitude and approach to life. Heidegger talks of the past as "having-been-ness" and that "everything we have been is an essential determination of our existence" (Leonard, 1989, p. 49). At the same

time, "what an individual seeks to become determines what he remembers of his has been" (May et al., 1958, p. 69).

However, the past is not simply something that has-been and is no longer of any value but is currently with us in the present. The past is not viewed as being most important and significant when it occurred in the past but rather how those experiences manifest themselves in the present and how they might affect future expectations. Van den Berg (1972) states that the past has no function as the past but only as it is lived and experienced now as "a present past" (p. 80). He makes the point that the past has a hold on people's perceptions and experiences in that past experiences influence the individual's current views, attitudes and general approach to life. These perceptions and attitudes affect our present and future behaviour. One only recalls that from the past which is relevant and significant and recall tends to be inaccurate as it is coloured by subjective interpretation of events. What a person recalls from the past will dictate, to some degree, the self that develops due to the large variety of possibilities and options open to the individual to recall. Past events and unresolved issues can impede the individual's growth in the present and stifle the possibility of future development and attaintment of goals.

Phenomenology thus views the past as setting conditions but the present, current behaviour as originating from the future because of an "expectance or wish or fear or desire" (Van den Berg, 1972, p. 86). Our current behaviour and choices are, therefore, not only influenced by past experience but guided by our future fears and desires. Van den Berg states that "the present is an invitation from out of the future to gain mastery over bygone times" (pp. 91 - 92). The future is thus a very important aspect of this view of temporality. One can really only understand behaviour if one is looking at the individual as he emerges into his future in the process of self-actualisation. Halling and Dearborn Nill (1989) state that one only gains a complete understanding of an individual as the "historical dimensions of a person's life become evident" (pp. 185 - 186). Likewise, as present attitudes and circumstances change, so does the recollection of the past and the more pleasant events are allowed to emerge as the individual grows and integrates.

Therefore, all three dimensions of temporality are present in any single one act, that is, "the past is within the present which is the way it is appearing now" (Kruger, 1988, p. 67). One cannot perceive time as a "series of ever new moments of the present" (p. 106) because it is always developing, moving, constantly incorporating and inexorably linking all three dimensions of temporality. Thus, one is always **being** rather than **is** or **has been** in fixed categories. This hermeneutic approach shows the need to constantly move from the whole to the parts and back to the whole, that is, from the present to the past to the future and back, in order to understand the whole (Valle et al., 1989).

THE PHENOMENOLOGICAL VIEW OF PSYCHOPATHOLOGY:

Phenomenology moves away from the concept that psychopathology or mental illness is a disorder or disease that can be separated from the context of normal, everyday living. Phenomenologists want to understand disturbed people within the context of their perspective and relation to the world just as they want to understand ordinary

people in the same manner. Thus, the aim is to use similar principles in conceptualising normal and disturbed existence (Kruger, 1988). That is, phenomenology seeks to understand the disturbed person in terms of the lived reality of his specific world, rather than viewing him through the eyes of the outside observer, looking at him from a medical or psychiatric perspective. If man lives and experiences as a whole unity within the world, then mental illness is not an external event that "attacks a person" but is a "state of being in which the person starts relating to the world and fellow man in ways which are not readily comprehensible i.e. socially validated" (Kruger, 1988, p. 170). Binswanger views psychology and psychotherapy as not only being concerned with man as a mentally ill person but with "man as such" (May, 1958, p. 4). As man is a unity living in the world, one cannot, for example, say someone has schizophrenia, but rather that someone is schizophrenic (Laing, 1969). A person does not have a disease or mental illness but lives it in his everyday world of relating and functioning. In order to meet and hear the illness one cannot simply treat the diseased aspects as they do not exist separately from the whole human being.

Binswanger believes that the diagnosis of mental illness is a cultural and societal judgement. However, if the individual's world develops historically within the context of community and society, then being normal or abnormal are simply different ways of being-in-the-world. So, abnormal behaviour can be understood within the context of the person's world. If man is in relationship to the everyday world, then the basic principles governing life also govern mental illness. As mental illness is not something that happens to someone but is rather a manner of inter-relating with the world, one can understand the person's problems by viewing how he inter-relates with his world and his experience of others' reactions to that (Kruger, 1988).

With the cultural and societal judgement that exists in defining and dealing with psychopathology and psychosis, comes a specific languaging which further categorises and dehumanises the individual. Halling and Dearborn Nill (1979) do not use the word psychopathology but refer to abnormal behaviour as "disturbed behaviour" (p. 180) which removes the stigma attached to terms such as mental illness. Van den Berg, 1955, (as cited in Laing, 1969) has stated that medical jargon is a "vocabulary of denigration" (p. 27). The languaging states that the patient is abnormal, that there is a pathology, that he is mentally sick which results in the patient having to deal with a negative attitude from society as well as his own problems. Laing (1969) cautions us to beware of words, such as psychiatric labels, which isolate the patient further and instead stresses the need to recognise the distinctiveness and uniqueness of the psychotic and his "separateness and loneliness and despair" (p. 39). Laing believes that as long as we have the attitude that "we are sane and he is insane" (p. 39), it will remain difficult to comprehend the patient's world. The current attitude of many people is that one sees a psychiatrist or psychologist because one is mad and this further alienates the person by either preventing him from seeking help or feeling ashamed about the fact that he has the need to. Whilst it is useful to have a terminology to clarify general guidelines of disturbed behaviour, extreme caution should be exercised to prevent destructive labelling.

The fact that in everyday life, the beliefs and approaches to mental illness are largely determined by the prevailing social norms, indicates that the world is a shared world.

Mental illness results in losing touch with that sense of a shared world. Van den Berg (1972) describes psychopathology as "the science of loneliness and isolation" (p. 110) as the individual is cut off from healthy relationships and a shared reality. He believes that "loneliness is the central core of ... illness" and "the nucleus of psychiatry" (p. 105). By defining psychopathology this way, Van den Berg is not implying that the mentally ill are a different species but that they have different perspectives of the world and reality which result in them feeling alienated and isolated from society. Boss agrees that psychopathology results in a loss of connectedness and openness to the world and views psychopathology as "an expression of the entire existence of an individual involving a limitation on his freedom of expression and action" (Kruger, 1988, p. 177). Boss thus views the patient's world as becoming narrowed and constricted through his attempt to make sense and control his way of being. Van den Berg (1972) states that the healthy person's world is characterised by "direction, utility and purpose" (p. 59) but, for the disturbed person, the world is no longer experienced as inviting and open to exploration. Merleau-Ponty's views support this as he submits that the rigid, determined forms of behaviour seen in disturbed people reflect the relations of a person who is unstructured and lacking integration (Masek, 1991). May (1958) describes the disturbed person as never developing beyond the limited and restricted forms of experiencing in childhood. In later years, the person tends to perceive others and experience life in terms of the same restricted and distorted views.

Isolation of the self and apparently incomprehensible ways of inter-relating means that there are large areas of experience that cannot be shared with others or understood in terms of common meaning. This results in the individual withdrawing further into isolation. Blankenberg, 1991, highlights the patient's sense of loss of inhabiting a familiar world as being the major change in the patient's being-in-the-world (Corin & Lauzon, 1994). This altered relationship to the world is indicated by the patient's inability to understand interpersonal and social rules. Gendlin (1964) describes how experiencing can become structure-bound where the individual relates and reacts to only a specific aspect of a situation. This constricted manner of experiencing traps the person in a static state where he is unable to accurately perceive the dynamics involved and this halts the process of any forward movement in insight and growth. The patient is also unable to project himself into the future as a realm of possibility or retain a clear sense of the past but remains in that static state where there is little of the active, dynamic quality of real living. This inability to fit into the normal world and the sense of unfamiliarity further exacerbate the feelings of loneliness and isolation but this state is often sought as a means of protecting the self from the world. Laing (1969) describes the ontologically insecure person as someone who does not have the sense of being real, whole, alive and continuous with a firm sense of his own identity and reality. The ontologically insecure person fears a loss of identity if he ventures into a world of relationships. This results in an isolation of the self in an effort to preserve his identity from threatened engulfment, annihilation and/or implosion. Laing describes this withdrawing and isolation of the self as a means of protection as it is the opposite of being engulfed and absorbed by the other. But the extreme degree of separateness makes any real meeting and connection with others very difficult to achieve.

The person loses his sense of connection to the community as well as experiencing an inner feeling of disconnection from the self. He thus becomes a stranger to everything

and everyone, including himself. Fromm-Reichmann and Sullivan's writings address the loneliness, isolation and alienation in a world where a person loses relationship to himself and the world. These authors view withdrawal, depersonalisation, detachment and the covering up of problems with intellectualising as common ways of handling this isolation (May, 1958). Gendlin (1986-87) speaks of the tremendous isolation and disconnection in schizophrenics and has a powerfully basic message he conveys in different ways to his patients. He states: "I'll reconnect you to the world and to me, and in a different way than you were before because that failed - there you were isolated" (p. 182). It is a message that all disturbed, desolate and fragmented patients should receive in their isolation.

In the isolated, nebulous state of the disturbed person's world, the person seeks desperately to find some meaning that will allow him to re-enter the common world of shared meaning. Hanna Colm reinforces that neurotic behaviour and symptoms are often the patient's attempt to live with integrity as he struggles between the authentic self and society's demands. There are certain options available to the individual. He may choose to sacrifice himself to society's demands despite a lack of congruence within himself or he may choose to be himself at the possible cost of being rejected by society (Friedman, 1985).

People experience the same world in different ways due to different perceptions and interpretations. As stated, the phenomenological view of subject/object is not in accord with the traditional scientific one where subject and object are perceived as being separate. How an object is perceived depends on the observer's relationship to it within the overall context of his life. So, each person's perception will differ according to his past experiences, the meaning for him in the current context as well as in the light of any future expectations. But, for each person, his perception is a reality. For the patient who is perceiving and experiencing in a very different way, the world feels like an alien place. Van den Berg (1972) reminds us that, due to the altered reality of the patient, what seems real to him does not exist in our view. He explores how the relationship between mind, body and being-in-the-world differs when one is disturbed. How does the reality differ ? The patient differs in how he remembers his past and this creates a different meaning for him in the present world of interacting. His perception and interpretation of the world differs from that of the healthy person. However, Van den Berg views the disturbed person as living just as constructively as the healthy person as each individual is attempting to cope with his world of experience to the best of his ability in order to make life more tolerable.

People can avoid connecting with themselves at levels that would assist them to understand their own thoughts and behaviour. Van den Berg (1972) refers to this as not-knowing which makes the patient different from people that do have knowledge and insight. Van den Berg views mental illness as an "alibi" (p. 41) used to prevent the not-knowing from coming into awareness and creating anxiety and distress. The not-knowing is thus often a means of ensuring safety from an uncomfortable reality. Van den Berg states that the disturbed person may avoid exploring his own dysfunctional thoughts and behaviour because it would highlight how different he is from others and the need to change his current behaviour and established, self-protective defences or ways of coping.

Phenomenology views the mind and body as one and disturbed behaviour is thus experienced and lived as a connected mind and body in the world. If the body reflects, lives and expresses the state of the person's being-in-the-world, it will also reflect the patient's inability to relate in an integrated manner in the world. The person who lives in an embodied way feels real and alive and is able to relate to others as a whole person. Laing (1969) states that the unembodied self is "felt more as one object among other objects in the world than as the core of the individual's own being" (p. 71). This means that the body is felt to be the core of an inauthentic self (False Self) and not the real self (True Self). If the person is ontologically insecure, he will experience himself as a mind-body split, more closely identified with the mind. Laing believes the patient may identify too strongly with the mind and feel detached from the body. If this occurs, the end result may be the start of psychosis. Thus, Laing stresses that one requires a firm sense of one's own autonomy in order to relate and be related to as one human being to another. If one does not have a firm sense of identity, every relationship threatens the patient with a loss of identity.

In attempting to understand disturbed behaviour, Jaspers (1963) reminds us that one can never totally know everything. He suggests that the more one attempts to reduce man to a stereotype of what is typical and normative, the more one realises how unique each person is. This makes it necessary to study actual experience, relationships and modes in which the patient's being-in-the-world is expressed. Likewise, not everything that happens in mental illness can be explained by the criteria of science. The psyche is viewed as being-in-the-world which unfolds in continuous experiences as long as the person lives. Thus, understanding disturbed behaviour necessitates entering the patient's world.

THE PHENOMENOLOGICAL VIEW OF PSYCHOSIS:

As stated, traditional approaches generally describe psychosis as a failure of adjustment, a lack of contact with reality and the subsequent creation of a different reality in order to create some stability and congruence in the person's life. Phenomenology's view that psychopathology is governed by the same principles as everday, normal, healthy life and that the primary difficulty lies in faulty relating-in-the-world provides a broader and gentler approach to psychopathology and psychosis. It also gives one the hope of connecting with and understanding even the most disturbed behaviour. Halling and Dearborn Nill (1989), writing from a phenomenological perspective, state that "even profoundly disturbed behaviour is intelligible, potentially at least" (p. 180) if one approaches it with a specific attitude and certain principles.

The psychotic's world is an isolated and often frightening one. With the increasing sense of isolation, comes a loss of the sense of self. Gendlin (1964) states that the self develops in interaction with others where the infant learns the ability to respond to his feelings. Appropriate behaviour and interpretation depends on the meaning attached to the felt-sense of the situation. He believes that when experience is narrowed or restricted the individual loses his sense of self and the ability to respond and interpret appropriately. The interactive process between the feeling and the event is limited or blocked. When there has been little sense of self developed in childhood, there is even less ability to connect in a relationship as a meaningful I. If events are perceived as concrete, objective, literal facts, there will be little felt-sense of the richness and variety

of possible interpretations and meaning for an experience. When this occurs, experiencing is no longer a process but structure-bound and static. The individual exists in an isolated and withdrawn world in which there are few links to a reality of being-in-the-world. Gendlin states that it is not the content of the individual's experiencing that is psychotic but the "structure-bound manner of experiencing, the absence or literal rigidity of felt experiencing and interaction" (p. 143). Psychosis is thus not "psychotic 'things' in a person, but a narrowed or stopped interaction process" (p. 146).

If the patient cannot take the "realness, aliveness, autonomy, and identity of himself and others for granted, then he has to become absorbed in contriving ways of trying to be real, of keeping himself or others alive, of preserving his identity ... in efforts ... to prevent him losing his self" (Laing, 1969, p. 44). Thus, relatedness to other people has a "radically different significance and function" (p. 43 - 44) for the psychotic or fragmented person because he is not secure within himself or his world. Laing states that the ontologically insecure person then becomes preoccupied with "preserving rather than gratifying himself" as life's problems are perceived as a "continual and deadly threat" (p. 44). Events thus have a more severe effect on the psychotic.

A major problem in understanding psychopathology and psychosis is that the patient's experience and altered reality is frequently very difficult for the well-adjusted person to understand and relate to. Jaspers (1963) suggests that one needs to explore both the form and content of the patient's experience to gain insight. Content is usually more easily understood as one is able to place it within the context of the individual's life experience. The shape or form in which the patient's experience presents itself, however, is often incomprehensible to other people. Jaspers feels that one can only understand the other's experience up to a certain point before it becomes impossible to relate to.

Later phenomenologists disagree with Jaspers, advocating that any human experience is possible to understand as the person's manner of being-in-the-world. Schwartz, Wiggins and Spitzer (1997) comment that no matter how different and alien the psychotic's reality appears to be, one can relate to it as a human experience. Laing (1969) believes, as many phenomenologists do, that the only path to understanding the patient is by entering his world, whilst drawing on one's own "psychotic possibilities" without foregoing one's "own sanity" (p. 35). All behaviour is in response to a context and therefore has a purpose. Even seemingly senseless, bizarre and self-destructive behaviour has a purpose for that particular person. To understand the meaning the experience has for the patient in his context, is to understand the patient and his world. Thus, Sass, 1992, correctly reminds us that we would be banishing the patient to an isolated existence if we did not attempt to enter his world, even if this is not with total understanding (Schwartz et al., 1997).

Hallucinations and delusions:
Phenomenology views an hallucination as a "perceptual act by which an alternate profile of reality appears" (Kruger, 1988, p. 184). Howard (1966) describes an hallucination as a "perceptual phenomenon" that comes "into being in a primary way" and has "no roots in a given perceptual reality" (p. 212). With the experience of a new

reality, alterations in the experience of time and space occur. This happens because the hallucination "occupies a literal space" (Havens, 1962 as cited in Prouty, 1992, p. 50). Howard (1966) states that the hallucination appears to the conscious self, within the normal visual field and is "bounded in space and time" and "takes on the character of objectivity as would any normal perception" (p. 212). However, hallucinations arise independently without the person's control. Lang (1938), a schizophrenic who experienced various types of hallucinations over an eight year period, writes that the conscious self is unable to replicate these phenomena and the self acts only "as a spectator. It does not anticipate, it does not initiate, it does not control the hallucination" (p. 423). He experienced his hallucinations as already organised phenomena and was sceptical of explaining them as a result of projection.

Prouty (1994) describes hallucinations as "the polar opposite of the fully functioning person" (p. 87). Gendlin (1964) describes hallucinations as "structure-bound" (p. 143) experiencing which means they are taken literally and experienced as an outside event and objective reality by the patient. The patient does not experience the hallucination as his as it is outside his boundary of the self (Prouty, 1994). The experience is then lived as an isolated incident and is not part of the ongoing felt-sense of functioning which is rigid and narrow. Gendlin views this structure-bound manner of experiencing as static, repetitious and unmodifiable. The hallucination transforms real life experience into an image that symbolises the individual's difficulties in being-in-the-world (Prouty, 1994).

Van den Berg (1972) describes how the hallucination is present for the patient. "The sick person who hallucinates has some objects for himself alone. He has a world of his own that is founded in his isolation" and "sooner or later, the lonely person will create his own objects" (p. 107). At the time of experiencing, hallucinations are very real to the patient and are taken very seriously. The patient's perceptions are a reality because that is how they have been experienced and lived. Van den Berg states that the mentally ill person will not accept the reality of the healthy person's world because his own reality is different. The mentally ill person is so alone and in such a "pathological way that he keeps to his own personal relationships" (p. 108) within his isolation. Van den Berg believes that hallucinations and delusions can only occur when there is a distance between the person and his environment. However, as man lives in the world, the patient's hallucinations and delusions are always apparent to others in his surrounding world of relationships.

Van den Berg (1972) reports how hallucinations, which are so meaningful at the time when they are experienced, become incomprehensible at times when the patient is living in a shared reality. The fact that one cannot see the other's hallucinations does not, however, preclude one from understanding them and the meaning they have within the patient's context. Prouty (1994) suggests that seemingly meaningless statements are often valuable clues to an important aspect of the patient's world. Kruger (1988) points out that if we are able to understand the patient's experience of his world, the experience will become meaningful and comprehensible. Thus, one does not discard, obliterate or label the hallucination, but accepts the reality of it. Howard (1966) says phenomenology is concerned with what appears in terms of more deeply understanding the patient's hallucinations, but the prime focus is on the form in which the phenomenon

appears. Thus, phenomenology provides a new manner of viewing the phenomenon in question and of broadening understanding.

As described, phenomenology views how the past is experienced in the current context of meaning for the patient. However, Gendlin (1964) states that in hallucinations one does not interpret and feel the meaning of a past event in the present. The patient tends to remain in the past which distances him from his current experiencing of life isolating him from his current day-to-day functioning. This leads to a rigidity or lack of felt functioning in the present which results in inappropriate, literal or concrete interpretations and the loss of a sense of self, further contributing to the sense of isolation experienced. Rogers, 1961 (as cited in Prouty, 1994), describes the hallucination as a process which assists in moving the patient from a rigid and alienating self-experience to "a clear, alive, immediate and integrated" (p. 78) self-experience.

Jaspers (1963) describes the delusion as "a transformation in our total awareness of reality" (p. 95). The disorder of perception is clearly evident in delusion and dominates the patient's experience of being-in-the-world. Van den Berg (1972) states that contrary evidence, even when it conforms to other people's reality, is ignored as the patient cannot afford to accept that reality. This would shake the very congruence he is struggling so hard to obtain and maintain as a form of self- protection. It becomes necessary for the patient to withdraw into his personal world to achieve this balance.

As with hallucinations, the primary experience of delusion is not easily understood by others and cannot be substantiated by the patient. The literal objects in the world have not changed. What has changed is the recognition of those objects as they are linked to an experience that has a different meaning for the patient. Hence, "all primary experience of delusion is an experience of meaning" (Jaspers, 1963, p. 103). Laing (1969) provides an excellent example of this different meaning in the delusion when he describes a man stating that he is dead when he is alive. Our society only views death as a biological fact and does not tend to accept psychic death as it is experienced by the patient. This results in him being judged as mad without any consideration being given to the meaning and experiencing for the patient.

It is clear that an altered view of reality, that does not conform to the average experience of man in society, is usually met with disbelief and viewed as abnormal. This results in isolation and loneliness for the individual living that reality and further exacerbates the difficulties that he experiences in the world. Phenomenology views man as a whole, unique individual whose reality should be accorded respect and understanding in terms of the meaning it has for him. This approach, therefore, offers a broader perspective of the understanding of disturbed behaviour as well as a deeper respect for the individuals's experiences and life.

CHAPTER 7 - THE IMPLICATIONS OF THE PHENOMENOLOGICAL APPROACH ON PSYCHOTHERAPY

Having stated the basic principles of the phenomenological approach, it is now possible to discuss the implications and usefulness of these on psychotherapy and the healing of the patient.

Phenomenology is not a school of psychotherapy but an attitude to human beings. As phenomenology describes rather than explains, psychotherapy is not viewed as a technique but an approach which brings us back to the basic human experience of being-in-the-world. May strongly believes that "therapy must be based on a human model, a science of man" (p. 33) that takes into account the uniqueness of man (Smith, 1979). Phenomenological psychotherapy is viewed as a "situation in which one human being (therapist) is available to other human beings (clients) as fellow human being in the attitude of Gelassenheit or let-be-ness which is a special and active rather than passive participation in the unfolding beingness of the other person aimed at grasping those relational meaning coherences of the world that are specifically the client's, so as to facilitate his taking upon himself that existence which is his own" (Kruger, 1988, p. 190). However, the therapist participates in the life of the patient for only a period in time and is not involved in the ongoing process of his daily life (Moss, 1989).

Psychotherapy is thus not something the therapist does and the patient receives but a mutual encounter between two people in which there is an attempt to understand how the patient is being-in-the-world. May (1964) states that the psychotherapeutic "encounter" is "our most useful medium of understanding the patient as well as our most efficacious instrument for helping him open himself to the possibility of change" (p. 31). Phenomenology provides a broader framework which allows a wider range of behaviours to be interpreted as it takes the patient's whole world into account (Corin & Lauzon, 1994). It also broadens the focus from the individual in isolation to a human being relating in and to the world. Laing (1969) states that psychotherapy is an activity in which the patient's relatedness to others is used for psychotherapeutic means. As human existence is interpersonal to the core, it is only in relationship that people can be healed, develop and grow. "For phenomenology, ongoing, direct contact is the basis out of which understanding unfolds" (Halling, Kunz & Rowe, 1994, p. 126).

May (1958) submits that the phenomenological approach emerged as a result of "a protest against the tendency to see the patient in forms tailored to our own preconceptions or to make him over into the image of our predilections" (p. 8). He also states that different patients may require different approaches and that one cannot stick rigidly to one specific theory. The willingness to dialogue and allow someone to be who he is without judgement cuts across all theoretical boundaries. So, as Kruger (1988) states, the phenomenological approach is "quite indifferent to techniques to the extent that one may be practising the method of psychoanalysis..." (p. 190) through different styles to behaviour therapy as long as one is grounded in the phenomenological principles.

THE MEANING OF SYMPTOMS AND BEHAVIOUR:

Man can only be understood in terms of his whole existence and not merely within the framework that makes a distinction between healthy and sick. Boisen (1962) states that observable behaviour cannot be studied without understanding the meaning of the behaviour to the patient as well as its relevance to his goals. In order to understand the person and the meaning his experience has for him, one must study him in the context of his being-in-the world which includes the patient's interpersonal sphere, the network of social relationships, significant others, social support links, the sense of integration into family life and his relationship to social norms.

This is very different from the scientific world where facts have always been explored rather than the pathic moment or immediate communication with the phenomena (Straus, 1962). Science has also taught us that it is easier to interpret and analyse specific phenomena in a more systematic manner than to explore the whole experience. Boelen (1963) describes how the scientist is involved in only a segment of the human being's world which reduces the individual to the ultimate 'It' where he is studied as an object. Thus lived experience tends to be ignored in favour of factual specifics. However, man exists in interaction as a whole so it is necessary to move from the Cartesian split to an understanding of the person's whole world. Everything man experiences is in the lived moment which includes spatiality and time, where there is only continuity and "no gap between observer and observed" (Krishnamurti, 1968, p. 32). So, despite the difficulties inherent in the phenomenological approach of exploring the underlying experience as a whole, it is vital to do so in order to understand the patient as a whole human being.

Phenomenologically informed psychotherapy focuses on the meaning of the symptoms rather than simply exploring the causes of the behaviour. The patient's experience, the strategies he uses to face or avoid challenges and suffering, how he inter-relates with others and the world is of more importance. Thus, the primary focus is on what the meaning of a particular mode of reacting and functioning has for the individual. As stated, people operate in relation to objects in the world which have a particular significance and value for them according to the world they live in. The fabric of the patient's world is woven from what the individual chooses out of the whole to be conscious of and what has meaning and reality for him (Jaspers, 1963). As one explores how the patient lives and he gains a sense of wholeness, the symptoms recede as they are no longer necessary modes of functioning and being.

The phenomenological approach advocates suspending explanatory theory and presuppositions whilst experiencing the patient's world with him. According to Merleau-Ponty (1967), Husserl's view of reductionism is to suspend any or all reality judgements concerning the person's description in order to concentrate on the meaning of this experience for the individual. What is valid and has meaning for this unique person in his experiencing of the world is what is of value and explored. Merleau-Ponty speaks of Husserl's view that the world is what we perceive it to be and "the world is not what I think, but what I live through" (p. xvi - xvii). This shifts the focus from the symptoms to the phenomena which are always experienced within the broader context of being-in-the-world (Corin & Lauzon, 1994).

Merleau-Ponty (1967) believes that phenomenology's greatest contribution is in uniting "extreme subjectivism and extreme objectivism in its notion of the world or of rationality" (p. xix). He states that rationality is "measured by the experiences in which it is disclosed" (p. xix) and views rationality as a result of perceptions confirming one another which allows meaning to emerge. This indicates that the foundation for rationality is in the world and in communication with the world. He describes the world as the individual's and others' experiences of meeting and engaging. But there is also a shared reality that provides some solid foundation for people to live with and move from.

As Kruger (1988) emphasises, the focus of exploring is based on a subject-subject relationship rather than a subject-object one. He points out that phenomenological research cannot be reproduced in scientific terms for comparability in other studies but has themes which may be explored to assess the reliability of the work. As phenomenology stresses that phenomena are not measured, it is not the facts that are studied, but how they are experienced and grounded in the patient's living and experiencing. For example, understanding that one has certain feelings is insufficient for change. There must be an experiencing of these feelings before the understanding is integrated (Gendlin, 1964). Lang (1939), a schizophrenic who writes of his own hallucinatory episodes, supports the belief that the form of the experience is more relevant than the content.

Man is grounded in his world but lives the meaning of his disturbance through the body. How the body manifests problems provides clues as to the dysfunctional manner in which the individual is living. When there is a distortion of the sense of self and the body in eating disorders, this is displayed by a mind/body split in the patient's perceptions of her body and how she relates to it. For example, the anorexic has a delusionary self-image of her body and believes herself to be immensely overweight (Moss, 1989). Physical symptomatology must be addressed in relation to the messages it is providing. By viewing man as a unity of mind and body living actively in a world of dialogue and relationship, the value of the patient's experiences, which have all too often been missed in narrower theories, becomes recognised. The uniqueness of each person's experience is recognised rather than the simplistic, mechanistic, logical manner of knowing people through convergent thought. Convergent thought tends to reach only the most rational result which fails to recognise the unique, richness of each individual.

THE INFLUENCE OF THE THERAPIST:

The phenomenological approach has enormous implications for psychological theory and practice. It is a challenge to researchers and theorists to acknowledge that there does not have to be a specific way to heal. It is a call for the therapist to leave stereotypes behind and instead search for meaning in wholeness and uniqueness. Van den Berg (1972) advises the therapist to leave "his convergent weapons where they are ... on the shelves of his bookcase" and work to return the patient to "an everyday, healthy .... equally divergent life" (p. 32). The primary aim becomes to observe, comprehend and make the experience explicit in order to understand its meaning. The phenomenological approach has shifted the emphasis away from the Cartesian view to meeting the human being in his entirety. To step from the clinical, neat, ordered

safety of diagnosis and specific ways of working in therapy is to step into a world rich in diversity and possibilities for exploration. However, as Van den Berg explains, there is also dilemma, uncertainty, confusion and emotion due to the broader, deeper perspective. The therapist must resist the temptation to avoid this confusion and anxiety by only sticking to simple and safe techniques. This does not rule out the value of theories but suggests that the foundation should be man in his lived existence.

May (1992) discusses how the goals of psychotherapy have changed drastically over the century as the Western world has moved to focus on the individual. This has resulted in losing the element of surprise and wonder in psychotherapy as therapists are viewed as a guide to individual gain. May (1992) warns of the danger of losing "our sensitivity ... We take refuge in definitions, putting aside our awareness that every moment in therapy is distinctive and needs to be seen as new" (p. xxvii). Smith (1979) queries the goals of psychotherapy. Are the goals to remove symptoms, reorganise the personality or adjust to the norms of society and culture ? The last goal is a dangerous one as it is not necessarily in the best interests of the patient's integrated being to serve society's norms. Smith states that there is a difficulty in defining goals when there are no universally agreed models of what constitutes health and normality. The phenomenological goal of psychotherapy is that the patient "experiences his existence as real" (May et al., 1959, p. 85) and that he understands the phenomena and their meaning and value as they are currently lived and experienced in the world. The aim is thus to assist the patient to see his world in a different light, to heal sufficiently to live in relationship with more authenticity and not just experience behavioural change. The cure of symptoms is only a by-product of the patient's changed relationship to the world.

The therapist plays an important role in this mutual encounter and task of helping the patient heal. May (1958) states that "the central task and responsibility of the therapist is to seek to understand the patient as a being and as being-in-his world" (p. 77). Giorgi (1970) believes the description of the patient's world and the meaning it has for him should be allowed to unfold in an unbiased manner. Van den Berg (1972) supports this with his statement that the "investigator remains true to the facts as they are happening" (p. 64). To allow the patient's story to be revealed, Binswanger states that the therapist must communicate with the patient as one human being to another (May et al., 1958). There must be commitment from both sides to gain the real experiencing of existence. One can only be open to insight and knowledge as one grows and connects with oneself. For example, if the patient is unable to express his felt-sense of an experience, the therapist's ability to express feeling becomes a critical factor in assisting the patient to re-connect with his experiences and relate to the world (Gendlin, 1964). As this process unfolds, there is change in the content of the experiencing as well as the feelings and interpretations attached to the event. Thus, contrary to the usual belief that understanding follows from using the correct technique, May (1958) stresses that "technique follows understanding" (p. 77).

The core of the challenge for the therapist is to enter the world and story of the patient. By entering the patient's world the therapist indicates to the patient that his disturbed behaviour and world is real and genuine but is not the only experience and reality which means change is possible (Moss, 1989).

The therapist starts working with the basic description of the patient's world. Many phenomenological clinicians caution the therapist to beware of the question "why ?" as this cuts short the descriptive quality of the patient's experiencing and can result in therapists rushing in with interpretations. Asking the question "what?" encourages the patient to provide a fuller description of his experience. As Fischer (1989) states, "Once we know the whatness, the 'why ?' question disappears. The therapist is required to bracket his own assumptions, especially those provided by the diagnostic understanding of mental illness and his own cultural values and attend closely to the description unfolding. Listening and encouraging the patient to describe his experiences allows the phenomena to emerge with increasing richness and variety (Margulies, 1984). However, therapists should keep in mind that they can never have a clear, objective understanding of the patient's experience (Leonard, 1989). Meaning is interpreted by the therapist so every attempt at understanding is an interpretation of the patient's interpretation. When interpretation is utilised wisely, Fessler, 1978 (as cited in Smith, 1979) describes it as a "mutual sculpting" (p. 44) of the meaning in the psychotherapeutic relationship. This signifies a relationship in which both therapist and patient are focused on understanding the meaning of the patient's world. However, when the therapist makes inappropriate interpretations, especially with patients suffering from a fragmented sense of self, the result is often a very literal or concrete interpretation on the part of the patient. The therapist must be aware of the dangers of misinterpreting the patient's experiences as this can damage the relationship and result in the patient acting out what he perceives as literal instructions or advice. For example, the therapist may suggest that the patient perform a mental exercise of imagining what it might be like to be feeling the way his partner is the next time they argue in order to better understand the partner's viewpoint. The patient may take this suggestion literally and give his partner instructions as to how they should perform this exercise during the next argument. This can result in further confusion, anger and hurt feelings.

The call is thus for the therapist and patient to move together in a dance of mutual encounter which requires the therapist to be connected in a real, human relationship. The therapist is required to be more open, flexible and to constantly fight not to be caught up in the familiar, known, set theory. This is difficult as the therapist can become anxious when uncertain what to do and the pull to know and do is a powerful one. Given that there is this strong desire for knowledge in the midst of anxiety, it is critical that the therapist resists the pressure to find a quick fix and instead moves at the patient's pace. The patient is blinkered and cannot see the peripheral view so it is the therapist's role to assist in broadening the horizon to allow the patient to perceive a different reality and allow the unknown to become the known. The therapist forms a link to connect these two levels of awareness and this can only be achieved by inviting the patient to talk of his world (Van den Berg, 1972). When the therapist shares his insights with the patient, the patient may begin to perceive and know how and why he is interacting in the world as he is. In gaining knowledge and insight he is brought from darkness into light with new meaning. May (1958) distinguishes between a knowing within and a knowing about something. He views knowledge as important but states that genuine knowledge is always grounded in the actual existence of the human being. Thus, May believes that the intrinsic element of man is self-consciousness. Man must be aware of and responsible for himself if he is to live an authentic existence.

The therapist can also become lost in the process of living the experience with the patient. Lawner (1981) speaks of the need for therapists to "allow ourselves to be still ... stay close to our partners in the dark" (p. 306). The therapist must tolerate feelings of confusion and helplessness and use the value of waiting as he helps patients learn to stay with being lost in the dark. There is frequently a demand and pressure on the therapist to provide control in the chaos. However, therapists are not controllers but guides, and techniques and strategies do not "run to the heart of a person's deepest concerns" (p. 309). The therapist can thus only get to the core of the problem by sacrificing control and prediction in favour of unpredictability and lack of control in order to allow the meaning to unfold "in an accepting, unintrusive relationship" (p. 309).

Lawner (1981) queries how much of the bizarre and psychotic behaviour is within the patient's control. How much is the result of 'thrownness' and a frailty of personality and the patient's distortions ? The therapist's challenge is to stay open to hear and not diagnose - prediction and control yield unpredictable effects and prevent the story from unfolding and being heard in a true manner. Control can be used as a tool for gaining power or a means of controlling the therapist's fear rather than caring and thus being open to the patient. However, sometimes theory and knowledge provide a framework for the therapist to prevent him from being overwhelmed and wanting to remove himself from the psychotherapeutic relationship. There is a danger of being-in-the-patient's-world without keeping a boundary for oneself. This balance can be difficult to achieve and the therapist must strive for a position of tension between the known and the unknown. But, Lawner states that therapists move predominantly in the unknown and must not fall into the trap of thinking they are "directors or creators of the therapeutic process, rather than its servants" (p. 312). The therapist should have the ability to meander down the pathway of the patient's experience, in the ambiguity of the unknown, as it unfolds rather than attempt to order its direction.

To understand the meaning, especially at pre-reflective levels, the therapist must provide a sound, safe and trusting relationship in which the patient is able to be open and free to speak of his being-in-the-world. Communication and dialogue are essential and the therapist will not know the patient's world until he listens and allows himself to enter it (Leonard, 1989). The therapist is required to give full attention to what the patient is experiencing as a felt-sense and not necessarily to do anything. This also focuses the patient on his feelings in a lived, connected way deepening the therapist's understanding of the experiences and how this is being lived within the interactions and connectedness of the relationships of this person in his world.

The values of the therapist must include openness, acceptance and hope so that the patient can discover and reconnect with some sense of hope for his life and future. Halling and Dearborn Nill (1989) state that the therapist should have an empathic, disciplined, imaginative and receptive stance. Gendlin (1986 - 87) stresses what this author views to be the most basic quality necessary in a psychotherapeutic relationship, that is, respect. In his work with schizophrenics he speaks of there always being a positive way to respond to even the most difficult of patients. He advises us to look beyond the self-defeating behaviour which is so successful at alienating the patient from others and see the patient's positive attempt to reach others, to live and to be real. This necessitates reaching into the patient's experience past all the negativity to the

core of the patient with respect. It is important when doing this that the therapist differentiate between his own feelings and the patient's in order to truly hear and meet the patient in his space. By doing this and allowing himself to separate the other from his own fears for himself and the need to be the good-enough therapist, it is possible to meet the patient as a separate human being one cares for. Linked to this is the quality of empathy which Margulies (1984) views as "a complex empathic state" which is "at once both a passive, echoing experience and an active imagining of the unknowable of the other" (p. 1032).

The self of the therapist becomes the instrument through which healing in the relationship occurs. The profound connectedness in the psychotherapeutic relationship is the most difficult form of relating and requires the "most skill, the most self-knowledge and the greatest care because its potential for careless or destructive use is so great" (Clarkson, 1990, p. 155). If one has the attitude that the patient is struggling with aspects of himself and his world, the therapist can hear the patient's reality without necessarily approving of his behaviour.

Van den Berg (1972) succinctly summarises the patient's world of experiencing in the title of his book A Different Existence. He says the patient's world is as real to him as our world is to us but reminds us that what seems real to the patient does not exist in our view. The patient's relationship to the world has changed and it is in his world that the neurosis has developed. This means his perceptions of the world and the meaning they have for him have changed. Thus, the therapist must focus differently. It makes little sense to explain to the patient that what he is experiencing is not real - he is, after all, living the experience daily in a felt-sense manner. So, the therapist would be incorrect in telling the patient that he is deluding himself or that he is mistaken about his condition. The point is that the patient differs from others in recalling his past and he has a different opinion about the reality of his childhood. There is no use in confronting the patient with contradictions which he has heard before and will, therefore, make him feel unheard and unmet. This would not help the patient to get better.

It is thus critical for the therapist to accept the patient's experiences as real for him and not to avoid his reality. This is especially true for psychotic experiences where the therapist may fear that the patient will plunge into psychosis again or because the patient's reality is so obviously bizarre to the therapist. Prouty (1994) advises the therapist to be empathic and understanding of any increases in delusional and hallucinatory experiences. For Prouty this means being "empathic to the lived experience of the psychosis" (p. 50). He has done valuable work with schizophrenics suffering from psychotic episodes without the use of medication simply by meeting the patient in his world. Prouty describes four stages of hallucinatory experiencing: 1) the self-indicating stage where the therapist focuses on the image itself to make it more accessible to both the therapist and patient; 2) the self-emotive stage in which the focus is on the image and the feelings required to maintain the unity of process; 3) the self-processing stage where there is a shift from the symbolic image to experiencing the feelings; 4) the final stage where the feeling "shifts from the hallucinatory image to the person's own sense of self, and is integrated, owned and experienced as self" (p. 81). In this way the hallucination is connected to the self and integrated so that it gradually becomes part of the self-sense of experiencing.

Prouty's work emphasises the need to move at a pace that is comfortable for the patient who would regress if the therapist met him too quickly. Laing (1969) discusses the feared loss of identity for the ontologically insecure patient when the therapist makes correct interpretations that expose the patient too quickly. This risks making the patient feel engulfed because, despite the need to be understood, the isolation protects the self. Thus, patience and much time, even years, is needed to reach and shift people who are deeply damaged and fragmented. Chessik (1986) reinforces Heidegger's view that a person will only be able to live authentically when he is connected to other humans in a common world. This state of being can only be achieved if the patient allows himself a quiet space in which to reflect and contemplate. Learning how to be re-connected starts in the psychotherapeutic relationship. Each meeting is a unique encounter so only the therapist and patient can ascertain what is effective for the psychotherapy in that relationship. This can differ from patient to patient and what works for one is not necessarily going to work for another. But the basic respect for and meeting of the other as unique and special does not change.

THE IMPLICATIONS OF THE PHENOMENOLOGICAL VIEW OF TIME ON PSYCHOTHERAPY:

With the phenomenological understanding of time in terms of the concept of temporality, views of psychopathology are altered. Psychopathology is viewed as a variety of distortions in the way an individual is conceptualising his past, present and future (Moss, 1989). The difference between neurosis and health is that the past has been chaotic/traumatic for the neurotic and thus makes the future inaccessible, for an "accessible future means a well-ordered past" (Van den Berg, 1972, p. 92). Thus, Van den Berg states that for the healthy person, the past has a value it should retain but, for the neurotic, it is important to view the past and deal with it because it can and will affect the present and future negatively. Anxiety and depression affect the perception of time. For example, anxiety results in the person experiencing the future as threatening. On the other hand, to be depressed means that the person anticipates what has not yet occurred as being like the past and is, therefore, not able to experience the future as a possibility. Moss describes the immobility of depression where "in the absence of an inviting, future horizon, existence coagulates and flows with ... sluggishness and inertness" (Moss, 1989, p. 202). Thus, the challenge is for the therapist to help the patient gradually speak about his past and to anticipate the future as a possibility. This can occur in the context of the psychotherapy enabling the patient to develop a different relationship to the present and future.

However, as stated, the past is frequently the major stumbling block cluttering the pathway to growth. Patients often grapple with working in the past because they feel they cannot go back to resolve something already completed. Some have difficulty in recalling past events which are forgotten because the present will not allow the past to appear as it is too much of a distracting factor. This prevents the future from becoming accessible. Kruger (1988) maintains that "the past that meets us out of the future is the past that can be recalled, because such a past already holds within itself the possibilities for the future" (p. 115).

The past has particular meaning for the patient due to the specific circumstances and interpretations he has imbued it with. This is relevant as it requires the patient to deal with the trauma and chaos and fulfil the task that the past has set. Much of the difficulty

of working with the past is many patients' perception of it. The facts recalled are often inaccurate and distorted as experiences can deeply affect the perception of events and, as one is unable to return to childhood in a literal sense, one has to deal with the patient's perception as truth. There is also frequently a fear of repeating the past in the future. "Nothing can be done about the past as it really happened" so the patient can only "alter the roles of the people of his childhood" and "do something with his time" (Kruger, 1988, p. 101) in order to change past perceptions.

Our past and recollections of it have a motive or task which affects how the past is perceived and how one will move into the future. Our lives are often strongly dictated to by the future and yet traditional approaches of psychology have tended to ignore the value and significance of the future. Maybe because, as Van den Berg (1972) states, neurotics are often more focused on the past. This means that therapists often become preoccupied with the past because that is what the patient primarily talks about. It is also likely that the therapist will be more focused on the past and its causes because the emphasis, in many therapist's training, has been on finding causes/origins for behaviour. Also, traditionally, past memory or perception has been viewed as real events that have already occurred and are more easily workable with whereas the future is not fixed and is viewed as being out of our control to a large degree. However, our action and behaviour is directed at the future and no action is determined solely by the past.

The task of the psychologist is to assist the patient in connecting the various time periods of his life-history in order to liberate him to find meaning and to be and become in the fullest possible sense. Jager (1990) views the therapist as someone offering support which allows the patient to explore and fulfil his role and reach his potential. By understanding and healing, the past and the present are opened up, revealing possibilities for the future. The phenomenological approach allows the patient to explore and discover what his capabilities are and what he may achieve in the future and what he is unlikely to. The future is so real that it can largely determine people's behaviour, that is, our behaviour is so interlinked that the future (already influenced by the past) is enveloped by the present. Just as the past is past NOW, so is the future NOW as everything is experienced in the present. An important point for psychotherapy is that just as the past has a task, so does the future have a function. How an individual tackles his life in the future will be affected by the past experience of that same situation. So, although the past is behind and the future ahead, both have value as they powerfully influence experiences in the present. However, too much focus on either the past or the future negates the experience of being in the present (Van den Berg, 1972).

As a therapist one, therefore, becomes less engaged in clearing up the source of the problem but on liberating the patient by focusing more on unfolding possibilities for the future. If, as Kruger (1988) says, "the future is a very present phenomenon" (p. 203) in this approach, it allows both patient and therapist a wider range of freedom and a less constricting way of working. He states that people do "tend to repeat self-defeating patterns" (p. 203) and thus no-one ever totally "leaves his family of origin" (p. 204). Therefore, there is a need to explore the past, but the phenomenological approach allows for a three dimensional way of working and thinking, not only of temporality, but

as the therapist and, for the patient, in attaining the goal of a fuller, richer sense of self.

The implication of the above views is that by exploring the patient's relationship to his current situation and the things around him, one helps him focus and think about his relationships, actions and emotions and how they are inter-connected. This will assist him to gain insight and knowledge to function in a more meaningful manner and in a more realistic sense. It will also provide him with the ability to begin to interact in a fuller manner with the therapist initially and, as he progresses, with the people involved in his world. Corin and Lauzon (1994) stress the need to then broaden the therapist's focus from the alteration of the patient's experiencing to include how he uses this growth to change relationships in the everyday world. The patient can not only understand, be heard and exist as the burgeoning butterfly in the psychotherapeutic encounter but has to live and work in a real world on a daily basis. It is critical for him to grow and gain insight in a manner that will be effective for his daily living. This allows healing through the meeting of dialogue in a continuous shift of knowing and not knowing and of helping create awareness so that the patient can focus, explore and gain increasing control of his own world.

The phenomenological approach thus calls the therapist to give of his whole self in the psychotherapeutic relationship. Foulkes (1982) speaks of the effects that a therapist's training has on his style of working. The suggestion is that the training becomes internalised and this may lead to problematic blind spots which could limit the therapist. This will affect the type of interventions made and possibly the outcome. Thus, techniques may be maintained but, once one adopts a phenomenological attitude one's whole centre as a psychologist has to shift as one could limit psychotherapeutic success by staying in a particular mould of technique. One has to broaden both in growth as a therapist and also in the style of psychotherapy with which one works and change in attitude will affect change in technique to a greater or lesser degree.

The phenomenological view assists heal the schism appearing in aspects of psychotherapy, not only in the concept of Cartesian dualism, but in the tendency to view man as made up of separate parts of his own life-history and existence. If this is the case, this viewpoint offers hope for people whose problems have frequently been viewed as hopeless.

The field of psychotherapy is very fragmented as indicated by the fact that there are over 400 different psychotherapy approaches in existence today (Arkowitz, 1992). May (1992) forewarns of the dangers in the Western world in that psychotherapy is becoming a self-concern, a "new cult, a method in which we have someone to act as a guide to our success and happiness" (p. xxv). Phenomenology offers a deeper, more respectful approach to healing the patient as a whole. Despite the enormous implications and possibilities for healing, phenomenology is still not sufficiently recognised in the psychological field. For example, in the "History of Psychotherapy - A Century of Change" (Freedheim (ed), 1992), the schools of psychoanalysis, object relations theory, behaviour therapy, cognitive therapy and the humanistic approaches are discussed. Under the humanistic approaches there is only a brief mention of phenomenology which does not even do justice to the basic tenets of the approach.

This author believes that if one makes the phenomenological-dialogal attitude the basic foundation of being-with-the-patient before one even thinks of a theoretical approach, a sound, healthy base for healing will already have been established. One must hope that the approach will become better known and incorporated into psychotherapy since phenomenology brings with it a deep respect for human experience and thus has much to contribute to growth and healing.

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 than 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.

CHAPTER 9 - THE CASE STUDY

BACKGROUND:

I am a clinical psychologist trained in the psychodynamic approach with various courses such as phenomenology, object relations theory (ORT), cognitive behavioural therapy (CBT) and the like being an addition to the basic master's degree. When I began psychotherapy with the patient around whom this thesis is woven, I was working in a psychodynamic manner and had not yet heard of dialogal therapy. Working with the phenomenological premise that man lives in the world, the Winnicottian and certain aspects of the object relations theory views of fragmentation made enormous sense of this patient's world for me. As the story unfolded and my patient and I travelled the road together over the first eighteen months, I began to question why I had not ever thought of referring her to a doctor or a psychiatrist for medication. I am a team worker by nature and, when medication is necessary, I do not hesitate to suggest that it is included as part of the process in order to support and assist the patient's growth to healing. There certainly had been many patients who were less fragmented and depressed whom I had referred. It became clear to me that what was holding and healing this woman was the psychotherapeutic relationship and what she was experiencing within it. In 1997 Professor Steen Halling came out from Seattle University, in the United States, to lecture the doctoral course students at the University of Pretoria, South Africa. I read, listened, absorbed and heard someone finally speaking the language I had intuitively been living. This dissertation is a discussion of the journey which my patient and I are still undertaking over six years later. The psychotherapy journey will be followed by a theoretical discussion of the relevant issues. The understanding of the dynamics of the fragmentation in Winnicottian terminology provided me throughout the psychotherapy with a clear picture in my head of her shattered existence. Placing that within the phenomenological context meant that I always explored and understood her within her world of relationships.

OBJECT RELATIONS THEORY:

As the theoretical framework in this case is based on Winnicott's views, it is necessary to provide a brief summary of the relevant aspects of object relations theory and his views here. Object relations theory has developed over the past fifty years as a result of the work of many theorists from a diversity of perspectives (Ivey, 1990). Melanie Klein is viewed as the founder of the classical understanding of this theory. Winnicott followed with some major changes of great value and significance as these adaptations broadened the theory by focusing more on the value of viewing the child as part of a wider context of relationships. Winnicott views Klein's lack of examining the nature of the mother's influence on the psychological development of the child as a failure in her theory (Ogden, 1986).

In a theoretical sense, Klein is a direct descendent of Freud. Classical psychoanalysis provides a broad theory and knowledge to explain and work with neurosis. This does not, however, deal with more serious psychopathology and there was a need for a broader, more in-depth theory to address this problem. Object relations theory was a response to that need. Klein's theory developed as a direct result of working with children and psychotics and realising that the traditional psychoanalytic approach did not adequately cover these categories (Ivey, 1990). Freud worked with adults and

traced their neurosis back to childhood. Klein, on the other hand, began with earliest infancy and described the psychological growth of the infant and child. With both Klein and Freud the major focus is on the intrapsychic, inner world of the individual (Segal, 1973). Classical psychoanalysis focuses on basic drives and needs and the defences the individual uses to prevent the direct expression of these drives. Object relations theorists argue that striving to fulfil those drives and instincts is "the means to the end of establishing intimate relationships with people" (Ivey, 1990, p. 8).
The basic premise of object relations theory is that the quality of our first experiences forms the cornerstone of our sense of self and the foundation of a psychological life. It is here that the ground is laid for later mental health, neurosis or pathology. Klein explores the relationship between the external world of people and the internal images of those relationships at the level of fantasy. The focus is on how primary relationships in the infant's external world become internalised into a sense of psychic formation and personal identity (Segal, 1973).

Although contributing enormously to the psychoanalytic understanding of how psychic life develops in infancy and early childhood, Klein's views on the internal world of fantasy are not this author's frame of reference. Winnicott broadened Klein's views even further to provide a sound theory of the emotional and psychological grounding and development of the self. Winnicott, Fairbairn, Balint and Guntrip maintain that the mother-infant relationship provides the foundation for the child to form meaningful I-Thou relationships (Ogden, 1986). This approach is of more value in viewing the individual as developing within and being an active participant in a world of relationships.

Winnicott and Kohut introduce the concept of the self rather than the ego and this is a central aspect of their work. Winnicott (1963) emphasises the effects of the environment and the mother-child relationship on the development of the self. Many object relations theorists view the infant as initially in a state of 'unintegration' and Klein regards the ego as initially "unorganised" (Segal, 1973, p. 24). Psychological life is seen as only beginning when the distinction between the self and the other, that is, a concept of what is me and not-me, is made. Winnicott (1960) views the early child-mother dyad as one entity and not as a separate mother and infant. He claims that "there is no such thing as an infant" (p. 39) in the initial stages of life. In this state of symbiosis, which Winnicott names "primary maternal pre-occupation" (p. 147), the infant experiences no differentiation between the inner and outer world and experiences himself and the mother as one whole unity. It is only as the infant develops that he begins to differentiate and experience himself as a separate human being. The sense of being a separate entity is important for a person's development of his own identity and for a cohesive, well-integrated and balanced sense of self to develop (Winnicott, 1965; Ogden, 1983).

Winnicott describes the child as being born with the potential for a unique, individual personality which develops within the containing, holding environment provided by the mother. The degree of healthy individuation and development of the self depends on the quality of the original caretaking. When the mother's caretaking is sufficiently adequate and "good-enough", the infant can develop a sense of self as the mother facilitates the child's journey to individuality by not interfering with spontaneous growth

and development (Ogden, 1986). The 'good-enough' holding environment exists when the mother responds intuitively to the infant's needs and gratifies and affirms the child. This encourages exploration which transforms experience and allows meaning to develop. Failing to respond appropriately to the child results in chronic disorders of the self in later life (Winnicott, 1965; Kohut, 1977; Ivey, 1990). The balance is achieved by failing to be a 'too good' mother which provides the infant with his first opportunity of an awareness of being separate and the beginnings of self-identity. Thus, good-enough mothering prevents unintegration from becoming disintegration (Ivey, 1990).

Boundaries are critical in the growth and integration of psychological life as they define the limits of separation between those aspects defining the self and the rest of the world. If these boundaries are not firmly established the individual forever struggles with a lack of integration and a solid foundation of self from which to interact and be in the world. Boundaries are present in the physical sense from the moment of conception when the growing foetus is contained within the boundary of the womb and mother's body. After birth the infant perceives the whole world as his container which is boundary-less in the sense that the infant **is** the world. It is only through adequate mothering, where a sound container for experiencing is provided, that the infant begins to conceptualise and differentiate physical and psychological boundaries between the self and others, between the me and not-me. Winnicott regards the mother's role as providing an environment for physical maturation during pregnancy and then, in the first six months of life, for psychological maturation as the infant experiences in relationship and through biological maturation. The mother sets a boundary by preventing the infant's opportunity to experience the knowledge of separateness too early - and then facilitates his growth to individuality by not interfering with his spontaneous exploration of the world.

The maternal holding environment provides the infant with a protected space in which to experience differently and to gain new meanings through interaction. Winnicott (1965) speaks of the potential space created in the physical and mental space between the mother and infant as providing the experience between fantasy and reality. In this space the dialectical relationship begins and the sense of "I-ness" and subjectivity start as a result of the infant being reflected by the mother as a separate individual. By identifying with the infant he can start "existing" rather than simply "reacting" (Winnicott, 1960, p. 148). Thus, the sense of I as an interpreter of meaning, subjectivity and the feeling of I-ness are created. This creates a space and a sense of boundary between the I and Thou. In doing so, there is the possibility for the new experience of the other as a separate being but one who may experience and feel in a similar manner to oneself.

Just as the interactions with the primary caregivers in infancy form the individual's sense of self, so they influence the child's manner of relating to others in the world. If the basis for relating in a healthy manner is not established at these early stages by the holding environment that the mother/primary caregiver provides, Winnicott believes the potential for pathological interpersonal relationships is set. He emphasises the child's interpersonal relationships as well as the interactions between the infant and his world.

Winnicott (1960) states that any breakdown in the infant-mother relating hinders the infant's development to integration. Therefore, to ensure healthy development, the timing of allowing individuation, whilst still providing a nurturing and confirming environment, is of paramount importance. If this is done too early, the personality will develop with rigid defences. Likewise, if all the infant's needs are met, he will not learn to differentiate between the self and others and will experience himself as neither subject nor object with boundaries between the self and the other. Thus, if the mothering is 'too good', the infant is prevented from experiencing the normal frustrations, tolerable anxiety and conflict which becomes part of life in reality. If there is a prolonged and serious lack of good-enough mothering, the infant will be in a state of chaos and experience "a disruption of his 'going on being' " (Winnicott, 1963, p. 183). The result of this is a lack of a sense of continuity of being which can manifest as childhood psychosis or the borderline personality structure. Kohut (as cited in Friedman, 1985) supports this and adds that the fragmentation of the nuclear self structures are "permanent or protracted disorders of the self" (p. 63).

The infant may then form a personality organisation where a False Self is created and presented to the world in an attempt to protect the True Self which is the vital core of the personality. Winnicott (1960) states that the False Self is created as a result of needing to conform to external demands and expectations rather than responding to the natural, spontaneous needs of the real self. Thus, the breakdown of the good-enough environment may be a result of the mother's impingement of her own needs on the child. This False Self protects the True Self by addressing the mother's needs and allowing the True Self some sense of separateness and integrity. This compliance in meeting the mother's needs and not having his own gestures mirrored and affirmed, results in the infant setting up a "false set of relationships" (p. 146). If the infant/childhood compliance continues and the child's needs are never met, the person never fully develops and exists as an individual but only as an echo of the maternal needs. The individual then lives in a state of constantly merging with others to try and gain a sense of identity. This leads to a helpless sense of confusion as to who he is and what is required of him in the world of relationships. There is little sense of authenticity in any relationship as the manner of relating is dictated by the requirements and demands of the other person/s and the False Self has little substance and depth. Thus, the individual lives as an actor playing roles with no sense of self, acting out and being what others require him to be in order to gain some affirmation and acknowledgement of the self.

The False Self system comprises fragmented aspects of the self and, when this system is very strong, there is no relationship with a shared world. The individual tries to cope with the world alone but is unable to which increases the feelings of boredom, emptiness, isolation, a sense of futility and despair. Laing (1969) is a proponent of the Winnicottian concepts of the True and False Self and uses this terminology in the context of discussing the schizoid and schizophrenic individual. He states that when the False Self is dominant, the person only lives "mentally" (p. 78). This occurs because his inner world becomes more impoverished and the fear of being turned into an It becomes more threatening. As the person is not sure of who he is and that he even exists as a whole person, he becomes self-focused and self-conscious as there is a powerful fear that other people have the power to annihilate the fragile sense of

self. Thus, there is a need for constant vigilance. There is also the fear of becoming one with others and of being totally engulfed by them thus losing any sense of identity that is desperately trying to be gained. The tragedy is that the more the True Self is defended by isolation, withdrawal and the presentation and living of the False Self, the more the True Self is destroyed. Ogden (1986) states that the False Self structure can be enormously powerful as the caretaker of the True Self. The False Self manages life so that the inner self is not annihilated by having to develop according to the mother's needs, desires and impingements. At times the False Self may even paradoxically move to suicide to protect the True Self from annihilation. Laing (1969) describes this as a "denial of being, as a means of preserving being" (p. 161). So, existential death may be accompanied by actual physical death.

When the False Self forms the total facade the sense of dissociation from the self is profound. Laing (1969) aptly highlights this with a description of one of his patient's experiences where "she could not be herself, by herself, and so could not really be herself at all" (p. 61). If the False Self is in control, the world is experienced as being unreal and meaningless, so action seems futile. A sense of emptiness and futility pervade 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 True Self does not have direct relations "with real things and real people" (p. 86) thus precluding any chance of an I-Thou meeting. The individual is frightened of the world and the withdrawal and isolation of the self is largely a need to be in control. If one is not open to others, there is less likelihood of being annihilated as the individual feels it impossible to trust and rely on others to meet him with respect.

Although there is a longing for complete union with another, the individual feels terrified as that would mean being consumed and thus the end of the self (Laing, 1969). Thus, Laing suggests that the individual's actions are not a true expression of the self but rather "dissociated and partly autonomous" (p. 76) aspects of the False Self system. The dilemma is between meeting the other totally and being consumed and being the True Self and annihilated. There is even a sense of danger from the overall power of the False Self. In all instances the True Self is disempowered.

The True Self is aware of the emptiness of life, the high levels of boredom, detachment and lack of spontaneity, but the success that the False Self has in protecting the core is extremely difficult to abandon. Life feels safer for the individual when lived as the False Self as it is the only known way of interacting and is perceived to be the most successful protection. Laing (1969) describes the True Self as being experienced as the core of the False Self making the True Self feel disembodied. In a sense the body is then living the False Self. This makes it extremely difficult for the individual to relate to the inner True Self as a real part of his identity.

The participation of the True Self in life is possible, but only in the face of intense anxiety. Thus, the therapist working with a fragmented and suicidal patient must attempt to use the trust and safety created within the psychotherapeutic relationship to assist the patient to grow and come to terms with **his** way of being-in-the-world. Once that has been established, it becomes possible to move on to the person's functioning in relationship in the world.

The Winnicottian view of the True and False Self is a useful analogy as it aptly describes the unintegrated sense of self in deeply pathologised states. It provides a solid framework for understanding the patient in this study. Winnicott also firmly places the individual in relationship. Although the True and False Self structures are viewed as intrapsychic, he describes how the individual lives and relates to others in the world. Laing (1969) particularly emphasises the importance of inter-relating in the world. The concept of the child's sense of self developing in relationship and the False Self being presented and living in the world instead of the fragile, inner core of the True Self is highlighted throughout the case study to follow. Winnicott and Laing's perspectives combine relatively well with both the phenomenological and dialogal therapy approaches. Buber (1958) considers relationship to be the primary focus of life and healing and does not enter into the intrapsychic realm. Winnicott stresses the importance of the relationship in the development of psychological problems. In his own work as a therapist, Winnicott (1977) regards the relationship he forms with the patient as well as the relationships in the broader context of the family as being vitally important. Parents are encouraged to participate and learn from interacting with their child in the psychotherapeutic process. This is highlighted in his case study of the little girl he calls The Piggle. So, it is clear that Winnicott too views the psychotherapeutic relationship as being part of the healing process.

THE PHYSICAL SETTING:
My consulting room is carefully arranged to enhance a feeling of comfort, safety and warmth. One whole wall consists of windows through which the morning sun streams. The room is furnished with two old wing-backed chairs and a low, broad chair surrounding a coffee table. My desk and coffee table are handmade items and not office-style furniture. There are plants and nearly always fresh flowers on the side table. Two of the pictures on the wall are gifts from patients when they terminated psychotherapy - one a photograph with a small doll sitting in a big chair which the patient saw as the inner child being healed here; the other a sketch copied from a cartoon depicting a mammoth chasing a terrified man which he humorously called "small steps" after my encouragement for him to always move forward even in baby steps. These pictures speak to many patients who interpret them according to their own needs and perceptions. The chair my patients usually sit in is the high backed chair with arms which gives a sense of support as it partially encloses the body. It is sufficiently large for a patient to curl up in and it seems to be experienced as a strong and comforting chair.

CASE STUDY:
In certain areas where it is relevant or it emphasises a point, I have put Rachel's exact wording in. All her quotes are italicised.

The beginning of the journey:
I began work with Rachel, a woman in her mid-thirties, in August 1993. Rachel is an intelligent and articulate woman. She is also exceptionally beautiful. She is tall, elegant with a lovely figure, usually impeccably dressed and made-up with beautiful and expensive jewellery adorning her clothing and fingers. She makes a striking picture. Appearance is a very important issue for Rachel as her mother taught her that the presentation was *"all"* and much of her worth in life has been judged on that

appearance. Despite this Rachel arrived for her first session in what she recently described as an *"old outfit with socks"*, that is, she was casually dressed in a tracksuit with running shoes and socks. She had no make-up on and looked drained and exhausted. My sense of her, both in the initial telephonic conversation and when she walked into my room, was of a tired and lost soul who had been searching for too long to find a place to rest.

Rachel had been seeking answers for some time in organised religion and had finally moved to the Buddhist doctrine in the hope of finding some peace within herself. However, the wise and deeply caring Buddhist she consulted referred her to me advising her that she needed to focus on herself first. Rachel presented with severe depression and suicidal ideation and immediately invited me to enter a world of overwhelming fear and chaos with her. In the first session she described herself as irrational and fearful of her emotions over which she felt she had no control. She felt as if she were *"melting down and fragmenting"*. In her first few sentences she was already describing the intense loneliness and lack of confirmation of her childhood years. She described how she had frequently looked at herself in the mirror and *"cried inside"* because no-one could see who she was. She had no friends and experienced school as *"isolating"*. She described the loneliness and lack of confirmation in the relationships she had with men who were largely unreliable, inconsistent and immensely denying of her core as a partner and human being. For example, she met a separated but still married Italian man at the age of nineteen with whom she fell in love. Her strict Catholic parents, unaware that he was already married, insisted she marry or end the relationship. They lived together for two years until his divorce and she then married him as she viewed him as the *"protector of her sexual naivete"*. He proceeded throughout the marriage to act out his sexual fantasies with her and also insisted on menage à trois liaisons at times. Living in Italy with no support systems available to her enhanced the isolation she experienced. When she announced that she intended leaving him he held a gun to her head, threatening to kill her whilst advising her that he had previously killed other people. She fled Italy and returned to South Africa where she divorced him in 1983. Despite the divorce, he returned to South Africa and pursued the sexual relationship with her. This ended when he was shot in 1986. She reported being shattered by this event and, withdrawing from all emotions, focused on her career. At that stage she was having a sexual relationship with a man at work.

The above information was presented in a fairly disconnected manner as if she were afraid to connect with the emotions and was merely telling me a story about someone else. Her tiredness, fragility and vulnerability filled the space and I felt deep compassion as I quietly listened to her. In the initial sessions I simply met and contained Rachel as a human being in a strong holding space as she was very suicidal and severely depressed. The focus was to assist her to survive the immediate danger of suicide with the long-term goal of connecting her with a sense of self. Over time this would strengthen her value as an individual separate from the world around her and allow her to return into a world of interaction. Rachel described herself, in those early days of psychotherapy, as "*falling down a dark abyss ... and you put out a hand to stop me*". She felt isolated, lost and completely negated in the world as if she were simply going to disappear in that black hole into death. She felt disconnected from her life experiences and I worked hard at helping her feel a sense of connection within the

psychotherapeutic space. I always maintain good eye contact with people which is even more focused when the patient is in deep pain as I believe that the eyes do reflect one's inner feelings powerfully. Essentially I believe that one's whole body stance and movement, mannerisms, eye contact and tone of voice can hold the patient as effectively as the words one is using. In fact, at times, this non-verbal communication can be the major factor conveying to the patient that she is being met and heard in at least one place in her world. This was especially important in providing a holding space for Rachel as she spoke rapidly, feeling there was never enough time in psychotherapy to tell me everything. How I was with her rather than what I said created the safe relationship.

Rachel presented at sessions in her normal dress style fairly soon as she was back at work and it was even more important that her appearance hide the chaos within. The split between her True and False Selves became apparent. She felt she was unable to give of her real self and this was most obvious in her sexual encounters which she enjoyed on a physical, superficial level. These encounters were often manipulatively organised and handled. One had a sense of that from her presentation - the immaculate woman who described herself as able to *"be cold and hard"*. For example, she would sit and talk in a matter-of-fact manner about sexual intercourse and the frequent need for self-stimulation to gain any satisfaction. She sounded as cut off as she obviously experienced herself to be in those instances where there was no warmth or reciprocal connecting at anything other than the physical level. Although the woman behind that appearance had a desperate need for confirmation, these connections were an endless, frustrating cycle as the only aspect of her being confirmed was the facade. This left her feeling even more bereft and lonely after each encounter. These relationships were always linked to her feelings about her deceased ex-husband and her experiences with him. This suggested that she had not been able to move on as the experiences and feelings had not been processed. It led us into exploring the damage resulting from the relationship and how she had left that young, idealistic, pure woman in a time frame which was inhibiting her from relating and functioning as a whole human being. She said she felt a sadness and a loss. The idea that she needed to mourn the loss of her innocence and her ex-husband before she would be free to live and grow as a whole person seemed to surprise her. Mindful of not plunging her into grief while she was in an already fragile state, I suggested that we explore these issues slowly. She was a little afraid of the depth of the grief and what would occur if she connected with it. However, she was *"amazed"* that no-one had ever seen so clearly that her needs had never been met before. This linked in with her sense as a child of no-one seeing her when she gazed into the mirror at her own reflection. Thus, in some way, this was the first sense of confirmation she had ever received and this helped to tentatively create a link in the psychotherapeutic relationship.

An interesting factor was that she conveyed very little of the pain and loss in her body, eyes or voice. It were as if the fear of connecting was too profound. As a therapist, I have experienced the usual sharing of emotions in the space together where both of us connect with the feelings. With some patients, who are totally disconnected from their emotions, I have experienced being given the entire load of feelings to hold and carry. On those occasions the patient has sat calmly whilst I have begun to experience strong feelings of pain, confusion, anger, etcetera. But this was not happening with

Rachel. Somehow, in these early days, she was not connected to the emotions at all, not even enough to give them to me for safe-keeping. So, I could feel empathy for her world but little of the actual emotions she was describing.

Rachel's connection with mourning her innocence and ex-husband identified the pattern she had lived with for many years and which she explained for the first time. When the pain of living was too severe, she would turn towards *"the comfort of suicidal thoughts"* as this often felt like the only solution to stop the pain. But, in connecting with the grief, she had discovered for the first time that suicide did not feel as if it were a comfortable option. Rachel was experiencing the mourning as healing but it was clear that, in spite of her obvious intelligence, it was a great struggle for her to gain any degree of clarity on her emotional life.

Rachel's separate and isolated manner of being in relationship continued to be highlighted in her sexual encounters. Her discovery that her lover at work was living with another woman made her contemplate whether she should rather become involved with the Chief Executive of the company. She felt frantic at the thought of being abandoned in any manner and the realisation that she was not first in her lover's world was extremely negating. Hence, she felt a desperate need to move on and immediately fill the void. For the first time she was connecting with the feeling in my consulting room. She sat there with sadness etched in her face but her body also indicated the anger at his daring to treat her this way. I recall feeling happy that she was starting to connect. However, there was a sadness that she had no insight into the fact that these men were involved in other relationships and thus would never be giving her the commitment she desired. As she connected more she relied more heavily on the facade to hide the frightened, vulnerable, uncertain person she really was. I felt it important to treat Rachel with extreme gentleness and acceptance to reassure her that she could share her whole self with me with impunity.

There were intense feelings of loneliness as she floundered to hold a balance in a world that was primarily fantasy with superficial connections and false images. The beautiful image that she presented was confirmed in the high-flying, monied career of finance but nothing of her real self was ever met. This continued to widen the gulf between the True and False Selves and increased the deep insecurity of any authentic sense of identity within her. As she began to experience her real inner self and emotions she fought hard to maintain the False Self image and needed to keep people at a distance whilst facing her own demons. I felt this to be a good move as it meant she was stepping back from the enmeshment which occurred in almost all her interrelating because she had no sense of boundaries. She had a tendency to be totally involved or completely detached. Due to her lack of a sense of self and boundaries she also tended to absorb and become whatever she believed others wanted her to be. This manner of relating was mirrored in psychotherapy and Rachel listened to my wording as if it were the very lifeline she required. I was mindful of the dangers of her absorbing my reflections or views as fact or a demand for her to be something she may perceive I required of her. Thus, it was necessary to be very aware of the exact wording I used as it seemed likely that she could take my wording literally and possibly act-out a symbolic explanation. This sense was correct as she did at times in the future do exactly that. For example, she and I might have discussed the dynamics of a person

in the work place and she would use that wording and understanding to confront the person in a more literal sense. Or I would ask a rhetorical question and she might take it literally and repeat it as fact in a subsequent discussion with someone.

The perfectly turned-out model was an interesting contrast to the extremely psychologically fragile woman sitting in my consulting room. There was the painted face, the elaborate hair style, the expensive clothes and out of that presentation came this frightened, lost and disconfirmed child. The contrast was definitely more marked than in any other patients I have worked with. I would note this mentally but always looked past that and focused on the frightened child and fragmented adult. I discovered over time that this was one of the most significant experiences for her. She had always been met and judged on her appearance and she noticed that her appearance had no effect on how I was in the space with her. Magnificent or casually attired, she was just Rachel and this profoundly strengthened her sense of safety in the space.

At this stage Rachel and I were exploring how deep and pervasive the sense of loneliness had always been for her and how she had never been confirmed as a child. As Rachel is intelligent and has read widely, she tends to articulate her thoughts well and often uses theoretical wording to explain her own world. Again this often felt like a contrast for me as she could understand so much on an intellectual level but was an innocent in the actual ways of relating in life. This could have been a trap where the tendency to meet and stay with the intellectual woman could over-ride the need to deepen and meet the real person. It was a trap I had to remind myself of occasionally as the elegant facade and intellect could lull one into a deceptively false impression of whom one was working with. I did not always succeed and sometimes came up with images that she took literally. Then I would pull myself up sharply and remind myself that she was a deeply fragmented human being who could not interact in a typically healthy manner in the world.

Her loneliness had been exacerbated by her ex-husband's confirmation of himself through her. This resulted in her continuing sense of disconfirmation and lack of any sense of identity based on the real value of herself as a person. Her world had become a constant search for confirmation from others which she experienced as a frantic, unsatisfactory, disconfirmatory way of being. She would sit there and talk of the feeling of uncertainty and fear with the look of a confused, little child on her face. It made little sense to her that others could reject her as she tried so hard to please them.

During this early stage in psychotherapy, Rachel presented with powerful feelings of guilt as she felt responsible for her husband's death. She believed she had manipulated him into marrying her and, because the relationship had failed, this had resulted in his being in the situation in which he was murdered. She was still firmly tied to the emotional relationship with her ex-husband which prevented her from making any new, meaningful connections. There was occasionally a desperate quality about her as she talked although there was still often a lack of the actual feeling of emotions in the space. Despite the sexual encounter at work, she advised me that she was engaged to another Italian. He was a married man who was separated from his wife and lived in another town. She was even wearing his ring. Her face was alight with excitement when she shared this news with me and I again connected with sadness

that she was so lacking in insight that she failed to see the potential emotional damage this could result in.

Issues were viewed as black or white for her as they had been in her childhood where she was frequently perceived and treated as the *"bad girl"* responsible for causing unhappiness and stress for her mother. Now she was living out the bad-girl role but with ambiguity. On the one hand she spoke as if her engagement was wonderful and then she would express guilt and concern that she would not be forgiven for her sins. She was completely split and felt vulnerable, confused and uncertain as to how to step forward without the constant burden of responsibility and guilt. This split was mirrored in the display of emotions and her choice of wording. There was genuine excitement when she spoke of her fiancé with no sign of guilt most of the time. Then, appearing out of nowhere, without any obvious sense of connection, would come the feelings of guilt and the 'bad girl'. It was strange to witness the completely separate display of emotions.

Rachel was always on time for her appointments and would stride into the room, sit down and start talking immediately. Even after months of psychotherapy, she tended to give me as much information as possible in the shortest time period - she always came with certain issues to discuss and told me it was important to do this as she required my input in order to deal with the next week. My input was extremely limited but it seemed sufficient at this stage for her to simply have some confirmation from me. However, this made deepening very difficult and I would frequently need to slow her down in order to explore the depth and meaning issues and events had for her. I was also encouraging her to explore the issues for herself so that she could start to have faith in her own decisions. I had to be constantly alert that she did not live her life according to Cathy Angus' recommendations and views. This was a very difficult edge to work with as she still tended to take everything I said very seriously and literally. This was made more complex, as stated, as she truly had little experience in relating to others in an authentic manner and she would often surprise me with how little she knew about everyday life. She needed guidance and teaching about the basic principles of interrelating and I had to provide this with extreme caution so as not to influence her own choices unduly. So, I found myself thinking very carefully before I uttered anything and yet it was important for me to still be spontaneous and authentic. Often a tiring balance to maintain.

The feelings of fragmentation were powerful and she described herself as *"lots of broken pieces of glass"* and the pull back to the black hole and suicide were again strong. Part of this despair was due to the fact that her lover at work had announced he was leaving the company. She experienced this as an abandonment and betrayal as he had come into her life and was now leaving it, *"like walking in and raping me and going"*. Her face crumpled and she wept bitterly believing that she had lost everything she was gaining in psychotherapy, flipping back into the black/white, all-or-nothing way of thinking and reacting. This led into an exploration of how her identity and self-image were totally mirrored by the behaviour and reactions of other people. Although the 'bad girl' usually took responsibility for others' reactions, her immensely fragile core experienced this as complete abandonment and disconfirmation of her self and worth. As she seldom cried outwardly, she experienced a release and relief that she could

express the intense vulnerability in a safe place. My whole self was very present as I explored through the fears and pain with her and held the chaos. She found the experience of facing the pain a novel one as this meant she did not always have to suppress it. This provided the first glimmer of hope of a light at the end of the tunnel.

Rachel was able to hold the pain over the weekend, face it and yet not regress further towards suicide. Her sense of fragmentation at the core was still powerful and this was exacerbated by her lover at work with whom she had sexual intercourse again that week. She was unable to face the reality that he may have used her but this was clearly in her mind as she offered explanations and rationalisations without my even suggesting the above. She described how she felt she had been standing on the seashore and had been hit by a huge wave but had been able to remain upright, that is, hold the terror and pain without being overwhelmed. The sense of this was different from her usual inability to withstand assaults to her being. She was *"bruised but alive"* and she seemed tired yet excited at this development. It was lovely to see that beautiful face light up with real hope and a sense of control. She stated that she knew she only saw herself in relation to others and realised that she was already moving into a relationship with the Chief Executive but was unable to understand the dynamics.

Recognising the behaviour and yet unable to understand the dynamics left Rachel confused and even more lost. In the light of her feeling like broken pieces of glass, I gave Rachel an image to ground her. I used the analogy of a broken mirror where I likened her inability to perceive herself as a whole person to the inability to view herself as a whole if the mirror were broken. Thus, I told her that she was seeing herself in each piece of glass or interaction with another person who reflected back what she believed was the whole rather than simply a part of her. This was an image that worked for her and gave her some understanding. It also allowed her to stand back to try and gain a sense of her whole reflection as standing too close to each broken fragment prevented her from gaining an overall perspective of herself.

The first sign of the presence of psychosis:
Rachel held that image and did not immediately step into another relationship. This allowed her to reflect on her relationships with men in general. She likened me to a mirror, but a *"professional one"* from whom she could learn. Looking at the fragmented pieces indicated to me the first signs of how chaotic her inner world really was. She described how she had inner images at times that she could not alter. For example, she described herself connecting with a presence which she believed to be the power of God. She described her fear when she felt drawn to merge with this power and how the presence of a friendly, benign, non-directing power told her she was *"not ready"* to merge. This had occurred a few years earlier. She spoke with awe and a deep respect for the experience. Her body was alert and her face animated and there was an intensity about her that was different from any other time she had shared experiences with me. She followed this with another description of her perception of being a film negative which has other peoples' images printed on it. That left her in a space of despair and blackness. She stated that she often felt as if she did not experience feelings except in relation to others which left her feeling disconnected.

Opening up with this description was clearly a frightening experience for her. She told

me of a pastoral psychologist to whom she had entrusted information of herself. This man had advised her she was damaged and *"trampled on me"*. The feelings of despair, betrayal and hurt had been profound and it was clear that she was exploring whether this would happen to her in this encounter with me. Her body language and tone indicated the immense vulnerability in allowing me to enter at her core. We talked through the feelings and I reflected the terrible damage this must have resulted in with deep care and respect in order to convey to her that this would not occur here. At no stage did I comment on her inner images as being strange or wrong or attempt any explanation or interpretation. I simply heard the information, formed no opinions and entered into her world of experience. It felt for me that this grounded and provided her with a sense of being connected to as a Thou rather than an insane It.

Meeting Rachel in this manner deepened the psychotherapeutic relationship and allowed her to start the process, throughout the time to come, of entrusting me with all her unusual and altered-reality experiences. I did not regard Rachel as psychotic and her experiences were understood in her world as *"psychic"*. I made no attempt to disprove her beliefs and could not have as I felt that, although psychology would describe some of her experiences as psychotic, this was an irrelevant label and categorisation within which to attempt to understand her world. I simply listened with interest and respect for her experiences. This will be described in more detail in the section dealing with these events.

As Rachel began to get in touch with her emotions and own them to some degree, she started to reconnect to and describe childhood incidents. For example, she and her family had gone to a coastal town for a holiday when she was about four or five years of age. She described how a strange man had approached her, taken and held her over the balcony of a hotel room advising that he would throw her over it unless she came with him. She stopped his attempts to feel her sexually by crying and stating that she would go with him if he would put her down. He did and she ran screaming into the passage to find her parents. She connected with the feelings with intensity and sobbed with terror at the memory - the helplessness, the total disregard for her life and being, left her shaking. For her this felt like yet another situation in which she had been abused for someone else's desires regardless of her terror and this was experienced as a total negation of her core. She was bringing the emotion into the room in a real and connected manner which allowed me to experience the feelings she was describing more powerfully. Being a more active therapist, I do occasionally allow my facial expressions to indicate feelings at appropriate times and at a sensible level. So, when Rachel was describing the above event, my face, eyes and words conveyed my empathy and understanding at the terror and helplessness. However, she was displaying the typical splitting of emotions that object relations theory describes where a person can be totally connected at one moment and then disconnected at the next. One minute the terror was there intensely and then it was completely gone. This had occurred at minor levels before. It is a disconcerting feeling as there is not even a sense of the deep emotions expressed a few minutes before and the atmosphere in the room is as if the intense display of emotions had never occurred.

Not only was I present for Rachel but I was authentic. Confrontation was a problem for her as she feared it could lead to the destruction of any relationship. She had stated

that she listened to everything I said as this was her first experience of a totally safe place where she could experience herself without too much fear of loss. We explored how she had been able to disagree with some of my comments and interpretations over time and that this had not threatened the psychotherapeutic space. She felt this had only occurred because I interacted with sincerity and caring and that the world out there was not to be trusted.

Due to the lack of boundaries between herself and others Rachel was still unable to recognise which emotions were her own and which belonged to others. Thus, she flipped from positive moods to uncertainty, fear and negativity quite quickly. Rachel has a strong need to understand the dynamics in order to understand her own chaotic world. We explored her perceptions of experiences, emotions and the meaning events had for her as well as how each person experiences events in a different way. This was not done in a theoretical way but rather based on specific examples that she had experienced in life with others. Differentiating who owned what emotions was important as, by experiencing all the emotions as her own, she took responsibility for others' emotions and behaviour. Hence the guilt about her husband's death and the feeling that she was more *"evil"* than he as she had felt a presence before his death asking whether he could be released and she had responded in the affirmative. He was shot shortly thereafter and she perceived this event as due to her thoughts and power. This magical thinking was powerful and we worked together at reducing the fear and guilt in order to experience her own strength in drawing a boundary and separating him from herself. She had never seen herself as having strength as her life experience had conveyed the message that she was the victim who no-one ever saw, heard or understood. Confusion and guilt were arising due to a past lover who had recently contacted her and wished to resume sexual relations with her. Her strict Catholic background and upbringing was an underlying current that would suddenly raise its judgmental head to remind her of her behaviour as it did in this instance. She felt that *"having an affair"* with the ex-lover would not be right as she was engaged (to a married man). There was little ability in Rachel to see the overall picture and pattern of her interactions and this led us once more into exploring the boundaries she needed to try and establish.

The lack of boundaries also made Rachel quite demanding in her interactions. She would seek attention from others at an intense level and it was evident from some of her descriptions that people would often withdraw. She was especially demanding when she felt victimised. She was not demanding in psychotherapy and I suspect this was largely due to the fact that her needs were met here. But I could imagine how tiring she must be at times.

At the same time she was experiencing the Chief Executive at work as *"manipulative and unethical"* as she perceived him as attempting to ease her out of her job. Although feeling overwhelmed and suicidal, she was unable to take her usual comfort from the suicidal thoughts as there was an aspect of her that wanted to fight and gain some control. This suicidal state was also partly due to the fact that I was taking three weeks leave over the Christmas period and she was fearful of coping on her own. It is likely that she was also experiencing this as abandonment on my part and she was weepy and scared. She was unable to cope totally on her own over the holiday period and

called me at home on three occasions when she was extremely low, lost and isolated. The contact, although brief, was sufficient to hold her until I resumed consulting in January.

The recognition of the False Self:
Rachel was asked to leave her current employment and she moved to a new company that was in a similar line of financial business. Her first move in the new company was a plan to give the Chief Executive a gift with a comment indicating how expensive it was as well as only the section of her curriculum vitae that had good recommendations. She felt vulnerable and was clearly trying to present the good part of herself rather than the whole. She felt the rawness and pain of the disconfirmation and lack of acceptance in her previous employment but had blocked these emotions during my absence. She was still struggling to have faith in any of her own decisions and would frequently need to check their validity with me. As this was a constant request, I was used to gently exploring why she felt she needed to perform certain actions and what they meant for her so that she could decide for herself.

In her previous employment, she had presented totally as the False Self whilst never allowing others into her lonely, cold world. The image of the sophisticated, impeccably coiffured, intelligent businesswoman was all. The sense of dissociation from herself was profound. Within the first few weeks in her new job, Rachel was top broker and still exuding the success of the False Self. She was beginning to realise though that something about this presentation was not functioning in her favour. She advised me that she had been asked to leave two companies before this last one due to the structures she was attempting to put in place. She had also been asked to leave a charity organisation as she was again trying to bring in her own manner of dealing with people which conflicted with their policy. It seemed that at times she was too powerful and demanding in her role and this offended other people. So, despite Rachel's attempts to behave in a manner that would appease others, this frequently failed and resulted in disconfirmation. Overall though, she was rewarded for the persona she presented to others whilst her deepest feelings and thoughts remained hidden and, therefore, unacknowledged. When the False Self failed to satisfy people and the True Self was not heard, the profoundly deep disconfirmation left Rachel bewildered as she failed to understand why she was never perceived as good enough. It was important to try and understand the dynamics to avoid a similar occurrence in her current and any future employment. We briefly explored the need for control to cope in a cut-throat business world but at what cost this was for the gentle, fragile soul she was. With the typical fragmented, black-or-white manner of viewing life, Rachel found it difficult to find the middle path between only presenting the facade or giving all of her inner core which risked being trampled on.

That week she discovered that her fiancé had been in town on business and had not bothered to call her. She dreamed that she was walking in the bushveld countryside with a person who was good. She felt herself being drawn back and an evil presence shooting the good person. She had walked around the body, seen the hole where the bullet had exited and the person had died. She had wept deeply at the waste of human life. In exploring the dream, I wondered whether she was connecting with the sense of the evil presence and the waste she felt when her ex-husband was shot. I also linked

it to her own current experiences of disconfirmation at work and with her fiancé. She described herself as feeling *"blown away"* just as the person in the dream had been. She sat quietly as we felt the enormity of her own self being blown away as a result of still not being met and heard in the world. Silence is not common in this psychotherapeutic relationship and I was well aware that this hindered our process of deepening. Rachel preferred to talk an issue through endlessly, from every angle, to understand it. After the sessions she would ponder and think through the issues at deeper levels as was evidenced by the feedback and questions which appeared in the next session. Thus, it was as if she were absorbing every detail she could in the session so as not to waste a moment of that valuable space and then she would work with it at home.

With the safety of the psychotherapeutic relationship firmly established, Rachel was able to explore the constant pattern of seeking confirmation in relationships. We queried the high price she paid when she simply gave herself to anyone who would confirm her. It was difficult for her to realise that the so-called confirmation she received from sexual encounters was indeed a false one which her inner core recognised as inauthentic and further entrenched the belief that she was worthless. Rachel's worthlessness was confirmed for her in many different encounters. For example, she wanted to settle down with her fiancé and advised him that she wished to marry him. In response to her enquiry of what his intentions were, he was adamant that he wished to be with her and advised her of his planned visit to Italy to divorce his wife. However, her attempt at contact with him three days later threw her into the dark hole of rejection and abandonment. He had answered the phone and, upon hearing her voice, had replaced the receiver, had not answered the phone again and finally taken the receiver off the hook. She discovered this when she called the telephone services to enquire whether the line was out of order. She was devastated and we explored whether the relationship was worth the pain and she was positive that it was. This theme was to be played out again and again in this relationship as well as with other men in the future as she constantly chose unavailable or damaged men.

During her fiancé's time in Italy, Rachel was struggling to understand the different facets of herself which were still experienced as separate parts. She was extremely anxious about the outcome of her fiancé's visit to Italy and the uncertainty of the relationship. We worked with holding the uncertainty just as I had been encouraging and teaching her to hold the pain. Her fragmentation was so severe that she struggled to believe that different emotions could be coped with in a similar manner. It was difficult for her to understand that merely holding the uncertainty until it was calmed was possible. Her fiancé returned and made no contact. Fearfully she called him and he promised to return her call within a few days but failed to do so. This threw her into an awful space of abandonment as she feared she could not trust him and that her whole being was at risk. The lack of contact from him was a pattern that had been present and worsened throughout their relationship and the feelings of disconfirmation resulting from this treatment were powerfully destructive. She was feeling depressed and hopeless and visited a psychic who advised her that there was a Carmelite nun and a baby angel watching over her which calmed her. It felt to me that if she could not find the confirmation she so desperately required from human relationships, she was going to find it in the psychic world or, as it later emerged, in religion. But she had to make

sense of her world. The news from her fiancé, after the initial failure to make contact, that he would not marry her made her more despondent and lost. Rachel lived this abandonment and disconfirmation in her every action. She was less careful about her appearance, there were dark circles under her eyes, her body movement was slow but she would still head with determination for the big wing-backed chair that she found refuge in. When Rachel is very vulnerable she sinks even further into its embrace. Despite the heaviness and despair, Rachel still spoke at a rapid pace as if it were even more urgent to use every minute of the session usefully.

Previously Rachel had experienced her overwhelming and all-consuming pain as a punishment for being *"bad and wicked"*. Her mother's repetitive message that she was bad had resulted in guilt and a profound lack of worth. She believed that her tendency to suicide also came from her father's rejection as he was a harsh and *"evil"* man who *"hates when his needs are not met"*. The combination of her parents' treatment left her feeling abandoned, rejected, worthless and lost. She was starting to see a little more clearly now why her lack of worth and self-image existed. This enabled her to look at the *"door of suicide"* first rather than simply rushing blindly at it. As I gained more insight into the family dynamics, I likened Rachel's parents to a pair of scissors with her father providing the blunt edge against which the mother physically and emotionally cut and hacked. Rachel instinctively became passive to avoid the cuts and this approach was reinforced as she grew older and witnessed the terrible damage her older sister suffered by trying to fight the scissor blades.

At this stage she was feeling very fragmented as if she were three different personalities - one who interacted with the people wanting to annihilate her, one who interacted with the lovers in her life and the last being the businesswoman. Although she was drawn to these lovers, ironically this was one of the most dangerous areas as far as disconfirmation of her being was concerned. As she felt the rejection from her fiancé she was being *"drawn"* back to another ex-lover and a married man at work who had asked her to go away with him for the weekend. She felt unable to draw a boundary immediately and refuse the married man as she had been punished in the past when not meeting others' needs, especially her father and ex-husband's needs. Together we were able to explore the reasons why she chose to relate to a particular type of person, especially males. She constantly opened herself to people who did not respect her value as a human being and were often abusive and manipulative. In order to gain some confirmation and avoid punishment she attempted to please people, especially men as they reminded her of the damage her husband had caused her. We explored the concept of how people can only cause damage or be damaged if they are emotionally close and thus one does not allow any person to simply walk into one's inner sanctum. An important fact was that Rachel believed that if she did not give her *"all"* immediately in a relationship, she would lose the other person. This belief and her inability to form clear boundaries between herself and others resulted in exposing too much of herself too early in any relationship. The understanding that one could take baby steps to know someone, each opening a little to test if one was met with respect, and slowly build a trusting healthy relationship was alien to her. But she could see the safety in taking those steps and she did not go away for the weekend with the married man at work.

Overall though, to put those baby steps into practice takes a long time. She has established some boundaries and generally allows people in carefully and slowly these days. Certainly her childhood had taught her that people were abusive, manipulative and disconfirming and she was living that out in her current relationships. We explored how her vulnerability, insecurity and fear of abandonment also contributed to her viewing the bad aspects of people as a whole. So, when people were kind and caring they were perceived as being all good. If they hurt her, they were experienced as all bad. At times of great vulnerability Rachel was more apt to have her so-called psychic experiences. Rachel reported seeing a white light around me at times which, according to psychic beliefs, indicates an *"old soul"*. That is, someone of wisdom who has experienced much throughout their lives and has thus reached higher levels. At times I felt like an old soul but more as a result of the tiredness involved in meeting people at deep levels rather than the above ! The first time Rachel mentioned this was towards the end of her first year of psychotherapy. Her lover from work had just been killed in a car accident and she had experienced his presence strongly at the time of the accident. She felt a sense of loss and loneliness. In this session she discussed an incident in which she had been given a message by a voice that the Church and mankind needed to forgive Judas (see Chapter 10 for detail). She advised me that she was afraid of her psychic powers. Every time Rachel shared her altered-reality experiences it deepened the psychotherapeutic relationship even more. I continued to listen and meet her with the same respect as I did when she told me about any other experience and did not make an issue of the fact that this story was different from the usual flow of daily events. I felt that many of these events were being shared specifically because she felt that this was a safe place to open without fear of ridicule or judgement. The loneliness she was currently experiencing was mirrored in these events - she had never been able to share them without disbelief which had increased her sense of isolation and loneliness. To hold and carry the feelings of horror, fear and joy of some of these incidents all these years must have been a heavy burden.

Rachel's journey to integration fluctuated as she gained some sense of cohesion but then experienced suicidal thoughts and feelings, the darkness and the sense of worthlessness. The relationship with her married fiancé resumed and, while he continued to live in another town, she felt as if *"he has gone to war and I must remain strong"* in his absence. However, the lack of contact and interaction with him and the many occasions on which he failed to keep the promises and appointments made, left her with overwhelming feelings of loneliness which resulted in her feeling worthless. Rachel felt she needed to make him all bad so that she could hate him. Whilst this was a useful defence mechanism I warned her of the dangers of only looking into the fragment of the mirror. This negated the reality of him as a whole person incorporating the good that she loved as well as the bad that hurt her. She believed she may as well go into prostitution and *"allow myself to be abused"*. Although this brought up feelings and thoughts of suicide again, she was able to hold the pain and survive it better than she ever had. The worthlessness brought up feelings of enormous pain and rage against her father who had allowed the abuse in her childhood. She recalled the inconsistency of treatment by her mother who would scream at her and physically lash out and then be loving and giving. For example, there was a particular incident when she was eight years old where her mother lost control, threw her to the floor and attempted to throttle her. Her mother was also shouting that she would kill her and this

was a terrifying experience. On that particular occasion, as with many of the previous beatings, her father was absent and unable to protect her. She experienced him as generally unloving and unable to protect her. Now she was feeling uncaring of herself, tired and passive - this sounded to me like a message of "I'm worthless, useless and only good for abuse, so abuse me".

To add to Rachel's burden, her fiancé again ended the relationship as he was unable, or unwilling, to divorce his wife and disconnect from his family and children. Despite the pain, she surprisingly did not become suicidal although this was partly due to her denial that it had ended. However, in the past she would not even have been able to hold the chaos in order to deny any reality. She held the pain which was a huge shift from her usual manner of reacting and she found it an amazing experience to hold and experience her own emotions. She found that she again needed to make him bad in order to distance herself otherwise she felt too vulnerable. Rachel had always been so emotionally blocked. She would be thrown into the feelings, panic and work hard to disconnect from them. So, she had never been able to hold the feelings long enough to explore and understand them and discover that she could survive them. She was slowly learning to do this. I encouraged her to hold the vulnerability as I had before - with a gentleness that she would hold a wounded dove - contained but softly with respect for the woundedness. She was more able to do this with the pain and vulnerability but was still unable to really connect and deal with the feelings of anger. Anger had been too destructive for her in the past and it made her fearful of its presence in the present.

By the end of Rachel's first year in psychotherapy, her fears of abandonment and her need to be the 'good girl' were strongly evident. Rachel felt she had lapsed when she telephoned her fiancé. She was fearful that I would be angry and punish her as she had been in her youth for any transgressions. She feared I would terminate psychotherapy as I might interpret her behaviour as a lack of progress and feel that the psychotherapeutic space could be better used for another patient who was more deserving. This was a terrifying experience for her and she was timid and slightly subservient in her manner when she told me. It was awful to see her vulnerable in that way. I responded with an understanding that she had needed to call him and that this was quite natural. I knew her terror at being alone without a relationship although I did not convey this to her. I also acknowledged her fear of punishment. I, however, only did this briefly in words as I felt it would be more confirming if I continued to simply be constant, that is, the same caring, nurturing and accepting human being I always was with her. I felt if I was consistent she would experience that there was no punishment and be calmed. Overall, I did not make an issue of it.

She went on to describe a dream where she and her younger sister had been walking in the snow and her sister fell and disappeared into a dark pit. Her sister was, in fact, in a deep depression and wanting to die at that time. Rachel also fell but hung onto the ice feeling that she was beyond death and more isolated than ever in her life. She did, however, manage to pull herself out. I met that terror of abandonment with extreme gentleness. Together we explored how she knew in her dream that she would not be irretrievably lost in the pit and how different this was for her from the experience of uncontrollably falling into the dark abyss when she first came into psychotherapy. This

gave her some hope.

My approach did seem to calm Rachel and allowed her to continue sharing her religious experiences with me. She described an awareness in herself of *"something big"* and perceived herself to be an *"instrument of God"*. She described hearing a voice which was more like a thought than an actual voice but she believed this to come from outside herself. This description was delivered in a long rambling manner which at times made me feel uncertain as to what to think or how to react. I have added an addendum, for my own use, to Gendlin's (1964) dictum that one must not interrupt the process with untimely interpretations but keep quiet and listen. My addition is "when in doubt of what to say, at any stage, keep quiet and listen" ! So, I listened with respect and right at the end of the session she asked me what she should *"do with it"*. I asked her if she was afraid of this experience. She was not so I suggested she simply listen and try to understand what it meant for her. My meeting her religious experiences with respect and making no attempt to label them as anything other than her experience, grounded her within the safety of the psychotherapeutic relationship. However, I was aware that she was extraordinarily vulnerable and at risk. I was uncertain as to how to deal with this. More evidence of psychotic behaviour in the traditional sense was appearing and I wondered whether she was modelling herself on Shirley McLaine's descriptions of her psychic connections. Either way, all that mattered was that these were her experiences and we would unfold the meaning for her as we progressed on our journey.

This was a very frightening time period for Rachel. She was connecting at deeper levels and continued to feel afraid of death. However, she was starting to recognise other people's psychological damage and was not assuming full responsibility for their behaviour towards her. The dream of losing her sister in the snow pit was followed a month later by a dream in which she and her sister fell into a hole of quicksand. Rachel dreamed that, despite my efforts to save her, the sand closed over her head. The key difference for me was that she had managed to hang onto the ice and save herself in the last dream whereas she was expecting me to save her in this dream - and I had failed. This indicated to me that it was very important for her to know that I had not abandoned her as she clearly felt overwhelmed and completely lost in the darkness. Her emotional abandonment as a child was being lived in the present making her feel helpless, out of control and terrified. Was she connecting only with childhood and life experiences or did she perceive me as having failed in some way ? And if so, how ? Had I not met her as well as I thought I had a month previously ? Or was it simply the fear that I too would abandon her as everyone else did ? I did not feel a sense that she was unsafe with me as she had continued to share and behave in her normal manner. She described her feeling about not being saved by me as the fear that I might not be able to save her at the very deep levels of her core. *"It was the not-knowingness that made me afraid"*.

Over the next few weeks I monitored the risk of suicide, kept the boundaries firm and containing ensuring that Rachel continued to experience the psychotherapeutic space as constantly caring and confirming. This was critical as her whole being-in-the-world had never been constant and she lived with the fear that life would annihilate her. Caught in the dilemma of living and trying to find confirmation in the false world of business, she struggled with the uncertainty of *"where I belong"*. It was extremely

difficult for her to accept that she could be both a business and spiritual woman. Her fragmentation and the tendency to see only her own reflection in each interaction were still powerful despite the beginnings of integration. However, over the next few weeks, the depression lessened as she blocked the emotions less and allowed herself to hold and process the pain more. Rachel's lack of sense of being a worthwhile person had been shattered by the end of her relationship with her fiancé and, in her usual manner, she turned to find that confirmation in relationship with a married man at work. For the first time she was able to think of the possible consequences before she acted and felt caught between the desire and society and the church's possible condemnation. This was especially painful for her as she had recently been to confession and asked her priest for forgiveness for having an affair with a married man. He had been unaccepting and unforgiving and had refused to grant her absolution. This was a powerfully negating experience for her. She furiously verbally attacked him on whether he thought he could withhold God's forgiveness and stated that she would not leave the church until he did grant absolution. He obeyed but this left her feeling even more betrayed by a religion that was not meeting her needs and yet to which she was so powerfully bonded. The two major areas of her life, family and religion, were constantly experienced as betraying and disconfirming of her. The fact that she could discuss all this with real feelings of anger indicated to me that any fear of abandonment from me had lessened. For the moment at least.

My realisation that the psychotherapeutic relationship was providing the foundation for healing:

It was at this stage, eighteen months into the psychotherapy, that I queried my own manner of working with Rachel. Rachel had survived relatively well until her early 30's despite the intensity of her way of being-in-the-world, her deep depression and loneliness and her immature and damaging manner of relating to others in the desperate search for confirmation. However, when she started psychotherapy her defences were unravelling fast and she was losing any sense of control over herself and her world. We had been on a roller coaster of emotions and experiences during this time and yet the suicidal thoughts were less frequent and she was not as severely depressed. This led me into querying why there were signs of improvement in light of the fact that I had not taken the action of referring her to a doctor or psychiatrist for medication and/or hospitalisation. She had, after all, described herself as slipping uncontrollably into the dark abyss when she came to psychotherapy. Why had I simply stayed with her in her chaotic and terrifying world when I had referred other less fragmented patients for medication? Why did I believe that she would not commit suicide and why was I not feeling more anxiety about her possible death and the implications for me as a therapist if she did commit suicide ? I certainly felt anxiety about many other severely depressed patients and I did not perceive her suicidal ideation as a manipulative measure. There was something about what we had created together that seemed strong enough to hold that chaos. At that stage I knew little about Martin Buber and nothing about the dialogal therapy approach. All I knew and felt was that this psychotherapeutic space and my deep respect and caring for Rachel were holding her. Winnicott's views on fragmentation continued to make sense but it was clear to me that it was in the relationship that the real holding, healing and growth were occurring. I was amazed at her courage in undertaking this journey and of her faith both in me and the process and was completely committed to offering her the

confirmation which she had always been denied.

As if to confirm my thoughts, Rachel experienced her first sense of a boundary between herself and another. I think I was more excited than she was ! She was awed at this sense of separateness and the implication that she could *"maybe"* rely on herself. That there even was a sense of self, albeit fragile, was wonderful. Rachel was a mixture of feelings - joy and excitement but also fear of what it meant to rely on oneself rather than simply being what was reflected in others' mirroring of her. The timing of this sense of boundary was important as, shortly afterwards, Rachel's damaged older sister attempted to invade her psychotherapy space. The sister telephoned me wishing to discuss Rachel's condition with her and her mother. She then arrived unexpectedly at my consulting room to "see what you look like" as she had been given positive feedback about me from Rachel. In both instances, I drew a kind but very firm boundary and ended both interactions within minutes refusing to discuss anything at all. In fact, I did not even let her into my room but stood at the door to talk to her. I knew the lack of boundaries in this sister and the likelihood that she would tell Rachel that we had met and discussed her. Although this was not the case, Rachel was likely to experience that as a complete betrayal so I immediately divulged the information to her at the start of the next session. The sister had, as I suspected, already mentioned to Rachel that she had seen me. However, despite her intense anger at her sister, she did not feel any sense of betrayal from me or insecurity about the psychotherapeutic space. She was very pleased that I had been firm yet gentle with her sister and this made her feel protected. She looked rather like a pleased child whose parent had, for once, stood up for her and it confirmed for her that this space was a safe and sound one that could be trusted.

The experiencing of a boundary and the confirmation of the safety of the psychotherapeutic space made Rachel feel lighter and she even laughed on occasion in the sessions. She was holding the pain better, picking up less responsibility for others' behaviour but still seeking confirmation in sexual encounters as she could not tolerate being alone in the world. She was involved with another married man. Finding men for superficial encounters was easy for her due to her stunning looks. But, the connection with her inner self allowed her to recognise that she had been living a facade and she wanted desperately to change that.

The first real connection with confirmation and a sense of worth:
Coping better with the Christmas holiday break, Rachel was able to survive well for the three weeks without me. This indicated her increasing strength. The sense of being confirmed by the new lover was short-lived when he announced his wife's return to the marriage in an attempt at reconciliation. The sadness of these endless abandonments was that her total commitment to the relationships was not mirrored by the men who had no intention of, nor had even promised, lifetime commitments. Her fiancé was the only one who had promised the world but he had then taken it away. Although knowing we were only in the very early stages of her journey, I found it sad to watch these events occur as they would rock her newly discovered sense of self. It was as if every time she took a positive step forward, her own behaviour and way of relating would test whether she could hold it. I frequently felt a heaviness at these stages and wondered whether we would fight through the battle to integration that she so deserved. The

timing of his announcement was again paralleled with a fear of abandonment by me as she could not financially afford to stay on in psychotherapy. The terror that her one safe place would be taken away was clear in her voice and body language but she did not ask for a reduced fee or free sessions. She simply presented the problem. We gently explored the feeling of possible abandonment on all sides and I then stated that I would not stop working with her and my reduced fee was accepted by her. She cried with relief as she stated that this was the first time anyone had shown her that she was important enough not to simply abandon at the first signs of difficulty.

Rachel believed that her mother was the oracle of all wisdom and truth about life. So, any statement or behaviour from her mother was heard at the core and experienced as a confirmation or disconfirmation of the self - usually the latter. We explored the value of her learning to assess issues and deal with life according to her own standards, values and principles. I encouraged her to question and be curious about life. However, this process could only begin to happen as she started to experience who she was as a person with her own boundaries and views. The helplessness of being controlled and living according to another person's values and principles brought up memories of some of her mother's beatings where she had also been helpless. For example, she recalled having weals on her legs as a result of thrashings and her mother attempting to throttle her and stamping on her when she was on the ground. These helpless feelings were dominant as she was also struggling to survive financially and the only emotional support came from her older sister with whom she had an ambivalent relationship. She had no friends and the lack of support and helplessness combined to deepen her depression and feelings of suicidal ideation returned. We explored some of the active steps she might take to gain some control in her life. She needed a sense of direction and forward momentum especially as she had decided that she was really deeply in love with the latest married man who was attempting to reconcile with his wife.

Her parents and brother made the decision that her flat would be paid for so that the financial burden could be eased. Whilst this was a relief at one level, she felt the control her family exhibited by not discussing the issue with her. This control had ruled her life so it was hard to even experience the positive that came from this decision. This further increased the feelings of isolation and she experienced a feeling of the loss of her self. This was not surprising as she had never really connected with her True Self strongly and she had only begun to do this tentatively in psychotherapy. I was aware of the danger for her in moving away from the False Self with only a fragile link to the True Self under adverse conditions. I worked primarily with her on re-establishing the sense of self and the boundaries between herself and others in order to protect and empower her. It was interesting to see how important it was for her at that time that I was obviously present. It was insufficient for her to have me listening, hearing and caring and she required me to bodily and facially indicate my confirmation of her. For example, if I was listening seriously and did not smile during a session, she would read it as disapproval. By my continuing to still respond in a caring and gentle manner, and hearing that vulnerability and need for reassurance, she was able to link that her mother never really listened to her. She simply waited for Rachel to stop talking so that she could impose her own views. The lack of control and fear of abandonment led Rachel into trying desperately to hold onto both the relationship with her fiancé and her current

married lover. Cautioning her to move slowly as both were married and had indicated that they were not available, she showed me that she was unable to do that. It was either all and happiness or nothing, despair and hopelessness.

This led once again into lengthy exploration about her mirroring her worth in others' images/mirrors. She found it useful to ground this with actual examples: if her boss was in a bad mood it devalued her; when she started to call me "darling" and "sweetie" at one stage I had asked her not to and this had hurt her deeply as she viewed this as valuing me. Many other examples came to mind and were explored to show that other people had their own views, space and boundaries which were not always mirroring her or her value.

The turning point - Rachel's decision to live life for herself:
One of the greatest difficulties with Rachel relying on other people's opinions, and especially her mother's, was that it negatively influenced the psychotherapy space at times. Possibly sensing the change in Rachel and the beginnings of some autonomy, her mother suggested to her that she start to wean herself off me. Rachel advised me that she was sharing most of her psychotherapy experiences with her mother and older sister who, inevitably, contributed according to their own viewpoint. As Rachel viewed her mother as the final word, this was an important time in psychotherapy. Her desperate need for approval and confirmation from her mother wielded enormous influence as she stated that she knew her mother would approve if she terminated psychotherapy. Would she obey her mother or choose, without pressure from me, to continue her own journey towards healing ? I believed it vital that she make this decision for herself. Rachel described how she felt her mother *"lives through me"* and that she does not feel she is an individual or separate person. Despite her newly experienced boundaries, her mother's powerful influence made her feel that she *"goes off the rails"* when attempting to live for herself or when her mother was not ruling and guiding her. My sense of her was that she was extremely fragile and close to losing that newly found and experienced sense of self which could fragment her even further. She was allowing her boundaries to be violated in many areas. For example, she allowed a blind doctor to touch her sexually during a treatment and then felt abused. However, she returned to have further treatment and allowed the sexual contact to re-occur. It was as if people could wander in and out of her centre at will without her control. This was partly due to her giving people mixed messages about any intrusion and violation. This was a difficult experience for me to endure as the desire to stop this abuse and protect that innocent core was strong at times. It was hard to stop myself from stepping in and taking control which was the very thing I did not want others to do for her. The only way to deal with it was to explore the feelings of abuse she experienced and what the experience was like for her when she gave the control back to the abuser.

This invasion of her inner world by other people was exhausting her. Events which were experienced as minor for others were felt as overwhelming for her. As with any other behaviour that displeased Rachel's mother, she was punished. If she refused to follow her mother's rules, her mother would verbally and/or emotionally punish her with disapproval and attack. Or she would completely change the game and rules and start a new attack as she became more angry. We likened her mother to a picador goading the bull by piercing him with more lances. Rachel was afraid of the result of making her

own decisions but was determined to be herself. So, despite the pressure from her mother, Rachel made the decision to live her own life which included continuing in psychotherapy. The expected result occurred as her mother became histrionic. For example, she started walking slowly as if she were a very ill person. She advised Rachel that *"one can murder another person and not even know"*, suggesting that this was what Rachel was doing to her by choosing to follow her own intuition. Her mother asked her *"what one would say when one met God"* after this decision. Rachel's faith had already been unsettled due to the church failing to meet her as a whole, fallible human being, and she felt that this question struck at the core of her faith. She spoke of the realisation that she needed to play her mother's games in order to avoid the terrible punishment being inflicted and how she was rewarded when she did follow the rules. Together we explored how, after 37 years, it was not an easy pattern to stop especially when the effects of rebelling were so clearly seen in her older sister and in her own current punishment. Knowing that if she moved even a small distance away from the scissor blades she would be cut, she was querying the pain she would inflict upon herself. This double bind was tearing her apart. She queried retaliating by being abusive in return but felt this to be out of character and a *"split between my inner and outer self"*. A split between the inner hate toward her mother and the outer behaviour for self-preservation. Part of the dilemma was that she did not wish to hurt her mother. Rachel perceived herself as so *"weak and pathetic"* in not moving away from the parental scissors that committing suicide was justified. There was also the fear that she was like her mother. This fear was calmed somewhat as I worked with her on who she is as a person, the honesty and innocence, versus the vindictive punishment. Her mother returned home to a neighbouring country and sent a postcard stating that she and her husband were very "sad and confused" about Rachel's "illness". She added that they had only bought the flat as her brother had advised them that she would commit suicide if they did not assist financially. In the light of her current behaviour (of being independent), they had decided to keep the title deeds to prevent her from selling the property.

It was an anxious and tiring time for me. I was able to really feel the horror of those scissor blades with her. I wondered whether she would succumb to obeying her mother's wishes and whether this would mean the end of psychotherapy and her in every sense. If she gave in I feared that she would simply allow herself to slide into the dark abyss forever. It felt that the outcome of this event would decide whether Rachel would continue to move forward and live or not. The only thing I could offer was the knowledge she had that she was treated as a human being in her entirety in our relationship and that she was confirmed as a person of worth by me. Thus, I made myself as present as I could be in interaction with her while she explored the issues. Would that be enough to hold her ? The continuing battery from her mother reminded her of yet another altered-reality incident and she began talking of an experience at eight years of age when she had contact with aliens (see chapter 10). At eight her mother had given her a severe beating and she had felt as *"if something broke inside"*. The experience of seeing the aliens occurred afterwards and resulted in the parents believing the house must be haunted. They moved to a new home.

Feeling lost, sad and confused at the parental response, Rachel withdrew from contact with them and did not reply to the postcard. She still came to psychotherapy, never

missing a session, and our relationship became stronger. This engendered strong feelings of relief in me that somehow we had come through the fire and it signified a turning point in Rachel's life. It was going to be her life even at great cost. This seemed to shift her into a deeper mode of relating with me and in May 1995, one year and nine months into psychotherapy, Rachel began to describe more and more of her strange experiences from the past. In order to have some understanding of these events I asked her to write down how she had experienced them. This was an exciting yet scary time for her as no-one had ever encouraged her to talk about these experiences and get in touch with the meaning they had for her. The incidents are discussed in fuller detail in chapter ten.

During this time, when Rachel took her first major bold step to defy her mother and live her own life, her need for confirmation was strong and led her into having sexual intercourse with a friend of the current married lover. She was surrounding herself with false validation as she attempted to keep the three relationships going - that is, with the fiancé, the married man and the newly-met, divorced man. She became fearful that she was being immoral and, that like her mother, I would become angry and punish her for breaking the rules. I was in fact feeling concerned about the risks of her behaviour and she sensed my concern and looked puzzled and uncertain. She was having sexual intercourse with two of these men. No-one was taking responsibility for preventing pregnancy and she seemed unconcerned about this and who the father would be if she did fall pregnant. There was also no concern about AIDS. We explored how she needed to start taking some responsibility for her behaviour. I was worried yet accepting of who she was as I wished her to learn to differentiate between my caring of her being and my concern about the results of her behaviour - that the concern did not cancel out her worth. I was not angry or harsh but explored with her the wisdom of taking precautions to protect herself rather than always pleasing others, that is, in having intercourse without a condom because the men did not wish her to use one. Again I felt a despair and tiredness that she would ever be able to protect herself. It was also difficult at times like this not to get irritable with her complete naivety about such basic issues. Yet, not receiving any punishment or disapproval, just concern, relaxed her and helped her to look at the practical issues in a more sensible manner.

Rachel's current life mirrors her childhood experiences:
A relationship began developing with the divorced man, Pieter, and this was to become the most powerful test of her sanity and new growth. During the next few years his attempts to annihilate her emotionally and psychologically, coupled with frequent physical attacks, was to mirror her childhood and marital experiences. His family also created similar dynamics to her own family which further mirrored her childhood experiences. The physical attacks consisted of him pushing her, for example, onto a bed, slapping her and occasional punches to her arms or body. That was the extent of the violence, bar two occasions, and this differentiation is important in light of the events which follow. Rachel differentiated between the levels of violence and what was acceptable for her. For example, had Pieter ever done severe damage, like broken limbs, she would have considered leaving. However, even this is in question as she had accepted violence and abuse on all levels all her life. At all times I viewed the physical violence, in any form, as completely unacceptable !

The kindling of self-preservation and individuality was encouraged as she began to feel herself as a separate person on occasion. In July of 1995, nearly two years after starting psychotherapy, Rachel's mother was diagnosed with liver cancer. Preparing herself to face her mother became a major task especially as her older sister passed on a message that her mother had said she did not love her anymore. She crumpled in devastation, pleading with me to help her understand how her mother could continuously be so cruel and vicious. It was clear that her mother had not forgiven her for continuing with psychotherapy and her own life and my heart ached for her at this lack of acceptance. We sat together in the sadness. I warned her that her mother may increase the emotional attacks as she felt her power and control being threatened by her own impending death and Rachel's independence.

The trip to visit her mother went more smoothly than expected. I was afraid that Rachel was emotionally detaching from the issue as she was far too controlled about her mother's illness. This was obviously a form of survival but nonetheless a concern as not processing the emotions would complicate the grieving and the issues were complicated enough.

During the next few months we focused on building Rachel's strength and she began to draw boundaries with people. For example, she refused to be spoken to in a negative manner about a particular issue at work and was fairly assertive, refusing to take responsibility for the problem.

We continued to explore the issues surrounding her mother. The inconsistency of her mother's behaviour had severely tested any sense of balance within her. She described the following childhood memories: her mother's rages and temper outbursts followed by intense displays of affection; her perception of only being breastfed when it suited her mother and the many occasions when she cried and was not attended to; her depressed state of mind at thirteen when her parents took her to the doctor and were told she was physically fine and the doctor suggested they buy her a dog to solve her problems. These incidents left her feeling negated, disconfirmed, confused, isolated and lonely. I noticed Rachel's attire and it would provide additional clues as to whether she was connecting more with the True or False Self in her outer world. However, the clothes were irrelevant in terms of how I reacted to her. But that day when she spoke of these incidents it was as if the striking appearance was not there at all although she was still dressed impeccably - she was simply a woman in deep pain and it felt as if she were not dressed in those elegant clothes but simple garments that suited her current state of mind and being. It was a very deeply shared session and I felt really connected with her.

Her mother's inconsistency was again illustrated when she showed care and support telephonically when Rachel broke her leg at this stage. This was after her cruel words and very little contact in the past few months. True to form, however, she completely negated Rachel when she flew into the country a week later and refused to see her, telling the older sister to advise Rachel not to call her. No explanations were given. This was similar to the treatment she constantly received from her ex-fiancé and she was utterly exhausted with the whirlpool of confusion and pain about this behaviour. She sat in a state of numbness for much of that session with her wounded eyes

speaking volumes. I could see why she was so fragmented and had developed very little sense of a stable self. It was strange too to see this behaviour directed at her as she impressed as a very nice person - a difficult, at times demanding and confusing one, but a person who had no malice or nastiness in her.

This fragmentation was clearly indicated in a session where she spoke of her fears that Pieter's female business partner, Querida, was demanding and receiving more of his attention. The situation was difficult as Querida is a physically disabled woman whom Pieter obviously deeply cared for. The feeling of being ignored or, worse still used, led her to describe an incident which had occurred when the family was on holiday when she was thirteen and her younger sister ten. The older sister had brought some men into the hotel room who Rachel says *"sexually abused"* the younger sister. She connected powerfully with the emotion and sobbed bitterly for a few minutes. However, she then changed the subject and began to talk, without any sense of emotion or aftermath of the past few minutes, on another topic. This was so strong that I felt we were racing from event to event like flipping television channels leaving the emotions behind in each snippet of the episode. Obviously in a state of panic about the threatened abandonment and emotional abuse, she then stated that she had seen a gynaecologist who had advised her she was fertile. This was alarming as Pieter had not even indicated that he wished for a long-term commitment.

Pieter was angry at her possessiveness due to a past relationship of his. He would not hear her insecurity or fears which left her feeling lonely and isolated within the relationship. In this vulnerable state she started experiencing the sense of what she described as a presence again. She was occasionally feeling a frequency, like a vibration, within her which was followed by a strange, neither salty nor sweet, taste in her mouth. Concerned about the possibility of temporal lobe epilepsy (TLE), I tracked for further clues but there were insufficient symptoms to make that diagnosis. She felt that she was being called to heal via spiritual guides and was reading about chakras, auras and spiritual matters. She would bring me reading material to enlighten me about the soul so that I could share her excitement and discovery. I read some sections and we discussed some issues but she did not feel a need to explore them too deeply with me as she was exploring many areas with interest. Her naivety was again displayed when she announced that she planned to do a short course on spiritual healing or reflexology and then make her own certificate. I explored with her the need to investigate further and train.

The death of Rachel's mother:
In the December of 1995, when we parted for the summer break of three weeks, Rachel's mother was very near death. Rachel was finding herself able to draw boundaries quite firmly with her father but her mother continued to send mixed messages which confused her. Knowing it likely that her mother may die during the break I left a telephone number where she could contact me. The first call I received was from Rachel's younger sister to ask my advice on how to deal with Rachel. Her dying mother has asked the family to leave her bedside and Rachel had become hysterical, wailing and thrashing around, which had resulted in her being heavily tranquillised by the hospital staff. She continued to be medicated over the next few days and I attempted to hold Rachel in a contained space from over 1 500 kilometres

away. How I wished that the telephone were not the only form of contact then. Although she sobbed so much that I was not sure she was absorbing what I was saying, it seemed to give her some semblance of reassurance to hear my voice and know that I understood and cared. This highlighted for me how vital the psychotherapeutic relationship was for her in attempting to hold onto some feelings of sanity as her core shuddered at the loss of the woman who had guided her thoughts and behaviour until then. I wished that we could have held that terrible pain and loss together in the psychotherapeutic space where there would have been no need for medication and tranquillising the pain away.

In the new year Rachel and I explored the events surrounding her mother's death. She had stated in front of her mother, who was awake and alert, that she felt her mother to be dead already. She was feeling paranoid about the family and their shocked response to her behaviour which she believed was honest and thus acceptable. However, in reality, this defence only isolated her from the family at a time when she critically needed to feel part of a close, sharing and supportive unit. She believed she had made peace with her mother and that there was no unfinished business. I did not believe this to be the case.

In order to avoid dealing with the grief, she withdrew from the family and focused on her relationship with Pieter. Two months after her mother's death, Pieter and she committed to a relationship together which led into her being emotionally attacked about her past indiscretions. His obsessive jealousy resulted in him querying her daily movements, wanting detail about her past liaisons, stating that he could not trust her even with his father and that he could not marry her because of her past behaviour. He showed her a pornography film to *"test my reactions"* and the mistrust crept into their physical relationship as well preventing even that from being a pleasurable experience. Throughout this time they were attempting to conceive a child and I explored with her whether the timing was right - the relationship was new and there was no solid foundation of trust or respect on which to found a long-term commitment with a child. She did not seem to find it incongruent that she could want to have a child with this man amidst all this tension and instability. As long as she received attention and thus confirmation, albeit negative, she was committed. She appeared happy and in love despite his behaviour. She was more energetic and often quite bouncy in her movements and she looked happy. I feared that the facade was back in full force.

The mistrust continued to permeate every moment of their daily life. For example, Pieter would even query whether she had been masturbating if she sounded slightly breathless from having run to answer the telephone when he called. Due to his own loss and abandonment his pattern was to become angry, lose his temper and then tell her to leave which fed straight into her terrible fears of abandonment. His jealousy of the psychotherapy space was also evidenced when he stated to her that he had no wish to marry me as well.

A brief background of Pieter is necessary to explain his fears and behaviour. He is approximately 185 cms tall and overweight. Pieter had a son in his previous marriage who had a serious medical condition. When the baby was six months old his wife left with the child. The boy died about four months later. It was clear that he had not

processed this awful abandonment and loss and he continued to play this out in his current relationship with Rachel. Helping her understand his feelings and fears assisted her in not always responding in a personal way to his daily attacks. Her reassuring responses also started to calm his behaviour a little about the sexual issues.

The alienation from the family and her current relationship began to rattle her facade and the feelings of isolation started creeping through. Worsening the situation was the fact that her mother had always laid down the basic rules for her behaviour, expected lifestyle and work, values and, she believed, even her thoughts. Now there was no-one to do that and she turned to me. Together we explored the need for her to begin finding the boundaries for herself, discovering her own values, beliefs, desires and principles. She began to sense a feeling of separateness that was different from the isolated, fragmented space she had lived in for most of her life. She was gaining a sense of who she might be but this felt overwhelming at times as she still did not have the ability to step back and see the overall picture. I worked gently at helping provide that larger framework in which she could find herself. This I did by respecting who she was regardless of her behaviour; by not punishing or criticising her for her endless past sexual encounters that she was now being severely punished for by Pieter; by seeing through the facade that she had erected and recognising the innocent yet damaged inner self; by not telling her how she must live her life and respecting that she would start to learn that for herself - yet also not abandoning her in the sense that she was very lost and did not have many clues of the direction in which to move forward. Exploring together what made sense and what was comfortable for her, helped her establish this for herself. There were times though when I had to suggest practical, sensible alternatives as she was truly a babe in the woods in many ways. I felt this to be important as Pieter was ill, still accusing her of sexual misdemeanours and stating he could not marry her. There were financial problems and yet neither of them was taking precautions to prevent pregnancy - she wanted to explore this and we looked at the possible consequences. Attempts at exploring why she was staying in the relationship at all were met with little discussion and the statement that she loved him.

Pieter's parents were living with them at this stage. The incongruence of her mother's behaviour was being mirrored by Pieter's mother. For example, she would be sweet and nice to Rachel at times and then nasty and insist on speaking their own language for the evening despite knowing that Rachel did not understand it. Rachel felt worthless with what she perceived as the insincerity from Querida and Pieter's mother and the increasing acceptance of Querida into the inner family circle which she felt she was not accepted into. This was exacerbated by Pieter's verbal attacks followed by his usual comments that she should leave if she could *"not take the heat"*. The need to perceive herself as a separate person and not simply a reflection of his aggression was critical for her survival.

Of importance was, that despite the trauma of the past ten months, Rachel was not suicidal and had not mentioned this as a choice in that time period. This indicated that the beginning of her feeling of cohesion within and a sense of self had held firm under the stress and attacks on her physically and psychologically. Although this wavered constantly she was not returning to the perceived safety of annihilation. But I feared that the continuous attacks would result in her newly developed sense of self

fragmenting if the situation did not settle. Pieter was losing control almost daily, asking her to leave and waking her at night to ask her whether she was masturbating. He told her he was deliberately trying to break her and that being physically abusive and waking people in the middle of the night when they are most vulnerable was a way to achieve this. This resulted in a panic attack which Pieter ignored as he viewed it as her being hysterical. A few days later he reacted with agitation when he heard his partner bang her wheelchair. This deeply caring attitude towards his partner whilst abusing Rachel shook her to the core and increased the feelings of worthlessness. She would sometimes sit and tremble as she weepily described these episodes. What was significant for me was that she was doing less of the flipping from emotion to emotion and one could see and feel that the emotions were more connected as she stayed with the feelings for longer periods.

However, the turmoil inside was shown by Rachel experiencing another vision where she saw her mother who told her to move out of the abusive relationship and not stay as she had in her marriage. By then, these hallucinatory events were simply part of the normal talk in psychotherapy - she was not hesitant to talk of them and I continued to treat them as I did everything else. We were able to move more deeply into why she was still in the relationship then and she admitted to fearing that she would return to *"what I was before"*, that is, a woman who moved from one sexual encounter to another. She was recognising her fragmented way of being-in-the-world at some levels and seeking a stability and constancy in one relationship albeit destructive. Rachel withdrew and formed a boundary between her and Pieter to protect herself. Her ability to draw a boundary had not been existent in her life until the last year so it was a healthy sign to see this happening. As often happens when first learning a new behaviour, there is an over-compensation. She became cold and vigilant and feared that this behaviour reflected who she had become now. Still unable to see that her core had not changed simply because she was protecting herself, she was unable to feel that she was many faceted yet. Working with this, she began to see that she was a separate person even if not feeling that she was a whole one. For the first time she began to feel anger at how badly she was being treated which was a welcome sight after the endless passivity of her childhood and life. She was starting to change the habitual manner of survival and explore new ways of facing the dangers to her world but she was desperately needy of my support as she seemed determined to face her dragon to the death if necessary.

Despite the obvious growth, I was immensely concerned for her at this stage - not because I feared that she would commit suicide but because I feared that her fragile self could shatter into a world of fragmentation and psychosis forever. During this time I kept the boundaries of psychotherapy very firm so that there was one place that she could rely on as consistent and safe regardless of her state of mind. This I achieved by being very obviously present and gentle and listening with intensity. At times this was difficult as she would race through a session discussing many topics indicating her own confusion and conflict and referring to many incidents. It was important to her that I did not fail to recall anything she had said previously and this required intense concentration on my part. I noted in her file that she had made me feel like a whirlwind in one session and it became even more important for me to provide a solid foundation if this was any indication of what she was feeling.

Pieter went overseas on a business trip with Querida and shared a hotel room with her in order to help her which meant a very intimate and close sharing. Rachel felt that Pieter empowered Querida even more by sharing the details of their personal and sexual relationship with her. I felt Pieter's psychological intimacy with Querida paralysed Rachel's soul as effectively as Querida was physically disabled.

In the midst of all this turmoil Rachel became pregnant and she, Pieter and his parents were delighted. Despite the fears about the relationship, this was one way she could hold Pieter and not lose him totally to Querida. A tentative peace settled for a few weeks and then Pieter's fears and damage in relation to parenthood erupted. His loss of control was evidenced in endless screaming matches where he would tell her he wanted to hit her, that she must have an abortion, that she should leave and that she should not be so jealous of Querida. Despite his own obsessive jealousy it did not seem to occur to him that sharing a bed and room with Querida for a week had any right to unsettle Rachel. Pieter's mother continued to mirror her mother's inconsistent behaviour by alternatively caring for her and then also wanting her to leave. Rachel expressed the feeling of being blown apart by a bomb when this happened. I felt quite hopeless at the continued assault on her being as she would not even consider leaving him.

However, over the next two months, Pieter began to show some gentleness and, with input from me to Rachel on how to hear his fears and reassure and calm him, he did become calmer. We began to explore what relationships consisted of in general and how she could exhibit different behaviour and still be the same person. It was clear that she did not know her own needs and desires as she had only felt and lived her mother's needs. Any other focus was on survival and existence. So, she had believed that her needs changed from person to person and situation to situation and if the needs were new the others became invalid. For the first time she was beginning to see a constancy in herself as we talked through her past relationships and what had essentially been needed and sought after.

In understanding herself and drawing boundaries she was able to prevent Pieter's barbs from being less damaging. He was sinking into a pit of feeling a failure as the financial situation worsened and he believed he had let down his partner, family and Rachel, in that order. Again, his manner of dealing with it was to tell her to leave the relationship and return to her flat and support herself. He threatened suicide in front of her and his parents on the anniversary of his child's death and admitted he feared they would lose this child. Rachel was able to stand back from his extreme messiness but was uncertain as to whether she was drawing a boundary for herself or caring less about him. This experience of withdrawing into herself and not automatically mirroring herself in another fragment of mirror was very alien and she felt isolated and strange at being a separate human being. My concern was whether any of the withdrawal was as a result of depression. It was no longer simply a concern for her mental state but that of her unborn child's life.

The relative calm that had existed for a month shattered and, when Rachel was four months pregnant, Pieter resumed his violent outbursts. On a weekly basis he lost control in the same manner he had always done but the physical attacks were now also

a threat to their child. The strength Rachel displayed was amazing as she firmly drew boundaries to protect herself by asserting herself and refusing to play the games that he and his family dynamics demanded. She began querying whether this was the same man she had fallen in love with or whether this was the real Pieter and this was very frightening for her. The good news in all this chaos was that the foetus was declared healthy. Caring for her unborn baby and Pieter were Rachel's first priorities. I slowly continued with the concept of also caring for herself as she was determined to make the relationship work *"at any cost"* and I feared that the cost might be her sanity. She was, however, beginning to see that her assertiveness slowed the process of attack down.

Sometimes bringing the issues to discuss with me first prevented some acting-out on Rachel's part that could have further damaged relationships. For example, a wild, rambling letter to Pieter's mother in response to her negativity towards Rachel was not given to his mother and the issue was processed in psychotherapy. Her tendency to spill out her emotions regardless of appropriateness and timing frequently caused problems in relating to others. One had a sense of what she was like when acting-out her feelings when she described them to me. She would speak in a dramatic manner describing herself as being *"raped and betrayed"* or that Pieter was *"utterly bewitched by that woman"*. Her whole body showed the anger and hurt. This was the only stage where any consideration of hospitalisation came into the six year psychotherapy. She had telephoned me in an hysterical state to say she was very suicidal and completely out of control. Pieter was being abusive. To avoid hospitalisation, I arranged for her younger sister to visit the home and take her away if the situation demanded it. Her sister and I arranged that she would be available at all times to go to Rachel if she called and Rachel accepted this support. I also made it clear that she could call me at any time should she deem it necessary.

Rachel's responses to Pieter's attacks were more emotional during her pregnancy and she admitted being concerned about the foetus who had been very active and agitated during the above outburst. With Rachel's permission I had a session with Pieter. We briefly discussed his own grief and loss about the dissolution of his marriage and the death of his son. We also explored various concerns including the difficulties he experienced dealing with Rachel's outbursts, her high libido and her demands in general. I spoke about the unacceptability of the violence. He was also open to hearing her damage and the pain he caused her. It was interesting to hear his experience of her. He found her beautiful, interesting, exciting but also demanding, exhausting, unreasonable and highly emotional which I could understand. Fortunately he took my advice and considered psychotherapy for himself to deal with his grief for the loss of his child. He has been intermittently since then to see a therapist.

Rachel realised she was viewing Pieter's mother as the fantasy mother in an attempt to have a good mother but that this mother, too, was destructive. This elicited huge anger in Rachel which was a relatively new emotion as she had always been punished for this in childhood. It was only as she gained strength and some belief in herself that she was able to connect with anger and at times it was quite startling to see. She would sit upright in the chair and raise her voice whilst telling me about the injustices that she previously had been so passive about. I would think "good for you" but always watched

for the edge where she would take it further and act it out. This was particularly important as Pieter's anger did not abate and the usual pattern of emotional and physical abuse was ongoing. Now there was the added threat of him taking her child away. I believed she and her child were in danger and discussed the possibility of her leaving the situation. Although I knew this was Pieter's worst fear, I could not stand by and watch her and her child abused. She refused to even consider this as an option.

A particularly ugly incident occurred early in November 1996 when Rachel was seven months pregnant. Pieter had been emotionally abusive and had physically pushed her around during the week. This built to a crescendo when he lost control, screaming at her to leave and that he would take the child. He then locked the bedroom door so that she could not escape. Continuing to be assaulted, she had retreated to the corner sobbing where she curled into a foetal position to protect her child. She described how she withdrew into herself and disconnected with what was happening to her. In this dream-like state she felt separate from her own body and a powerful image of my face came through replacing her vision of him and the room. She held onto that image stating that this was *"what pulled me back from the edge"*. He fortunately stopped hitting her at that stage. Afterwards, he apologised and brought her a cup of tea but, as usual, took no responsibility for his behaviour. When she described this to me I was appalled. She sat there, so vulnerable, tired and drawn and we had one of our first real silences as she sobbed quietly and then simply sat. I felt helpless and hopeless with a desire to put that inner child on my lap and protect her. So, I did this mentally and imaged soothing and comforting this lost being. She seemed to tolerate his abuse just as she had passively tolerated the abuse in her childhood and adult life. I felt it was a vital part of the ongoing process of psychotherapy to teach her that she could choose to make other decisions and that she was not deserving of this treatment no matter how worthless she thought she was. It was often bizarre as she would not even go through to his parent's section of the house for protection as she did not want them to see how awful their son was. It appeared that they were aware to some degree of the conflict but certainly not of the extent or frequency. However, on one occasion, Pieter had hit her in front of his parents and his father had done nothing to protect her. This was reminiscent of her childhood where her father had never protected her. The above trauma reminded her of her feelings when asked to leave her mother's hospital bed and the sense of entrapment she felt as a child when she could not escape her mother's beatings. She felt that the only way she could stop the beatings as a child was to show her mother the pain and so she pulled out her hair. She also allowed Pieter to see her pain but in neither situation did this stop the abuse and I gently reflected that all that happened was that she was hurt and negated even more.

All this abuse in her exhausted state made her extremely vulnerable and she sailed into my room the following week. Bearing in mind that she is nearly 180cms tall in her shoes and I am only 160cms and always open the door to invite the patient in personally, it really felt as if she had sailed in past me. She was in a terrible state that this *"was the last session of the year"*! I gently explored why she thought this as there had been no mention of it and we still had another month before the Christmas break. It was as if she physically deflated back to normal size as she sank into the chair and we explored the feelings of real abandonment from Pieter and the church and feared abandonment from me. The church was a particularly problematic area as she was

unmarried, pregnant and *"I know I will be condemned"*. She was racked with guilt. As with many of the more dogmatic and guilt-inducing approaches to religion, her entire upbringing had been based on the view that God was judgemental, harsh and punishing. I listened with compassion and some anger that anyone would want to condemn this lost soul.

The abuse continued every few nights in the next month and I was desperately worried about her, thinking of her a great deal and having some very unsettled nights. It did not feel as if it was enough to simply hold the chaos in the alchemical vessel of psychotherapy and help her through it but I was also mindful of not giving her the message that she was helpless and unable to care for herself. How to find the balance between her psychological and physical safety and her continuing growth ? She would not allow any interference despite my exploration of options for her to leave for both her and her child's safety. The only way she would have left would have been if I had forcibly removed her and that would have caused her extreme anguish and distress and I knew that it would shatter the relationship of trust we had so carefully nurtured and built over time. And removal would still not have been to a hospital. However, I believed her to be in danger and, with her permission, advised her younger sister and Pieter's therapist of what was occurring. The family dynamic of passivity by the children was shown again as the younger sister frequently visited and called Rachel but made no offer to take her to her home until the child was born. The fact that Rachel would have adamantly refused to go was immaterial - the offer was not made and I knew her sister really cared. Rachel would not allow me to call Pieter as she feared he would retaliate by attacking her. He was hitting and slapping her and once hit her head against the wall as his terrors escalated out of control. But she would not call me when this happened despite my offer for her to telephone me at any time of day or night. She felt disoriented and experienced the presence of her mother in a sudden blast of wind that blew into the room with such force that it knocked the Christmas tree over. Rachel showed a strength throughout this time of which I had previously not believed her capable. The growth in her and how she had started to form boundaries was sufficient to prevent complete fragmentation. Despite feeling shattered she did not once, in those weeks, even contemplate suicide as an option. I was tense, anxious and yet so proud of her strength.

The birth of Mark:
Rachel produced a beautiful son in early January 1997. She brought him to her first session of the year when he was only ten days old. She handed Mark to me to hold for the whole session and smilingly joked that he was starting psychotherapy at an early age to prevent any damage like hers. She also added that in my arms was the best place for him to be. We were both a little tearful with the mixture of joy and poignancy. She was very tired and vulnerable as her son had been rushed off to ICU by the doctor and Pieter shortly after the birth as he was not breathing properly. She had panicked and feared that Pieter was following through on his threats to take her child away *"now that I had done my job"*. There was little to say in the face of that horror and we both sat there with the feelings in the safety of our relationship and that room. Words were not necessary to convey my empathy and caring and we were content to simply be together with Mark.

Surviving the pregnancy and the abuse without needing to be removed to a safe place and the birth of a healthy son, changed the dynamics within Rachel. She drew boundaries and became assertive with Pieter when he yet again, only three weeks after the birth, entered his maelstrom of emotions and started slapping and throwing her around. Rachel faced him, spoke back to him and then slapped him in the face. He stopped. Although it was effective in stopping the abuse this threw her into the confusion of the days when she was presenting the facade in her high-flying business career. She disliked her behaviour as she felt it to be her whole being now. We explored the familiar issues of her being many facets and how important it was to protect the core and not passively allow it to be trampled on. I drew the parallel to her mother where she felt she was either all good or all bad. On the negative side was that their financial situation was so bad that she had to accept nappies for Mark from Querida. This left her feeling humiliated and angry at Pieter for allowing this situation to develop. It also reared the head of the abandonment monster again as she now feared she would be unable to pay for psychotherapy at all and she hated not being able to offer her contributions to what she perceived as a very valued space. My reassurance that we would work it out and I would not abandon her left her weeping copiously with relief. At no stage would I have or ever will abandon her as she is honourable about meeting her commitments to psychotherapy, both emotionally and financially. Another sign of Rachel's growth was that she was connected to her emotions in a more authentic manner and was able to stay with the mood of the moment - the splitting off of emotions had reduced considerably.

As the attacks continued Rachel began to see that Pieter was a very psychologically damaged man and that she was compromising herself when she grasped at any straw to find him good. The violence escalated. For example, on one occasion, he tried to throttle her whilst she was holding Mark. She managed to put him down safely but Pieter threw her violently against the wall, tried to throttle her again, threw her across the room and threatened to leave. She fought back and told him to leave. The fact that she was fighting back was a sign that she was no longer going to stand passively and allow herself to be abused. I fed back that she was starting to change the life-long pattern of passivity and that she was no longer simply allowing the scissors to hack at her at will.

Over the next months, as she continued to defend herself, she started to connect with the anger at enduring a lifetime of abuse and of having to be passive to survive. This resulted in powerful images of picking up a knife to stab Pieter or of putting a pencil through Mark's fontanelle. Her mother had told her a story about a woman doing this to a baby when she was a child. It seemed that she was connecting with all the childhood and current abuse and she wanted to annihilate everything that had damaged her. This was a total shift from the usual desire to annihilate herself ! Rachel had even been assertive with her father and older sister who ironically, considering she had been most damaged by the parental scissors, was starting to fill her mother's role in the family. I warned Rachel that she should expect to be punished by her father and older sister for what was perceived as her rebelling so that she did not run back into appeasement mode. Sadly, her older sister has disintegrated considerably and is today living with the father fulfilling her mother's position in every sense except the physical. And Rachel has never gone back into the appeasement role to placate them despite

considerable pressure.

Rachel and I worked through the violent images which horrified her especially the one of hurting her child. She was confused and frightened by them and did not trust herself. I suggested that she was processing some of her issues by being the all powerful one who could annihilate just as her mother and Pieter had always been able to do. The difference was that she did not need to act those images out. I was very clear on this issue due to her frequent inability to differentiate between imagery and concrete action. The image of hurting her child left her shaking. I knew she would never hurt him and we talked through the pain of a mother abusing a child and she connected with the awful fact that her mother had done this. I gently connected her with how she was with her son and how she was trying to provide him with everything that she had been denied in the areas of confirmation and caring. When I reflected this and added that maybe this was also a way of healing her own inner child, she broke down and sobbed. That she could also be healed through the love she gave provided her with hope for herself and her son. By allowing the images the space to exist without judgement over the next few weeks they reduced and finally stopped. She also started having dreams where she was connecting with some of the good qualities her mother had.

Rachel fluctuated over the next months, often being firm and assertive with Pieter but sometimes appeasing to reduce the conflict and have some peace. She was understanding his dynamics more and was saddened that she allowed so much abuse to occur to avoid being lonely. This was a good insight. She envied her son for the fact that he was receiving Winnicott's 'good-enough' mothering and had images of herself being taken from the breast before she was nourished and comforted. She hated her son at these moments and was sometimes less nurturing of him. This always raised guilt and confusion in her and she was appalled at her own behaviour. I continued to hear and be with her without any judgement at all which she found reassuring but at times confusing - how could I be so consistently caring when she was so awful ? Why was she not being punished as she always had been when she was perceived and judged as bad ? That I did not perceive her as bad was difficult for her to understand but something she gratefully accepted.

She often wanted to leave Pieter but felt the risk of herself shattering if she did. The fact that she would be repeating his previous unresolved experience and fulfilling his prophecy was something we explored. It was as if he were testing her by frequently shouting at her to leave and giving her every reason to do so. Every time that she did not leave should have reassured him but it was not enough. At this stage she realised that she had never had a real relationship with a man and this deeply saddened her. With the growth and insights came great pain but she never stopped in her attempts to move forward and heal the damage within. I so admire her courage and strength.

Rachel started controlling some of Pieter's rages by quietly, rationally but firmly telling him not to hit her. Then, when she had removed Mark to safety in his room, she would tell Pieter what his behaviour did to her - for the first time she was calmly verbalising it rather than pulling out her hair or simply becoming hysterical. For example, she would tell him how he devalued her in the relationship. Anger was the force giving her strength now and she no longer needed to withdraw into isolation and dissociation. As

a reaction to the abuse from Pieter, Rachel still occasionally connected with the *"good treatment"* her son was receiving and this brought up more childhood memories. For example, he made a small whimpering sound when she put him into a bath that was slightly too hot and she immediately jerked him out. She relived hearing the same sound at an intensified level coming from herself when her mother put her in a bath that was too hot - her mother did not remove her. She also dreamed of little girls in a Chinese concentration camp and she identified with one of the abused, neglected girls. Rachel was in a cauldron of emotions of guilt, anger, horror, sadness and fear of hurting her child. The sense of abandonment was powerful and the fear of annihilation was present in a more general sense than because of any specific incident. We would together try to comfort the little girl she had been with great caring and empathy and I tried to help her see that the inner child and her son were two separate people which was difficult for her. I also reflected that she did not have to be the perfect mother to compensate for her own experiences and that it was real to be tired and frustrated at times. So, the parallel process of healing the inner child and caring for her own child adequately continued.

This process developed into her exploring how empty her past relationships had been when the False Self ruled. The growth of her True Self allowed her to mourn the loss that came with that lack of authentic relating and opened up the possibility and hope that she might achieve this in the future. She already had the sense that she would not achieve this with Pieter and was viewing his inadequacies in relating in a more mature light. For the first time she drew a firm boundary with Pieter in a violent situation and walked away feeling good about it. There was no sense of guilt that she was bad at protecting herself. There were more reasons to celebrate as she was doing the official reflexology course and was achieving over 90% for all her examinations. She was also indicating growth by the way she dressed. She would often arrive in casual pants or even a tracksuit and was relaxed at doing so. Even smart slacks had been taboo in her mother's dress code and we would sometimes smile at what her mother would be saying looking down at her !

Rachel's commitment to further growth and life:
In June 1997 Rachel turned forty. It was her usual day for psychotherapy and she was excited at sharing her birthday with me. She stated that she could not believe she had *"made it"* as she was convinced she would have committed suicide before then. She had dreamed the previous night of falling into a mud hole (which seemed better than ice or quicksand) and being aware that she would drown if she stayed there. Aware that no-one would know why she had died, she pulled herself out of the hole, her clothes all torn and tattered, covered with mud, slime and *"gunge"*. Telling herself that she could take these outer garments off as there was something better underneath, she was able to discard the filthy clothing and although naked, wet and mud-spattered she was fine. Both externally and internally I responded with "wow" as I smiled at her. She understood what the dream meant and stated that she wanted to make the best out of what she was, whether that meant thirty or eighty percent.

Pieter's health was poor as he is overweight, stressed and takes little care of himself. In July 1997 he nearly died and three days later he attempted to suffocate her. For the first time she connected with the very real danger of his attacks and this was very

frightening for her. She also watched him split off as he calmed down and was then angry that she had not made him his usual cup of tea five minutes later. We explored the reality that he may die and, obviously connecting with abandonment, she again brought up the issue that she paid me a lower fee. She stated that I was *"the rope holding me from being swept away in the storm"* and I again quietly reassured her that the fee was not an issue for me and dealt with her feelings of abandonment.

In that same month Rachel announced with great excitement that she had felt my confirmation at a very deep level. Her face was alight and she positively glowed as she told me that this was the first time she had ever felt FULLY affirmed as a human being. Her parents and people in general had constantly invalidated her feelings and thus her sense of reality and ability to judge for herself what was real or false. I had not realised that she had never felt this so deeply - it had taken four years of psychotherapy to achieve this. She enlightened me to the fact that she had heard and felt it at some levels but that this was the first sense of fully integrating it and *"owning it"* at the core. These are the moments that make all the effort worthwhile and I was delighted to see and experience that feeling of joy and lightness with her. I felt quite humbled.

This feeling of confirmation at the core changed her reasons for being assertive. It was no longer simply anger at being abused that drove her to protect herself. Now she cared about herself and felt she was worthy of not being abused. This was a powerful shift and when Pieter shouted at her that the relationship was awful and told her to leave she immediately agreed on the relationship issue, suggested he leave and went on with her activities. This statement startled him into calming down and there was no conflict for a week. We were both very pleased with her progress and it was lovely to have a session that was not only anguish and pain. A further reason for her being assertive was that she did not want Mark negatively affected by the violence. My fears about how Mark might have been affected during the pregnancy and ongoing relationship had been confirmed as he was an insecure, clingy, sensitive baby. She followed her intuition to nurture and always tried to remove him from the scene if there was an outburst but the effects were being experienced. This made her even angrier with Pieter.

Throughout psychotherapy, Rachel struggled to integrate her intellectual thoughts with the bodily expressed feelings. Exploring where she felt the emotions revealed that she had disconnected emotions from any bodily felt sense since a child. Now she was able to state that she experienced emotions in the pit of her stomach and then her throat. She could connect with a feeling of wanting to scream with rage briefly and then she would cut the process out of habit and a fear of a loss of control.

Rachel's isolated lifestyle was worsening as Pieter's fear for his son resulted in him keeping her housebound. He even insisted that he drive her to psychotherapy. This meant that her only connections outside of an emotionally unhealthy household were the few reflexology sessions she did from home, the occasional visits from her younger sister, very few social engagements and her weekly psychotherapy sessions. This made it hard for her to put into practice her newly developing confidence. The only person to practise on was Pieter and she displayed the concreteness of the fragmented person again when she took a mental exercise I gave her to do quite literally. We had

been discussing how it is useful to step back mentally and try and understand what the other person is feeling - an important exercise for her in not always viewing herself as the one at fault. The next time Pieter was verbally attacking her, she stopped him to ask him to describe his feelings and advised she would then describe her own. The result was that he told her he did not care at all about her and her feelings which made her *"cry inside"*. She dreamed of a huge leguaan (large primeval-type lizard that can be up to a metre long) springing at her face and she was only protected because she had a perspex shield in front of her. She likened the leguaan to Pieter which was a terrifying image. I shared the horror with her and we explored how the boundaries she had drawn to protect her core were signified by the perspex shield which prevented her being savaged. Worse, was that Mark was portrayed in the dream as a baby leguaan. We explored her fear that Mark had been negatively affected by all the violence and emotional outbursts. It terrified her that he might grow up to be like his father and this strengthened her resolve to give Mark a good mothering experience. I also gently explored the dynamics of not acting out mental exercises.

She continued to hold the boundaries, at times with difficulty, as she grew stronger. It was wonderful to see her becoming more cohesive and continuous in her expression of herself especially portrayed in her connection with emotions. For example, the emotions that could shift in a few minutes were now with her for hours. I had already asked Rachel's permission to write my thesis based on her experiences a few months before and it was at this stage that I asked her to write about her experience of psychotherapy and me as a therapist. Not wishing to influence her in any way, I simply asked her to write down what she had experienced as useful and not useful and to be honest about the negative as well as the positive. I left her to choose how she would do that.

Predictably but sadly, despite feeling and holding the emotions, Pieter's ongoing outbursts wore Rachel down and towards the end of 1997 she was feeling lonely, lost and depressed. She felt suicidal for the first time in over a year and had wanted to fling herself from the moving car. Despite understanding his dynamics there were times I actively disliked the man and wished he were elsewhere on the planet. He increased the physical attacks and advised her he had been to see a lawyer, stating that he was *"clever and manipulative and will take Mark away"*. She felt he was trying to push her into behaving like a *"mad woman"* so that he could prove his constant accusations that she was a *"bad mother"*. These accusations stabbed Rachel to the core in the light of her own childhood experiences and her obvious attempts to give Mark a different experience.

The new year started with Rachel testing her ability to relate to new people in her world. Encouraged by me to join a mothers and toddlers group, she and Mark were enjoying this activity on a weekly basis. Again, in practising a new behaviour, Rachel stepped from the extreme of opening her core to all to keeping the boundaries so firm she allowed no-one in. The other mothers were thus not welcoming and friendly. Feeling the lack of response to her as rejection she became very critical and judgemental of other people's behaviour. This time she was able to do the mental exercise with me of seeing how she might be perceived by others and vice versa without acting it out. Her naivety about the basic rules of interacting highlighted the complete lack of healthy

relating in her early years.

Rachel's newly developed lack of tolerance for Pieter's attacks reached a peak when she reacted by handing him a knife and taunted him to stab her. She then ran to the upstairs balcony intending to jump off to get away as he always locked her in so that escape from his attacks was impossible. Fortunately he did not retaliate further and the situation was brought under control.

Rachel's experience of psychosis in my consulting room:
Rachel was very vulnerable and, without my knowledge, attended a Reikie course. Reikie is a form of healing of Japanese origin. It is based on the concept of universal energy and how the conscious self-application of this energy can be used, by channelling, as an instrument to heal another person. The process can also involve regression into past life experiences. Rachel had seen vague images in my consulting room once before but she connected very powerfully with images in her next session. She was sitting talking to me about the Reiki course and making her usual good eye contact. Suddenly she exclaimed, looked slightly to my left and stated that there were *"little people"* standing next to me. Her eyes were absolutely focused and she was animated and excited. Her whole body was alert. I felt a little disconcerted but asked her to describe them to me. She described seeing the silhouettes of people who were grey in the middle but had the colourful lights of their chakras around them. One was a man, another a child who was *"peering ... innocent ... so sweet"*. She described them as very closely gathered around me and at one stage one was kneeling down right next to me looking at me. Wanting to make her feel comfortable I looked at the space next to me and said "hullo". She was utterly fascinated by these images who were not frightening her at all. I have to admit to feeling a bit uncomfortable and silly greeting something I could not see but I thought I should pay respect to her and anything else that might be present ! She told me that if she tried to bring the images closer they started to disappear but remained strong if she simply looked at them. It sounded similar to those three-dimensional pictures that were so popular then - a flat, one-dimensional, patterned poster which would shift into a full three-dimensional picture when one shifted focus to look through rather than at the poster. After a while, she described how she felt the images were coming from inside her and being projected out. If she reached out a hand to touch them they were insubstantial yet she could see them as clearly as she could see me. She concentrated, reached her hand out, staring intently past me and then as she brought her hand closer towards herself she felt the images were from inside. These images were there for the whole session. As stated, she has often seen lights around me but this has lessened considerably over the years and this was my first experience of sharing a hallucinatory experience. It was fascinating but I was concerned about her continuing to attend the Reikie course as the woman running it had no concept of the depth of Rachel's vulnerability and suggestibility. She agreed to advise the Reikie teacher that she was in psychotherapy and not allow her to regress her into a past life. When she left I was a little unsettled and went for a walk to clear my head. I thought that if I had to have visitations from little people, I was grateful that they were friendly and liked me !

My fears that she was too vulnerable were confirmed. The next session of Reikie resulted in her losing consciousness. The teacher had been doing a 'balance' when

she began to feel ill, heavy, wanted to detach from her physical body and then fainted. She described a vision where a man in a robe came and offered her huge tablets which initially seemed comforting but then she became agitated and came to with a bad pain at the top of her skull. The balance was completed but she began to feel ill again and stopped the course. This was very frightening for her and I suggested that she was perhaps in too fragile a state to be exploring deeply into these areas. She agreed with this. I felt some anger at what I perceived as carelessness on the part of this Reikie teacher allowing a woman to explore deep issues with no understanding of who or what she was working with.

Throughout the first months of 1998 Rachel had a few incidents where she wanted to throw herself out of the moving car. This usually occurred when she and Pieter visited his parents, now living in the country, and his mother often verbally and once physically attacked Rachel. It felt as if she were dealing with her own mother all over again and Pieter never defended Rachel but supported his mother. She sat in my consulting room quite broken at the continuing unpleasantness as she had so hoped that his family would provide the warm, loving unit she had been deprived of as a child. She felt everyone was telling her she was *"bad"* again so I tested her growth and asked "Are you bad" ? She was quiet as she pondered this and responded with *"only a little because I want Pieter to be able to support my son and me".* She could relate to herself as having good qualities too and my heart ached for her as she asked for so little - simply to be accepted and loved. And even the natural desire for protection and support was perceived as being bad. She was aware that had these episodes occurred two years before she would not have been able to cope at all. It was vital to connect Rachel with her strength as it is still something she fails to recognise.

Pieter's continuing ill health concerned Rachel as she was quite unable to see further than the horror of losing him and being left alone. But she was drawing the boundaries even more firmly with Pieter as far as the violence went. She was able to feel that she did not deserve such treatment and did not want her son affected in any way. So, the next time he assaulted her and tried to stop her moving out of his reach, she hit him a number of times and told him to leave. Seeing that she meant this, he crumpled and she saw for the first time that there was nothing under all the brashness and violence. Having explored his dynamics, fears and the frightened little boy inside him many times with her I found myself being surprised that she still had not really understood this. But, by putting myself in her shoes and trying to be the fragmented, vulnerable woman attacked by a large man shouting for her to leave, telling her she was not a good mother and that she was a whore, I was quickly able to understand why she still struggled to really connect with his dynamics other than at the intellectual level. Her determination to find her whole reflection in the shattered mirror pieces we were slowly pulling together was powerful and she would pull that magnificent body up straight and hold her head up high as she re-iterated her desire to be a whole person.

Having passed her examinations with flying colours, Rachel was practising reflexology using crystals. She described a session where she saw the images again and asked questions of the *"healing spirits"* who *"put"* the thoughts into her head. She stated that she did not interpret but merely channelled the healing she felt coming through her as she feels she has no control when this happens. She felt great joy and happiness and

her patient felt cleansed and continued to see her for appointments. I wrote in my notes: "Does it matter whether she is channelling spirits or having thought insertion and hallucinations ? What is important is that she is loving her work and the patients seem happy and she was more content today than I have seen her in a long time. Her work is her passion, is her life, is her sanity. It is the one place she feels truly at home".

Over the next months Rachel was assertive with Pieter and his mother and we drew the parallels between her mother and his mother and how differently she was handling life now. His mother's verbal attacks had less effect on her now as she could withdraw to observe the behaviour in perspective instead of withdrawing to avoid it completely. This made her feel more in control and her audience of one in psychotherapy was mentally applauding with great gusto. She described again how she had always been totally negated especially in relation to what she termed as weird experiences. She had been advised that, as they could not be scientifically proved, they could not be reality. She gave a different description from the one she gave when she walked into my consulting room five years earlier - *"It felt like a holocaust out there"* where she felt she was burned by the radiation fall-out and *"when I came to your door I was just bones and marrow"*. She stated that had she not been treated with utter respect she would have disintegrated. It took years before she knew she truly was totally accepted by me as I constantly and simply accepted her reality for its own value. This allowed her to start *"growing in the belief"* that her world was real for her. It also allowed her to talk more about her childhood experiences of altered reality and I asked her to add to her previously written descriptions the feelings and meaning for her. Rachel is so excited about this study as she is utterly convinced that the healing is through the meeting and offered to do anything she could to help. Mindful of keeping her space sacrosanct and the psychotherapy on track I have generally discussed the dissertation with her in separate interview sessions. Even then I have been very careful to ensure that our relationship remains one of respect, safety and authenticity and there is no invasion of her as a human being. I also stated early on that if the dissertation were to impinge on her and our psychotherapeutic space in any negative way, the work would be stopped as my first priority was her. She was deeply grateful for this reassurance. Rachel also gave me copious pages of religious writings. She does not view these as her thoughts and views but information that she has been instructed to write down by a voice in her head. This voice is not heard as an external one but rather like thoughts in her head. She described the writings as not occurring as a result of her own volition or decision but almost as information being channelled through her.

Despite the obvious growth, Rachel still frequently fell into the trap of feeling worthless with Pieter especially when he accused her of being a bad mother. This was possibly the worst attack that he could mount and it stabbed at her core every time. Financial reasons necessitated her exploring the possibility of going back to full-time work as the reflexology was bringing in insufficient funds. I was supportive of this as it also meant she could be financially independent if she chose to leave the relationship. She was offered employment in the same financial field she had previously been successful in. Pieter immediately accused her of having an affair and stated that he would kill her, Mark and himself. Although torn between being with her son and the need to pay the bills, Rachel accepted the job. However, on the morning she was due to start she sent a facsimile stating that she would not be arriving at work as she had changed her mind

and she effectively cut off that whole world - the only one in which she was highly skilled and had been financially successful. Although now a reflexologist, she had few patients as she stated that Pieter controlled that area of her life too.

I then made a mistake. In my concern for her to be financially independent so that she could choose to leave and be psychologically and emotionally safe, my initial reaction was one of disappointment. I did not verbalise it but my tone and the questions I asked must have displayed this. I did not meet her as I should have. So, although I told her I would support her through anything she chose to do, she was terribly upset and wept that I was disappointed and maybe angry. In some ways she felt she had let down the only good-enough mother she had. What I had failed to realise fast enough was that the world she was rejecting now was the same one in which she had manifested the False Self image to survive and which had continued to suffocate the True Self. She was wisely afraid to enter that world again and we explored her fears of becoming the hard, cold *"bitch"* she had needed to be to survive. The good that came out of this mistake was that she did not kick into abandonment and remained firm in her decision to do something more true to herself and I supported that totally. She had survived the 'mother's' disappointment and remained true to herself. In the next session she told me that she had realised my disappointment had come from concern and we discussed that I may sometimes give an overall perspective that might contradict her viewpoint. Instead of automatically fearing annihilation at what she could perceive as confrontation, she stated that she relied on me to provide that perspective and that it did not feel threatening with me.

Rachel is determined to offer Mark a more balanced environment. This is extremely difficult in a home where verbal and physical abuse is common. But she offers Mark as much consistency, love and support as she can which tends to over-protectiveness. This creates problems when they are interacting with other mothers and toddlers. She is learning to see that events which evoke similar feelings are not the same events as her childhood and thus do not necessarily have the same consequences. Her skills as a parent are based on her own childhood experiences and much of her manner in dealing with Mark is based on the values and principles instilled in her by her mother. She constantly checks her way of dealing with him with me and we have lengthy discussions about raising children in a balanced way. I have realised that this practical input will continue to be a part of psychotherapy until she has the faith in herself to trust her own intuition. The problem is that she was not taught many basic skills especially about relating. With few friends over the years she has not absorbed and learned by proxy and her whole life continues to offer her poor examples.

At the end of 1998, Rachel announced that she would like to have another baby with Pieter. She was in a fragile state again where she was seeing colours around people and was starting to dress in the fancy clothes and make-up. Her long hair which she had worn casually and loosely around her shoulders for two years was suddenly being taken up into the elaborate hairstyles of old. The False Self mask was coming up as she was drawn into Pieter's business ventures and she was feeling much confusion inside about her sense of self. I did feel concern and some disbelief that she could even consider having another child with this man in these circumstances. Aware of my recent mistake, I voiced my concern with extreme gentleness ensuring I was still

confirming her but my eyes must have mirrored my confusion. I was falling into the trap of assuming her to be more cohesive than she was - she had made a sensible decision in not taking the job offered to her and that had fooled me. She had come a long way but she still had a long way to go. I queried with her how much she felt she had learned about herself and her strengths. She understood where I was coming from but only wanted to use Pieter as a *"sperm bank"*. Although I undoubtedly could have handled my initial reaction in a better manner (see theory section for further discussion), it did result in us exploring the practical realities which she had failed to even consider. This indicated to me that she still was unable to look at the broader perspective and explore the possible consequences of her actions. She wanted a baby so it was simple ! We explored the facts that Pieter was absolutely neurotic about Mark, that he failed to see her as a good mother and that it would be his child too which meant he would have rights and responsibilities. This helped her get a perspective and made her think about the circumstances which was all I wanted.

The start of 1999 highlighted that Rachel still often had to check her decisions and actions with me before she could internalise them as her own. There had been a vast improvement from the young woman who could not even make an initial decision and wanted to rely on me for everything to the person who felt "*almost sure*" but required my reassurance and confirmation. Her younger sister's new relationship was mirroring for her what she would like to experience and we discovered that she had always viewed herself as the relationship. Hence, if the relationship failed she was deemed to have failed and to be unworthy. I described how a healthy relationship involved two separate individuals and likened it to our psychotherapeutic relationship where two people met with respect and caring and, although we had created something different, we were still separate individuals. She was amazed and delighted at this concept. It is always such a pleasure for me to see Rachel when she gains some insight into a world that offers hope and a real sharing for her.

Rachel understands her hallucinatory experiences:
Writing up the notes on our psychotherapy for this study had been an enriching experience for Rachel as she stated that it highlighted for her how much she had grown and she was excited at the prospect of future growth. The exercise had also made her contemplate in depth her hallucinatory experiences. She again described how when she tried to touch the images in my consulting room, they were closer than her hand and eventually went *"back inside me"*. She now suspected that, had she been able to do this test of reality before, that all her hallucinations could have been experienced in this way. She explained that she had only been able to conduct this test because I made it acceptable for her to have been afraid of some of the past images. My stating that I too would have been afraid made her feel safe to experience fear and thus have the curiosity to explore the phenomena. This resulted in a reduction of her fear so that she could understand that the images were not real in the *"lived sense of the three-dimensional world"*. I had been curious and not afraid to explore the little people images which gave her courage. So, although she experienced the gnomes as real, solid phenomena as a child, she could now understand that they were probably projections from within due to fear and not the result of a haunted house. She understands that her hallucinations are not visible or measurable in a three-dimensional world and perceives them as having more reality in the sense of a powerful energy field.

For example, the knowledge that she would lose the images if she blinked helped her realise they could not be solid and real (see Chapter 10 on psychotic episodes). Rachel believes that the thoughts in her head are a higher level of consciousness which may be of herself or God. She describes these thoughts as coming through her and not disconnected thoughts or voices coming at her. Rachel sat there so strong, bold and clear about what she was saying. It was a revelation to her to finally make some sense of these weird happenings. They had become more acceptable to her because I had accepted and explored them with her, but now she felt a meaningful connection inside herself which was powerfully liberating. I smiled occasionally as we explored the excitement of a new sense of meaning and control for her.

She ended that session telling me that she was concerned about her anger which was resulting in her using foul language. This was so contrary to the soft, gentle woman I knew and I asked her for an example. When she enlightened me, I burst into laughter as it was incongruous to hear those words coming out of that mouth. I then more seriously dealt with the issues around how she had always been punished for expressing anger as a child as well as being punished when other people were angry - for example, the beatings she received when her mother was out of control. I empathised with the fear of losing control and linked it to her violent images when Mark was a baby which helped her understand that she would not necessarily lose control and act out. She later explained that my laughter had assisted her in stepping back, seeing the whole picture and realising she had choices. For example, she had found herself thinking of expressing foul language the following week but had chosen not to articulate it.

As she was able to view her family's damage more clearly she began to talk of forgiveness and how liberating this felt. She stated that when one is bitter, sulking or judgemental one is in the control of the person one has not forgiven. So, she was forgiving her father and their relationship has calmed although never deepened. Forgiving Pieter was not as easy but she was dealing with many of the attacks better and they were not as frequent. On one occasion in March 1999 when he viciously attacked her again, she lost control and attacked him back. She collapsed to the floor weeping and he refused to let her go to Mark who was crying with fear at the scene. This distressed her enormously as she constantly feared the effects the violence would have on Mark.

This fear was real as Mark started to react in a physical manner with his peers and Rachel continued to be rather too over-protective. Occasionally she found herself being critical and punishing as her mother had been and we discussed the similar dynamics. She began to be firm but loving, reprimanding him for his behaviour but not continuing to punish him as the whole child. This made her feel she was shattering the shackles of her past by making it different now. She recalled how she spent much of her childhood trying to work out what NOT to do to avoid the punishment and it was far easier to achieve this by being passive.

She advised me that she could pay full fees by September 1999 and would like to pay back what she perceived as a loan from the reduced fees of the past. I showed appreciation at her offer but stated that the lower fee had been the agreement, that I

had been happy about the arrangement and did not need repayment. She was astounded that anyone could simply give her something without wanting something in return and, in an achingly sad tone, added that she would like to be like that. I reflected that this was exactly how she was with Mark. There was another of the few silences in six years of psychotherapy and she had nothing to say as she absorbed this. Then she smiled.

The current situation:
The violence continues and, on a recent trip to America, Pieter verbally attacked her so frequently that she ran from the parked car across a lawn with the intention of running in front of the cars on the highway. She stopped at the edge of the highway to ask herself the usual question of what I would say in the situation and did not follow through with the action - she knew she was too valuable to throw her life away for Pieter. Her behaviour of running away gave her the insight that part of the horror for her is that Pieter never allows her to remove herself from the scene which increases her sense of being trapped and panicky. Twice recently she has managed to remove herself from the house before the violence escalated and has felt more in control as it has not resulted in physical violence. She has also continued to face him and push him back physically whilst stating that this is unacceptable behaviour. He recently told her that another woman he knew was to blame for the abuse she received because she failed to stand up to her boyfriend. She was appalled at this and felt she had been absorbing the damage and gunge of Pieter every time he *"spat it in my face"* and had been chewing and ingesting it. I asked what she would do if he literally spat gunge in her face. She looked disgusted and her mouth twisted with revulsion as she stated *"I'd wipe it off fast"* and then nodded sagely when she realised the implications of that question. She can now connect in the situation with the fact that it is his damage and not always her fault. Overall though, the violence has lessened in frequency. Pieter has not physically attacked her for a month and she has started to be assertive about his general manner of relating to her in a way that he is responding positively to.

In drawing boundaries with others in the world Rachel is starting to learn how to gauge degrees of giving in a relationship. We recently explored friendships, from the casual to the deeper levels of relating and she had been unaware that there could be so many levels of connecting. She is slowly starting to step into the world of relating now. She did, however, state that she often feels a pressure from everyone to leave Pieter. I stated that if she chose to stay with Pieter forever I would still understand and she burst into tears with relief at that reassurance. A week later, she advised me that he had attempted to physically attack her again. She drew a firm boundary to prevent the physical assault, removed herself to another room and then kept a firm emotional boundary by not simply accepting his apology and *"moving on as if nothing had happened"*. For the first time she has been able to imagine herself separating from the relationship. *"I can see that there might be a time when I will outgrow his inability to give to me ... but I am not ready for that yet"*.

One of the most profoundly important steps of growth and cohesion was taken by Rachel towards the end of the year. She had experienced an ugly incident in a parking garage where a woman was abusive and suggested she was crazy. She was very assertive in response and advised me that she had not cared that the woman was

judging her. She spoke of how she would have been totally condemned by her mother had she behaved like this in the past. She stated that she would *"not have changed a thing"* about her reaction in the situation and realised that she was no longer judging her own behaviour according to her mother's standards. At this stage she only appreciates a little of the value of what she has achieved as she is so accustomed to being condemned that it still tends to swamp the feelings of achievement and growth.

The journey continues ...

CHAPTER 10 - DISCUSSION OF PSYCHOTIC EPISODES

For easy reading and flow this chapter starts, after a brief introduction, with a summary of Rachel's psychotic episodes. Again, her wording is italicised and in quotes. This section will be followed by a discussion of these episodes and will conclude with a consideration of hallucinations and delusions. The psychotic episodes illustrate how an individual will adapt, sometimes with extreme measures, in order to create a world that offers some structure, stability and meaning. Thus, the meaning of Rachel's psychotic episodes is of vital importance as it indicates the necessity for her to create this world as well as her desperate need to have a cohesive sense of self. The next two chapters discuss the general themes that appeared throughout the psychotherapy and the effect that the psychotherapeutic variables have on the 'healing through meeting' respectively. Overall, the aim is to indicate how the psychotherapeutic relationship provided a solid foundation for that healing.

Dialogal means relational and the infant is in relationship from the moment of birth. Phenomenological and dialogal therapy view psychopathology as a disturbance of the person's entire existence. Phenomenology believes in understanding the disturbed person in terms of his lived reality rather than clinically observing and labelling him from a medical stance. The whole human being is involved and disturbed behaviour is viewed as a "state of being in which the person starts relating to the world and fellow man in ways which are not readily comprehensible, that is, socially validated" (Kruger, 1988, p. 170). Thus, one does not have a problem but lives it in one's everyday world of relating and functioning.

If a solid, cohesive sense of self has not developed, the individual will be unable to relate in a healthy manner to other people. The focus of the person's being will be on psychological survival. The basic skills of inter-relating are not learned when the centre of one's attention is on avoiding annihilation. If there is no clear sense of self or skill in interacting, the person is unable to step out into a world of relating with any competence. The most sensible reaction is then to withdraw, build up the castle walls and isolate oneself from the dangers. Other people are uncertain quantities, offering gifts whilst hiding the dagger of possible annihilation under the cloak of friendship. The fear of reaching out is real as life experience has taught one to be wary. The scars are constant reminders of the results of offering one's real self in interaction. In few relationships has one found confirmation and simple acceptance of oneself as a human being. Isolation becomes an attractive alternative to the shared world. The other option is to step out in disguise and test which facade will be welcomed and applauded. Whichever guise receives the best response will become the favoured and strongest facade. Regardless of the alternative chosen, the real inner core still thirsts for authentic and genuine meeting. The quest for confirmation and real living for the fragmented soul is an exhausting and lonely one. This has not, however, prevented Rachel from that quest.

The information about the family history and behaviour is authenticated by Rachel's younger sister who was in psychotherapy with me from June 1994 - June 1999. She verified the physical and emotional attacks on Rachel. Although the stories told by these women differ according to their own perceptions of events, the major dynamics

of the family were viewed in a similar light by both of them. The focus is on Rachel's story and her younger sister merely provides a verification of certain events discussed in this work. The younger sister also displayed very similar dynamics to Rachel in her inability to relate to the world. This made her ill-equipped to deal with a difficult marriage and she too withdrew into passivity and severe depression. As the emotional abuse had been less severe and she had escaped most of the physical abuse, she had a stronger sense of self and boundaries. She did not experience psychotic episodes except for seeing the man and angel in the third incident described by Rachel. Although she was severely depressed, I also did not refer her to a doctor for medication. Her more intact inner core allowed us to progress further in a shorter time period in psychotherapy. She is currently in a relationship with a balanced and decent man and is able to give of herself emotionally in a connected, reciprocal relationship. Rachel aims for that same goal.

Rachel's parents had both come from emotionally and financially impoverished backgrounds. For example, her mother's father had died when she was three years old. Her mother, wishing to avoid the constant reminder of her husband, had *"given her away"* to her deceased husband's brother. However, the wife did not welcome her and eventually passed her on to a relative who did not have children. This family kept her but it was not a happy experience. She discovered her history at the age of ten. Rachel's mother had thus experienced abandonment and learned little about interacting as she had been met as an It for most of her life. Rachel's paternal grandfather was from a very large, poor Russian family who had experienced both the pogroms and Nazi concentration camps. Her grandfather had been a *"violent and crazy"* man and so her father had learned to be passive to survive.

Rachel's childhood experiences had ill-prepared her for life. The second daughter in a family of four, with the only son as the youngest, Rachel suffered a great deal from the parental damage that was continuously acted out. The eldest daughter had borne the brunt of attacks from her mother and rebelled against this endlessly. Rachel had been passive from a very early age in an attempt to slow down the physical and emotional violence she experienced. Rachel's family unit was socially isolated with no adult friends visiting and the children were not allowed to bring friends home. There was also little relaxed play allowed as the children always had to be neat, tidy, well-behaved and clean. With no role modelling of healthy relationships but only closed, destructive, damaging ones, Rachel was unable to learn a healthy manner of relating in a shared world. Her parents were inconsistent and unpredictable in their responses so she never knew what to expect which further confused her and prevented a solid sense of self from developing.

A thread running through Rachel's life has been the importance of religion. Raised in a strict Catholic home, her mother ensured that the family followed those principles closely and religion was the backbone of the family structure and beliefs. The family reinforced the religious aspect constantly. For example, when there was a problem, the frequently offered solution was to pray. The church was a powerful influence and, combined with her mother's strict views, resulted in Rachel believing that the authority figures in her life were judgemental, unforgiving and punishing. This reinforced her lack of worth. Over time, certain members of the church did judge Rachel as unworthy. For

example, the priest who refused to grant her absolution because she was having sexual intercourse with a married man deeply wounded Rachel. She was so angry at the judgement that she refused to leave the church until he did grant her absolution. She felt betrayed and abandoned by a structure that was as integral to her life as her family was. Her perception and belief that God was punishing and cold, like her mother, increased her desire to be accepted by both God and her mother. Rachel endlessly struggled to deal with the apparent paradox that God was hard and punishing and yet her sense of him within herself was that he was good and kind. She did not have the same perception of her mother as is indicated by the episodes that follow. Overall, the influence of the family's strong belief in the strict principles of the Catholic church deeply affected Rachel's sense of self and worth. This is clearly illustrated by the role that religion plays in her psychotic episodes.

Rachel is able to recall what occurred in her early childhood. Even at that early point, she had a conflicting sense of her mother. At times her needs were met but the primary feeling is of not being perceived and treated as a person of value. In her efforts to survive she always tried to behave in the correct manner that would bring confirmation. This did not happen at a sufficient level and she began to experience psychotic episodes which occurred at intervals throughout her life. She experienced some incidents during her time in psychotherapy, including one event which occurred while we were together in my consulting room. There were many less significant experiences for her which occurred so frequently that she seldom bothered to mention them. I only became aware of them in later discussions when she was beginning to understand and clarify why and how the major experiences functioned.

An abridged version of the major incidents is provided below in Rachel's own wording in order for the reader to be able to enter her world of experiencing with her. Only minor corrections have been made, such as spelling mistakes and the deletion of names for the sake of confidentiality. A full description of the events is provided in Appendix A. Brief comments are made for clarification and a full discussion follows in the theoretical section. The first eleven incidents occurred before she entered psychotherapy. During the six years we have worked together there have been fewer and fewer of these occurrences. The last event which occurred in my consulting room was the breakthrough for her in understanding the visual hallucinations.

SUMMARY OF PSYCHOTIC EPISODES:
The first eleven incidents were written in retrospect as an adult. One must allow some licence as Rachel's recall was now coloured by nearly two years of psychotherapy. The first incident is clearly a reconstruction of a vaguely recalled incident although Rachel is adamant that she has full recall of it. The memory will thus not be accurate but the meaning and the feelings she attaches to it are vitally important. Overall, the attempt was made to be as true to the experiences as possible.

First incident:
Rachel states that her first recollection of experiencing her life in a different manner was just before the age of one.

"I could speak another language. I had other conversations, like memories in my mind

and I could see myself as another person fully conversing in a language known to me and to those with whom I conversed. I was understood. I could communicate in this language. I could understand the language communicated to me and I had the distinct awareness that my own feelings and thoughts I could communicate in return and be understood. The language was like a memory of me communicating. I recall my Mother and Father talking to me in a strange language. It was not long before I understood that I was supposed to learn their language and communicate in their language. It was then that I recognised that I had no power over my mouth or tongue muscles. I wanted to talk as fluently as I knew how to them and show them that I could talk ! I knew that it would surprise them and possibly shock them because even then, I received a form of guidance that this was not supposed to happen. I was comforted in my struggle with my tongue and mouth that because it was not supposed to happen, it could not and would not. I felt quite desperate and continued to struggle to communicate in my own language. My effort was blunted by my Mother laughing at me when my efforts came out garbled. Her affections did not penetrate into the awareness that I just might be struggling to say something".

Rachel goes on to describe learning her new language of English which she found difficult and the knowledge of the old language beginning to fade. She felt desperate as she lost this special gift and *"I decided to look at my Mother and hold her eyes to try to communicate via my awareness. She did not see. I was treated as a baby. I was not a baby. She did not see my awareness. I could not communicate my presence in another language. My memory was slipping of the language. I knew I would lose all recall so I decided to try to hang on to at least one word ! A word I could bring to the world as proof and recognition that what was happening to me was exactly the reality that I already knew would be denied in the world".* She wished to protest by not learning English but *"I think my decision went against a certain law ... I felt without any objection or concern a presence that came to me and said this was not okay to do and I argued my position".* She was advised she would be *"granted the memory only that I knew and was able to fully converse in a different language before I gained control of my body muscles as a baby. It was a small consolation".* So, Rachel mastered her own language but experienced this as *"only a small effort placed in this regard because, as I mastered the language and managed it into sentences, I received applause and laughter that I could do such a thing and not once did the awareness of those around me, look deeper at the deeper significance of my effort. This result quickly erased my efforts.*

I recall the colourful rattle toy my Mother draped across my pram. I recall she looked at it with much happiness and enjoyed it more than me. I remember her telling me to look at it and she played with it as if to show me what to do with it. I distinctly remember thinking how stupid this was and asking myself what it was for. I remember thinking, if only she knew, if only she could be aware that I am not the age or awareness of the body I was having to learn to master". When she did reach out to the rattle her mother was delighted but this response made her feel *"quite hopeless in my effort to express my thoughts and knowingness that were fading as I gave in to the effort I required to master my body".*

Rachel *"lost memory of the language, the words, the grammar, the very form of the*

language. I do recall that it was very different to English ... I have not one word with which I could seek out and find my language and be 100% certain of identification. I am aware, to this day, of this loss. That this is the form which was decided and given to me as a baby in which I would retain this experience. I had no choice and this is a gift, a consent".

Rachel's reaction:
"I was quite anxious at first because I wanted to communicate to others. It felt like I was ignored because I could not communicate to my parents and their friends. I did not understand the language I was born into. I felt ignored because I could not speak and I wanted to change that. As I realised that my muscle control was not efficient and that I could not articulate my tongue to say the words in my mind, I felt frustrated. I wanted to talk in my language even if others did not understand. I felt sure someone would recognise a different language and the feeling of being ignored would then be removed and they could then understand a lot more. There was only very little comfort when I was made aware that I could not change things, that I was not supposed to change things as they were. I felt in the presence of higher beings who gave me this advice and who tried to comfort me. They did not succeed but they did say there would be more and I would open the dimensions to connect with the earth dimension of consciousness, in time. They did not say this to me in this way but I was assured I would connect, not fully though, the passage way between the two dimensions and worlds. I felt like I was given, in recognition of my sorrow before such unawareness and knowingness that I could understand and converse in a language, I was given a kind of reward. I would have a thread, like a single thread, in the future, only when I was grown up to connect the two worlds. It was not enough. I was still angry that I could not reach out and be understood. I do recall that I was very upset so I asked if I could have just one word which was denied. I was very unhappy that this too would be taken. I felt sure, that with one word, I could prove my language as soon as soon as I could linguistically articulate it. Again in recognition of my despair I was told that I could keep the memory of this incident and that was all. This was against my will and there was nothing I could do about it but struggle, and struggle I did".

Rachel recalls losing her last word. *"I could not get it back. It was gone ... I knew I could not get it back and there were other things to concentrate on like growing and using my effort to develop muscle co-ordination and vocal co-ordination. I did remember that my language was gone. I did remember that there had been a body of persons advising me and watching over me. It was not them that stopped me from speaking, it was the condition of the human body I had in infancy that obeyed other laws that could not be broken even though I tried. I was not alone because I did have the advisers and comforter but my will was even against their will and the laws of the human condition and in this I felt betrayed even by the spirit council. This spirit council was like a group of elders in spirit wisdom. They were not visible but I felt them and received their presence as if they were behind me. Even lying down in the cot, they were mentally behind me in mind not in physical reality near the cot but behind my mind behind my consciousness.*

I felt the spirit council presence as if I knew them and they were familiar to me. I felt them with acceptance but with anger when they would not break the rules of the human

condition and the laws governing lives here in this world. They said they could break the rules but that would be breaking higher rules that I was not aware of and that that would not be good and it would have very wrong consequences for all. This would include those to whom I wanted to communicate and I did not want that to happen because I wanted them to be enlightened not harmed. This is what made me acquiesce. It was this argument. When I asked about the higher rules I was not informed. I was told. It was not for me and that my direction was human life. I was prepared to die to bring the knowledge to the earth, but that was not accepted. I said I would give my life. It stalled the spirit council and brought with it sombre and deep tones. It felt like it was resonating with such great love it hurt them. I could feel this from their communication to me when they came back to me but even that did not change the rules to ***allow me to speak from the crib "!***

Second incident:
This occurred at three years of age in the garden at home.

"My older sister and I were outside in the garden. She was in front of me at some distance. I stood up to walk over to her and felt myself being thumped very hard from behind on my left shoulder. It was a powerful thump that sent me flying. I fell but did not hurt myself. I started to cry, not because I had hurt myself, but more from the shock of being thumped so hard. I did not know why I had been thumped and that was also a shock. I looked at my sister and thought that somehow she must have been the one who thumped me. My Mother ran out of the house and picked me up. She was in quite a state. I accused my sister and she said 'no' it was not her. My sister looked surprised and concerned. My Mother said she did not know what it was that thumped me so hard but it was not my sister as she had seen what happened".

Rachel's reaction:
"Before being thumped I felt a presence that was gathering force like a ball of energy waiting to explode. I was concerned and wanted the presence to go away. It just got bigger. I could not see anything but I could feel where it was and that it was like a ball getting darker and darker. Rather like seeing a person go from calm to very angry until they hit something. I was really scared. Firstly, I felt being thumped and it was hard and a real knock. I did not enjoy the suddenness of the thump nor the force with which it threw me and that it actually hit me. That was shocking. That it actually hit me and I was doing nothing but playing in the garden. That it was not my sister who knocked me made me feel even more scared because my Mother had not seen anything hit me so she could not defend me from something she did not see. This made me scared and anxious. It worried me for a long time. It was not the first time I had felt being touched but it was the first time I had been knocked over very hard. I had been touched before but it did not hurt or worry me. It was like little pats that did not worry me because they did not hurt even though I could see no-one touching me. It was just something that happened that did not worry me until I got a huge clout. From then on I did not want to be touched, patted or knocked over again. It felt like all the pats were just a build up to a huge knockout and I did not want any part of it and I did not want it to happen ever again. It did not. The earlier pats took place only over a period of a few days on and off before the big thump".

Third incident:
This occurred at the age of eight in Rachel's bedroom and is the event which she described in psychotherapy as the aliens.

"I woke up and saw people in my room. They were adults and they were talking among each other. The room was filled by their presence and there were about four or five of them. I then noticed that they had noticed I was observing them. One of the men came over to my bed side. He crouched down to bring his face to eye level with mine. He had bright green eyes and his face glowed light from inside him. He smiled at me but it looked all too glary bright and out of the ordinary because the lights were off and the room was dark. I looked at his face and his jersey was of a most unusual knitting pattern. His smile and eyes just seemed to glare brightness at me and seemed to penetrate into my own beingness with intensity that I shut my eyes and started to feel very frightened. I said to myself that I would shut the sight out by closing my eyes. I was so afraid I could not even move my body. Hoping he had gone away, I opened my eyes just a fraction to look and was shocked that even with only barely opening my eyes again, his full face and smiling menacing glare came full into view. He said he would not go away and would come back again. I was terrified. I then, with great resolve, managed to turn my body over to face the wall. It was then that I went to sleep, determined to sleep and find safety there to shut out the images in my room.

The next day I had full recall. I tried to tell my Mother, but she brushed what I said aside and said it was a bad dream. That night I was terrified to go to my room to go to sleep again and insisted that the door to the room be open and a light outside in the passage be kept on". There was a similar visitation that night where the forms took shape out of the door handle and *"grew"* into the presence of people. She heard a serious discussion and was again terrified by the same menacing man. She again blocked these images out by *"willing"* herself back to sleep.

The next day, her mother and father again insisted that she was having a bad dream. Her father advised her to pray. *"That night, the appearance of the people again came about before I could go to sleep. There was a speed of appearance this time, as if they all knew I could see them and their appearance was without restraint. Only this time it was very different. The conversations became loud and fierce and then a fight broke out. One of the adults drew a knife and stabbed the other man who fell. They dragged him across the room. I was so afraid I started to pray the Our Father, at which point a small white light appeared right in the centre of all the goings on. It grew into a small white angel of intense white light that was not of a kind that extended itself into the room. It was white, self-contained light. At that moment the passage light went on and I could hear someone coming out of my parents bedroom. The images scurried for cover with one of the men coming to hide right behind the dresser next to me. He saw me observe him and commanded me to 'Shhh' then disappeared. When the room had returned to normal in the few seconds, I dived out of bed and ran to the passage, throwing the door open where I saw my Father, fully dressed in his day clothes coming out of his room. I ran into his arms crying and explaining the people were in my room. He held me in his arms and asked me if I had prayed. Yes I said feeling certain that was why he had come out of his bedroom on his way to the bathroom just when I needed him ! He encouraged me that all would be alright. I told him what I had seen*

and he said all would be fine now and I returned to my bed and went to sleep feeling better.

The next day I was in happy spirits that my Father had been there at the precise moment I needed him and that the people had not come back. My parents did not inform me then, that my Father had not come out of the room and he only asked me what he was wearing. I told him and that was the end of the discussion except for the fact that there was a scratch across the room where I had seen the people drag the body. I pointed it out to my parents to make them believe what I had seen. They did not believe that part and I was puzzled. The mark on the floor was there. I had not put it there and I had seen why it had appeared. My Father, I was later to learn, had no recall of coming out of the room to comfort me. I was sure it was my Father who came out the room and even as my Father said he did not remember, I knew that my Father came out his bedroom and I had seen him do so. He asked me what he was wearing and I explained. That he had come to my rescue was all that mattered to me whether he could remember or not. The people then went away after that night and no longer appeared to me. My Father had not come out of his room that night, and my parents decided that the house was haunted and we moved to another house as a consequence to another incident that made me scream in such terror I frightened my eldest sister who recalls the incident. I was not to know that my parents had decided to move from the house due to these events until some ten years later when the event by casual discussion came into our conversation. I was quite astounded by this news because at the time, my insistence of the event was treated as if I was dreaming bad dreams".

Her younger sister confirms that she too had seen a form of a man leaning over her who then moved over to her sister Rachel. She described it as an ordinary looking man but she could not see his features in the dark. She then saw an angel in white kneeling and praying and, feeling unafraid, went to sleep. She did not experience or witness any of the other events Rachel describes.

Rachel's reaction:
She still finds this event disturbing as she cannot find an explanation for it and she feels more comfortable if she can understand things. The fact that she could see the man's whole face when she squinted makes even less sense for her. She found the experience of the menacing man smiling at her *"rather intimidating to me because smiling was so rare in my life. The glow from the face was not normal to life either and this also unnerved me".* She found the unnaturalness of their appearance terrifying and worse was not being able to relate this to her family *"with any hope of understanding or appreciation".* She believed that because the event took place at night when everyone was asleep, her experience was invalidated by others which made her feel very unprotected.

"When I saw the angel preceded by a few flickers of white points of light, one at a time to only then disappear, I concentrated my fervour in prayer and the angel appeared like a white flame. I was very happy and felt only then that something had come to protect me and to save me from the terror I was feeling".

Fourth incident:
This occurred in her sister's room when Rachel was eight year's old.

Rachel and her older sister were swimming and Rachel was afraid to go back into the house to fetch her towel. Her sister went with her as far as the door. She was certain something bad would happen.

"I took a deep breath, ran into the house, into my room and grabbed my towel, turned and walked quickly out. Passing my Sister's room, I got the fright of my life ! There in her room were red gnomes with one of them with his head in her beach bucket. They were only playing, I knew, but it was not right that I should see them. I was so instantly shocked, I let out a scream of terror and ran with all my strength to get out of the house. My Sister heard my scream from outside and by the time I reached outside, I was crying from terror. She was quite shocked ... I was crying and Mother came to see what was happening. I was so distraught that my Sister explained to my Mother what I had seen. I was very frightened. Mother took me in her arms and calmed me and we returned to the swimming pool after she assured me she would tell my Father and they would do something about what was happening".

Rachel's reaction:
"I felt ready to die. I was so unhappy and I felt so sure that I would not be believed. There was comfort in my older sister's concern that I looked as white as a sheet when I ran out the house but that did not remove the terror that I was the only one getting to "see things". No-one could comfort me ... and this was very distressing".

Fifth incident:
Rachel was fourteen years old when this event occurred in her bedroom at home.

"I had decided to enter the school diving competition. I had only two dives that I could do to some extent. I needed to have a third dive for the competition". The third dive she decided on was a complex one which, if not accurately performed, could result in her hitting her head on the board. Encouraged by her teacher she decided to enter but felt anxious and afraid that she was *"doing the wrong thing".*

On the weekend before the competition, whilst riding her bicycle, she *"had a thought enter my mind that something bad was going to happen to me. I had a thought that I might harm myself in the diving competition but I put the thought out of my mind".* Praying to God she received another thought that *"something bad would happen because I was good"* and that she was not being punished for being bad.

On the Thursday night, I woke up in the middle of the night. I woke up gently, not sleepily, but clearly and gently. There at my bedroom door stood a beautiful golden, glowing person in a long molten gold to the floor garment. I could not discern whether the person was male or female. The person's face was also golden and the features were chiselled and perfect. What a beautiful sight. The hair was thick and gently wavy in thick locks of golden brown shoulder length in a glow of light. Standing at the door, the person said, 'Do not be afraid'. I was instant in my response, 'How can I be afraid? You are so beautiful'! The person smiled as if my reply had given the person the way

to now come near to me. Smiling, the person came right up to my bedside and crouching down to face me, told me not to speak, but to talk with my thoughts so we would not wake anyone. I was happy and excited to feel the radiance of the being with me. I was very happy. The being said to me that there was news for me. I was at once curious. I was told not to be worried. That God did not want me to think I was bad because an accident had to take place in which I would be slightly hurt. I asked why such a thing had to occur feeling quite worried in that very instant. The angel person asked me to remember the diving competition. 'Yes' I answered. Then it was explained to me, that my decision to dive at the competition was going to lead me to do the dive in front of all the people. I was shown, as if on a movie in my mind, that my dive would result in a head injury in which I would be killed. I was very stunned and the angel person then continued to say that this was not what God wanted for me and so I had to be in a small accident to prevent me being part of the competition".

Rachel begged the angel for recall of the incident but was advised she would only be given a small reminder. The following day she did not have recall. Riding home from school, a friend *"lifted his leg up and kicked out his foot against my bicycle handles and sent me flying in a somersault over the handle bars at full speed. I went crashing to the ground, my face hitting the tar road and in that instant I blacked out ! In the blackout, I had full recall of the Angel's visit" !* She was taken to the hospital to receive stitches.

Rachel did not tell anyone of the angel's visit. Upon hearing of the deliberate action of the boy her father went into a rage and was going to sue her friend's family. Her father was serious about taking the boy's family to task and she was determined to prevent this. Asking him not to take action against the family only made her father angrier so she told her parents about the *"person ... in golden garments ... I was very forthright about God not wanting us to hurt anyone. This succeeded. My Father did not pursue legal measures ... nothing was said again of the matter".*

Rachel's reaction:
"I was not going to say anything to anyone because I was so used to hearing the 'Yeah yeah' response. It was only when my Mother said that my Father was going to punish my friend's family that I felt I was now duty bound to prevent a court case. I had to convince my parents not to do such a thing because I was spared and they had to not be angry with anyone... There was some comfort from my Mother who was not so quick to disregard what I was saying and she took up my cause and won on religious grounds and persuasion. I had said I would have no part of any fight in court. To go against my parents was not comfortable but what had happened with my Angel visit had happened and there was no getting past that. It happened and bad could not come of it ...".

Sixth incident:
This occurred in Rachel's bedroom at the age of sixteen.

"I woke up. I felt something was about to happen. There was an intensity, a frequency of some kind that I could feel. The room was in a natural soft dark shadow. It was night time. Something was going to happen. I could feel it. Something imminent was about to happen. I felt a white being at my right shoulder. I was comfortable with the sense of the being in white light at my side. The presence of the being seemed to be quite

natural and comfortable. I felt it communicate to me to be unafraid that yes something was about to take place and at no stage would the being leave me. Then I saw it. It was a purple light. It had a life of its own. A cobalt purple light that appeared in a dimension all of its own I noticed. It appeared as a small spot of light appearing out of a great distance while yet against the cupboard door that was near to my bed. The light had its own dimension and was imposed against the normal regular dimension of my cupboard distance from my bed. This was the first strange thing to me. I reached back in resistance to turn to the being at my side and received the communication not to look at the white being at my side. That the being is my guardian and that all would be well. I looked at the light and sensed a velocity of speed as it was in high speed as it travelled into view and grew in size. When it arrived fully in my room, it was a ball of purple light that took on a solid form of a small little beast of a blob of animal but not animal appearance. It had a long snout and black eyes that glinted at me as it seemed to see me. It just looked at me. Pretty harmless, I thought. So, now what I thought. The being next to me informed me to pray the Our Father. I did so and as I uttered the words, the little, strange looking thing let out a huge scream. It snarled and its mouth curled back over its teeth. The white light being said I should keep praying and as I did so, I noticed that the words of the Our Father seemed to be killing it. It could not come near me and it went backwards into the ball of light and reversed back over the same path which it had appeared in my room. Then it was gone. The being of light was still with me. So, what was that for I asked ? I felt safe and was informed that the prayer I had said had been my protection. I knew I was safe and wondered at the intense frequency I had felt ahead of the thing coming into view. I felt sorry for it because it looked as though the prayer had strangled it and like it was in intense agony as it reduced in size and vanished. I had also noticed its intent to harm me if it had been able to attack me in defence but it was unable to harm me as the white being had assured me. That was the only remotely scary thing about this event and the frequency of speed of an approaching dimension was the scary part. I felt throughout the incident that I was safe and in no way did I feel that I was in danger as I was assured that the prayer would protect me and that the being of white light was near to also help were it necessary. I was quite puzzled after the event. I noticed that I was not so scared and that was a comfort. I was disturbed that there was a dimension that had made itself visible to me and that its intensity was greater than the intensity of the regular world. It had interfaced over it like a live hologram".

Rachel's reaction:
"I had felt protected from the very start of this experience. I felt rather puzzled as to the meaning of the experience in the first place other than to convey the power of the prayer the 'Our Father'. It left the question in my mind ... was I going to need it in the future ? That was disconcerting to feel I might be alone in the future where the only thing I have to hold onto is the prayer 'Our Father' where even my protection would be removed. I felt worried but not too worried because I had felt protected through a very bizarre experience".

Seventh incident:
This occurred in Rachel's bedroom where she had seen the purple light described in the previous incident. She was seventeen years old.

"I woke up with an instantly fresh and alert mind. I had for some months been doing yoga meditation. This was done in my room alone and the feeling I got from the meditation was simply a feeling of my body becoming very heavy and then like a concrete cask. During the meditation I had become aware of a cloud like vapour above my head. Like a dark rain cloud... over the days, the grey thing above me grew. I was perplexed. I sought to be in a state of goodness and went through my conscience with a fine tooth comb. I could not find any error or guilt in me... I was seeing a 72 year old Swami at the time ... and I asked him about it and he told me not to worry".

That night the grey cloud moved above her head and had grown larger. She woke to see a beautiful looking man in a bright orange tunic and turban sitting in the Lotus position in the centre of her room. He was levitated off the ground. *"As I looked at him, he looked into my eyes and I realised that if I as much as blinked, he would vanish. I regretted this knowledge as his appearance was very beautiful, especially as he was levitated about eight inches off the ground and his face and eyes were soft and good, filled with warmth, seeing and connection with awareness of him. He knew I saw him and it was as if he was there to be seen and I was to see him only for a second. I panicked that I would not remember this, so I quickly scanned his face for a feature that I could remember in the morning. I took in his eyes and forehead, and then blink, he was gone. What a pity ! He was so welcome. The sight was too brief I felt. I felt only sorrow that he had not stayed and that he was lost in a blink" !*

Her family flew to London the next week on holiday. She had arranged to visit a Swami at the Ashram in London. The cloud had not disappeared. Rachel visited the Ashram and whilst waiting to see the Swami she paged through a photograph album that was on display. She saw the picture of the Swami she had seen in her visitation. She asked who he was and the Swami responded by enquiring why she had singled that photograph out of the many different pictures in the album. *"I told him I had seen him. He asked me when. I did not want to go into any detail so I answered simply 'about a week or two ago'. The Swami replied with a gasp, 'Oh strange, he has been dead for over one hundred years' ! I felt embarrassed so I said, well I had seen him in a dream and remembered what he looked like. The Swami asked if I was sure. I affirmed yes, and then he returned to me with a book all about the Yogi I had recognised. The Yogi, in his life, had been a very holy man and his book is highly regarded about his miraculous, holy life".*

On her return to the hotel with her newly purchased books she again felt the presence of the grey cloud. This angered and perplexed her as she felt herself to be *"in a state of goodness and yet this contradiction of a grey cloud following me was more intense than ever. Walking back to the hotel I was in conversation in my head to God".* An unshaven, scruffy-looking man appeared, walked up next to her and started a conversation. She had a conversation with God in her head and was angry when advised to be polite to him. *"I was appalled. It didn't make sense. I quickened my steps and my thoughts advised me to hurry to the hotel and that once inside I would be clear of the man who would not follow me into the lobby looking the way he did".* She raced into the lobby and told her younger sister who reassured her and they sat in the lobby. *"I put my two heavy plastic bags of books down and noticed a brown package tucked under the chair next to me. I had no concern for it and as I glanced up, I saw the man*

again, who had followed me. I felt a sharp rush of panic and dashed up off the chair, grabbing my bags, and running across the foyer looking for my Sister and heading for the lifts. I found her and, not wanting to go without her, I grabbed her arm with force and insistence. I explained I had seen him again. Where, she asked ? I looked again and saw him. 'There' ! I almost screamed, and not really worrying if she saw him or not, as the lift doors opened, we both hurried inside. As we got to our floor we got out the lifts to go to our room. As we were opening the door a huge explosion went off. We rushed into the room shutting the door and rushed to the window to see what it was. We saw the people on the street below as if they were frozen in their tracks for a split second before turning to run like mad people screaming in the opposite direction.

My Sister and I did not understand. We decided to go and see what happened and as we opened our bedroom door, a thick blanket of grey smoke like a wall met us. Sixty four people had lost their lives in the first IRA bomb attack on a London hotel in the Hilton lobby where we were staying. The brown package I had seen moments ago, I think must have held the bomb that was so devastating to cause the glass windows to shatter glass across two highways in front of the hotel. I had not trusted God. I had said so. I was very sad at this realization. No-one in my family had been hurt".

Her sister confirms that there was an IRA bomb blast in the hotel where they were staying and that she and her sister narrowly missed injury or death.

Rachel's reaction:
"The build up of grey cloud that I felt over my head but could not see, was very worrying. I did not know what it meant at all. I felt guilty yet I could find no reason to feel guilty. I could not relate the grey cloud to anything pleasant or worthy. It was not something I wanted in my life. So it was very upsetting and it would not go away. I could go away from it by aiming my awareness to daily life but it would not go away from me. It would make itself felt in quiet moments of reflection and contemplation that were part of my meditation exercises that I was doing daily. The cloud got bigger and seemed to have a life of its own quite removed from my will for my life to be cloudless. There it was. In my consciousness and it was going nowhere, just getting bigger.
I was very concerned because I could not see the run up of events that were to take place in London that would occur and save my very life. I could not see the future and if I could, I would fight not to be there even though I would be unharmed".

Eighth incident:
Rachel was married at this stage and this event occurred in her bedroom in Italy at the age of twenty two.

I was missing my husband dreadfully. It was a most stressful period of my life as he was working in Libya three months at a time with two week breaks back in Rome where I was staying with my Mother and Father-in-law.

One night I dreamed that my husband was slouched over the steering wheel of his car with a dagger in his shoulder. I felt the pain in my own shoulder that made me recall the dream and consider it meaningful. When I woke up the following day I recalled the dream and pondered the feeling it had left in my emotions. My shoulder was feeling the

pain. It was distinct and as I thought about it I felt a presence, in a dark shadow form, stand before me and ask me if I was willing to let my husband go. I thought about it and said no.

He returned from Libya early with an injury to the same shoulder I had seen wounded in my dream. He explained that he had received a powerful electric shock that had been so strong as to throw him off his feet into unconsciousness. He only survived due to the quick thinking of a colleague who unplugged the machine that was carrying the voltage that tore the nerve endings in my husband's shoulder. It took four months before he was fully recovered.

My husband returned to Libya and again, some several months later, the shadow presence came to me asking me whether I could let my husband go. This time, I had no dream of any danger or harm that my husband was facing. I questioned the presence and was informed that if I was to say yes, that I wished to be released, he would die. That was too much for me, to contemplate his death and yet I was informed that he would die as I requested release, in that moment ! I said no. When my husband returned he told me he had gone fishing and had swum too far out to sea. It was dark and he started to sink under the water. He explained that a good feeling came over him as he drifted down under the water". At the same time that she had advised the presence not to let her husband die, he experienced a vision of her under the water and he surfaced and swam back to the shore.

The shadow presence reappeared to her on their return to South Africa where she was asked whether she needed to suffer more in her situation. She experienced her marriage as a *"brutal experience. Once again I was asked if I could let my husband go. I knew by now that this meant his death so I argued that it was not Godly to say yes and so be the cause or desire of anyone's death no matter what my suffering. The presence did not leave but stood, as if held in sorrow for me, and again asked me if I was now ready to let my husband go. I thought about it and then took a most bold step. I answered with my arms open wide in image of Christ the crucified, 'May the will of God be done, I embrace my destiny'. I did not know if I was the one who was going to die after I affirmed my final answer. Aware of this, I was most conscious of the events in my life and the time that lapsed.*

The shadow presence was not something I saw with the naked eye. It was a presence felt and can only be described as a shadow presence that does occupy a place and form that is felt not seen. Some three months later, my husband was killed in a tragic accident". He was, in fact, murdered.

Rachel's reaction:
"I was in an urgently unhappy relationship and marriage. I felt such pain when my husband died but I was so grateful that his passing had not been my decision. I would have felt like a murderer. The absence of such a feeling only gave more space to feel the devastation of his death without cramping self guilt. A hopeless utterly destroyed incoherent space of soul. His life in my life was pain. His death in my life was pain. A double-edged sword. What for ? I felt his presence for many years after his death. I only felt released from him when a Mass was said on the anniversary of his death for

the intentions of his soul and his relatives by a very good Priest friend of mine who opened the Mass with the powerful invocation to God - 'Oh God, if thou shouldst mark our guilt, who could ever stand before you ?' That Mass gave me tears of joy. I felt pure joy in the core of me radiating into my bones and flesh leaving me trembling all over. I knew my husband had ascended from my mind and thoughts that his soul was earthbound. I felt so happy for him and for the first time I felt free from pain and loss".

Ninth incident:
Rachel was 34 years old and this occurred in her bedroom at a London hotel.

Waking slowly one night she *"entered into a different, altered state of awareness of myself inside myself in the region of my head. The first thing I recognised was that there was a tall being of white light at my right hand side guiding me in walking towards the centre of my own self... I then became aware of 360 degree inward sight. It was a most extraordinary experience. It lasted a while and confirmed that I was seeing inside me, not outside ... As I continued with the guide behind me, we came to a faceted obelisk metal structure right in the centre of me ... he encouraged me to take steps to approach the structure. As I took a few steps forward I became aware that the structure was 'all powerful' ! I was quite stunned as I contemplated this and felt that it was communicating to me that it was the power that created the planets and systems of the universe. I was quite amazed. It called me to approach it and with the awareness of what it was, I started to think that I could share its power. I felt what it was like to create a planet and to reverse it into non-existence. I was awed at the thought that this was inside me and to approach and merge would erase me as I knew myself in the outside identity of my experience of my own life. I was unable to move forward and share the power of the structure and, as I decided this, veils started to fall. First one, then another. I regretted not merging with the structure and felt the desire to be at one with it and felt my deep regret and urged the white being to allow me another chance.*

The veils lifted. I took two steps forward and again felt the power, the greatness that again overwhelmed me and I could not go further. 'God' I acknowledged. 'Yes' was the most subliminal response. The veils fell again, and this time I was very sorry I had not been able to go forward. I pleaded again for a chance to go forward. I was denied but at my urgent insistence, compassion again let me try. Even before the last veil was lifted I knew I could not of my own strength approach God. I accepted. I was sad. The white figure next to me of a shaft of light, said I was not ready.

I re-entered my awareness of the room I was in and had full recall of what had just taken place. God was with-in me ! I saw. I knew and experienced inward sight with no question of a doubt ! I had not even the imagination to have created such an experience or dream. I was awake. I was exhilarated ! Thrilled, excited and very happy".

Rachel's reaction:
"I was sad with myself that I was not strong enough to go forward and merge as I thought would have happened if I had stepped forward. I had been invited to do something and I could not. I wanted to, but I could not. I did not have the fearlessness. That was what stopped me in my tracks. I felt sad at myself but not in a reprimanding way. It could not be helped. I simply was not ready and there was no punishment

attached. I have since been advised, in 1998, by a person who I consider to be very spiritual with whom I shared the experience, that if such an experience should ever happen again, I can equip myself with the precursor of whatever is to follow by saying, 'For the good of all Mankind only'".

Tenth incident:
This occurred in 1990 in Rachel's Cincinnati apartment just before dinner when *"I felt a presence over at the window. It was unavoidable. It was felt and I could shake the feeling had I wanted to. That was an option ... I just felt like the presence would go away if I chose ... I got the feeling that it was in a large grey orb. I have since discovered that the reason I felt this was that the grey orb was a veil to the presence's intense light that would otherwise harm me to see into it because it is so bright. I am comfortable with that explanation that came to me some years after the event.*

When I went over to the window, the presence said I should take off my shoes as I was standing on holy ground. The ground referred to was the ground immediately in front of the presence and not the ground of the apartment as such. The presence said I should pray ... as I prayed ... the presence said to me in a stunning thought - I should pray for Judas - the Judas that had betrayed Christ. I was stunned. The presence did not feel to me to be unholy. On the contrary. The thought of doing such a thing went far against all I had been taught. The presence gently said that what was wrong in the world is that Judas is still not prayed for or forgiven by us, mankind.

I felt a huge excitement ... the presence asked me to get a pen and paper and write down a prayer. I was to give this prayer to the priest. That was the very hard part. The prayer was dynamic in terms of everything I had ever conceived of in religion - but to pass it on, that was really very hard. I had not written it. How could I explain any of this ? I was in conflict. I did not want to put myself into any question. I did not want to have to do what was asked of me. As I wrote the prayer down I was thrilled. It felt like a huge holy revelation. I was so very excited and happy and I felt very humble and amazed. The presence left as these feelings took over ... There was just excitement, thrill and responsibility to pass on the prayer".

Rachel advised me that she had gone to a particular, senior Catholic priest and told him of the message she received. She did not want any publicity or to have to follow through with any other action as she was afraid of the power of the message. She felt herself unworthy of having been the recipient. He mentioned a priest who had likewise received a message from God and had been ostracised from the Church for some time before being re-accepted into the faith. The priest did reassure her that he believed this message to be a spiritual one. Rachel never followed up on this incident.

Eleventh incident:
This occurred within the year before Rachel started psychotherapy.

"When this happened I was at the height of my career and the depth of despair. I felt like I had nothing. Yes, I had the material comforts and security but love was missing and I felt awful ... Feeling filled with poverty, I stripped down and got down on my knees. I started to pray. Look at me I pleaded. I have nothing and I am so sad. It was

in this state of prayer that I felt a presence come to me and standing above me said to me ... what do you want ? The question was not audible nor the presence visible. It was felt ... The thought came to me. It was like telepathic conversation ... I answered that I did not know and that I wanted to be helped out of my sorrow and loneliness. The thoughts came back to me in the form of instruction. I was crying my heart out ... the thoughts said I should get some wine and make a sign of a cross on both entry and exit points over all the doors in my apartment. I did not know why but it came to me that from that moment on my apartment would be blessed and no-one would come or go who was not screened by this watching presence. I obeyed. As I did this I was relieved because it felt like something constructive. It felt like I was being saved from a terrible fate as I recalled that the ancient Israelites had to put lamb's blood over the entrance of their homes to guard against being killed when the angels of death flew over their homes".

Twelfth incident:
This is the event that occurred in my consulting room in February 1998. Rachel had, however, experienced these images on many other occasions before the event in my room. A summary is provided here to remind the reader of the event. Rachel had attended a Reikie course in February 1998. In the next session she connected very powerfully with the images. She was sitting talking to me about the Reikie course and making her usual good eye contact. Suddenly she exclaimed, looked slightly to my left and stated that there were little people standing next to me. Her eyes were absolutely focused and she was animated and excited. Her whole body was alert. She described seeing the silhouettes of people who were grey in the middle but had the colourful lights of their chakras around them. One was a man, another a child who was *"peering ... innocent ... so sweet"*. She stated that they were very closely gathered around me and, at one stage, one was kneeling down right next to me looking at me. Rachel was utterly fascinated by these images who were not frightening her at all. She advised me that if she tried to bring the images closer they started to disappear but remained strong if she simply looked at them. After a while, she described how she felt the images were coming from inside her and being projected out. If she reached out a hand to touch them they were insubstantial yet she could see them as clearly as she could see me. She concentrated, reached her hand out, staring intently past me and then as she brought her hand closer towards herself she felt the images were from *"inside"*. These images were there for the whole session.

DISCUSSION:
As indicated, the primary caregiver's role is of paramount importance as the first person interacting with the infant (Winnicott, 1963). The dominant, unconfirming mother can result in the child becoming overly dependent, submissive and passive (Cameron, 1947). However, it is not only the mother that may negatively affect psychological development but the whole context in which the individual is raised and interacts. The total "family situation may impede rather than facilitate the child's capacity to participate in a real shared world, as self-with-other" (Laing, 1969, p. 205). This is recognised by many authors. For example, Boszormenyi-Nagy and Krasner (1980, as cited in Friedman, 1985) stress the importance of the family in that "the long term legacies of parental accountability are inescapably weighty" (p. 110). Cameron (1947) states that

what is learned in relating with the mother and family at home is generalised into the world as social techniques and this is clear in Rachel's whole manner of inter-relating with her world.

The effects of both the mother and family dynamics are very apparent in Rachel's family where the manner of relating was faulty and often bizarre and violent. As mentioned, I likened Rachel's parents to a pair of scissors with her father providing the blunt edge against which her mother physically and emotionally cut and hacked. Rachel intuitively became passive to avoid the cuts and this approach was reinforced as she grew older and witnessed the terrible damage her older sister suffered by trying to fight the scissor blades. The younger, favoured sister was treated more gently as the mother's anger diluted and the son fared best. All, however, were negatively affected and the whole family were unable to function adequately in relationship.

The damage Rachel suffered in her early years left her feeling fragmented and lost with no sense of a cohesive self or boundaries. The fragmented self results in a lack of experiencing oneself as a separate individual with subjectivity. With no understanding of symbolism, life events are experienced as concrete, literal and real even if they are meant symbolically. There is no experience of thoughts or feelings being one's own and little possibility of interpreting within a broad range of meanings. There is no sense of shared experience and high anxiety is present due to the threat of annihilation. Laing (1969) terms this 'ontological insecurity' which occurs in a situation where the False Self, instead of the True Self, becomes confirmed.

When the facade is the only aspect of the self being confirmed, the person is not met in an I-Thou manner. If the I-Thou relationship is severely disrupted, the infant/child's self is never adequately confirmed and, thus, forever seeks confirmation from others. As the confirmation is only meeting the facade, the individual dwells in a never-ending cycle of inauthentic meeting and false confirmation. This exacerbates the sense of isolation, of being different and out of step in the shared world. The sense of being fragmented is highlighted by interactions with others which increases the need to withdraw and strengthen the facade even more.

So, as stated, relatedness to other people has a radically different significance and function for the fragmented or psychotic person because he is not secure within himself or his world (Laing, 1969). Preservation of the self against a threatening world is the major priority. Laing views psychosis as sometimes being "the sudden removal of the veil of the False Self" (p. 106) which has been maintaining an outward normality for years. This implies that the inner core would then be revealed. Exposure to the real world without the facade for protection would be perceived as too threatening. So, an alternative reality must be created immediately and psychosis develops. Thus, one must look at the meaning and sense of the hallucinations and delusions. What function are they performing ? They are there to protect and are manifestations of the person's inner feelings, desires, wishes, dreams and needs. One must discover in what way they are true reflections of needs rather than viewing them as absurd. The psychotic's world is as real to him as any other person's world. However, others do not share and understand the psychotic's world. The psychotic fragmentation results in problematic perception and meaning for the individual in his whole world of relating (Friedman,

1985). His reality is not in a shared world which increases the sense of isolation. This was true for Rachel.

Rachel's need to create her own world where she was viewed as special and protected started at an early age. This is indicated by her retrospective interpretation of her first year of life where she describes having her own language. In this first awareness of herself as different from others, Rachel was already experiencing the world of relationships as negative. Her mother did not understand her and was perceived as derisive and negating when she *"laughed"* at Rachel's efforts to talk. There is no sense of shared connecting with a mother who might have been laughing with delight at her baby's first attempt at speech. There is the first sign of guidance from a presence outside her which advised her that she was not meant to communicate in her own language and must accept that she would forget the language and adapt to the world she lived in. This was the start of her world of isolation. Her sense of not being heard or understood was exacerbated by the fact that she believed her parents could not recognise that she was not a baby but someone who was more intellectually developed and had powers that were unusual in infants.

The sense of estrangement and isolation is highlighted in her words *"not once did the awareness of those around me look deeper at the deeper significance of my effort"*. That her mother expressed joy in her efforts to master language and her body, for example with the rattle, made her feel hopeless. This signifies that she felt that only the superficial facade of the physical movements was being recognised and not the depth within. The inability to retain recall of that language and that special world was perceived as a loss which caused sorrow and despair. There was even a desire for death rather than being denied the ability to enlighten people fully. The fact that she feels she was only understood by the spirit council and only in their language already signifies the sense of being different and not understood in her being-in-the-world. She felt ignored and not recognised which was highly frustrating. There is a strong sense of betrayal and anger about the lack of understanding and recognition of her special qualities from the human world. This was added to by a sense of betrayal from the *"spirit council"* who would not allow her to retain her language. However, there is a sense of love from the Spirit Council too which is the start of many instances where she is loved in the altered reality in a way she is not in the real world. Feeling that she had been born into an *"unaware world"* suggests the start of the despair of having to live in a world where she would not be understood and accepted for who she really was. This is highlighted by her sense of being special which was then removed leaving her in a state of isolation.

Some developmental thinkers, including object relations theorists, may interpret this as a sign of Rachel struggling to relinquish a sense of omnipotence. From their stance, that would be a viable explanation. As stated at the beginning of this chapter, my sense of her writing of this incident was that it was a reconstruction of a vaguely recalled memory. She subsequently may have attached deeper meaning to this incident and it may be the first signs of her psychosis.

In the second incident Rachel's mother came to her rescue and was clearly concerned about her daughter. However, this did not reassure Rachel. The fact that her mother

had witnessed that her sister had not hit her created anxiety that there was no-one who could protect her. This would have been especially anxiety-provoking as her parents would not have been able to protect her against something they did not believe in, even if she had been able to describe it then, as she can now. The sense of isolation is powerful in this description especially as the presence here was threatening and damaging.

In contrast to my findings, Jaspers (1963) states that psychosis is often "un-understandable" and that delusions "remain largely incomprehensible, unreal and beyond our understanding" (p. 98). Phenomenology also disagrees with that viewpoint and states that the value of any experience lies in the meaning it has for the patient and his lived reality. In my experience, hallucinations and delusions have always been grounded in the reality of the patient's lived experience. When healthy contact is denied and the self is not met, the individual seeks to create a reality in which basic needs will be met (Eigen, 1993). I agree with Eigen who states, there is a "kernel of truth" (p. 9) in psychosis. It is not simply a matter of a mind gone haywire but an attempt to alter a reality that exists. The meaning for the individual is bound up with his experiences but the altered reality presents in an exaggerated form. As Schwartz (1997) states, the meanings that emerge in psychotic states are more "forceful, explicit and graphic" (p. 180). The expanded horizon and explicit meaning makes the psychotic's world more unmanageable and complex. When there are an overwhelming number of possibilities and experiences available, there is a need to reduce this complexity. Thus, the individual will automatically select a particular, relevant meaning which is conditioned by his past beliefs and experiences. The aim is to have control over frightening and chaotic experiencing. This helps provide and heal the lack of whatever has been missing in the patient's past experience. This is still not, however, shared by others and the individual remains disconnected and isolated.

Rachel had the feeling of being different and isolated in a world where she perceived her parents as being unavailable and unable to protect her. She began to create a reality that reflected her inner fears and met her need to be protected and special. The vulnerability and disconfirmation is again highlighted in Rachel's description of the third incident. Rachel was eight years old and had been given a severe beating from her mother shortly before the incident - it felt as *"if something broke inside"*. In the midst of the terror of the aliens' appearance, the white light (angel) appeared to comfort her. This was followed immediately by her father's image appearing in the passage. Creating the angel and father image fulfilled a powerful need for protection at a time that was terrifying and out of control for her. His appearance also served the function of dispelling her images as she did not experience them again. Rachel was thus creating what she needed and desired, that is, a father who did protect her from harm and danger. This was not what occurred in the reality of her daily life where his absence resulted in a failure to prevent her mother's beatings and emotional abuse. Her need was such that, in the face of his denial that he had been there, she simply refuted his words. For her, he had been there. Her parents' disbelief about the incident and particularly the scratch on the floor left her feeling more disconfirmed and confused. The scratch was there to be seen and yet it was still denied which resulted in her withdrawing from sharing these experiences. Although her younger sister had witnessed part of this incident, I am not certain if she told Rachel that she had. This

would have confirmed Rachel's experience and reduced the sense that no-one ever believed her.

When her mother wanted her to *"wean"* herself off me in psychotherapy, Rachel recalled this incident. I wondered whether the person who was killed in the incident could have been her psychological and emotional self. When her mother beat and tried to throttle her like that, it must have felt that physical death was a possibility too. Her father had not been able to save her then, so she created his image to rescue her in the hallucinations. A similar dynamic connected to emotional death appeared when Rachel's mother suggested she leave psychotherapy. This was the only safe haven she had ever found in the world and her mother was attempting to destroy that too. This would again have broken something inside Rachel. It was highly significant that she drew a boundary and chose psychological life in the face of the punishment she knew she would receive.

The lack of desire to share her strange and terrifying experiences is highlighted in the next incident where Rachel saw the gnomes. Her comments on the fear of disbelief from others, the *"terror"* that she was the *"only one getting to 'see things'"* and how *"distressing"* it was that she could not be comforted, say it all. There are signs of confirmation throughout these incidents which tend to become lost in the general feeling of not being heard and met. Linking with the mother's delight and joy in her as an infant in the first incident, is the acknowledgement and belief from her older sister and her mother's instant reaction of holding and soothing her in the second. There was a reassurance given that something would be done. And this was followed through, when the family moved believing the house may be haunted, although she was only to know that in later years. At the time she did not experience it as a confirmation and concern for her. It is interesting and somewhat incongruent that, despite the strong religious beliefs, Rachel's parents viewed the house as haunted. It does not appear that her parents prayed to solve this problem. If the belief was that the devil was involved, one could speculate that they might have called in a priest to exorcise the devil/spirits. However, as little detail is known, it remains a query and incongruent point.

This is the second mention of Rachel's mother comforting her and she ignores this on both occasions. It is as if her mother's input is experienced as negative or irrelevant from the beginning. For some reason she is not allowed to play a positive role. One has to query whether the inconsistency and abuse was already resulting in Rachel being unable to trust any good treatment from her mother. Or was Rachel, at some level, already becoming the victim and thus unable to absorb good and valuable treatment ?

There is a break of nearly six years between major hallucinatory episodes and it was a time where Rachel withdrew and became depressed. Her family and the world continued to abuse her. Her younger sister's sexual abuse by the men visiting the room at the hotel also traumatised her. This was followed by the doctor advising her parents that she needed a dog and again no-one heard and acknowledged the needs of the lost child. It was shortly after this that she experienced the incident where the angel appeared to her. The angel told her she was not *"bad"* and that God did not want her killed so a small accident had to occur to prevent her participating in the diving

competition. Here again, someone is making her important and special. Not just anyone, but God. There can be no more powerful a message of one's worth from a father figure than the acknowledgement that God will protect one from danger. Her father did not fulfil his role as protector and denied doing so in her alien hallucinations. So, she created God as the Almighty Protector. This met her need to be recognised as well as protected at a time when this was primarily being denied in life. Her father did in fact come to her rescue here by wanting to sue the boy's parents and then agreeing to drop the charges at her and her mother's request. Rachel did not perceive this as protection. Yet again there is some support from her mother when she argues her case with her father thus indicating some measure of belief in what she said. This provided Rachel with little comfort.

Rachel told me about this incident at the start of the second year of psychotherapy. This was the time when her fiancé had abandoned her and she feared I would follow suit because she had lapsed and called him again. She was perceiving herself as a bad girl who had been abandoned just as she had at that earlier stage of her life. Perhaps she was also trying to give me the message that she was not bad as God had not found her so. Or perhaps she was able to share the experience with me because she knew, at some level, I was unlikely to abandon her and she was simply sharing the fear ? The first statement seems more likely to be correct.

At times of danger, usually psychological in nature, Rachel would experience the presence of a white light which always signified protection. This is apparent in many of her episodes. She sometimes saw a white light around me. She initially put it down to the intellectual as it was around my head but a psychic had advised I was an "old soul". The implication is that the old souls are wise, having learned from past life experience, and are thus more equipped to heal. I linked it to her possible view of me as the protector of her psyche and soul in some ways. She only ever saw the white light at times of extreme vulnerability both in childhood and in psychotherapy. For example, the first time she saw it around me was just after her lover from work had been killed and she was extremely distressed and in need of comfort. She also mentions in her notes on the experience of psychotherapy that she pictured my hand as being *"white as a light"* reaching down to save her when I stated that I would not abandon her even if she followed the path to suicide.

The sense of a holy presence to protect her from harm continues in the sixth incident. This occurred at a time when Rachel was again very vulnerable. There is a strong sense of protection and safety despite the little creature being vicious and frightening. She knows the angel will protect her. Her creations meant that some part of her was starting to feel safe within despite the lack of external protection. This episode was not mentioned in psychotherapy but discussed as one of the incidents she had written down at the time when making the decision to stay in psychotherapy. Perhaps this indicated her sense of strengthening within despite her mother's attacks. She knew psychotherapy was the right path for her.

The next hallucinations occur a year later just before and during a visit to London with her parents. Rachel had extended her spiritual interests into the realms of yoga and meditation which were providing her with some satisfaction. This incident, combined

with the bicycle accident which prevented her being killed diving and the protection by the angel from the angry little beast, convinced Rachel that God was her protector. She had stopped expecting her father to fulfil that role. Now she has a warning from God, via a scruffy old man whom she wishes to elude. She takes her sister upstairs to safety - ostensibly from the old man but, as it turns out, from death. Here was another sign of her being special and protected despite her faltering belief in God at that stage. This convinced her that God's protection was very real. The build up of the cloud as a warning made her feel guilty as if she were questioning herself about being bad again. The cloud, however, clearly signifies the dust from the bomb blast. It was thus a warning and of value for her. As stated, her sister confirmed in her psychotherapy that there had been an IRA bomb attack on the hotel which her family had narrowly missed being injured by. This incident is particularly why Rachel perceives herself to have psychic powers.

In the eighth incident where Rachel experienced the thoughts and presence about her husband's possible death, she was desperately unhappy in the marriage. She felt there was little chance for escape and here the presence was offering her that opportunity by his death. There is an enormous sense of guilt at desiring release from his abuse. The perception that she had the power to have her husband killed by simply acknowledging to the presence that he could be released, is important. It indicates the enormous power she believed she had. Here she had the power to change the status of victim and take control - over life and death. That power frightened her and the guilt did not go away. She clearly had not resolved those issues and in her first month of psychotherapy she was discussing this. She only told me much later on in the psychotherapy about these incidents when she was once again discussing her late ex-husband's influence.

The ninth incident indicates her sense of being asked to merge with God. This was about two years before she came into psychotherapy and she was suffering extreme despair, was very suicidal and beginning to feel that she was *"falling down a dark abyss"*. Again, there is the sense of being special that God should chose to reveal his presence to her and that she was somehow worthy enough for that whilst life had denied her a sense of worthiness. There was a desperate need to be confirmed at a real level - by anyone. Not only is she allowed to witness the power of creation, she feels she can share this awesome power. To create and reverse planets into *"non-existence"* is an extraordinary power. She was utterly lost and this must have felt like the ultimate in comfort, confirmation and being special - to merge with God and his power. It is possible that her lack of ability to step forward and merge with God meant that she was not yet ready for death. She states that merging would have meant the erasure of her as she was in life. It felt close and possible but part of her chose to live. Rachel discussed this incident at the time when her lover from work mentioned he was leaving the company. She felt abandoned and betrayed. This made her feel she had lost everything she had learned in psychotherapy. This sense of being shattered and lost was similar to the feelings she was having when the original episode occurred. In both cases there was utter despair and the desire for suicide. In the current situation she was able to deal with her emotions slightly more effectively and controlled the suicidal ideation despite feeling like *"lots of broken pieces of glass"*.

Rachel was still in a fragmented space after the ninth incident and it was shortly thereafter that she received the Judas message. This further highlights her specialness. To be the instrument that is chosen to pass on an important message to mankind that she believes will change religion in a spiritual and moral way is powerful. There is a sense of awe, of her being humbled, of her fear that she was not worthy. This confusion would have been further exacerbated when the priest confirmed her yet advised her of the dangers when people have not been believed. Rachel had experienced that disconfirmation and disbelief all her life so to leave the message in the priest's hands and exit the scenario would have been the safest thing to do. To not have her message believed on a large scale would have destroyed her and intuitively she knew that.

During psychotherapy, when Rachel and Pieter were living together, Rachel was also in a fragile state. Pieter's family did not accept her, Pieter was losing control daily and deliberately trying to *"break"* her. At the same time he was displaying care and affection for Querida. Rachel then had the vision of her mother telling her to get out of the relationship. This is the first time she created her mother as giving advice and guidelines just as she had done while she was alive. However, this time, her mother is protective which had not been Rachel's experience of her. This seemed to be the start of re-connecting with her mother in a positive way.

In the eleventh incident, one can see the depth of despair in Rachel. She felt that she had material comforts and security but was impoverished in the realm of real, connected relationships, emotional security and love. Feeling *"filled with poverty"* of spirit she prayed for guidance and help. The presence asked her what she wanted and her response was *"to be helped out of my sorrow and loneliness"*. The presence advises her to paint the sign of the cross in wine on both entry and exit points over all the doors in her home. There is an immediate sense of relief and safety that the presence would be watching over her and that constructive action had been taken. Rachel was very suicidal at this stage and this is clearly illustrated by her feeling that she was being saved from a terrible fate like *"the ancient Israelites"* who *"put lamb's blood over the entrance of their homes to guard against being killed when the angels of death flew over their homes"*.

Although there is the impression that Rachel suffered very few hallucinatory experiences, she was in fact frequently in touch with images and had many minor experiences throughout the years. She also had the period where she wrote copiously as if instructed to by God. The incidents discussed are the most vivid of her experiences.

Overall, some of the incidents are frightening and some soothing. The danger to her psychological self is apparent in these incidents. In most of them she creates a protective, caring presence who fulfils the role her parents never did. The confirmation that she is worthy enough to be protected is thus provided at one level. But, it is then negated by the disbelief that she encounters in most cases when she chooses to share her experiences. She was simply not met in the shared world. The more she was negated and disconfirmed, the stronger the need for a higher power to provide protection. Hence the movement into the religious episodes.

As previously stated, the content of the psychosis provides one with important clues and information as to the nature of the difficulties experienced. This point has been documented by a variety of clinicians from different perspectives. Prouty (1994) has explored the importance of the frequent connections to religion in psychosis. Eigen (1993), writing from the object relations perspective, describes that hallucinations frequently incorporate erotic and religious elements as well as the individual, personal meaning for the patient. Boisen (1962) found that religious psychosis arose out of the requirements of the life situation and were an attempt to meet the stress of a complicated and demanding world.

The result of being raised in a strict Catholic home has been highlighted clearly in the religious tone which permeates Rachel's life and psychotic episodes. The judgment and lack of acceptance of her by the family was later reflected in the church so there was a tremendous need for her to find some acceptance and peace with her religious superiors. The views of Boisen (1962), who himself spent many years in a mental institution, clearly illustrate this point and support my findings on Rachel's religious experiences. Boisen explores the hypothesis that there is a relationship between pathology and religious experience. He views both as arising from a common situation. He states that the only difference is in the outcome. If the experience is gauged to be successful, it is viewed as a religious experience. If not, the judgement passed is insanity. Boisen gives the example of Paul's hallucinatory experience on the road to Damascus which can be equalled in wonder by many psychotic religious experiences. He draws the conclusion that it is finally not a distinction between normal and abnormal but between spiritual defeat or victory. A major distinction is that the accepted religious experience achieves the result of reducing the sense of isolation as the individual is welcomed into the fold. However, the unsuccessful and unaccepted resolutions of hallucinations and delusions are ignored by the church and others which increases the isolation, loneliness and sense of being different and abnormal. In studying psychosis, Boisen found a high percentage of the 173 cases studied to be linked to the patient's sense of an impending world change, of important issues being at stake and exalted ideas of the patient's role. He views religious experience as an attempt to raise the person's values to the cosmic level and to establish and maintain a relationship with those who represent the highest order.

The lack of confirmation from people and the sense of failure in the shared world leaves the individual no option other than to seek that confirmation from elsewhere. The highest order may feel like the only option left. However, this can boomerang if people then further disconfirm the individual by viewing the religious experience as a sign of insanity. Many of Rachel's hallucinations have been in the "mind's eye" which was accepted in the age of St. Augustine (A.D. 354 - 430) as being a revelation from God. Today that belief is usually viewed with scepticism and the tendency is to think pathology as the first option. Rachel believes that her Judas message, her religious writings and her meeting with the God presence are a sign of a higher level of consciousness which may be from within herself or from God and are a sign of further progress in her spiritual growth. Boisen discusses the case of a man called Fox whose religious message was accepted and, with increasing social approval and acceptance, his disturbance lessened. Rachel's message regarding Judas was accepted by the priest she discussed it with and this allowed her to make some sense of the event.

Although she did not feel worthy of receiving the message she felt confirmed as valuable.

The vision of the angel and white protective lights, which she has described to me as angels, in four of the incidents (3rd, 5th, 6th and 9th incidents) had powerful meaning for Rachel. In the third incident she was experiencing herself as in extreme danger from the violent men who were murdering someone in her room. The appearance of the white light which turned into an angel helped soothe and calm her a little. Likewise the golden man/angel appeared to warn her of the dangers of the diving competition and the white light protected her from the creature who wanted to attack her. The final white light/angel presence helped her connect to God. These incidents all signify that someone cared enough to protect her from harm which meant that she was worthy. As discussed, this was clearly her desire and Rachel views this now as a manifestation of that need for protection.

Rachel perceived that she was not valued, loved enough or understood so, in the awful loneliness of that space, she fulfilled those requirements by being rescued and protected by her father, God and the angels. Her father is a particularly important issue for Rachel as he failed to prevent any of the emotional and physical abuse by her mother and was thus experienced as participatory in the process. This is frequently felt as a worse betrayal than the abuser - as an adult she could understand her mother's behaviour as a result of her own background and life experience but that her father could comply and ally with that is extremely difficult. In many senses the father figure is the one who should be able to protect the children and her father's absence meant there was no-one attempting to stop the violence. Her father only raised his hand to her once. He pretended to hit her hard and then whispered that she should cry. This was the only sense of protection from him. If he had not smacked her, her mother would have. And it would have been far more severe. To gain protection, Rachel had nowhere else to turn except her mind.

Thus, it can be seen that Rachel's religious hallucinations and delusions of influence and/or grandeur are closely linked to solving her problems within both the family and religious arenas. Since the hallucinatory experience with the little people in my consulting room, she believes that a higher level of consciousness, whether it be oneself or God, exists. Recently, Rachel has begun to connect with her spiritual life in a calmer and deeper manner. Having fought the judgmental attitude of Catholicism all her life, she is finally connecting with a God that is kind, accepting and confirming. This has been reinforced by her reading Walsch (1995) who portrays a gentler picture of God and his intentions than she was ever taught.
Prouty (1994) states that many psychotic patients are too regressed and socially isolated to be able to communicate in any effective way. It is true that many psychotic, schizophrenic and fragmented people have difficulty in describing their experiences. However, Rachel is articulate and intelligent and well able to vocalise what she is experiencing. This has contributed to the therapist being able to enter her world and understand the meaning these experiences have for her.

The narrowing of experience in psychosis has been discussed. When the focus is on the current meaning and experiencing, the broader perspective is lost. The intense

focus in Rachel's hallucinations is highlighted in the writings of many clinicians. Eigen (1993) accurately describes hallucinations as bringing "experience to a standstill, and one small portion of experience is heightened to an extreme degree. The subject is hypersensitive in a highly selective way. Everything seems to gain its meaning from this small portion of experience" (p.125). Thus, the emotional quality involved in hallucinations and delusions results in a lowering of the critical ability to judge. Sass (1994) describes the world of psychosis as "a place not of darkness but of relentless light, which is the natural metaphor for conscious awareness" (p. 94). The heightened focus increases the intensity of the experience and narrows the field of experiencing. Boss (1975, as cited in Kruger, 1988) correctly views the patient's world as thus becoming narrowed and constricted in an attempt to make sense and control his way of being.

I agree with Gendlin's (1964) view that the interaction process between the feeling and the event is limited or blocked. When there has been little sense of self developed in childhood, it further exacerbates the inability to connect in a relationship as a meaningful I. If events are perceived as literal and there is little felt-sense, then experiencing is no longer a process. The individual exists in an isolated and withdrawn world in which there are few links to a reality of being-in-the-world. Rachel's world is aptly described by Gendlin when he states that it is not the content of the individual's experiencing that is psychotic but the "structure-bound manner of experiencing, the absence or literal rigidity of felt experiencing and interaction" (p. 143).

Thus, Rachel had to adapt and change her relationship to the world as there was little ability to understand interpersonal and social rules. This factor had been exacerbated by the family's closed world and lack of healthy interaction. There is also an inability to project oneself into the future or have a sense of the past. Gendlin states that in hallucinations one does not interpret and feel the meaning of a past event in the present. The patient tends to remain in the past which distances him from his current experiencing of life isolating him from his current day-to-day functioning. This leads to a rigidity or lack of felt functioning in the present which results in inappropriate, literal or concrete interpretations and the loss of a sense of self, further contributing to the sense of isolation experienced. This is precisely what occurred with Rachel's experiencing. May (1958) adds that the disturbed person never develops beyond the limited and restricted forms of experiencing in childhood. In later years, the person tends to perceive others and experience life with the same restricted and distorted views. It requires a strong desire to alter those restrictions and views and to learn a more practical and functional way of relating in the world. Fortunately, Rachel has that desire.

Rachel did not have a clear sense of self or the skills required to interpret and behave appropriately in social situations. However, her determination to function better in life is powerfully strong. The severe difficulties with boundaries leaves no possibility of distancing and creating boundaries as fragmented people (and psychotics) are "obsessed by the compactness of their being" (Corin & Lauzon, 1994, p. 44). Rachel does evidence many signs of concrete thought and interpretation where meanings are perception-bound and there is very little ability to see the broader context. She has sometimes taken suggestions and comments literally and acted on them. For example,

when she stopped Pieter in a fight to ask him to describe what he was feeling with the intention of then describing her own feelings. She has also often reminded me of words I have used which she has completely literalised. This indicates the structure-bound functioning in her world and the narrowing of experience and focus on the self. This is clearly illustrated in Rachel's inability to see another's perspective or to put herself in someone's else's shoes. For example, there was usually complete surprise when I ever pointed out a different view of someone's behaviour. Her comment was often *"oh I didn't know that you could ..."* feel or behave that way. Despite this, her capacity to inter-relate is there.

The patient's perceptions are a reality for him as they are experienced and lived as real. However, Prouty (1994) speaks of the patient's inability to own the hallucination as 'mine' as it is experienced outside the body. Thus, although experience as a whole is perceived as real, there is a sense of a mind-body split occurring at times. Certainly, many of Rachel's experiences were felt as separate to her. This is most clear in the twelfth episode with the 'little people'. Prouty describes hallucination as a process which moves from a rigid and alienating self-experience to "a clear, alive, immediate and integrated" (p. 78) self-experience. It can be seen how Rachel followed the four stages of hallucinatory experiencing : 1) the self-indicating stage where the therapist focuses on the image itself to make it more accessible to both the therapist and patient; 2) the self-emotive stage in which the focus is on the image and the feelings required to maintain a unity of process (Gendlin, 1964); 3) the self-processing stage where there is a shift from the symbolic image to experiencing the feelings; 4) the final stage where the feeling "shifts from the hallucinatory image to the person's own sense of self, and is integrated, owned and experienced as self" (p. 81). In this way the hallucination is connected to the self and integrated so that it gradually becomes part of the felt-sense of experiencing. This is what occurred with Rachel as she moved through the process from experiencing her visual hallucinations as external events to understanding that she had created them within to satisfy her needs. She could finally own them as 'mine'. However, she has still not shifted her views on the Judas message and the inspiration for her religious writings. Rachel is convinced that this is a higher level of consciousness.

David (1990) discusses how insight consists of three different phenomena. The "recognition that one has a mental illness, compliance with treatment, and the ability to relabel unusual mental events (delusions and hallucinations) as pathological" (p. 798). Whilst I agree with the process, I do not believe that one needs to label the events as mental illness or pathological. In the light of the above discussion of Rachel's realisation that the images came from within her, we still do not talk of them as pathological or psychotic. They were understandable ways of reducing the chaos, her sense of worthlessness and isolation. In that way they were valid and helpful in retaining her sense of value and sanity. If the world was not confirming her, who would ? Only herself in an altered reality. She was able to recognise that she had life problems that were making her dysfunctional but we did not label that as sick. In fact, it was my respect in not telling her she was mentally ill and pathological that allowed her the space to connect deeply and come to her own insight about the hallucinations.

I believe that treating her as damaged due to her life experiences and her own

vulnerabilities is a better approach. She occasionally stated that the fact that I did not label her, as she knew traditional diagnosis would do, was the ultimate respect. Basically I bracketed any conceived ideas about her pathological experiences and simply went into her world of experiencing and understanding. I do not believe this has led to any delusion or conclusion that she was or is a totally integrated and balanced human being. She knows she was not functioning or relating in the world as she wanted to and has gained good insight into her damage. She also realises she has a long way to go. As long as she is not in danger from the process or a medical condition (like TLE), there seems little point in disrupting what is slowly becoming a more stable world. It is enough that she can understand the phenomena better for herself.

I also do not agree with Jaspers' belief (1913, as cited in David, 1990) that psychotics can only gain transient insight. For insight into an hallucination to occur, there must be the direct felt-meaning of the experience plus the description, where the patient can understand that the perception is false (David, 1990). This has occurred with Rachel. The twelfth major incident which occurred in my consulting room proved to be the turning point in the hallucinatory experiences. Rachel recognised her images were figments of her own creation at times of need and she still retains that insight.

Her vision during her second day on the Reikie course indicates that, despite her strength and growth, Rachel is still very vulnerable. She is only starting to consolidate a stronger sense of self with boundaries and I believe that any forays into the realms of altered experience would be negative for her. One has to have a strong knowledge and sense of self before these areas can be entered with safety. Personally I do not believe Rachel should ever explore those routes.

HALLUCINATIONS:
From a clinical perspective, Rachel appears to have experienced both true and pseudo-visual hallucinations. She has also felt presences without a visual appearance. For example, the presence of the spirit council was not a visual hallucination in traditional terms. She describes it as a mental presence behind her level of consciousness. On most of the occasions that a presence was felt, it was not visible. The presence in the eleventh incident spoke to her but the question was not audible nor the presence visible. However, many of the hallucinatory events did include visual presentations. For example, the gnomes, the aliens, the white lights and angels, the Yogi levitating, the purple creature and the many visitations of the little people.

Jaspers (1963) states that there can be a transition where pseudo-hallucinations can change into true hallucinations or a state where they combine. He believes that pseudo-hallucinations cannot be deliberately altered or evoked and may manifest in the form of pale, vague images. Rachel has experienced the moving, opaque figures just as Jaspers states and Lang (1938) described in his writings on his own hallucinations. Lang (1939) describes that, due to the hallucination being out of control of the individual, the individual then perceives the hallucination as an external phenomenon. Rachel was able to shift from that belief to the recognition that the images were being projected from inside. As with Lang, Rachel's hallucinations appeared without warning even as a child. Despert (as cited in Sedman, 1966a) also found pseudo-hallucinations to be present in a few children with emotional conflicts.

Noyes (1963) views hallucinations as being projections onto the outer world of the individual's psychological difficulties. The hallucination thus provides valuable clues as to what those difficulties are. Rachel felt that her hallucinations were a projection of her own needs and has come to understand their value in providing solutions to those difficulties. As stated, the images faded when she got close and attempted to touch them. Lang (1939) experienced his hallucinations as already organised phenomena and is sceptical of them being viewed as a result of projection. Maybe it is simply that they have no concrete substance rather than that she was actually projecting them. But the hallucinations lost their power when she touched them. So, she has been able to recognise that the little people and the other visible phenomena in these events were a product of her mind. She realises that she experienced them through the mind's eye and that she was not perceiving real objects (Sedman, 1966a).

Many psychotics view the world in a literal and concrete manner as Rachel has done. Sass (1994), discusses Schreber's Memoirs of my Nervous Illness, a case which Freud made famous. In exploring Schreber's psychotic states, Prouty argues that this literal and concrete manner is lacking in his case. Schreber provides an interesting example of how his own hallucinations are subjectively created in relation to him. Schreber describes how "human shapes were set down for a short time by divine miracles only to be dissolved again or vanish" (Sass, 1994, p. 85). So, they were not always experienced as concrete and real in an objective, external world but rather as "fleeting-improvised-men" (p. 85). Schreber thought that "I was faced not by real people but by miraculously created puppets" (p. 86). Until Rachel understood that the hallucinations were her own creation, she had a similar sense of the images of the little people.

As stated, many approaches to psychology, including phenomenology and dialogal therapy, believe that psychotic episodes always have a meaning for the individual. Sedman (1966a) found that most pseudo-hallucinations were psychologically meaningful for patients. They reflected the patient's emotional climate, past experiences and future wishes. In this way they were closely related to the self in both form and content and were perceived in colour, full detail and fully projected in three-dimensional form. Sedman's patients required a conscious act to make the distinction between reality and the images and it made little difference whether they were fully conscious or in a half-waking state. Lang (1939) disagrees stating that his hallucinations often lacked any connection to the current experiencing of the situation. These findings support Sedman as it is possible to find deep meaning in Rachel's episodes. She has stated, however, that she finds it difficult to understand the significance of the episode in my consulting room as the little people were not psychologically significant for her. Interestingly, that episode was the one which allowed her to realise that she was creating an altered reality and that all the other visions had not been objective as in a shared reality.
Jaspers (1963) states that "observing an object brings the visual pseudo-hallucination to an end" (p. 141). Visions, such as pseudo-hallucinations seem to vanish if people move forward to touch the images. As stated, this occurred with Rachel when she reached out to touch the images in my consulting room. Rachel understands that her hallucinations are not visible or measurable in a three-dimensional world and perceives them as having more reality in the sense of a powerful energy field. For example, the knowledge that she would lose the images if she blinked assisted her in realising they

could not be solid and real.

In June 1999, Rachel and Pieter went to see a three-dimensional film whilst in Disney World. In order to achieve this effect, special glasses are worn. She describes the wonder of a butterfly when it *"jumped off the flat screen and flew up through the audience to flutter right in front of me at a distance of about one foot away from my face" !* It suddenly struck Rachel that this was *"exactly how I had experienced my visions ... I could see the butterfly. It was there ! But it wasn't ! The impact of the similarity was like a shock ... here it was ... something clicked, connected ... It is a happy feeling - like finding evidence or something special to uncover".* Rachel was very excited and told me this on her return to South Africa. She queried whether the depth of her visions had happened *"because somewhere in my brain circuitry there is a momentary connection that allows me to see a third dimension".* She describes the experience further: *"You see what you see. It is there ! But you know it is not ... It alters perspective. It changes emotions and can be very powerfully felt but when you reach out to touch it, or face that it is there ... it is not tangible but you still see it. Just reaching out to accept it and touch it to discover it has no physical substance is awesome - scary and very challenging. How can you see something that is not there ? Explain that and 'that' is how my visions are ... they are there when I see them, but not in any sense of any reality that is tangible, explainable or logical in terms of any physical reality. That is and has been the huge pain and sorrow and aloneness for me".* This is a vivid description of how the visual hallucinations were experienced for Rachel.

Rachel's voices were not true auditory hallucinations. The voices were not localised outside nor heard as a separate voice in physical space. She is aware that they were not real but experienced them as a process occurring from the higher level of consciousness. At the time of the Judas message and her religious writings, she believed the words came from God - that they were being channelled through her. Many of the conversations she had with the presences and angels were experienced as thoughts in her head. It felt as if she were not owning her own thoughts which removed any sense of control and mastery. Jaspers (1963) states that this can be experienced as being in the power of some external control or force that suddenly provides one with intrusive thoughts or messages. Gruhle (as cited in Jaspers, 1963) describes the thoughts as coming "like a gift and I do not dare to impart them as if they were my own" (p. 123). This description exactly fits Rachel's sense of the voices. Today, she is not certain whether the voices are a result of a higher level of consciousness within herself or God. And she is not actively seeking an answer to that question. She simply accepts that it may be either reality.

DELUSIONS:

Delusional perception describes events that are normal to most people but interpreted by the psychotic as having a special significance for him. The following clinicians describe the value of delusional belief which supports my findings. Sass (1994) states that delusions are not always in the shared world but "rather, it is in the mind's-eye world where emotions, other people, and even the patient's own body exist as purely subjective phenomena, figments of an abstract imagination" (p. 92). The patient is always the centre of his delusion. When someone experiences an hallucination there is a powerful need for that experience to be grounded in reality. Delusions are, thus,

often associated with hallucinations in an attempt to support and make sense of that reality. Thus, delusions can be viewed as simply an exaggeration of the normal beliefs people use to bolster their perceptions of themselves and reality (Noyes, 1963). When there is a large discrepancy between a person's experiencing and what appears to be the norm, the need to make the experience congruent with the personality becomes a high priority. So, the patient's reality is not necessarily a disorganisation but a "choice that has a superior claim to reality" (Kaplan, 1964, p. x). The above is clearly demonstrated by Rachel's absolute belief in her hallucinations until she understood the significance and meaning they had provided for her at critically dangerous times. Some people would still call her delusional in her uncertainty about whether she can channel thoughts from God or a higher level of consciousness. As long as this does not lead her further down paths of altered reality, it is not an issue for her or me.

DISSOCIATION:
Dissociation of the self from the body is normal under severely stressful situations. Feelings of estrangement and derealisation (Laing, 1969) are common. The self is usually alert and may be thinking with "exceptional lucidity" (p. 83). Dissociation usually occurs without the person's control and is an instinctively protective response. There is an ability to develop a schizoid state where the person becomes a mental observer, looking on in a detached and impassive manner at what is being done to the body. There is a powerful need to separate mind and body at that stage of helplessness. The dissociation is a way in which to cut oneself off and reduce the strength of the emotions.

Rachel's dissociation, when Pieter was beating her when she was eight months pregnant, was understandable. No-one had ever protected her and she had learned to be passive in the hope that this would reduce the intensity of the beatings from her mother. Having never protected herself from the abuse in the past she did not know how to do that, despite being pregnant. So, instinct made her curl into the foetal position to protect the baby and she sought help in her head as she had always done. She had a powerful image of me which she *"clung"* onto for life and sanity, again creating a protector that would help her through the nightmare. I felt the dissociation to be an improvement in Rachel's manner of dealing with life. She could so easily have slipped into psychosis at this extreme time of danger for herself and her unborn child. Her strength allowed her to contain the terror in a less defensive way. This incident was followed a few days later by the presence of her mother, again in a situation in which she needed protection. I wondered if this ability to create her mother, instead of her father, was happening because her mother was dead. Or had she learned from my support that the mother figure could protect ? Certainly she needed to heal the relationship with her mother. She had wanted protection from her father but the ultimate choice would have been that she did not need protection from her mother. I felt this to be critical and maybe the vision and presence were the first steps in the right direction. Rachel then started having dreams where she connected with some of the good qualities her mother had. The healing process is definitely in motion.

The question of how to deal with Rachel's psychotic experiences was a pertinent one for me. As stated, I never labelled her or the experience but simply entered her world with my senses attuned to what it meant for her. I was open and very curious ! Prouty

(1994) views hallucination as a "fragment of the self" and the "successful treatment of hallucinations is a restoration of the self" in order to restore a "communicative human self that was lost in madness ..." (p. xxii). As I confirmed her, she became less fragmented and it became less important to turn to an altered reality to find that confirmation. As she has begun to feel a sense of worth within, so has she been able to remain in the lived, shared world more and more. Thus, I agree with Jaspers (1963) when he says that hallucinations and delusions can be sources of human potential and possibility, not only deviations from the norm.

The above clearly indicates that man can only be understood in terms of his whole existence and not merely within the framework that makes a distinction between healthy and sick. Integration occurs if the sane and mad aspects are allowed to integrate and not be kept apart. Thus, as Laing (1969) states, one does not work at increasing defences against the psychosis but rather incorporating the hated and feared aspects of the self. This allows the person to relate to the world in a more balanced way.

The above discussion of Rachel's psychotic episodes illustrates how man will alter reality in order to create a way of being-in-the world which meets his needs. This creates an illusion which provides meaning and stability in a world of chaos and fear. Most importantly the discussion highlights that man lives in relationship and needs to adapt to being-in-his world with some degree of comfort.

This section deals with the major themes that have been dominant and critical in Rachel's life and psychotherapy. The significance of the phenomenological and dialogal approaches is explored as these principles are clearly highlighted in her journey to healing. Her path to integration, a more cohesive sense of self and the beginning of relating to the world in a healthy manner are the major focus.

PSYCHOLOGICAL AUTONOMY:

Man lives in relationship. It is in the person's manner of relating, therefore, that the answers to his problems must be sought. Hycner (1991) states that the disturbed person's trusting relationship to others has been injured and is not whole and this is clearly the case with Rachel. The healing of the problems and the patient's world is to be found in the meeting between two people in relationship (Buber, 1958). However, to develop a true relationship the person needs to be psychologically independent (Buber, 1965). Winnicott (1963) and Laing (1969) support this when stating that a firm sense of one's own autonomy is required in order to relate as one human being to another. To feel autonomy, one has to realise one is a separate person. Otherwise every relationship threatens the individual with a loss of identity as there are no boundaries to protect the self.

This is especially true of the fragmented or psychotic person. Buber (1965) states that this type of person is at extremes of distance and relatedness or closeness where either the whole or nothing of the real self is shared. This makes it difficult, if not impossible, to relate in a balanced manner with another. These extremes are apparent in every relationship Rachel had until she started to form boundaries. Her tendency to expose her innermost thoughts and feelings and become completely emotionally involved with people immediately resulted in her risking annihilation of the real self. For example, Rachel had voluntary sexual intercourse with the man at work whom she then felt abandoned by as if he had walked in, raped her and left.

When there has been little sense of a cohesive self developed in childhood it further exacerbates the inability to connect in a relationship as a separate and meaningful I (Gendlin, 1964). Buber (1958) states that meeting someone in an I-Thou manner involves fully connecting in a meaningful relationship in which the whole human being is met - body, mind and soul. The I-Thou is spoken with the whole being and hence is the primary word of relation. Rachel had never had the experience of being met as a Thou before psychotherapy. Her feeling of being a film negative on whom other people imprinted their lives and experiences highlights this statement. An I-It encounter treats the other as an object and a means to an end which devalues, dehumanises and alienates the person by viewing them as a separate object. This kind of separateness creates barriers between people, hence Buber's view that I-It is the primary word of

separation. Rachel experienced herself more and more as an It in life due to the complete lack of regard for her worth as a human being.

If one is not relating as I-Thou in the world, events are perceived as literal and there is little felt-sense of living. Experiencing is no longer a process. The individual ends up living in an isolated and almost autistic world with few connections to other people and a common social reality. Ebner (as cited in Friedman, 1985) believes the damaged person speaks past people and is thus unable to communicate with a "concrete Thou" (p. 185). Thus, the I-Thou connecting is faulty and impoverished. The lack of ability to feel separate and communicate effectively hindered any sense of forward momentum in Rachel's life and increased the feelings of isolation, helplessness and dependency. For example, she could not make her own decisions and relied on her mother's views to guide her journey in life.

THE SENSE OF BEING A SEPARATE PERSON:

One has to experience oneself as separate in a healthy manner in order to relate. And one must be confirmed at the core as worthy in order to gain a sense of a cohesive self and separateness. Buber (1958) views psychopathology as the absence of confirmation. Both Winnicott (1960) and Laing (1969) agree with this and it is the most basic and powerful factor in Rachel's fragmentation and lack of a cohesive self.

Buber (1965) emphasises the importance of relatedness but does not equate that with conformity. However, the fragmented person desperately strives for confirmation and acceptance. When the family structure is disturbed, the individual will conform if that is equated with acceptance and confirmation (Winnicott, 1960). Rachel's whole sense of being relied on conforming to her mother's standards and demands. Her conformity also reduced the violence and punishment she so regularly received at the hands of her mother. Even her father *"hated"* not having his needs met so the pressure to conform was great. Relating as her real self was not even an option let alone a choice. The attempt to receive confirmation became the total focus of her whole being and life. In the absence of confirmation there is a sense of emptiness and futility. False confirmation is viewed as better than none at all despite the whole self being at risk (Laing, 1969).

Laing's (1969) view that the False Self can become "compulsively compliant to the will of others" (p. 102) is an accurate description of Rachel's facade. The compliance of the False Self is linked to fear but also to hatred at having to be what others want and having to risk annihilation to gain confirmation. One has the sense of anger with Rachel's first description of having to comply with the spirit council's desire that she remain in a human form and not share her higher knowledge at that stage of her life. The compliance is also seen throughout Rachel's life in her interactions with others. For example, Rachel was unable immediately to turn down the invitation by a married man at work to go away for the weekend as she did not want to offend him. The fear is clearly indicated in her compliance towards her mother's demands that she live according to her standards and expectations. She felt as if her very life depended on complying with her mother to gain confirmation and avoid punishment. Her mother's demands, desires and wishes became the foundation upon which she based her own principles, values and assumptions about the world. The False Self tends to assume "more and more of the characteristics of the person or persons upon whom its

compliance is based" (Laing, 1969, p. 106). Rachel became just like her mother and lived the image that had been required of her. This was evident not only in her belief and value systems but also in the dress code and the genteel and proper manner of behaviour she displayed.

Rachel always expected punishment if she did not conform or if she displayed any negative emotions. This was evident in most interactions with her mother. An excellent example of her mother's punishment is the reaction to Rachel's decision to stay in psychotherapy against her mother's wishes. Her mother's attempts to annihilate her emotionally were powerful and horrific. The expectation is also shown by her fear of punishment and abandonment from me when she followed her own intuition. For example, she feared my disapproval when she called her ex-fiancé after he had ended the relationship. It was again evident when she timidly advised me that she had resigned from her new job in finance without even going into the office on the first day. In that instance, my immediate response was a form of disconfirmation for her. Unfortunately, Pieter always punishes her and threatens abandonment which fuels her belief that she is unworthy. She has always been punished because she lived in an alternative reality. As stated, the mentally ill have generally been punished over the centuries with few exceptions. Rachel is no exception. I have been the only person in her world who has simply accepted her hallucinatory experiences without judgement or disconfirming her.
If one is not confirmed but punished for being real, a strong sense of unworthiness develops. The frequent punishment Rachel received, both emotionally and verbally, reinforced this belief. There is a continuing thread throughout the psychotherapy of Rachel believing she was bad. This was based primarily upon how she believed her mother to perceive her and subsequent reactions from people in the world - especially Pieter. She had been told she was bad because she caused her mother unhappiness and stress. The fact that her mother could even threaten to kill her felt like a statement that she was bad and worthless. This felt like an annihilation of the self for her - it highlighted her worthlessness and was one of the most disconfirming experiences in her life. Rachel described the helplessness and how she made no attempt to fight back. This passive behaviour in the face of even a life-threatening attack was to set the pattern for the future.

Previously Rachel had experienced her overwhelming and all-consuming pain as a punishment for her being *"bad and wicked"*. Her mother's repetitive message that she was bad had resulted in a guilt and lack of worth which was so profound that she often felt death was the only option. This is where the dynamics of Rachel's guilt and taking responsibility for others' behaviour started. For example, she often felt guilty when she behaved in a manner that did not match her mother's standards or values or felt responsible for her mother's moods. An excellent example of this is her feeling responsible for her mother's anger when her mother beat her so badly at the age of eight. And her mother reinforced this belief until she died. Rachel never questioned this - it was simply how it was. The first time she ever consciously thought about who she really was occurred when she stated she was bad and I asked her if she really was. Her response of *"only a little because I want Pieter to be able to support my son and me"* indicates how deeply this judgement had struck at her core. To believe one would be judged as bad for desiring protection and support from a life partner highlights the

pain and despair she suffered in her quest for confirmation.

In order to reduce the punishment and sense of being bad, the facade or False Self becomes very powerful in protecting the core. But the facade is felt as inauthentic. The inner self may even hate the characteristics of the False Self and its compliance but it also "fears being engulfed by the spread of the identification" (p. 109) with the person it is conforming to (Laing, 1969). The individual does not only identify with the outward manner of appearance and behaviour. The influencing person's belief and value system can also be internalised as was the case with Rachel. Furthermore, the characteristics of the person on whom the compliance is based may be absorbed. For example, Rachel began to observe her own behaviour through her mother's eyes. Where her mother had been judgemental, so Rachel began to judge herself.

Rachel hated her cold, hard, bitchy presentation when she was at the peak of her career and she resisted this facade when she was invited to return to that world a few years later. This was partly due to an active dislike of herself when she was behaving in that manner but also because it represented everything her mother had stood for and which she now feels to be false. Her change in appearance also indicates her stepping away from conformity to her mother's dress code and the necessity for the presentation of the perfect image. This was a major step as the False Self and the all-important image had as much of a dominating influence for Rachel as it had for her mother. Her mother had role modelled the image as being the necessary presentation for survival. For example, at no stage was Rachel ever allowed to wear long pants or to fail to have the full regalia of clothing and make-up on. Minor infringements of these rules were punished verbally right up until her death in 1995 which was early in Rachel's third year of psychotherapy.

By conforming and presenting whatever facade Rachel felt would meet others' needs, she hoped to be confirmed. But, although Rachel appeared to be in relationship, she was never authentically interacting with others and thus was never really met and confirmed at her core. She could only be herself in isolation but that came with a sense of emptiness and unreality. The more she kept the True Self hidden, the more compulsive the need to present the False Self became (Laing, 1969). This conformity occurs because the infant is able to identify with the powerful other with ease. As Winnicott (1960) says, the mother's impingements result in the infant learning to meet the mother's needs and never identifying his own needs and thus sense of self. Rachel's lack of a cohesive sense of self is clearly illustrated by her compliance to her mother's wishes most of her life. As a child and adult, she presented what ensured psychological and emotional survival. Rachel has never been in touch with her needs but only her mother's. As stated, she had believed that her needs changed from person to person and situation to situation and if the needs were new the other needs became invalid. As she has been confirmed in psychotherapy and begun to feel more of a cohesive sense of self, she is beginning to identify her needs. She has always been clear about her need to have a deep, fulfilling and meaningful relationship. She had no knowledge of what this entailed or meant, but the desire was and is strong. She even recognises that this goal is an extremely difficult one to reach due to her damage.

THE SENSE OF BEING AN AUTHENTIC PERSON:

To live effectively in the world it is not only critical to be separate but authentic in relationship. Laing (1969) states that there is a strong need for one's total existence to be recognised and confirmed. In the empty and isolated inner world of disconfirmation, Minkowski (1933, as cited in Laing, 1969) states there is a "loss of 'vital contact' with the world" (p. 148) because relationships are the product of the facade. So, the individual may appear normal but, as Laing describes, "what was designed ... as a guard or barrier to prevent disruptive impingement on the self, can become the walls of a prison from which the self cannot escape" (p. 148). When these defences fail, anxiety increases, nothingness overwhelms and the inner self is experienced as "split and dead" (p. 148). This makes it impossible to relate to the world in a normal way as the person is disconnected from others. The person who cannot sustain his sense of identity from within may feel that he is only real when he is experienced as such by another. Thus, there is a constant need for others to affirm his identity. "The self can be real only in relation to real people and things" (p. 152). There has to be a meaningful and authentic connection to be real.

An immediate sense of authenticity and real connection to the world cannot be sustained by the False Self system alone as it cannot put reality to the test. Testing reality requires an independent self that can make choices. The True Self cannot adapt and continue to respond to what is socially acceptable so it withdraws leaving the False Self to adapt and establish a defence system. However, the mask of sanity people wear is not always good for them and can even be destructive. Rachel's mask when she worked in the high world of finance was very destructive as she was totally disconnected from any sense of her real self. Instead of simply protecting the True Self, it began to smother it. When this occurs there is frequently a sense of dissociation of the self from the body which lends itself to the psychotic position (Laing, 1969). There is no reciprocity in relationship and psychosis may develop. This is when the individual may begin to experience his perceptions and thoughts as not being his own. This is highlighted throughout all Rachel's hallucinatory episodes. For example, the feeling that God's thoughts were coming through her when she felt compelled to sit and write endless screeds of religious writings and when she received the Judas message.

In this isolated space the person feels as if he is only being related to as an It. Laing (1969) speaks of the terror of the fragmented person when he is treated as an It. As stated above, he then requires constant confirmation from others of his own existence as a person. Rachel described herself as being *"only a response to other people"* with no identity of her own. There is a constant sense of being different and not quite connecting for Rachel.

Exploring what this world was like for her brings to mind Van den Berg's (1972) description of pathology as the science of loneliness and isolation. Rachel has lived the tremendous sense of this isolation and aloneness characteristic of the fragmented or psychotic person. The feelings she describes about her psychotic experiences highlight the unbearable loneliness she experienced. Her words at the end of the description of her visions, after seeing the three-dimensional film at Disney World, highlight the sense of isolation. *"... 'that' is how my visions are ... they are there when I see them, but not in any sense of any reality that is tangible, explainable or logical in terms of any physical*

reality. That is and has been the huge pain and sorrow and aloneness for me". This is similar to the description given by Chessik (1996) of severely mentally ill patients who describe the "unendurable state ... as a sense of nothingness, meaninglessness, chaos, or a 'black hole', a falling through space into a void" (p. 581). In this space there is the experience of extraordinary isolation and terror as the individual is disconnected from any meaningful relating.

To avoid the terror she presented the facade. The more the facade presented, the more isolated she became. Corin and Lauzon (1994) support the sense of isolation when an individual is unintegrated and there is an initial lack of boundaries. They state that the sense of where the self ends and the other begins is blurred and this openness to the world and experience can result in a frightening feeling of the loss of the self, or invasion and a threat of annihilation. This can lead to an inability to maintain a sense of mental space to allow the internal ordering of experience to occur efficiently (Eigen, 1993). Furthermore, at the level of the person's experience of themselves as an embodied self, there is a sense of a split between the self and the body.

Isolation may provide a sense of safety for the individual by preventing disconfirmation. If no-one is allowed close, there will be less ridicule, judgement, rejection and pain to contend with. Isolation may also be perceived as protecting the other. In the early days of psychotherapy Rachel had a fear that I would be damaged or annihilated if I connected fully with her chaotic world. This made her initially wary of opening her core and telling me of the psychotic episodes. It also had the effect of keeping her in the lonely and isolated space. Rachel tentatively tested my reactions to her altered reality experiences. Finding no other response than the usual respect, care and acceptance, she was able to open more and more in all respects. Freud (as cited in Eigen, 1993) is accurate in his belief that the ability to be out of contact is more common than believed and that the "ability to be in touch richly and accurately with ourselves and others is a precious capacity and one not to be taken for granted" (p. 367).

Rachel's need for confirmation, the lack of boundaries and the resultant loneliness is also shown by her sexual life which has not been for mutual sharing or to gain physical satisfaction but to seek security. Rachel opened her inner core to relative strangers simply because they were having sexual intercourse with her - and, in exposing her inner self too quickly in those situations, she risked the core every time. And she was damaged every time. Rachel has never experienced an authentically close and genuine sexual encounter. She shared a moment with me recently in therapy where she stated that she did not know, until very recently, that sex could be a warm, intimate, sharing and caring act. This was not because she had experienced it as such but because I explained that it could be so. We explored her pattern of relationships, especially with men, and she could see that the repetitive pattern was a self-fulfilling prophecy which further objectified and devalued her as a human being. Part of the dynamic is that she has always chosen men who were unavailable in both the literal and emotional sense. This may partly be because of her fear of and inability to commit her real self in genuine, authentic relationship. By selecting unavailable men she may unconsciously be trying to protect herself as there cannot be a mutual commitment if the man is not interested in that level of relating. In fact, this damages her even more as she is constantly disconfirmed. Nothing is learned either as no-one has truly given

themselves to her so that she can experience a fulfilling and sharing sexual encounter. Her inability to relate in a whole, authentic manner to others thus fulfils the prophecy and the feelings of isolation and the loneliness of her world are perpetuated. Very recently she told me that her father has been seeking confirmation in relationships with much younger women. She feels sad as she can see the same pattern in herself in her past behaviour with men. This insight has been a major step forward in the recognition of her own dynamics and past behaviour.

Rachel's sense of herself and of her world has thus been damaging and negating. The frequent abuse from her mother, the lack of protection from her father and the disbelief of her altered experiencing resulted in her becoming passive to survive. The meaningless sexual encounters, the lack of genuine friendship or interaction in life, the abuse from Pieter, the incident in the hotel where the man held her over the balcony all perpetuated the disconfirmation. The passivity of her youth continued to provide a sense of protection. But, just as her perceived confirmation was false, so was the protection. Her passivity inhibited her interactions in the world as there was the necessity for constant vigilance in order to ascertain what was required of her to be acceptable to the other. A good example of her passivity and need for confirmation was when she was having sex with the married man and with Pieter and no-one was taking responsibility for preventing pregnancy. Rachel seemed unconcerned about pregnancy and who the father might be and whether she would contract AIDS. The passivity that she learned in childhood was playing itself out in a dangerous way in the present. Any spontaneous behaviour from the inner core had been suppressed unless it fitted the image required and it seldom did. Any sense of authenticity was smothered. Allowing her to connect with her inner core to discover who she really was became an even more critically important aspect of the psychotherapy in order for her to dialogue with any real meaning and begin to relate as an authentic being in the world.

Unfortunately this passivity often resulted in her taking responsibility for other people's actions as she viewed their behaviour as a reflection of her unworthiness. Or she flipped into the other extreme of perceiving herself as the victim. This has left her open and vulnerable to other peoples' influence which has resulted in her frequently being emotionally and at times physically abused. She would go into a relationship and become completely emotionally involved immediately and people did not respect this and often abused it. Her whole attitude of not being worthy spoke to others in her behaviour, attitude and manner. For example, her fiancé would frequently cancel or simply not arrive for appointments they had arranged. She never drew a boundary or indicated that this was unacceptable behaviour so he continued to do it without apology. Part of the continuing disrespect in that situation may have been that he had ended the relationship but she was always available for more. Maybe his own guilt or attraction to her kept the relationship limping along. At one stage within that relationship, she believed she may as well go into prostitution and *"allow myself to be abused"*. In some way she was giving a message that "I'm worthless, useless and only good for abuse, so abuse me". Her experience in psychotherapy has shifted the sense of always being a victim: *"My experience gives me the handle to rise up out of my pain into understanding and into the direction opposite to being the victim. I am feeling less and less like the victim as I continue in therapy"*.

In order to gain some confirmation and avoid punishment Rachel has always attempted to please people. An important fact is that Rachel believed that if she did not give all of herself immediately in a relationship, she would lose the other person. And in a sense, herself. This highlights her lack of separation of the self from others. This belief and her inability to form clear boundaries between herself and others resulted in her exposing too much of herself too early on in any interaction let alone relationship. This often resulted in her being rebuffed or misunderstood. Then she would withdraw in pain. Withdrawal is a technique used to protect the self, find peace and settle things within. Rachel and I explored the concept of how people can only damage one if they are emotionally close and have some influence. I explained that a stranger's reaction need not affect one negatively and one does not allow any person to simply walk into one's inner sanctum. The understanding that one could take baby steps to know someone, each opening a little to test if one was met with respect, and slowly build a trusting healthy relationship was initially alien to her. As stated earlier, Rachel's distance and relatedness tended to be at extremes and there was no comfortable balance of shifting along the spectrum according to the given situation. My behaviour in drawing boundaries helped Rachel gain some perspective on what this meant. For example, when I drew a firm boundary to prevent Rachel's older sister from invading the psychotherapy space, this showed Rachel how boundaries can be kept firmly yet gently and how often people do respect the boundary drawn. Her older sister made no further attempt to intrude. Thus, my way of being with her and living what I was trying to help her understand showed her a balanced manner of being.

THE SENSE OF BEING A WHOLE PERSON WITH BOUNDARIES:

To relate as an authentic human being requires not only a sense of separateness but also a sense of wholeness. The distance between the reality of the inner core and the presentation of the facade is indicative of how disconnected the person is from the real, inner core. As Winnicott (1960) states, the individual is an actor playing roles with no sense of self. Rachel's physical presentation highlights this. When she needed the protection of the facade, she became the elegant, magnificently attired and coiffured presentation. When she first met me and was in a state close to psychological and emotional death, her attire was casual and under-stated. As time passed and she connected with and started to live her real self more, her attire was generally casual-smart with the occasional move to either extreme as the situation demanded. She was at her most casual in terms of attire in the first year that she was a mother. And this was the most authentic relating I had ever witnessed from her - the bond she had with her child was deep and genuine. Her clothing definitely represents her state of being.

Her presentation of the facade was most obvious in her work in the financial field or when her mother was visiting. Until she learned to draw psychological boundaries the clothing and her manner provided the strongest boundary. Then she started to draw physical and emotional boundaries. Her ability to draw a boundary had not been existent in her life until two years before and had not developed much since then so it was a healthy sign to see this happening. Not only did she find herself more worthy of protection but she now had a child and she wanted his world to be a more positive, nurturing and confirming one than her own had been. A clear boundary was drawn when she slapped Pieter just after Mark's birth to stop him becoming violent with her. This was a complete change from the usual passivity. She was no longer tolerating

either the physical or emotional abuse from Pieter. She was attempting to change the pattern of her life and was not accepting the so-called scissor treatment from anyone. Initially this led into the opposite dynamic where she began experiencing the desire to be violent. Her violent images indicate her tendency for all-or-nothing responses. In her mind, if she was not passive, she would be full of anger and thus bad. There was a strong desire to annihilate all the people who had hurt her. This was indicated by her being assertive with her father for the first time. The growth and strength in Rachel is indicated by the fact that she has never gone back into appeasement mode with her father or family. This indicates her own sense of worth. One of the more recent signs of her worth is shown by her decision not to run in front of the cars on the highway in America. She knew she was too valuable to die because of Pieter's damage.

An interesting point was that although she had no sense of boundaries when she entered psychotherapy and would walk right into situations with other people with no concern, she almost never over-stepped the boundaries with me. Despite the beatings and verbal abuse, she did not call me at home unless she felt it to be an absolute emergency - clearly what she and I defined as an emergency was different. She has never displayed the manipulative and often abusive behaviour of some fragmented people who will call at any time of day or night regardless of one's privacy. I have wondered whether this was partly due to her need to please and/or keep the sanctuary she has in therapy whole and whether that was a stronger dynamic than allowing the chaos to reign. But, as I have heard and understood her demands on others, my sense is that our relationship has been one of mutual respect and that she has not had a need to manipulate, demand and abuse me precisely because this **is** a sanctuary for her. She stated recently that she has always had a great respect for me because of how I have responded to her.

There was only one incident when I felt uncomfortable with a boundary with Rachel. She began to use endearments with me which she had experienced as confirming for herself and which she felt showed her appreciation to me. I felt this could be shifting the psychotherapeutic relationship onto a more friendly basis. The words sounded incongruent in the situation. Aware of the dynamic of her difficulty with finding the balance in the extremes of distance and relatedness, I asked her not to use those terms. Knowing her fragility and the likelihood that she would feel abandoned I tried to be as gentle as possible. However, she still experienced it as abandonment at one level. My next step was then to role model and show her that one could confront and deal with issues without it meaning the end of the relationship. Her words poignantly describe the feelings. *"Cathy explained to me that it did not have the same effect on her at all to hear me call her 'sweetie'. She explained that such language was reserved for the appropriate relationship. I felt she was very adamant and that hurt. I felt hurt because I was trying to show Cathy appreciation. It felt like I had lost Cathy. It felt like she was not there with me. I have never used the casual endearment language inappropriately again not because I felt bad but because I learnt something. I realized that words have meaning and should be used accordingly. Trying to show appreciation to Cathy by calling her 'sweetie and dear' was not doing the job ... Cathy did not leave my hurt feelings unattended ... Cathy asked me if I was feeling hurt by what she had said to me in the previous session. She explained that she sensed I was hurt. This felt like Cathy was seeing that I had been hurt and was returning me to myself. She had*

not changed her position about not wanting to hear me call her sweetie. Knowing that it was hard for me to experience a boundary, Cathy gave me the sense that she was back with me. Her kindness was back. She was listening and hearing my pain. We were not even talking about boundaries at that stage. It is only in hindsight that I can assume that Cathy was seeing my response to boundary setting. I could not handle it very well. A few more boundaries and I can assure you, I would not have survived. I needed to be heard. I needed to learn to hear myself. More than that was beyond me".

The dangers of the fragmented person experiencing openness as friendship are real. Rachel later experienced me as a *"professional"* friend but this never affected the integrity and professionality of the psychotherapeutic relationship as she had a more cohesive sense of self. I kept the boundaries firm and never allowed it to shift to that state and we have continued to work at the same professional levels. Later on in psychotherapy she had an experience with me that gave her a perception of what love should be like. This occurred when I reduced her fees and reassured her that I would not abandon her. She explained that *"in both instances of feeling what friendship should be and what love should be, Cathy did not personify herself at a personal level. I never felt that Cathy intended herself to be the focus of my need for love and friendship. Cathy offered nothing of herself at a personal level. I still did not know Cathy. She was an example. Her example gave me hope that I could experience love and friendship outside therapy one day".*

Overall, drawing boundaries and connecting with me and with her child authentically allowed us to deepen the exploration of her dynamics. We were then able to discuss why she was still in the relationship and she admitted to fearing that she would return to *"what I was before"*, that is, a woman who moved from one sexual encounter to another. She was recognising at some levels her fragmented way of being-in-the-world and seeking a stability and constancy in one relationship albeit a destructive one.

THE MIND-BODY SPLIT:

Being whole requires functioning as a unity of mind and body as well as relating in the world. Phenomenology states that one **is** one's body and how one carries oneself as an embodied being expresses the personal meaning that events have for one. If there is a mind-body split, the individual experiences himself as dissociated and fragmented. Laing (1969) states that when the False Self rules, the body is "felt more as one object among other objects in the world than as the core of the individual's own being" (p. 71). Thus, the body is experienced as the core of the False Self and not as being connected to the True Self. Rachel's inability to be a connected whole in experiencing is indicated by the mind-body split she experiences in her sexual encounters. She experiences no sense of emotion in the interaction. Rachel only ever experiences her physical body in the sexual act. That she cannot give her whole self in the encounter highlights the meaninglessness of the act for her as a whole connected human being. Gaining confirmation is the sole aim. She states, in her account of psychotherapy, that *"sex was a way I tried to obtain approval and affirmation of myself. I did not know that was what I was doing and I did not know how to stop either".* After her lover at work had made it clear that he was involved and thus uninterested in her, the True Self had to remain well hidden behind the magnificent facade of the False Self which she continued to develop more strongly. Relying on this facade of image as an indication of who she

was highlights the phenomenological view that the body is a living, experiential, active body, dynamically involved in relationship in the world. Rachel was living and interacting only in a superficial, false manner which was contradictory to the fragile being she was.

Rachel's disocciation at the time when she was pregnant and being beaten by Pieter, is an excellent example of the mind-body split. She could not remove herself physically from the event. Her only option in dealing with it was to remove herself mentally. Likewise the separation of body from mind when she attended the Reikie course. She began to feel ill, heavy and wanted to detach from her physical body and then fainted.

Rachel also shows the mind-body split in her tendency to suppress emotions and intellectualise. This intellectualising is a defence to block the feelings of pain, betrayal, rejection, disconfirmation and abandonment. To be in touch with those powerful feelings threatened her with annihilation as has been indicated throughout her life. For example, when she did spill out her emotions regardless of appropriateness and timing, this frequently caused problems in relating with others. When she did fully connect she would speak in a dramatic, passionate manner describing herself as being *"raped and betrayed"* or that Pieter was *"utterly bewitched by that woman"*. She would be equally dramatic in her gestures. So, she learned that safety lay in not feeling or expressing the emotions.
However, remaining in the head only increases the terror of what effect the feelings may have. Gendlin (1964) states that connecting with the full meaning of any event will only occur when the intellectual understanding is connected with the felt-sense in the body. One must be attuned to the feeling process, that is, what is concretely sensed and felt in the body. It is not enough to intellectually understand the process - one also has to feel it. The therapist needs to respond to what is implied in the patient's words and not simply to the words. Thus, the therapist pays attention and focuses on the felt-meaning of the experience which the patient may not yet be able to articulate. Once the feeling is identified and felt within the body, the individual will feel a sense of relief even if it has not been clearly conceptualised. As the felt meaning becomes more congruent with the intellectual understanding, so there will be forward movement in the process. Not only do mind and body become linked but the process of positive growth and change continues.

The split between Rachel's emotions and intellect started at an early age. She described in psychotherapy how she had disconnected her emotions from a bodily-felt sense since she was a child. The connection would be brief and she would then cut the process out of a fear of a loss of control and punishment from her mother. The split was initially highlighted in psychotherapy in her first description of sexual encounters. For example, Rachel spoke in a disconnected manner about her need for self-stimulation. It was also evident in the early years of psychotherapy when I felt that she was so disconnected from emotions that she could not even bring them into the psychotherapy space let alone share them with me. When she did connect, the rapid shift from emotion to emotion indicated the splits within herself - hence the feeling of being like *"lots of pieces of broken glass"*. The quick shifts in emotion also indicated her fear of being overwhelmed and shattered by connecting with emotions. For example, when Rachel described the event at the hotel where she was held over the

balcony, she connected with emotion at a very deep level. However, she almost immediately flipped back into the safe space of being totally disconnected from emotion. This prevented her from connecting for long enough to process the emotions. It also highlights her typical life-long pattern of suppressing emotions.

Because Rachel seldom connected with emotions and had no clear boundaries, she was unable to identify which emotions were her own. So, if she did connect, she felt everyone else's emotions in the interaction as if they were her own. This accentuated the confusion within her. If she could not identify her own feelings, how could she react to and control them ? As she learned to stay with the emotions and hold them, so she began to identify them. She was also more able to experience the felt-sense in her body. She identified that she feels anger in the pit of her stomach and then her throat as she has sometimes wanted to *"scream with rage"*. A lifetime of silence wanting a voice. Rachel says I taught her *"that it is okay for me to feel anger also. This gives me another positive sense of my own value ... I have not been able to master being angry as I would like to but Cathy is reassuring that it is natural not to be able to master anything at the first attempt ... Cathy showed anger and indignation on occasion towards many of the things I expressed. Her indignation and anger were not at me. That helped. It gave me a sense of what was okay to be feeling. I had lost touch with feeling anger and indignation. Cathy showed me that it was okay. She felt what it was like for me at a level I had lost touch with. Cathy joined up my consciousness with my reality"*. The time she became angry and made a rude finger sign and swore at the driver of another car also highlights the linking of feelings, body and mind. The incidents where Rachel connected with the violent images just after Mark was born indicated the strength of a lifetime of pent-up emotions suddenly surfacing. On exploring this, we came to the realisation that she had never been allowed to express anger as she would get punished. Her mother's anger also resulted in her being punished. For example, her mother viciously attacked her in a rage when Rachel was eight years old because her mother was in an emotionally poor state. This explains the passivity in Rachel's responses but also highlights that she was required to split emotions from any bodily link in order to survive. Her mother's acting-out behaviour and the strength of her emotions made Rachel fear a loss of control when connecting with emotions. Her own desire to jump out of the moving car on many occasions and the time she ran towards the highway with the desire to throw herself in front of a car reinforced that connecting with emotions could be dangerous for her life.

The experiences of allowing the violent images a space and realising that she did not have to follow through with action, controlling the foul language by thinking it and not vocalising it, has made a vitally important connection for her. This connection of the felt-sense and mind has shifted her to realising that the emotion-intellect split does not have to exist to keep her safe. The mind and body can operate as a whole without annihilation being the result. Being able to express her emotions in the safety of the psychotherapeutic space without judgement, punishment and disconfirmation has been a major factor in healing the mind-body split. My laughter and the following exploration when she first verbalised the foul language assisted this process. She stated that my response affirmed her and allowed her to view the event from a different perspective. The issues were dealt with seriously but there had been a shared moment of lightness. The new understanding helped empower her to have the control of expression or

silence.
Rachel herself recognises the above splits. It was early in psychotherapy that she stated that she realised she only saw herself in relation to other people. She comments in her notes that she believes that *"with continued therapy I shall feel more comfortable about the distance I feel between my emotions and intellect"*. As described above Rachel has begun to connect the mind-body and emotion-intellect splits within her. Over the years in psychotherapy she began to live the emotions in her body. For example, her behaviour when she was asked to leave her dying mother's bedside indicates a time when she lived the connection between mind and body. She was thrashing around so violently that she had to be tranquillised. This signifies how she was bodily living the agony and devastation of that loss. Her whole psychological self had died in some way as she had lived according to her mother's standards and rules. I also had a sense of her being more connected generally. For example, the anger when she strides into my room, the heaviness and slowness of movement when she is sad or despairing and the lightness in her step and voice as she begins to excitedly live life as a whole human being all display this connectedness.

Rachel speaks of the beginning of a connection with feelings: *"I had never felt what it was like to have a person respect my pain. The little I was feeling of my pain, Cathy was able to magnify for me like no-one ever had. It felt good. I was only saying what I felt on the verbal intellectual level. Cathy was listening. And in that moment when I said something very significant, Cathy pulled it into reality by responding. In that way I could start to feel what I was feeling. Up until that moment when Cathy gave feeling to my expression of her hand reaching down to me in darkness, I could not really connect to what I was feeling in any emotional way and it was very self-defeating. It made me doubt myself terribly to be able to articulate what I 'felt' was going on inside me and not to fully connect emotionally to the feeling. I felt like a contradiction. I felt dishonest and worthless. This state of being was extremely hard for me. It had brought me to the suicide 'solution'"*.

Rachel felt that my acknowledgment that I would also have been afraid in some of the psychotic situations gave her a right to her feelings. She could then own them. It was a similar situation regarding her sexual encounters. *"I really had some very sensitive issues regarding sex. Cathy never made me feel bad about how I felt about myself even though I was out of control. Cathy explained, very gently and sympathetically that my sexual behaviour arose from my seeing myself in others, rather like looking into a piece of a mirror. Cathy did this in a very accepting, gentle but at the same time matter of fact way that made my feelings of revulsion and hatred for myself experience something quite different - compassion and authentic understanding. This direct understanding expressed compassionately to me by Cathy felt like a blanket of understanding over a very cold self hate"*. Over time she has been able to view herself with more empathy and recognise the same dynamics in her father's recent behaviour.

The major split between her real, inner core and her outer facade has healed considerably since she made the comment that she hoped to learn to be more comfortable with the split between her emotions and intellect. One of the most obvious signs of Rachel's growth was her decision to stay in psychotherapy despite her mother's desire for her to leave. Another clear sign is when I made the mistake of not hearing

her terror of returning to the false and superficial world of finance. The one safe place where she felt most accepted and confirmed was suddenly perceived as threatening. She experienced it as *"rejection, disapproval and failure"*. She acknowledged that I was afraid and concerned for her and then went on to say that these feelings were *"not coming from Cathy, it was coming from inside me ... I have however started to distinguish this ... identify these feelings in myself and explain that this was so like the feelings impaled in me by my Mother"*. I did not meet her and yet she remained firm in her resolve not to return to work in that field. She was deeply upset at my initial reaction but remained true to herself. It was a test, albeit an unintentional one, that she sailed through with flying colours. A definite sign of integration within. Of even more value is that she was able to recognise that these were the same feelings that her mother engendered in her. This allowed her to process and start differentiating feelings, that is, that all the feelings were not being projected by me but were similar feelings she was feeling as a result of her childhood experiences.

The fact that she made the decision to stay in psychotherapy despite her mother's punishment and remaining true to herself by not returning to the world of finance also made her more congruent. I believe this has enabled her to step forward into the world with more determination to be a connected whole. After her mother's death she was able to stay with the emotions and experience them in a deeper manner and was less inclined to leap from emotion to emotion. She states: *"Cathy returned me again and again to how she saw me as being a piece of a mirror. The aim being to draw those pieces together. This effort is ongoing as I grow in the consciousness of my self"*. This also signifies the increasing cohesion within.

As Rachel moved further towards inner integration she had the dream of falling into the mud hole. She did not want people to be ignorant of why she had died if she allowed herself to drown. If she drowned she believed her life would have been a waste for herself because it would have meant that she was behind her own annihilation and that was not her aim. Her pain has been *"in trying to avoid annihilation and not authenticate it by committing suicide"*. This has been *"the whole struggle"* as the messages she received from her world were that *"I was nothing. That has been my 'sickness' and still is to varying degrees and different angles"*. This is reinforced by Pieter who constantly tells her that she is nothing by his behaviour towards her. *"When I know that I am not nothing, the struggle will be won"*. In the dream she was able to pull herself out of the mud without my assistance or even the need for it, as she had hoped I would do in the quicksand dream. This highlights the desperate struggle within Rachel to prove she is worthy and indicates a newly discovered inner strength. The description where she takes off her soiled and ruined outer garments of the facade to reveal the value of the real, inner core is wonderful. Finally she has started to realise that she is a worthy, valuable human being simply for who she is. This was a profoundly important dream as Rachel was able to recognise this herself. This increased her commitment to growth. The fact that she dreamed this the night before her 40th birthday is also significant as Rachel's birthdays are always important for her and she had not believed she would be alive by then. To be alive and growing was a highly important event for her. Rachel had felt many instances of confirmation from me. For example, she feared abandonment because she could not pay me the full fee and my reassurance that I would continue to work with her at a suitably agreed reduced fee was accepted by her.

This was her first experience of anyone indicating to her that she was important enough not to simply abandon at the first signs of difficulty. However, it was shortly after the mud hole dream that Rachel was able to experience a sense of full confirmation for the first time in her life. It is almost as if having survived, she could finally allow herself to really feel my confirmation at deep levels. Her parents and people had constantly invalidated her feelings and thus her sense of reality and ability to judge for herself what was real or false. The fact that it had taken four years of psychotherapy to achieve this demonstrates the length of time that it can take for a fragmented person to really begin to feel confirmed. Her fears in the quicksand dream had been unfounded. She now knew that I could meet her at those deep levels which has freed her to grow further. This confirmation at the core also changed the reasons for her drawing boundaries and being assertive. It was no longer just the new way of surviving and protecting a core she felt **may** be of value - now the core was without doubt worthy of protection. Sadly, this belief in her worth fluctuates and it is a constant battle to consolidate that sense of worth.

THE MAN-WORLD SPLIT:

As human beings interact and relate in the world, the fragmented person also experiences a split between himself and the world he lives in. When the sense of I is lost or heightened due to the split between the self and the world the person is incapable of experiencing a common, shared reality (Eigen, 1993). This lack of shared meaning and the resultant withdrawal to protect the inner core results in strong feelings of isolation.

The most obvious split between Rachel and her world is displayed by her hallucinatory experiences. Altering and creating a new reality is the most effective way to separate oneself from an unbearable world. Rachel's whole being-in-the-world was experienced as dangerous. The story of her life that unfolded in psychotherapy abounds with examples of this. For example, the very real physical and psychological dangers suffered at the hands of her mother and then Pieter; the emotionally abusive behaviour in her relationships with men; being the victim and needing to turn to suicide as an option and her fear that the violent images would result in her hurting her child, highlights the dangers. Two important factors which added to the split between her and the world were the disconfirmation and condemnation received from her family and the church. Thus, there was little sense of being connected to a shared world of safety and care.

Beginning to relate in a meaningful manner to others requires the individual to step out into the world. Public contact contributes significantly to the reorganisation of the patient's world. It may fill the person's empty world but it also provides the opportunity to learn. Religion may offer this whilst still allowing a distance to protect. Thus, it is frequently used as the first step in entering the realm of relating. Sadly, the church did not offer Rachel the space to learn to interact with safety but frequently made her feel judged and disconfirmed. Rachel also has no real, deep friendships and only a few acquaintances. She experiences difficulty in forming relationships. As stated, she does not have the basic understanding or skills required to enter into a relationship in a healthy manner. Her naivete in these areas is expressed by her frequent comments throughout psychotherapy that she did not know that people can feel, behave or think

in many different ways. Everything has been based on her mother's statements and her own experiences. Our mutual exploration of relationships towards the end of the case study highlights her ignorance.

Ordinary social situations are experienced as daunting for Rachel. Superficial, social chatter is experienced as alien, awkward and extremely difficult. Her naivety about the basic rules of interacting highlighted the complete lack of healthy relating in her early years. When Rachel joined the mother/toddlers group for Mark's sake we also saw this as a golden opportunity for her to learn how to interact in a more authentic way. She has struggled to do this. Firstly, she opened herself too quickly and the other mothers withdrew. Then she moved to the other extreme and was aloof. The women in the group seem confused by her and are polite but not very welcoming. Her natural response to that is to withdraw completely. Another woman she had dealings with recently also withdrew from her and she felt like the bad girl again as *"no-one likes me"*. We explored how she may give the wrong impression when the facade is up and how demanding she could be when only interacting as one fragment of glass from the shattered mirror. Together we have explored what people's perceptions of her might be and this has helped her understand and continue with the group in a more relaxed manner.

By giving her a different experience of the world in psychotherapy she has developed a sense of self and strength with which to step out into the world. For example, by my drawing a boundary with her older sister to keep her psychotherapy space safe, she was able to see and experience how that was done and what it felt like. That it protected her was the important aspect - no-one had ever protected her interests before. She felt that no-one had ever cared enough or found her worthy enough to defend so she must be of some worth if I did safeguard her. Likewise, my not ending psychotherapy due to financial issues gave her the message that she was worthy. And she has responded to that by keeping her promise to pay the full fee. As she experiences a sense of worth, her whole being is stepping forward into relating in the world. This is, however, a slow and uncertain process as long as she continues to live in relationship with Pieter.

Overall, the fragmentation within herself and with her world have healed considerably. In October 1999 Rachel described how she had identified an emotion immediately after a fight with Pieter. He had withdrawn and not come to placate and soothe her as quickly as usual. She felt *"fear"* as he has hurt her so much in the past and still has the power to do so in the present. She was able to hold the emotion, process it and feel that she was still going to be who she is and was not going to change to suit him. This made her recognise some of the strength within herself. A while ago I had shown her a computer screen saver which I felt depicted her situation in the reverse. There is a picture of a kitten seeing a lion in the reflection of the mirror and the caption reads "It's not important how others see you, but how you see yourself". I had explained that she was a lion seeing a kitten in the reflection as she finds it extremely difficult to recognise her own strength. In a recent session she stated that when Pieter was trying to hit her and when she drew the boundary she had imagined me sitting in my chair and talking about the lion. For the first time she was able to connect with being strong. I acknowledged this and suggested that maybe it was partly because she was no longer

ingesting the *"gunge"* Pieter threw at her but throwing it straight back at him. This was what she had stated she would do if he literally threw gunge in her face. Now she is doing it psychologically. He finds it startling but it disarms him. He has been in complete control either through aggression or by presenting the hurt, little boy she has to stay to protect. Now he is confused but is calming down. Possibly he is trying to assess the situation. It seems that there is also a fear that she will leave him fulfilling his prophecy. In the past he knew she did not have the strength to leave. Now she is clearly indicating her intolerance of his unacceptable behaviour and he can see her strength.

This episode led her into feeling like a *"separate person"*. She was very excited and feels that now she can be separate and yet a whole person and thus more authentic in her interacting. She made the insight and spontaneously remarked *"I see it ... it's a paradox ... you have to be separate in order to be able to be close to people"*. She is beginning to like who she is and is feeling the boundary firmly protecting the core. *"I want more of this"* was her excited comment. This shift and recognition that she needs to be separate in order to relate fully is one of the most important steps in her growth.

Throughout the unfolding of Rachel's life story and time in psychotherapy, I have always experienced her as naive, innocent and totally honest at the core. The savagely destructive behaviour of her family and subsequent experiences of her life have hammered and battered her. Her soul, however, appears to remain uncontaminated which has been an amazing phenomenon to observe. Laing's case study of his patient, David, has an interesting similarity to Rachel. Laing (1969) found an inner honesty in David just as there is in Rachel. This indicates that Rachel's life experiences did not destroy the true, inner core of her and suggests that the presentation of the False Self and the withdrawal of her True Self were successful in protecting her core.

HEALING THE PAST WITH TIME:

Another important factor in Rachel's integration and growth is that she has been healing the past by living it differently in the present. The abusive experiences with her first husband and Pieter were similar to the whole dynamic of her living and mirrored her childhood. This inhibited her from growth as she continued to use the same patterns of behaviour to survive. As phenomenology indicates, the child learns dysfunctional ways of behaving and perpetuates the same pattern in adulthood. Rachel repeated the same patterns endlessly until she was given the space and opportunity in psychotherapy to explore and learn new ways of relating to herself and the world.

Rachel's experiences with Pieter and his family proved to be the most powerful test of her sanity and new growth. During the next few years his attempts to annihilate her emotionally and psychologically, coupled with frequent physical attacks, was to mirror her childhood and marital experiences. His mother's attacks and his father's failure to protect her completed the mirror of her whole childhood. By re-experiencing her childhood as an adult and being able to deal with it differently she has been able to change the meaning the past had for her. She even stated at one point during this process, when she too recognised the similarities to her childhood experiences, that she sensed she needed to stay in the relationship with Pieter to be able to heal the past damage.

When Rachel dreamed of falling into quicksand and the sand closing over her head, she was experiencing strong fears of punishment and abandonment. She had failed to be the good girl and her emotional abandonment as a child was being lived out in the present. She was feeling helpless, out of control and terrified. She was expecting me to save her in this dream and I had failed. No-one had ever been there to save her and she had to learn, via her good experience of not being abandoned in psychotherapy, to do this for herself. That is, not to be dependent but to begin to rely on herself.

Another good example of Rachel reliving and changing her past in the present was when she attempted to substitute Pieter's family for her own. Rachel realised she was viewing Pieter's mother as the *"fantasy mother"* in an attempt to have a good-enough mother but that this mother was destructive too. This elicited huge anger in Rachel which was a relatively new emotion as she had always been punished for this in childhood and thus suppressed it. She had not been able to be angry at her own mother but, over time, has stood up to her mother and Pieter's, drawn boundaries and survived. Pieter's father also did not protect her when Pieter hit her, which was reminiscent of her father's lack of protection. Likewise Pieter did not protect her from his mother's verbal onslaught or her one physical attack but actually sided with his mother against Rachel. It was like a cycle of abuse and lack of protection from each member of her new family mirroring the pattern of her own family. By allowing the anger to emerge and experiencing the huge disappointment and pain, she began to realise that she needed to create her own family unit which could be different in the future. This has been extremely difficult as Pieter's violence and emotional abuse also mirrored her childhood. But she is learning from this experience how to handle the situation differently. She is no longer tolerating the abuse and protects the valued, inner core of herself. This is the complete opposite of the passivity and need to please of her previous way of being.

The violent images also allowed Rachel to connect with the abuse and lack of caring in her own infancy and childhood. She was healing herself through changing the pattern in rearing her own child. Her fears that her childhood experiences had negatively influenced her way of being-in-the-world and that she would continue to emulate her mother were partly justified. Much of her manner in dealing with Mark is based on the values and principles instilled in her by her mother. She had not been taught many basic skills especially about relating. With few friends over the years she has not absorbed and learned by proxy and her whole life continues to offer her poor examples. Due to his experiences at home Mark started to react in a physically aggressive manner with his peers. She was generally over-protective but occasionally she found herself being critical and punishing as her mother had been. We discussed the similar dynamics and how to change them by trusting her own intuition and not blindly following her mother's role modelling. Rachel began to be firm but loving, reprimanding him for his behaviour but not punishing him as the whole child. For example, she and Pieter recently fought and Pieter again pushed her. Rachel was able to recognise her own dynamic in Mark when he announced "Mark a bad boy" with distress during the incident. She gently and simply explained that a person can become angry but this does not mean he is bad. He beamed and put his arms out to hug her. We explored how important it was to prevent the same dynamic of the bad child developing in Mark and haunting his future life. She was also able to see that by

preventing this and soothing her child she is able to start healing the inner child who is experienced as a bad girl. This made her feel she was shattering the shackles of her past by making it different now and thus for the future. Overall, the lengthy discussions about raising children in a balanced way have assisted her to gain some confidence in her own parenting skills.

By changing from passivity as the answer to survival to action and drawing boundaries, she also changed the past. This has been a critical factor in her own growth as it has allowed her to step forward into the world with some sense of confidence and faith in herself. Her assertiveness and strength are still facets that require much encouragement and bolstering but she is determined to function in the world in a psychologically healthy way.

The above examples clearly illustrate the phenomenological view of how the past is actively lived in the present. They also highlight how the past, present and future are inexorably bound into the current, lived moment in the present. As Van den Berg (1972) states, "the present is an invitation from out of the future to gain mastery over bygone times" (pp. 91 - 92). Rachel has accepted that invitation.

GUILT AND FORGIVENESS:

Rowe et al. (1989) stress the need for forgiveness of the past and significant others to prevent progress and growth becoming stunted. To forgive requires one to step back to gain some perspective of the events. If this is attained, the clarity reduces bitterness, resentment, anger and blame. Forgiveness changes one's relationship to the past and provides a sense of renewal for the future. Many authors agree that "there is a restoration of the order that previously had been violated" (p. 236) when forgiveness is granted (Rowe et al., 1989). This is a liberating experience as it involves an acceptance of the self as well as the other which allows one to move forward.

As Rachel has processed and integrated, she has made some peace with her father. As stated, she has drawn firm boundaries with him and interacts on a friendly but superficial level which is comfortable for her. She chooses what issues she will discuss or not. Sadly this has resulted in her father and older sister turning their destructive attention onto the younger sister who is being damaged severely by this behaviour. Fortunately, the father no longer has the power to affect Rachel's sense of inner balance. This is a profoundly important step forward for her. It signifies that she no longer allows anyone, even family, to simply step into her inner world and create havoc. Events may upset and hurt her, but they do not have complete control of her being as they did in the past. The presence of her deceased mother warning Rachel to remove herself from the damaging relationship she was in and the dream highlighting some of her mother's good points, highlights how Rachel has begun to connect with her mother in a positive way - albeit small at this stage.

Rachel has been able to step back and view the family dynamics as extremely dysfunctional and damaging. As she has gained perspective she has begun to talk of forgiveness and how liberating this feeling is. She stated that when one is bitter, sulking or judgemental, one is in the control of the person one has not forgiven. So, she was forgiving her father and their relationship has calmed although never deepened. Overall

there is a sense of sadness and the beginning of forgiveness for the whole family. This will free her to move and grow further as she will not be stuck in the past.

RE-ENTERING THE WORLD OF RELATIONSHIPS:
In psychotherapy Rachel has experienced an I-Thou relationship. She has experienced a genuine dialogue in an authentic manner with me and been met at her core with respect. This has allowed her to feel the depth and reality of connecting at this level without the need for the facade. It has also given her the hope that this can occur in other relationships in the real world.

As Rachel consciously draws boundaries to avoid annihilation and experiences herself as stronger and having a more cohesive inner self, she is feeling herself to be a separate person. This has decreased some of the sense of isolation. As the isolation and loneliness decrease, the ability to look outward to the world increases. The blinkers of psychosis have almost totally been removed and the need for complete focus on emotional survival has reduced considerably. This has allowed her to start exploring the richness and diversity, not only within herself, but in the world of relationships.

It has taken six years of psychotherapy to reach this point. She is still fragile and vulnerable in many ways and her sense of worth and belief in herself still fluctuates. Her curiosity about life and the world and her desire for growth is enormous. This enhances her forward movement in healing. With the foundation of a more cohesive sense of self, Rachel can only now truly start moving into authentic and healthy relationships with others in the world. The next leg of her arduous but worthwhile journey is beginning. She has stated that she has no intention of leaving psychotherapy until she feels she is functioning in the world in an adequate and satisfactory manner. She will move to a new position in the margins of social life and I hope become a comfortable participant in society. This may not necessarily be defined as normal within the social context and she does not need to conform totally. Her uniqueness is what makes her a special, interesting and valuable member of society. Above all she must be true to herself and find a comfortable balance within herself and with her world.

Her words written in her notes on psychotherapy in January 1999 (see Chapter 13) reflect the recognition of her value as well as that of the psychotherapy: *"I have come a long way from this point of feeling so very lost and worthless because therapy gives me a completely different experience of myself. The experience of myself through therapy makes me briefly at a time, glimpse and experience myself as being very precious".*

CHAPTER 12 - INTEGRATION AND CONCLUSIONS

This chapter specifically discusses the nature of dialogal therapy and how effective the approach of 'the healing is through the meeting' is in this particular case. It in no way suggests that this is the only way to work with patients but highlights the value of this approach to working and interacting with people. There is a large quantity of philosophical and theoretical literature available on dialogue and the dialogal therapy approach which enriches and tantalises the reader to explore further. However, there is little written on the practicalities and concrete experience of how the dialogal principles function in practice. This study has attempted to provide some substantial examples to fill this gap and indicate that dialogal therapy is a viable way to work with disturbed patients. Thus, my work is not unique and merely provides an example of the larger tradition of belief in this philosophy. It should, therefore, be borne in mind that the broad, basic principles of phenomenology and dialogal therapy were the foundation from which I worked even though I had not initially been introduced to the dialogal approach.

The issues raised in the literature from chapters 2 - 5 are compared to and expanded upon in relation to what has been learned from this study. That is, there is a discussion about the influence of the patient, the therapist, the situation and the psychotherapeutic relationship on the healing process. Although a single case study is being explored, I also draw on feedback given by other patients over the years as it is pertinent to what I bring into the psychotherapeutic equation and substantiates and highlights certain issues.

Once I had Rachel's permission to discuss her psychotherapy, I requested her to write about her own personal experiences in the psychotherapeutic relationship. She was asked to describe both the positive and negative aspects of her psychotherapy and her account provides a good overall perspective if read in one flow (see Appendix B). Her account was written in January 1999 just before she recognised that she had experienced hallucinations. Excerpts from that document are included in the discussion to emphasise certain points. Her description is rather flamboyantly written and at times appears exaggerated but it clearly indicates her feelings. There are also certain interpretations that she makes about my feelings and reactions which are not accurate but are accepted as being her perceptions. At no stage during the psychotherapy has she expressed her feelings about the process itself or my contributions so reading her account was an interesting and moving experience for me. To obtain an idea of what Rachel feels she had gained thus far, I asked her in November 1999, to write a brief account of where she currently perceived herself to be on her journey.

1. THE PATIENT:

Chapter 2 explored the patient as a variable in the process of psychotherapy and any resultant success. Factors which research has highlighted as positive contributors to the process were discussed.

1.1 **Initial state of adjustment.**

Most researchers agree that this is a high predictor of successful outcome. Whilst I do agree with that point in general terms, Rachel's progress has suggested that clinicians

should not allow that belief to hinder their commitment and motivation to the healing process. If anything, Rachel's initial state of adjustment was a poor indicator of a successful outcome. And she has proved that there can be enormous growth and healing despite fragmentation and emotional chaos.

1.2 Patient expectation.

Much of the research indicates that there is a positive link between patient expectancy and perceived symptom reduction and success. As stated, congruence between the patient's and therapist's expectations has been consistently related to psychotherapeutic progress. Rachel walked into my room with some positive expectations as she had already felt a strong connection with me due to our telephonic contact. However, there was still some uncertainty of whether psychotherapy would meet her sufficiently as she had experienced extreme disappointment and negation from the church where she had expected to be met with respect and caring. She had *"heard of psychologists who were 'no good' exploiters"*. She felt as if she was *"melting down and fragmenting"* and *"falling down a dark abyss"*. She was desperate for life and, based on that initial contact, came with a certain spiritual faith and trust that she would meet the right person and the right process. But most of her was mistrustful that anyone would be able to meet and respect her as a whole human being. It took a very long time before she could trust that process and me completely. She has a determination and will to grow and achieve her goals of a separate and healthy self and meaningful relationships in her world. This indicates that there will always be exceptions to the general rule and the therapist needs to be open and willing to work with patients even if these first two factors are poor prognosticators.

1.3 Level of motivation.

Rachel's level of motivation is high and this supports Malan (1973) and most of the other clinicians' findings quoted that this factor is one of the most important indicators of successful outcome in psychotherapy. Motivation is linked to commitment. The more motivated the patient is to be healed, the more committed he will be to staying in psychotherapy. Rachel has been totally committed to the process. After the first telephonic conversation with me she felt she had made an *"agreement"* and this made her feel she could cope, despite the suicidal ideation, until the next day when she could see me. She then committed to the process with *"honesty"* which was the gift she brought to the encounter. These were the first steps in laying down the foundation of trust in the psychotherapeutic relationship.

1.4 Patient involvement in psychotherapy.

I have never worked with a patient who has been as motivated and involved in the psychotherapeutic process as Rachel. I believe these two factors have been powerfully important in her gaining insight and growth and this supports the findings made by Mathieu-Coughlan and Klein (Rice & Greenberg, 1984), Gendlin (1964) and Truax and Carkhuff (1964). Without involvement the patient would not gain the bodily, felt-sense necessary to move through the struggle of growth (Gendlin, 1964).

1.5 Referral.

Whether the patient has voluntarily come for help or has been brought under duress is an important factor linked to motivation. If an individual is motivated to seek help

voluntarily the prognosis is better as it suggests that the symptoms are egodystonic. These findings support that the patient's desire to seek help does influence the final outcome in psychotherapy. The patient's level of motivation and involvement is thus critically important in any forward movement in the psychotherapeutic process.

1.6 **Age.**
The majority of researchers have found there to be little link between age and successful outcome in psychotherapy. This thesis has not found it to be a relevant factor.

1.7 **Gender of patient.**
Most of the researchers cited have found women to be more successful in psychotherapy than men. As this is a single case study the only comments that can be made are that Rachel is a woman and she has achieved progress in psychotherapy.

1.8 **Education and socioeconomic status.**
Rachel is an intelligent woman and this has certainly assisted her in understanding concepts. Her verbal ability has allowed her to articulate her experiences clearly and has been a factor in her gaining insight about herself and her hallucinations. Thus, it can be seen as positively contributing to her progress. Whether socioeconomic status has been a factor is hard to define. Certainly people from a high socioeconomic background have more opportunities for education and learning. Rachel's father has been a successful businessman and Rachel has been successful in a tough, male-dominated, financial work environment. Perhaps this provided her with more opportunity to expand her own learning but her relentless thirst for knowledge and understanding has come more from within herself than any outside influence. She is constantly reading books about spirituality, religion or anything she believes will assist in her personal growth.

1.9 **Severity of symptomatology.**
This ties in with the level of adjustment in point one. The suggestion that the more egodystonic the symptom is, the higher the motivation for change, has definitely been a factor here.

1.10 **Patient's perception of the therapist/perceived similarity to patient.** This has been found to be a critical factor in most of the research. In my opinion, if the patient perceives and experiences himself to be heard, accepted and confirmed in the psychotherapeutic relationship, this is of more importance than any perceived similarities between the two people. In my practice, I work with a wide range of people from different spectrums of life and culture. Initially there may be some uncertainty on the part of the patient that he will be understood. For example, men are often unsure that they can discuss sexual issues in depth, women sometimes ask if I am married and have children and teenagers wonder if any adult will understand their problems. Once they realise that I listen to any issue with the same caring attitude, they relax. Perhaps at some psychological level this creates a feeling of being similar to the therapist because the patient experiences an environment in which they are heard and understood. This means that the patient's perception of the therapist is important. Rachel's first perception of me on the answering machine was that I was professional

yet kind. In her first telephonic conversation with me she felt heard and met which laid the first brick in the foundation of our psychotherapeutic relationship. However, my belief is that it is the overall attitude and approach that allows people to trust and open more than any actual similarity in terms of race, gender, religious or cultural beliefs.

1.11 **Patient satisfaction.**

If this is partly judged by the patient's perception of being heard and accepted, then Rachel would state that she is a very satisfied patient. And I agree with Cartwright's (1955) finding that if the patient deems psychotherapy to have been successful, the therapist tends to share the same feelings. I have deemed Rachel to have achieved much growth but we both are aware that there is far more to be learned and gained.

2. THE THERAPIST:

As the person who supposedly brings knowledge and skill into the equation, the therapist has an important role in establishing the psychotherapeutic relationship. The therapist's influence is powerful and can encourage, hinder or destroy a possibly successful outcome regardless of the patient's motivation, commitment and desire for health. The therapist is not the person opening his core and sharing his innermost fears, vulnerabilities, hopes and dreams. It is thus the therapist's responsibility to ensure he treats the patient and the psychotherapeutic process with respect. Friedman (1985) highlights this responsibility and accountability when he cautions therapists not to turn "healing through meeting into injury through mismeeting" (p. 191).

May (1958) states that "the central task and responsibility of the therapist is to seek to understand the patient as a being and as being-in-his world" (p. 77). The core of the challenge for the therapist is to enter the world and story of the patient. By entering the patient's world the therapist indicates to the patient that his disturbed behaviour and world is real and genuine but is not the only experience and reality which means change is possible (Moss, 1989).

2.1 **Accurate empathy, non-possessive warmth, genuineness and authenticity.**

Many clinicians agree that the above qualities named by Rogers (1954) are very important in creating a sound, trusting psychotherapeutic relationship. They definitely were positive contributors in the current case.

However, the qualities of being genuine and authentic appear to be even more powerful in encouraging growth and change in the patient. In the dialogal approach, being genuine means meeting the other as oneself, as a whole human being. Buber (1958) believes a genuine meeting can only occur when the therapist attempts to meet the other as a Thou. That is, there must be a genuine interest in the patient as a valuable, separate and unique person. Being genuine and authentic as a therapist allows the patient to reciprocate and open in return. Rogers et al.'s (1976) statement that the realness of the therapist allows the patient to express his real feelings without fear which allows for exploration and growth is especially highlighted in this study. Rachel stated that the only reason she could share her psychotic episodes and learn to

understand them was that I always accepted them with a genuine interest and respect. I also expressed that I would have been afraid of some of the incidents myself - this seemed to give her permission to have her own fears. By meeting Rachel with the genuine response of humour when she spoke to me of her lewd thoughts, she was able to gain a new perspective. She stated: *"It was the combination of gaiety in a really light pure and funny way with affirmation of me that gave me a terrific new way of seeing things. It was Cathy's humour and lighthearted response with affirmation of* ***me*** *that won for me an incredible sense of* ***relief****. Cathy gave me a new slant on how to see".*

I am authentic with my patients primarily because that is how I am as a person in interaction, but I love the work I do and have a genuine interest in my patients' lives and an honest desire to help them achieve their goals. A frequent comment made by patients upon termination is that, although I was being paid to do the job, it was clear that I genuinely cared about them. These people and Rachel have found genuineness to be one of the most important aspects of their growth in psychotherapy. An example of how my authenticity assisted Rachel was when I stated that I had not realised how severe the pain was when she first started psychotherapy with me. She states: *"In my experience, Cathy went from being the intense listener to the vulnerable person. She was not covering up. She was showing me what it felt like to feel ... Cathy's response carried enormous meaning and depth. In this way Cathy gave my pain a kind of livingness that enabled me to feel it also in an atmosphere of deep respect. I felt like I was not dead inside anymore. I was starting to feel my pain. I was starting to experience it through another human being. Cathy. My pain was being held, seen not admired, respected with care and deep compassion".* Rachel also respected my authenticity in admitting that I did not always have the answers. She said: *"Another very important answer that Cathy has given to me when I ask her a question is 'I don't know' ... Seeing that and experiencing another human being as aware by choice and still not knowing the answer gave me incredible advantages. I could see it was okay not to know ... in not knowing Cathy was the same Cathy. She did not cringe or feel bad and her self-esteem appeared to remain constant".*

Allowing oneself to be real and genuine as a human being in encounter with another human being is one of the most valid and basic principles of dialogal therapy. Patients are quick to recognise the lack of authenticity in therapists and this can damage the working relationship. I view this principle as an essential factor in the psychotherapeutic relationship and encourage all therapists to allow themselves to be real with their patients as the difference this makes is enormous. This study has shown that if the patient experiences the therapist as being prepared to bring his whole self into a genuine encounter, the patient will feel safer about responding in kind.

2.2 **Gender of therapist**.

The literature suggests that the importance of this factor varies considerably. Rachel has indicated that she would have been *"uncomfortable"* with a male therapist *"because the affirmation of myself"* was sought through sexual encounters. Therefore, she would have been more *"vulnerable and thus less capable of healing"* with a male therapist. This suggests that, for some patients, this is a pertinent factor depending on the individual person's issues. My practice currently consists of approximately 36% male and 64% female patients. These figures support my earlier speculation that the nature

of the problem being dealt with plays a role and perceived therapist-patient congruence is critical for self-disclosure and effective psychotherapy. However, each individual case is unique and this factor may be relevant for some but certainly not for all.

2.3 **The therapist's experience.**

Overall the literature supports the theory that the more experienced the therapist is, the better the psychotherapy will be and the more successful the outcome. I agree with this in principle. However, it is an interesting point as there are some therapists who have been in the field for many years and still do not have the same success as some less experienced clinicians. My belief is that the qualities of the person and how they use knowledge and experience are of greater importance.

2.3.1 **Intuition.**

I believe that one of the qualities which ties in with experience is intuition. After many years in the field one learns to trust the gut-feeling that appears quite strongly from time to time. As Lawner (1981) states, the therapist can become lost in the process of living the experience with the patient. Lawner speaks of the need for the therapist to "allow ourselves to be still ... stay close to our partners in the dark" (p. 306). The therapist must tolerate feelings of confusion and helplessness and use the value of waiting as he helps the patient learn to stay with being lost in the dark. Only then can the meaning unfold. It is often at times like these that one feels an intuition to respond in a certain way. There is seldom a theoretical connection but merely a feeling of what would be right.

Rachel was desperately afraid that she would act out her images of hurting her son. I had the intuitive gut-feel that, despite acting out in other areas, she would not do so with her child. Thankfully I have never been wrong in following my intuition as a therapist and so I followed them here. When I reflected my feelings and showed my utter faith in her, she broke down and sobbed with relief. She never did act the images out and, by allowing them respect and a space, they disappeared over the next few weeks never to return. Had I appeared concerned and suggested she hand the child to the maid or Pieter when she felt this way, I believe she would have become more afraid of the power of the images and more at risk of following through on them.

In another case, I was working with a very fragmented child whose world was very difficult to enter. Her mother left her with me and went off to have fun with her sister at a Saturday morning exhibition at the shopping centre. She stood at the window of my consulting room and sobbed and wailed with the tears pouring down her cheeks. She was calling desperately and repetitively "Don't yeave me ... don't yeave me" - she has a speech impediment. Attempts at consoling or distracting her were met with louder wails and a concerned passerby advised the doctor next door that a child had been locked in the room. I am not certain she was reassured when advised that it was alright as the child was with the psychologist ! I retreated to the end of my room where the play area was and sat and waited. She cried for fifteen minutes which was a lifetime for me. She then calmed a little and tentatively came and hid behind the bookcase separating the adult section from the play area. At the first sign of her movement away from the window I had started quietly playing with the toys. Then I started a spontaneous conversation with the so-called fairies, quietly explaining to them about

the problem I was having talking to a very nice, little girl. I would say something, then sit quietly as if listening to their response, comment on that response and continue talking. After a few minutes a head of blond curls could be seen peeping around the end of the bookcase and she came and lay on the big cushion next to where I was sitting on the floor. I ignored her completely and continued my conversation so she joined in and she and I started to communicate. Throughout this entire interaction I followed my intuition, when to talk, when to be silent, to ignore her joining me and the imaginative fairies initially and then to include her. It seemed to be the turning point in our psychotherapy as she allowed me deeper into her world after that.

2.3.2 **Appropriate input.**

Another aspect of experience is learning to provide what is going to be most beneficial for each patient. In the psychotherapy with Rachel I worked very closely and deeply on therapeutic issues as well as practical ones as I sensed that this was what Rachel needed. With less fragmented patients I obviously bring in little on the practical issues and leave those choices entirely up to the patient. With Rachel those practical issues needed to be voiced as she had not even considered many options due to her lack of ability to relate. She also needed to have alternatives to explore as her mother had laid down all the rules all her life. Rachel did not know how to view life from a different angle.

2.4 **Theory and knowledge.**

As Buber (1958) and Gendlin (1974) state, theory and knowledge can be harmful if used too rigidly. I believe that theory should be used cautiously as a guideline as it can provide one with valuable information and understanding in general terms. Exploration means moving away from the safety and certainty of theory into a world of mixed feelings - wonder, curiosity, uncertainty, fear and excitement (Stern, 1983). Curiosity encourages exploration. Rachel comments: *"Regarding my psychic experiences, I feel Cathy also shows curiosity. This feeling is very complimentary. I feel good about it because it gives me an emotion of curiosity through which I can look at my own experiences that have been riveting and unexplainable in any logical way"*. The key is to remain focused on the uniqueness and individuality of the patient with knowledge as a framework in the background. A high priority is to treat the patient as a subject in psychotherapy and not some object to be studied so one cannot be scientific about the approach if one is meeting the human being in his entirety. Research studies of large samples of people provide us with valuable generalisations. However, if one focuses primarily on the diagnostic label and categorisations, the essence and richness of the individual's life and experiencing is lost. I agree with Jaspers' (1963) comment that knowledge of the self brings freedom. Understanding oneself is the first step to freedom away from the blind, overwhelming sense of being lost in the lack of self-knowledge which inhibits any insight and growth. Although it involves risk, exploration and reflecting brings self-awareness as it allows for conceptualisation at a conscious level which leads to growth.

When I use theory I do not explain in a theoretical manner. I give an example relating to the patient's experience and world. Rachel describes this: *"The expansion of my conscious has not been based on what Cathy knows, but on what Cathy has helped me to experience and that, as a consequence, brings me to the start of my own*

knowingness. For example, Cathy will not talk about 'boundaries' at a purely conceptual level. With the feeling of pain that I have suffered by not having or even knowing about boundaries, Cathy takes my experience, and relates to it. My experience gives me the handle to rise up out of my pain into understanding and into the direction opposite to being the victim".

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. This is particularly important for Rachel as she had feared I could be damaged by her chaos. 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. However, it is critical for the patient to understand that the therapist is not all-knowing and all-wise. To pretend to be so would lose one credibility and reduce the sense of authenticity. As Lawner (1981) states, it is acceptable for both therapist and patient to be lost in the unknown. Rachel found this a valuable lesson. As quoted above, she said: *"Another very important answer that Cathy has given to me when I ask her a question is 'I don't know.' When Cathy has answered me in this way she does so with awareness open wide and utter perception in her eyes. Seeing that and experiencing another human being as aware by choice and still not knowing the answer gave me incredible advantages. I could <u>see</u> it was okay not to know. I could see that not knowing did not in any way diminish consciousness. I could experience appreciation for Cathy because in not knowing Cathy was the same Cathy. She did not cringe or feel bad and her self-esteem appeared to remain constant".*

Thus, it is not the therapist's model of training that heals but the wholeness and availability of the self.

2.5 **Therapist's ability to listen.**

2.5.1 **To the patient**.

The value of listening at deep levels to a patient's experience cannot be over-estimated. Many clinicians and writers have highlighted listening as critical in any genuine dialogue. People feel invalidated and disconfirmed when others do not listen to them. Lara Jefferson, a hospitalised patient, aptly describes the sense of not being heard. She experienced the psychiatrist as having little understanding of her as a person: "I was talking across the great distance separating us" (Kaplan, 1964, p. 39).

There are many levels that one can hear a person at and listening requires intense concentration on both the facts of the story as well as the deeper meaning behind the words. Focus on the content alone obscures the real picture. One must focus on the form as well, that is, what the experience and its meaning is for the patient at deeper levels. This would be impossible to achieve if one only focused on the superficial behaviour. And the deeper the level one hears and meets at, the closer becomes the bond formed between patient and therapist.

When Rachel told me in a matter-of-fact manner that when I advised her I would be able to tolerate her suicide and would not abandon her even if she were in that space, she stated that it *"felt like a hand reaching down to me in a very dark underground cold place ... I was only saying what I felt on the verbal intellectual level. Cathy was*

listening. And in that moment when I said something very significant, Cathy pulled it into reality by responding. In that way I could start to feel what I was feeling ... Can you imagine how I felt after so long of not being heard and then feeling like I was being heard for the first time ever with no vested interest following any of my discussions afterwards ? ... Talking to Cathy felt like what I said was being heard with absolute clarity without any rose tinted glasses. Cathy was not questioning my honesty or experiences. That was so vitally refreshing. Cathy was hearing me. I really truly needed to be heard ... She chose to comment about the deepest issues I was fast-forwarding over. That is where I got the sense that Cathy was listening with acute focus and not casual interest". Responding to the deeper level and hearing her pain helped Rachel shift from the usual response of turning to suicide as an option. By truly hearing Rachel I was also indicating my genuine interest, care and concern for her which confirmed her and helped her realise her own value. Rachel feels that being heard has confirmed her at the core and *"this experience has given me life".*

It is fairly common for patients to make a casual comment about an important issue and wait to see whether the therapist recognises the value and depth of the issue. This is a good test of whether the therapist is truly listening and, if that moment is grasped, the psychotherapeutic relationship will deepen. If it is lost, the patient may feel disconfirmed and withdraw from allowing the therapist to enter more fully into his world.

Another important factor is detail. I usually manage to remember considerable detail which many patients have commented on with surprise. This also indicates to the person that he is important. To forget detail is felt as negating for the patient. To recall detail means one is really listening which values the patient and his experience. Thus, listening for deeper meaning and retaining content are both important.

The therapist's whole body can indicate how intensely he is listening. For example, the stillness, eye contact and absorption in what the patient is saying all indicate a concentrated focus on the patient's world. Rachel comments on this in her notes: *"Her listening to me was not felt to be passive. It was felt to be very intense".* Thus, it is with one's whole being as a therapist that one listens to the unfolding of the patient's life story. It is a challenge for the therapist to be in the subjective world of another and this requires focus and concentration.

2.5.2 **To himself**.
However, there is another factor of listening which is important and seldom mentioned. It is insufficient to listen to the patient - one must listen to oneself, how one sounds and how this may be perceived. Much of the value or judgment perceived by patients is picked up by the actual wording, tone and manner in which the therapist communicates. For example, my tone of voice indicated to Rachel that I was disappointed in her for not taking the job in the financial world. She also felt I was *"shaken"* and *"upset"* when she told me she wanted another child.

2.5.3 **To the interpretations**.
Dialogal psychotherapy stresses that the therapist should listen to the problem the patient is communicating and make it comprehensible for him. This interpreting enables both the therapist and patient to dialogue with the problem. The incident with

the tissues highlights the difference in interpretation made by the therapist and patient. I asked her if she would mind throwing her pile of tissues away at the end of the session. She initially looked shaken and apologised. I had mentioned it casually. She interpreted it as a large issue of boundary drawing and a measure of her worth. Her wording describes the incident well: *"The next boundary I felt was when Cathy asked me to take my used tissues and put them in the bin before I left a session. This 'boundary' felt very different. When I apologized and said I was not aware of leaving my tissues behind and how awful of me, Cathy said she knew. I knew she knew. She was with me. It did not take the next session to grasp that. I did not feel abject remorse or deep pain. I felt exposed but not uncomfortable. I knew and felt that Cathy knew that I would never consciously do such a thing as to leave my used tissues on her table where her next patient was to sit ! That I had done this repeatedly and unconsciously did not make me feel bad about myself. It made me feel a small sense of humour towards myself that I had not felt before. I could feel this only because Cathy again confirmed me by saying she knew that it was unintentional. She said this with meaning, awareness and kindness towards me. That gave me the opportunity to experience myself in a humorous loveable light. I was not being punished. I was not being demoted or made to feel less worthy".*
Likewise, the depth at which she reacted to the incident where I asked her not to use endearments to me indicated her deep insecurity. She heard my request at her core and it was an extremely difficult issue for her to deal with. These incidents remind one that what may feel like a minor issue to the therapist may be interpreted as deeply meaningful for the patient. This is especially true of fragmented patients and should always be borne in mind. This does not mean that one does not draw the boundaries but rather that one must be aware of how that might be experienced by the patient.

There were many times when she perceived my interpretations as being correct for her which started to give her another perspective on life: *"I have not done justice to the lightning perceptions that Cathy gave to my conversations at the beginning. Her statements eventually became something I looked forward to experiencing. I started to hold onto them after therapy. They went with me into the world. I started the work of changing my perspectives to ones I had direct experience of being more comfortable with in therapy".*

This highlights how the therapist must listen at all levels to both participants of the psychotherapeutic relationship. A tiring but necessary and rewarding process if one wishes to fully participate in the patient's journey to healing.

2.6 **Therapist expectations.**

Much of the literature indicates that therapists prefer to work with less severely disturbed patients. This is logical as there is more chance of success, it is less emotionally draining and overall less taxing on one's whole being. The expectations of patients and therapists also differ considerably with some seeing symptom-relief as successful and others personal growth and improvement in social relationships as the goal. Neither Rachel nor I had specific expectations but do now have the same goals of her gaining a cohesive sense of self and operating in the social world in a more comfortable manner. One of Rachel's main aims is to rid herself of the feeling of being *"nothing"*, that is, completely unworthy. As stated, she views this as her *"sickness"*.

2.7 Patient attractiveness.

Overall the literature suggests that likeable and attractive patients engender more of a positive response from therapists. Obviously, it is easier to work with likeable people and the connection of genuineness and authenticity will be formed more easily. I agree with Barbara Sullivan's (1989) view that it is not possible to form a healing environment with someone that one does not like. However, I suggest that if one looks past the dislikeable behaviour to the core, one is usually able to empathise or find some aspect with which to relate. This is very important as some patients are problematic and difficult and one must find some element that allows one to respond with respect and decency. This may make the relationship more difficult to form but it does not mean one is necessarily unable to help. Fortunately I genuinely like Rachel so that has not been an issue in this psychotherapy.

2.8 General personality characteristics and attitude of the therapist.

The therapist's personality and attitude are important factors in the dynamics of the psychotherapeutic relationship. I believe that the ways of being with the patient make an enormous difference to the outcome of psychotherapy.

2.8.1 Respect.

Respect is central to Buber's concept of meeting the other in an I-Thou relationship. This respect provides the basis for the healing through meeting. I believe it to be the most important factor in any relationship. The patient in psychotherapy is in a vulnerable position. He is entering into a relationship which will require him to open at the core and share his deepest fears, weaknesses, hopes, desires and dreams. If one meets the other with a basic respect for him as a human being then one can hear him at a deeper, more meaningful level. 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. The ability to share this world will only occur if the psychotherapist inspires hope, faith, trust and the freedom to be real (Wolberg, 1977).

I have treated Rachel with respect throughout the psychotherapeutic process. Her descriptions of her psychotic episodes, her endless affairs with men to gain confirmation, her helpless passivity which resulted in her tolerating physical and emotional abuse from her mother, Pieter and many others with whom she interacted, all gained the same response from me. Acceptance and respect. When I felt concerned or exasperated at repetitive negative patterns of behaviour which endangered her, I would look past the behaviour to its reason for being there. What was the value and meaning in this behaviour for her ? That I could always respect. I tried to guide Rachel to find answers and perspective for herself by: respecting who she was regardless of her behaviour; by not punishing or criticising her, for example, for the endless sexual encounters that were damaging and which she was being severely punished for by Pieter; by seeing through the facade that she had erected and recognising the innocent yet damaged inner self and by not telling her how she must live her life and respecting that she would start to learn that for herself - yet also not abandoning her in the sense that she was very lost and did not have many clues of which direction to move forward in. Exploring together what made sense for her, what was comfortable for her and what worked in her world, helped her establish this for herself. This offering of different perspectives allowed her to explore the possibility of

different views, decisions and choices which Rachel found to be critically important.

Rachel said she would not have been able to stay in psychotherapy, feeling held, met and growing without the obvious respect I had for her and her experiences. I also allowed her to own herself and her own world as something of value by not taking away her experiences by labelling them or negating them or, worse still, by saying they were not real.

2.8.2 **Presence**.

The therapist's presence is experienced by the patient in the first interaction between them. I changed my wording on the answering machine many years ago to include my recognition that it was difficult to talk to a machine. This reduced the number of people who did not leave messages by at least 30%. The next contact is usually when talking to the patient on the telephone to make the first appointment. This can convey caring and warmth which is the start of the psychotherapeutic relationship. So, a bond can begin to form before the patient even meets the therapist. The first telephonic conversation was experienced as powerfully important for Rachel and allowed her to take the first step towards healing: *"I believe my first experience of therapy began over the telephone. Cathy's answering machine answered my first call. That's when I first felt what therapy could be like. The sound of Cathy's voice held a tone of kindness but was also very 'together'. This was a person who was professional. I did not think then that I deserved to have anyone 'professional' waste time on me and also I was scared. Cathy's voice did not scare me. The tone of discipline and astuteness scared me. I was in a real mess emotionally. I did not think I deserved help. I could not help myself. That much I knew. (She did not leave a message). The next call to Cathy, I also got her answering machine. This time I left a message. I was suicidal and very scared ... When I first spoke with Cathy on the telephone I was crying and talking to a complete stranger. It still makes me choke at the depth of feeling even as I write about it now. Cathy was 'there'. That is what makes me have the feelings well up inside me. Not that I was suicidal. Cathy was and felt as though she was <u>there for me</u>. She was on the phone but her voice was really close. It felt as though she was really close. Not in a physical sense but in a conscious sense".*

Presence is recognised by the dialogal therapy approach as being fundamental to psychotherapy. In being an alive and perceptive presence, with the ability to play, the therapist offers a rich psychotherapeutic environment for exploration. The ability to play allows the therapist and patient to explore experiences and new alternatives with an openness and wonder. Being present in a palpable manner provides the patient with a sense of safety. For example, at the time Rachel's parents and brother made the decision to buy her a home without any discussion with her, she felt the usual overwhelming control from the family. At that stage, she required me to be obviously present. As stated, it was insufficient for her to have me listening, hearing and caring and she required me to bodily and facially indicate my confirmation of her. This highlights the importance of needing to be an active presence at times, especially with fragmented people, in the sense of being connected with one's whole body and mind. There is little ability, in that turmoil, for the patient to read subtle signs and one is called then to respond in a more obvious manner. By my continuing to still respond in a caring and gentle manner and hearing that vulnerability and need for reassurance, Rachel was

able to make the necessary links in the process. However, in the psychotherapeutic sense one must still be what Buber terms the detached presence in that one has not become one or enmeshed with the patient.

I have a sense of being more present and active than most other therapists although this tends to alter according to the patient's needs and the psychotherapeutic moment. Thus, I do occasionally allow my facial expressions to indicate feelings at appropriate times and at a sensible level. The key is to do this in a balanced way where one is really connecting and yet clearly not being overwhelmed. Many patients have reflected that I am "real" and that they could not have opened at deep levels if I had simply sat there, occasionally nodding and responding with conciliatory sounds. Comments have been along the lines of "I couldn't bear it if you just sat there and never responded to me". My belief is that when people are very fragmented and lost they need a very clear indication that the therapist is truly and authentically in their space. This does not always necessitate much languaging but requires one to be present as a whole person. One of the therapists I was trained by was a very wise man. He taught me that one only spoke when it was necessary and I have stated my dictum of "when in doubt of what to say, at any stage, keep quiet and listen" ! This therapist also cautioned that when one does speak, the words should have been carefully thought about and valuable as they will often be recalled ten years down the line ! One does occasionally get feedback on words spoken in the past - a patient who states "but you said ..." months later.

I said little in the years with Rachel as she filled the space so completely with her world, but when I did react, it was in a real, connected manner. Hence her comments about how my spontaneous laughter at her foul language assisted her in gaining a new perspective. Rachel words her sense of my presence: *"In the first few years of therapy Cathy said very little. What she said was very important. It was like I was fast forwarding on a video tape. When Cathy spoke, it felt like she had pressed a pause button that only required a fraction of a second. What she said I felt to alter the course of the fast forwarding in that it gave me a new perspective. Her statements validated me. I cannot recall exactly what she said. I recall the feeling. Whenever Cathy said something it gave me a deep sense of healing. The urgency of having to say so much more was never interrupted by Cathy".*

Her writing is also interspersed with frequent comments about my being present: *"Cathy was and felt as though she was <u>there for me</u>. She was on the phone but her voice was really close ... Cathy is with me, where <u>I</u> am, in <u>my</u> moment not hers and this experience has been <u>beyond</u> words. I feel my eyes start to well up again as I write this. The experience has been so breathtakingly healing and wonderful. There can be no value placed on this experience. It is beyond any price paid for therapy ... Cathy never diminishes the pain. She is <u>with me there, with the pain</u>. That is how I have been able to see an alternative view of myself. I see how Cathy handles it and then I know it is possible".*

I give of myself appropriately in the interaction in an alive and connected manner. For example, I laugh with the patient, show concern and sometimes anger at his circumstances or an event that has hurt him. This is always at a much lower key than

how I am as a private person and is never portrayed as sharing emotions with a friend. Rachel reflects on this: *"This act of great kindness and generosity and being on my side in a very deep sense, gave me yet another role model. This is what love should feel like. In both instances of feeling what friendship should be and what love should be, Cathy did not personify herself at a personal level. I never felt that Cathy intended herself to be the focus of my need for love and friendship. Cathy offered nothing of herself at a personal level. I still did not know Cathy. She was an example ... Cathy shows genuine interest in what I say. The interest is not felt to be personal, it is felt to be professional. This makes me feel like someone knows what is going on".* Patients seem to call forth from one what is required and what works in the psychotherapeutic space. With many patients, I say little, with others I respond more and with one patient I wonder what I am doing there. She has been travelling her journey and growing with me for nearly three years and I feel that all I am providing is a safe, containing vessel. She certainly is not learning on the path from any wise interpretations made by me ! This highlights how important presence and listening are.

The above supports the dialogal approach's view that ultimately it is the therapist's whole self which must be fully present. By being fully present in the psychotherapy, the therapist provides the basis for a deep, respectful, sound and solid psychotherapeutic relationship in which to begin healing. Being fully present allows the therapist to experience the patient's world more deeply and thus with more understanding. Thus, presence is not simply an attitude but how the therapist views human beings.

2.8.3 **Calm and caring**.
A comment frequently made by my patients is that I am very calm. Questions are asked about whether I ever get rattled, comments are made that I seem to be calm despite everything. Many patients state that they are calmed and settled simply by being with me even when I say nothing. For example, one woman stated that the space quickly became a "sanctuary" as she found me always calm no matter what was happening and she felt "safe and calmed" by that. When Rachel was struggling to decide whether to succumb to her mother's wishes to leave psychotherapy or stay, I was strongly and calmly present without in any way indicating my fears that she might emotionally shatter if she left psychotherapy.

Part of this sense of being calm is that I give myself at far deeper levels than many other therapists do. I have been made aware of this in group supervision and general conversations with colleagues. Many patients feel this deeper caring
and the major feedback over the years has been that I care - patients experience it as genuine and not me simply doing my job. For example, Rachel could not understand why I would be accepting of her regardless of anything she did or said. My response elicited the following: *"'Because I care' was said with neither any vulnerability or any sense of making me look inadequate. The consequence of this answer and tone spoken was to bring into my consciousness the following that I thought and still remember thinking: Ah! So <u>that's</u> what it means to care' ! I felt my mind leap up to grasp, so that is what it means to care ! ... Now I know what was missing! "*

Caring is shown in body language as well as wording. The way one sits and moves, the eye contact which mirrors the feelings the therapist has and the tone of voice can all

indicate caring. One's whole body is indicative of how one is in the space with the patient. Rachel picked up on that factor in our very first meeting. She comments: *"When I first saw Cathy, she came across as an intensely astute consciousness. Her eyes spoke and showed awareness. Maybe someone at last would be able to see me as I felt".* This gave her the hope that she would be heard and met and my eyes continued to be of importance to Rachel as she comments in her writings of the psychotherapy experience. When I stated that I would never abandon Rachel even if she were on the brink of suicide she commented: *"When Cathy looked at me again with her answer, her eyes carried incredible intensity. I could see she had committed herself ... I was to experience that wonderful expression in her eyes many times afterwards especially when she was to tell me that I was not bad".* When she realised I was not all-knowing she stated: *"Another very important answer that Cathy has given to me when I ask her a question is 'I don't know'. When Cathy has answered me in this way she does so with awareness open wide and utter perception in her eyes. Seeing that and experiencing another human being as aware by choice and still not knowing the answer gave me incredible advantages".*

Being calm and caring form part of the containing vessel that provides the patient with a haven in which to express himself and explore his issues. Although it is critical to be present in a calm and caring manner, one is still separate and Buber's (1965) dictum that the therapist must be a detached presence should always be adhered to.

2.8.4 **Consistency**.
This is a vitally important aspect in dealing with a fragmented person. The knowledge and experience of the psychotherapeutic space as consistently safe, stable, accepting, respecting and confirming provides a solid vessel in which the patient may explore the fragmentation and chaos of his world. This grounded Rachel many times. For example, the time that her fiancé finally ended the relationship and she was fearful of my punishment as she had telephoned him. She was also fearful of abandonment and was attempting to be the good girl to ensure I too would not desert her. I acknowledged her fears, said little but was very consistent with her to ensure that the holding space did not waver. This enabled her to experience the psychotherapeutic space as safe and containing and led her into sharing more of her psychotic episodes.

Throughout the psychotherapy I have been consistent with her. Overall this tells the patient that no matter how chaotic and unstable his world is, there is always one place that can be relied on to be constant. A haven of safety in the storm of life.

2.8.5 **Commitment**.
A point seldom mentioned in the literature is that of the therapist's commitment. It is equally important that the therapist be committed to the process of healing. It is of little use if the therapist realises, over time, that he is working with a very disturbed person with a poor prognosis and then loses commitment. The patient will feel that and it could do enormous damage. If I take a person into psychotherapy, I am committed to whatever can be gained. The therapist who trained me, as mentioned above, advised me in my internship year that if I kept a particular borderline personality disorder patient alive for the year, I would have achieved something. She had specific problems with her father and he died during that year. With the expectation of only keeping her alive,

we were delighted that she handled his death without the usual self-mutilation at times of stress and she was getting in touch with herself fairly well when I completed my training and moved on.

Rachel comments on my commitment to her in the first session and she was right. My commitment has been absolute. I have always been there and will continue to be so until she feels she has gained enough and chooses to terminate psychotherapy. Her growth is my reward.

2.9 The therapist's self.

Eckler-Hart (1987) speaks of the need of the therapists-in-training in his study to form a professional identity to protect the psyche from the demands of patients. As it is ultimately the whole self of the therapist that must be present, this is an understandable desire. I do not agree with Bollas (1987 as cited in Ivey, 1990) that a union is required between the therapist and patient where there is "a going mad together, followed by a mutual curing and a mutual establishment of a core self" (p. 48). I agree that one may feel that way when one is working deeply with psychotic and fragmented patients but it is important for the therapist to maintain a sense of separateness for both oneself and the patient's safety. My being experienced as a separate person was important for Rachel: *"I am not saying here that it would have made me feel better if Cathy had given me information about herself. Doing that would have made my work of getting better very difficult if not impossible. I did not need to have to process things about learning about someone else ... I was not in therapy to get to know Cathy. I was there to get to know myself".*

Dialogal psychotherapy includes the essential elements of mutuality and inclusion and these elements have been highlighted in this study. 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) states 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. By being real, actively and yet appropriately involved as a therapist, one is able to experience the psychotherapeutic relationship from both sides. Buber (1965) states that the element of inclusion includes 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 (as cited in Friedman, 1985) describes this as "a bold imaginative swinging ... into the life of the other" (p. 198) where the therapist is able, with a concerted effort, to go to the patient's side and yet still experience himself. 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). It would be unhealthy, inappropriate and unhelpful for the patient's growth if the therapist were to be enmeshed in his world.

Buber believes inclusion is broader than empathy. Empathy is defined as "the power of identifying oneself mentally with (and so fully comprehending) a person ..." (Tulloch, 1993, p. 480). 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 thus implies a far deeper entry into the patient's world than

empathy does. Buber states that 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. My understanding of Rachel's world was achieved by entering more deeply into her world of experiencing. By having the qualities discussed above, I believe it is possible, as Jourard does (as cited in Friedman, 1985), to "provide(s) the patient with a role model of authentic being with which he can identify" (p. 171). For example: my being calm; the drawing of boundaries gently and firmly with her and her older sister; showing emotions appropriately at appropriate times; indicating by my anger when she had been beaten again that this was not acceptable and that she was worthy and did not deserve to be beaten, are all helping teach her that she is worthy and can defend herself by drawing boundaries both physically and emotionally to protect herself. Rachel makes frequent comments about learning from how I handled matters. For example: *"Cathy showed me it is okay not to know something and just* ***be*** *there in that space. Experiencing it by seeing it achieved by another person has helped me to find myself more and more ... That is how I have been able to see an alternative view of myself. I see how Cathy handles it and then I know it is possible".*

Thus, it can be seen that the therapist's self is an integral part of the healing process.

2.10 **Confidentiality**.
Without doubt confidentiality is one of the most important factors. Without this there would be no place of safety created and no trust. Ultimately, if the patient knew of a breach of confidentiality, it could destroy any progress achieved and shatter the patient's world of faith and trust. To allow this to occur would be the ultimate betrayal from a therapist.

2.11 **Acceptance and confirmation.**
In my view, confirmation is the most critical aspect of healing. Buber's view that psychopathology is the absence of confirmation has been highlighted throughout this entire case study. Buber's (1965) belief that one only experiences oneself as human when one is confirmed by another with complete acceptance is evident in every aspect of Rachel's experience in psychotherapy.

An important facet of acceptance is that the therapist accepts the whole person with all their emotions. Many people have had the so-called negative emotions denied, either by punishment when the emotions are displayed or a general role modelling and encouragement to suppress them. The person then does not learn to deal with negative feelings and views them as unacceptable within the self. This is precisely what happened to Rachel. In psychotherapy she has found the ability to express her anger, sadness and fear in a safe space to be deeply healing. It has allowed her to experience the feelings fully for the first time as well as the expression of emotion without fear of punishment. This has resulted in her experiencing herself as a whole human being, with both negative and positive facets, without the sense of being bad. Confirming and helping Rachel accept that she was allowed negative feelings of anger and indignation made her feel she was being healed. She stated: *"Cathy became like an angelic surgeon. There were times that I really felt stitched and bandaged up after therapy".* But the constant crises she experienced in her life resulted in her feeling that it was an *"embarrassing and awkward situation because I felt like Cathy was doing such a good*

job but I kept coming into therapy bleeding". Rachel felt this was a wasted exercise for me and stated: *"I felt far worse and less valuable. Cathy reassured me. She said she would not ever abandon me. She assured me that everything was as it should be. She did not mean that my wounds were as they should be. She meant that my wounds should be bound and healed. That made me feel very good. It made me feel that there was value in getting the sense of healing and help that I was feeling. It gave value to my inner wounds in a very healing way".*

This acceptance of negative feeling is confirmed by another patient of mine who is an intern psychologist with a couple of previous psychotherapy experiences. She has been in psychotherapy with me for three years. She spontaneously commented recently that she feels there are two very valuable things about my way of working which have helped her. One is that, despite being in psychotherapy before, I was the first person to really make her feel that it was acceptable to be angry with her father as "his behaviour has not been acceptable". This enabled her to connect without always feeling she was betraying him by talking about him. Secondly, she has gained the understanding that she was NOT a "bad" girl but simply a child and that he was damaged and "wrong". During the first two years of psychotherapy her father continued to emotionally and physically attack her as she was still living at home. Understanding that he was damaged assisted her through many of his subsequent attacks as she would stand there and repeat in her mind "it's not me, I'm not bad".

When Rachel initially began psychotherapy she asked if I would cope if she committed suicide. I had answered in the affirmative. In her description of psychotherapy she describes that it *"felt like a hand reaching down to me in a very dark underground cold place and the hand was white. Not white in a skin colour way but white as a light shaped in the form of a hand that reached me and took hold of me. I can still see this impression today that came to my mind then when I expressed this to Cathy. I can still see it because it was not lost. Cathy saved it for me because she gave it great meaning. She was stalled in her seat. Her face showed her mind going inwards to some place I could not follow. Her words were the indication. As she looked at me her eyes showed horror".* I recall this incident and her description of how deeply she felt the pain. I recall feeling immense empathy at the depth of her pain and acknowledging that. My feedback conveyed that I now understood how deep the pain was at the core and respected that but I certainly at no stage experienced horror. Although her choice of wording perhaps suggests a different meaning, fortunately she did realise that I was connecting deeply with her vulnerability and pain and this was experienced as very positive for her. She clearly picked up my feelings of respect and this confirmed and connected her to her pain making her feel less alone. *"This feeling was to be one of many steps in the climb away from suicide".*

An example of the confirmation I gave Rachel is expressed in her words of my listening to her: *"Talking to Cathy felt like what I said was being heard with absolute clarity without any rose tinted glasses. Cathy was not questioning my honesty or experiences. That was so <u>vitally</u> refreshing. Cathy was hearing me ... This was no small issue. It was a deep life experience" !* As stated earlier in this chapter, Rachel feels that being heard has confirmed her at the core: *"I was starting to feel better and the feeling was being felt in a <u>very</u> deep part of me - a part of me I had not felt before was <u>coming alive</u>*

... This was a very new experience of well being - something that is becoming quite familiar I am very happy to say, through therapy ... this experience has given me life".

The recognition, acknowledgement and respect that forms part of confirmation is highlighted by Rachel's words: *"Cathy validated my pain ... I got the sense of Cathy being an incredible consciousness that had skills I could not define. What or how she was giving me a deep sense of reality and comfort I did not know. All I knew is that she was. Her awareness and input together was really helping me at a very deep level ... Sometimes I felt like I was not getting to the goal fast enough. Cathy validated me, and still does, where I am in the moment. This has been very important to my experience of self-acceptance. It has been vital. Cathy reminds me, and still has to as I meet new levels of my own awareness, that it is 'baby steps'. 'Oh ! Even here' I sometimes catch myself thinking ! Cathy is with me, where I am, in my moment not hers and this experience has been beyond words".*

Rachel has found the acceptance of her psychotic episodes to be one of the most confirming experiences of herself. *"Regarding my psychic experiences - Cathy has been wonderful. Cathy made my experiences not something I had to cut off from myself because they were unacceptable to Cathy. Cathy again was there with me in my experiences. What has been so extraordinary for me is that Cathy did not make me feel like I had to amputate my experiences from my own acceptance or sense of reality regarding how my psychic experiences made me feel. My experiences made me feel a whole variety of feelings and Cathy did not cause me to think I had to be ashamed of any".* My acknowledgement that I would also have experienced fear in some of her psychotic episodes assisted her in accepting it was understandable to feel that way. It also allowed her to step into exploring the experiences with a sense of safety. Of primary importance was that I did not label her as sick, mentally ill or pathological. This allowed her the space to connect deeply and come to her own insight about the hallucinations. She felt that the fact that I did not label her was the ultimate respect.

So, by simply accepting these experiences and not questioning them, Rachel felt confirmed. *"At several times she so very kindly and gently affirmed that I (may) have psychic qualities. That was so wonderful. It is really not easy to have psychic qualities. Again, Cathy showed acceptance and I could experience her stability with acceptance. This became a very powerful feeling of terra firma under my consciousness that really swivelled around not knowing how to handle inexplicable experiences. Feeling accepted I was able to be okay with experiences I could not explain ... When I first came into therapy, I always felt as if people thought I was lying and so I felt I had to prove everything I said. Cathy never made me feel as though she doubted me and that was because she handled what I was saying as if it were the truth. It was awesome to experience this. I had never felt this before. It gave me a way back to myself not because I was not telling the truth, but because someone 'out there' was believing me without question".* These last sentences are vitally important. Allowing the patient's experiences to simply stand as the truth for them, meets the patient at the core with total acceptance and confirmation for who that person is in his world.

In my work with Rachel's dreams she comments on the process and indicates her extreme vulnerability and need for confirmation. She says I do not devalue her when

interpreting a dream which highlights how much she has been disconfirmed in the past when sharing experiences: *"She tells me what she sees from her point of view - a wonderful experience for me. In this I have been able to get out of the feeling of being held captive to pain or captive to the way I see and experience things. Cathy gives me an alternative way of looking at things in a way that does not diminish or devalue me. It is quite extraordinary to experience this. It allows me to absorb a new way that feels so much better. Cathy does not rush me on this either. Cathy is affirming of my own time. So it feels as if Cathy is okay to take baby steps with me - even though she is a giant ! She is not trapped in any of my own issues".*

My confirmation of Rachel the person without judgement of her sexual behaviour was an extremely important factor for her. Again, it confirmed for her that the psychotherapeutic space was a safe one where she could bring all of herself. *"I really had some very sensitive issues regarding sex. Cathy never made me feel bad about how I felt about myself even though I was out of control. Cathy explained, very gently and sympathetically that my sexual behaviour arose from my seeing myself in others, rather like looking into a piece of a mirror. Cathy did this in a very accepting, gentle but at the same time matter-of-fact way that made my feelings of revulsion and hatred for myself experience something quite different - compassion and authentic understanding. This direct understanding expressed compassionately to me by Cathy felt like a blanket of understanding over a very cold self hate. The comparison was that I felt warmth for the first time ... Intelligent explanation that was presented with compassionate understanding gave me the experience of compassion and I could then start the work of trying to feel that same compassion for myself".*

Allowing Rachel to be herself and make her own decisions increased her sense of inner strength. It also increased the feeling of ownership of feelings and thoughts. She was able to experience herself as a whole person with choices. I confirmed her when I gave her the freedom to choose and acknowledged the results. She stated: *"Cathy always makes my achievements feel special and she strengthens them for me in order to make it real, valuable and something **I** can claim".* Rachel stresses how important choice is for her when she quotes from Walsch's (1995) book: "... all life arises out of **choice**. It is not appropriate to interfere with choice, nor to question it. It is particularly inappropriate to condemn it. What **is** appropriate is to observe it, and then to do whatever might be done to assist the soul in seeking and making a **higher** choice ... **Allow each soul to walk its path**" (p. 47). This last sentence highlights the importance for her of accepting and confirming her simply for who she is.

The penultimate paragraph of Rachel's account indicates her sense of being totally confirmed: *"Cathy said I could say whatever I wanted to say and do whatever I wanted to do and it would be okay with her. That really made me not understand something. Cathy allows me great listening space to talk my feelings out and so I could ask her <u>why</u> it was okay. Why would anybody be okay with whatever I do? I have never experienced such a thing although I have <u>been experiencing it in therapy for the last five years</u> ! But, nevertheless, in that moment, I could <u>never</u> have guessed the answer even if my life depended on it. The answer Cathy gave me was spoken with what I sensed to be great balance in Cathy and she answered, 'Because I care' was said with neither any vulnerability nor any sense of making me look inadequate. The*

consequence of this answer and tone spoken was to bring into my consciousness the following that I thought and still remember thinking: 'Ah! So that's what it means to care' ! I felt my mind leap up to grasp, so that is what it means to care ! And tact ! Cognition ! Now I know ! Now I know what was missing" !

By meeting and confirming Rachel, she has been freed to connect with her experiences and remember her past. This is highlighted by how much more Rachel recalled, began to experience and unfolded as the psychotherapy process continued. I appear to have provided what the dialogal approach views as an experience that is unique, meaningful and confirming for the patient.

3. THE SITUATION:

3.1 **Length of psychotherapy.**

Rachel has been in psychotherapy for over six years and there is a steady growth and healing of her fragmented self. Although the progress has been slow, the healing has been happening at deep levels and the core of her real self is being addressed and met. This argues in favour of long-term psychotherapy for severely disturbed patients. Working with and observing Rachel's growth has clearly indicated that any short-term work would have been insufficient and possibly damaging. To have completed only a short-term psychotherapy with her would have abandoned her in the middle of a process which is changing her life and future. This does not, however, rule out that short-term psychotherapy can be very successful for many less fragmented and disturbed patients.

3.2 **Type of psychotherapy.**

The dialogal and phenomenological approaches are not schools of psychology or techniques but philosophies which provide a basic approach to and understanding of the nature of man and his being-in-the world. Thus, there is no attempt made to state that either approach is better than any psychological school of thought. Rather, the case argues that the basic foundation of working with patients can be provided by these approaches. If the therapist views the patient within the phenomenological context and has the dialogal principles of healing as the foundation of his way-of-being with the patient, the therapist provides a context in which to assist healing and returning him to a world of relationship. Theoretically any theory could then be applied to the basic philosophical principles of these approaches. I do not, however, believe that this is so. Any psychological theory which views the patient as an object to be studied in isolation cannot be applied to a philosophy that views man as a subject in-the-world. A theory must have a basic belief in and respect for the patient as another human being in order to blend with the phenomenological and dialogal approaches. Different techniques may be used within the foundation of these two approaches but the core of the psychotherapeutic relationship must always remain one of respect for the individual. Fortunately, many therapists do not view theory as a rigid truth but are open to experience and learning as they gain value from the process as it unfolds.

This also does not rule out that certain theories have been extremely successful with specific problems. For example, cognitive behavioural therapy is successful in aiding people to manage panic attacks. However, the core of the patient is not met and the deeper issues are not addressed. Cognitive behavioural therapy would have been

disastrous to use in Rachel's case as it would not have confirmed her at deep, core levels and would have made her feel like an object. What is clear is that specific interventions may assist with specific problems in specific situations. But the same intervention may not work for everyone. However, deep respect for the patient as a human being always meets the other.

3.3 Tape recorded sessions.

None of the sessions was taped so this factor cannot be addressed.

3.4 Setting and atmosphere.

My room creates a comfortable atmosphere in which Rachel is able to relax. She feels completely comfortable partly because the furniture and setting is not reminiscent of an office or doctor's room. She is then able to forget that this is a work environment and can enter her world and the psychotherapeutic relationship with ease.

3.5 Client's cultural setting.

These findings partially support those of Wolberg (1977) that the patient's prevailing lifestyle can neutralise or encourage success by how the social network reacts to the patient. However, Rachel has shown that there can be growth in spite of the lifestyle/home environment being negative. For example, Rachel's mother was determined that Rachel should terminate psychotherapy when she realised that her daughter was gaining her own independence. Despite the importance of her mother's opinion, Rachel fought against that discouraging influence and continued her journey. The case indicates that Rachel is growing, not only in spite of the negative social support network, but because she is learning from it how to make her world and future different.

3.6 Payment of fees.

This has been a particularly relevant issue in this case. The overall findings indicate that paying patients are more motivated. Rachel has always viewed payment as important. It was clear that she never intended to have psychotherapy free of charge and twice she feared abandonment and loss of the psychotherapeutic space due to her inability to pay the fee. In both cases her gratitude at being offered a lower fee that she could afford, confirmed her value and worth as a person. Rachel's own words aptly describe the above: *"There were several times when I felt that I would have to discontinue my therapy - my lifeline, due to financial constraints. Cathy was extremely considerate. Again Cathy met me at my level. She heard me and she gave me a huge benefit of not increasing my fees. At one point she did not charge me for a whole month of therapy. This act of great kindness and generosity and being on my side in a very deep sense, gave me yet another role model. This is what love should feel like".* She kept her agreement to return to the full payment of fees as soon as she was able which increased her feelings of worth.

The discussion of the points above clearly indicates that situational variables do play an important role in the psychotherapeutic process and relationship. There has been little research conducted on these factors and it is important that their effects continue to be explored in future research.

4. THE PSYCHOTHERAPEUTIC RELATIONSHIP:

The dialogal approach states that 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). What is clear from the case study and the discussion thus far is that Rachel and I have formed a deep, meaningful, interpersonal relationship. We are mutually involved in a unique relationship that **is** a "powerful joining of forces" (Bugental, 1987 as cited in Clarkson, 1990) that supports the "long, difficult, and frequently painful work of life-changing psychotherapy" (p. 150). Psychotherapy is thus not something the therapist does and the patient receives but a mutual encounter between two people in which there is an attempt to understand how the patient is being-in-the-world. Psychotherapy is always in process and every forward movement in psychotherapy redefines the whole (Boelen, 1963). The whole process relies on the relationship built between patient and therapist and the richness of what is shared and explored in that encounter. Heard (1993) maintains that the therapist enters the psychotherapeutic relationship "totally dependent and accepting of the direction that arises from it without foreknowledge or control of what may come forth" (p. 9). The therapist seeks a relationship with the patient's uniqueness and wholeness as the purpose of the patient's life is to fulfil his uniqueness which unfolds in the dialogue. Thus, Heard maintains that the meaning of existence is not found in the psychological self but in the dialogical self. The emphasis in the healing relationship is on the between and the meeting. If the patient finds wholeness in his interactions in the world, he will find a direction in life that will bring purpose and meaning to his existence.

By viewing the psychotherapeutic relationship as a connected, mutual encounter between two people, the variables discussed above are understood to be interlinked in an ever-changing, living flow of interaction in relationship. As indicated, the patient, the therapist and the situation all contribute to greater or lesser degrees to the relationship as a whole.

This ever-changing, living flow of interaction is clearly highlighted in the relationship which Rachel and I have. Although I had been intuitively working in the dialogal manner, the awareness and focus that the psychotherapeutic relationship was the basis of healing resulted in a shift for me. One can speculate that living and reflecting on being a dialogal therapist also created a shift in Rachel and her experience of the relationship. When there is a change of thought or awareness, this can have positive or negative results. There were some major shifts in Rachel within the eighteen months following my realisation that the psychotherapeutic relationship was providing the foundation for healing. Shortly after my realisation, Rachel experienced the first sense of a boundary between herself and another. This enabled her to withstand the attempted invasion of the psychotherapeutic space by her older sister. Over the next months Rachel experienced the first real connection with confirmation and a sense of worth which was followed by her decision to live for herself. Eighteen months after my realisation and shift in awareness, Rachel was able to feel my confirmation of her at the core. Feeling fully confirmed as a human being changed the dynamics within her. Instead of simply protecting herself from her partner's abuse because it was damaging, she now believed herself to be worthy and not deserving of abuse. The questions

arising from this are: Would Rachel have continued to grow as she did because I was providing a safe, respectful and confirming space for her? Or did my awareness of how I was being with her enhance that growth ? I firmly believe that Rachel would have continued to grow and heal as we had established a sound psychotherapeutic relationship. Certainly, I became more aware of the dynamics and power of that relationship which further deepened the relationship and heightened my commitment to the process. This undoubtedly could have impacted positively on Rachel and the psychotherapeutic relationship in that, as the relationship changes and deepens, so does the likelihood of healing. A constant has been that the relationship allowed Rachel to steadily move forward on the journey to healing. As trust developed and Rachel felt heard and safe, she was able to unfold more of her life story. As her life experiences continued to be met and validated, so the trust deepened. As this cycle of opening and deepening continued, so Rachel was free to grow. This could only have happened in a caring, confirming, trustworthy relationship where Rachel's whole way of being-in-the-world was met with respect. The basic condition for forming the psychotherapeutic relationship was present, that is, my meeting Rachel in an I-Thou encounter. This provided the potential for healing and relating to the world.

The process in the psychotherapeutic relationship is one of dancing with the patient in the ebb and flow of relatedness and separateness. The development of a deep and healing psychotherapeutic relationship takes time. This is especially true for the more disturbed or fragmented patient. This has been highlighted by many therapists in the field. Laing (1969) states that the task in psychotherapy is to make contact with the true, original self and help nurse it back to life (p. 171). However, the therapist's understanding of the problem can threaten the core of the patient in the early stages of psychotherapy. The patient is still uncertain as to whether it is safe to reveal the self and it can be experienced as overwhelming to have someone psychologically close. Thus, despite the patient's desire to be known as a whole, Binswanger (1963, as cited in Laing, 1969) warns us not "to get too near, too soon" (p. 176). If the therapist moves cautiously until the patient does not feel threatened, the patient will feel less hopeless and isolated. The building of trust and the ability to open and be vulnerable takes a long time because the patient fears the core being further damaged or even annihilated. The key is to be flexible and allow the process to move in a natural and comfortable manner at a pace that is comfortable and experienced as safe for the patient.

I agree with Laing (1969) when he states that the therapist must not ask permission to enter the world of pathology as the patient is already afraid that the therapist might be contaminated and damaged by his illness. This would add guilt to an already heavy burden. So, the therapist should simply walk in slowly and carefully, with care and respect, but with extreme sensitivity to the timing. Each door can only be opened if there is enough trust and faith to allow that to be done with safety.

This is what occurred in the process between Rachel and me. The pace was set, to a large degree, by her woundedness and vulnerability. I never rushed the process and moved with her in that dance of relatedness and separateness to allow her to open only when she felt secure enough to do so. Rachel acknowledges this: *"The healing process in therapy was a process. It could never have been a quick fix. I <u>had</u> to become aware of things. This could only happen over time. That is another point I*

would like to mention. Sometimes I felt like I was not getting to the goal fast enough. Cathy validated me, and still does, where I am in the moment. This has been very important to my experience of self-acceptance. It has been vital. Cathy reminds me, and still has to as I meet new levels of my own awareness, that it is 'baby steps' ... Cathy does not rush me on this either. Cathy is affirming of my own time". As Gendlin (1964) states, to have raced in with deep interpretation too quickly would have resulted in her slamming the door shut on me. But I was also not afraid to step forward with curiosity when the door to further sharing was opened. I walked calmly but confidently into her life and this made her less afraid of her own self and life experiences. This was made easier for me as Rachel showed little resistance. There was no need for me to be in dialogue with any resistance - the challenge was rather not to fall into the trap of shaping her by guiding her too strongly. The relationship formed slowly but surely. However, it took nearly four years for her to feel the confirmation totally at her core. This confirms the importance of allowing her to move at her own pace. Once the confirmation was experienced at the core though it was a deep, meaningful experience for her and not a superficial feeling. This assisted in cementing the sense of an integrated self at the core.

This case highlights what many thinkers and clinicians, Buber (1958), Friedman (1960), Rogers et al. (1976), Fiedler (1950), Guntrip (1961), Shainberg (1983), Norcross (1986) to name but a few, recognise - that is, the psychotherapeutic relationship is a result of both the patient and therapist. Each contributes to the encounter, each influences the other and together a new and different relationship is formed. Rogers et al. (1976) conclude that the more defensive, unmotivated and reluctant the patient is, the more difficult it is to deepen the relationship. The authenticity and genuineness of the relationship can be affected by how protected the core of the patient is. Winnicott (1971) stresses that the aspects of spontaneity, creativity and realness that allow honest and genuine interaction can only be felt by the True Self. If the caretaker, protective False Self is too rigid, the therapist will be unable to enter fully and wholly into a genuine relationship with the patient. The fact that Rachel is motivated and determined to heal her damage has been one of the strongest contributory factors in the psychotherapeutic relationship and process. Despite the fear and pain, she has moved forward with courage and determination. Her genuine desire to be healed and her openness to the process has allowed the relationship to deepen. In turn, meeting little resistance, has allowed me to enter fully into the relationship.

What Buber calls the 'between' has thus been soundly established. The genuine, authentic meeting has created a safe environment for full exploration of her experiences. This has allowed for a healthy dialogue to develop in the psychotherapeutic space. Rachel has learned how to dialogue and explore with curiosity in our interactions together as the sense of isolation and loneliness has diminished. Now she is using what she has learned in the psychotherapeutic encounter to start connecting in a different way in her world of relationships.

The psychotherapeutic relationship has been formed in the mutual meeting of two people and each has a certain amount of responsibility attached to that. The therapist first has a responsibility as the trained professional being paid to provide a service. Secondly, he has a responsibility as a human being in the encounter. Gottsegen and

Gottsegen (1979, as cited in Eckler-Hart, 1987) comment on the perceived notion that therapists-in-training have that they are completely responsible for the other person. In his study, Eckler-Hart (1987) found that therapists-in-training distinguished between "therapist selves" and "personal selves" (p. 686) and felt most vulnerable when they allowed themselves to relate to the patient in an "unmediated, natural way".

I believe it important for the therapist to present a professional self in the sense that little personal information is revealed and the focus of the psychotherapy is on the patient and his healing. This does not, however, mean putting on a facade. The very dangers of the facade have been highlighted in these writings. Being authentic is critical. If the therapist fails to bring himself fully into the relationship, the patient will sense that. Any healing in that situation will never be achieved to the same degree as when the therapist is present as a real person. One of the major factors in Rachel's healing has been my genuine presence in the encounter as a human being. She feels she has been met and confirmed by another person and not simply a professional spouting the correct words.

It is also critical for the therapist to be in touch with himself and have a handle on his own issues and failings. This ensures that he can differentiate between his own and the patient's issues. The chaos and confusion in a fragmented person's world creates a whirlpool of emotions in the 'between'. Both patient and therapist are in danger at times of being sucked into the whirlpool so it is vital to be able to identify whose emotions are whose. As Rachel already had a problem with identifying her own emotions it was even more important for me to be certain of my own balance when I boldly swung into her world (Buber, 1958). This helped create a solid foundation for her as I was totally focused on her world and she experienced me as being totally present. She states: *"So it feels as if Cathy is okay to take baby steps with me ... She is not trapped in any of my own issues".*

I have taken full responsibility for what I have brought into the psychotherapeutic relationship with Rachel. As a therapist I am very aware of the responsibility one has to meet the other as a Thou and of the damage that can occur when therapists do not.

However, the patient is responsible too - for his own decisions and life. The therapist is on the journey as a guide and companion, not as an all-knowing Merlin. Buber and the dialogal approach make it very clear that both patient and therapist have a shared responsibility - although most of the responsibility must lie on the therapist to meet the patient in the most authentic manner and he must use his knowledge and training with great care and respect. I believe that caring, however, must not take responsibility away from the patient but be part of the process where the patient learns to take responsibility for himself. Responsibility means guiding and not telling the patient how to live his life. Rachel remarks: *"Cathy never told me what to do. That has been so essential to my experience of getting in touch with me. On the occasions that I asked Cathy what to do, Cathy has encouraged me to take baby steps or just hold the pain like a little bird close to me".* One must allow the patient to experience one's whole attitude as open, flexible, caring, non-judgemental and available. Having faith in the patient's capacity for growth, encouraging him to live his life without justification, accepting him as a whole with both the negative and positive aspects of the self are

important factors. This will assist the patient to grow through the fear of a new, freer existence and what that might offer and entail. However, the answers lie within the patient and his world. The patient needs to take responsibility. The challenge for the therapist is to accept the patient by allowing him to be authentic, real and become what he already is but has had to suppress through fear. The patient has to be responsible and committed to his own struggle and growth, learning to live to the best of his potential.

Rachel has struggled to make decisions and take responsibility primarily because she has been so isolated from any real connections to other people. Her mother's powerful influence destroyed any belief she had that she could stand alone as a separate being. This also prevented her developing the necessary skills and insight required to judge and evaluate in order to make her own decisions. She lived according to her mother's world.

A good example of the lack of responsibility shown by Rachel was when she having sexual encounters with two men and no-one was taking responsibility for preventing pregnancy or protecting themselves from AIDS. Clearly she needed to take some responsibility for her body and behaviour. Yet had I not taken the responsibility of pointing this out, she would not even have thought of it. The therapist must proceed with caution when making these decisions as there is a fine line between assisting a patient to take responsibility and rescuing a patient. Rescue is not the aim - the patient has to live and die by his own decisions. I am very aware of the power we can have over our patients. For example, Rachel would listen to anything I said just as she had with her mother. This was a dangerous edge and one I had to be endlessly watchful for as she sometimes did act out mental exercises we discussed. It was very hard at times not to step in more actively but allow her to make the decisions - wrong or right. This factor further enhances the need for the foundation of the psychotherapeutic relationship to be based on respect for the I-Thou. To allow the patient to live his own life even if it is not as functional as the therapist may wish it to be. It also highlights the need for the therapist to be well-balanced and in touch with his own issues. Both the therapist and patient can manipulate the situation to fulfil their own needs. In the end, the responsibility is a mutual process.

In the psychotherapeutic relationship Rachel has slowly gained a sense of an integrated self and has, thus, been able to begin to make choices and take responsibility for herself and her behaviour. Unfolding the meaning of her decisions and choices and assisting her to be in touch with and know herself has helped Rachel confront all that speaks to her in her world. For the first time, she can own her issues.

Silence is often part of the process in growth. A strong psychotherapeutic relationship provides a firm foundation for silence that is comfortable and allows for exploration. If the patient can sit in quiet reflection, without interruption by the therapist, the process deepens and the patient can absorb, reflect and make insights about his world. Gendlin (1986-7) discusses the use of silence for exploration and process and states that individuals who talk all the time are not deeply involved in the psychotherapeutic process.

Rachel has seldom allowed silence to reign due to her tendency to talk a great deal as if there will never be enough time to unfold and share her story. She will be silent if I am speaking in order to absorb information and confirmation from me. However, she seldom uses the silence constructively as stated above. This has interfered with the deepening process and may, to some degree, have slowed her progress. My belief is that she has had to learn to slow down and this has happened over the years as she has integrated from within. She does, however, do a great deal of processing once she has left the psychotherapeutic space. She takes away what she has gained and works constructively with it in her world. This is clear from the growth in her. What is encouraging is that she does explore her world by asking questions, working hard at her issues and facing her monsters. This has allowed her to get more in touch with herself and her world. So, I cannot totally agree with Gendlin's statement as Rachel is deeply involved in the process.

There have been only a few silences in the last six years. For example, when Rachel had been disconfirmed at work and by her fiancé, she described herself as feeling *"blown away"* just as the good person in her dream had been. We had sat quietly as she felt the enormity of her own self being blown away as a result of still not being met and heard in the world. On another occasion, Rachel described the incident when Pieter beat her when she was seven months pregnant. She was able to hold the pain and horror and sit quietly with the feelings then too. There was another time when we both connected deeply with emotion in the first session after Mark was born. She was able to sit in silence with me without the need to voice her thoughts. This was a recognition that the relationship between us did not always need words as I understood her so well but it was a quiet, shared moment and very special. Another moment was when I reflected that she gave love to her son with no expectation of gain and she realised this to be true. She seemed humbled and sat quietly absorbing that insight and the implications thereof.

The primary importance of the psychotherapeutic relationship is that it is a relationship. If man lives in relationship and it is the person's trusting relationship to others that has been injured and is not whole, then the healing must occur in a healthy relationship. It is only by living the experience of healthy and confirming interaction that the patient can learn to interact in a healthy manner with others in the real world. Buber's (1958) statement that the healing of the patient's world is to be found in the meeting between two people in relationship has been demonstrated by Rachel's growth and inner integration. Her experiences of interaction within the psychotherapeutic relationship have undoubtedly been a major factor in Rachel's healing as her account of psychotherapy indicates. Her final words state: *"So you see, my therapy has been a wonderful privilege of learning to be ... The wonderful, holy and awesome process continues".* Of more importance is that I always ground her experiences of her living and being in the real world in which she relates. This is ultimately the task of the psychotherapy -- to return her into her own broader world of relationships.

5. MY EXPERIENCE IN THIS PSYCHOTHERAPEUTIC ENCOUNTER:

Garfield (1992) correctly challenges and queries the therapist's potential bias when evaluating his own therapy. It was thus felt to be very important to have Rachel express for herself, her own experiences within the psychotherapeutic space and relationship.

She was requested to write about both the positive and negative experiences of the process. Garfield (1992) states that the correlation rates between patients' and therapists' perceptions of success are low. This was not found to be the situation in this case. The aim of this study is to explore how valuable the psychotherapeutic relationship is in providing a base for healing through the meeting. Thus, the patient's descriptions are highly relevant and Rachel has confirmed that the psychotherapeutic relationship is of critical importance. Her whole account of psychotherapy highlights the relationship right from her initial contact with me when she first heard my voice on the answering machine.

The above section on the therapist highlights many valuable points for the therapist to learn from. However, there is also value to be gained from the mistakes I made. No matter how hard one tries to be fully present in an I-Thou encounter in sessions, it is tiring and demanding and one's humanity and fallibility will surface. In some ways this highlights for the patient that the therapist is also just another human being who does not always perform perfectly. The patient is in our hands, however, so one has to be constantly attentive to how one is being with the patient.

Working through the case study provided me with a condensed version of six years of psychotherapy. In hindsight it is easy to make good links, interpretations and comments on the process or lack thereof. There is a bird's eye view of Rachel's life and world neatly laid out to give perspective. It is another story when one is in the process trying to gain clarity and an overall perspective. The process of questioning oneself, one's judgement and decisions, especially when another person's life is involved, is a challenging and vulnerable one. It is also challenging to lay it out on paper for colleagues to assess and make their own decisions as to what they might have done in the same situation. Writing up the story and reducing Rachel's life into a chapter, connected me in a very intense and focused manner with the horror, fears, hopes and joy that have occurred thus far on this tortuous and winding journey. I relived the horror of the constant abuse she suffered, I cried when recalling the shared joy of Mark's birth after the nightmare of violence leading up to it, I smiled at her amazement when I had laughed at her lewd and foul language. I have learned so much more about Rachel and the psychotherapy process in standing back and viewing it all with a new perspective. This has added a richness and new insight which will be incorporated into the ongoing process to further enhance her growth. Most of all I have admired Rachel for her courage and strength. To have endured what she has, with little sense of an inner, healthy, strong self, is amazing. This has highlighted for me how strong she really is - something I have struggled to help Rachel understand and appreciate until very recently. Even now it is a small ember that needs to be gently blown on to encourage further growth.

5.1 **Querying the process and my interventions.**

I have queried the process and certain interventions I made:

5.1.1 **Addressing the hallucinations**.

Rachel calmly announced that she realised she had been having hallucinations and was not psychic. She was quite relaxed and had more pertinent issues to discuss so she moved on. I did not wish to push her into any theoretical explanations to satisfy my

understanding. I respected her need to discuss what felt more significant for her that day and she genuinely seemed quite unphased. I assumed we would come back to that process eventually so we wandered down the path continuing her journey. Little was I to realise it would take nearly another year before she voluntarily discussed the issue again. Thus, it was only in writing up her thoughts on the psychotherapeutic process that she explored the hallucinatory experiences more deeply. This raised the question for me of whether I should have brought the issue up in psychotherapy. If I had not, would we ever have returned to explore the hallucinations more deeply ? If we had not, would that have made her psychotherapy less worthwhile ? Would her growth have been slowed without the further understanding ? I am only feeling that now that I am writing the case up in a clinical sense. She certainly has gained more insight although we have only discussed the meaning and sense of the hallucinations spontaneously at appropriate times since then. She has at no stage wanted to focus intensely on them. Her focus is on continuing to connect with a sense of worth. My feeling was that we would return to the meaning of her hallucinations naturally. I did not want to suddenly focus on them as being different from any other experience she has had. That could have made her feel I was viewing them as pathological just as they are in the eyes of the psychiatric world and even in certain schools of thought in the psychological world. I wanted her to know that whether she had failed to make the connection that her psychotic experiences were an altered reality or not was irrelevant for me. All that mattered was her and how she experienced her life. And that is how it will remain.

5.1.2 **Practicalities**.

I wrote about the time before Mark's birth and the abuse Rachel suffered during that period. I stated that I was uncertain as to whether it was enough to simply hold the chaos in the alchemical vessel of psychotherapy and help her through it. She would not allow any interference despite my explorations of options for her to leave for both her and her child's safety. Believing her to be in danger, and with her permission, I advised her younger sister of what was occurring. But I did not remove her from the situation. Writing this I wonder if I was negligent. The only way to take her out of the situation would have been to forcefully remove her which I felt would have broken trust at a very critical time. It may also have given her the message that I believed she was incapable of making the right decision and I wanted to show some faith in her. On the other hand, removing her from the situation may have made her feel protected, a feeling she had not experienced much of in her life. My intuition stopped me from forcibly removing her but I know that I would have had she or the foetus been physically damaged by the attacks. The fact was that Pieter had not actually physically damaged her and his track record showed he never went further with the violence. But, what if he had snapped ? It would have been too late. Where is the line between rescue and a genuine need to step in and interfere for the safety of the patient ? I feel tense and anxious as I write this and am transported back to that place. However, holding the chaos was sufficient and helped her in the fight to stand and protect herself. Perhaps it is just as well one is not always able to see psychotherapy compressed into a very compact story as it is terrifying at times and that could result in one interfering with the process. I wonder if I would have had the courage to hold the situation if I were seeing the danger through the eyes of hindsight. At the time, one simply makes the decision and handles it.

5.1.3 **Mistakes.**

I have also tried to learn from my mistakes. I mentioned that I had shown disappointment in Rachel when she chose not to re-enter the world of finance. I did not verbalise it but my tone and the questions I asked must have displayed this. I did not meet her as I should have. So, although I told her I would support her through anything she chose to do, she was terribly upset and wept that I was disappointed and maybe angry. In some ways she must have felt she had let down the only good-enough mother she had. By reacting as I did, I unintentionally did punish and disconfirm her when she made a choice and followed her intuition. It is not surprising she felt shattered. It must have felt as if her mother had come back. I was too focused on the practical and she was telling me clearly that she could NOT go back to that False Self presentation and the false world of relating where she was not true to herself. And she was right. Her growth was fortunately enough to help her stand firm in her decision despite my perceived anger and punishment. That is a very positive sign of her strength! The psychotherapeutic relationship was also fortunately strong enough for us to be able to survive and learn from this experience. Her quick recovery from the incident indicates that Rachel and I had formed a solid, trusting relationship where she was able to deal with the temporary mismeeting. Rachel's interpretation of the incident feels for me that she has blurred the feelings and time period between the incident and her subsequent insight. She was definitely shaken at the time but was calmer the next week. It is almost as if this section is written with the focus more on retrospective thought than only indicating her feelings at the time. She states: *"Cathy again expressed this concern. What came across to me was rejection, disapproval and failure. It was not coming from Cathy, it was coming from inside me. That is very awful ! I have however started to distinguish this. What was great is that I could identify these feelings in myself and explain that this was so like the feelings impaled in me by my Mother"*. Rachel and I have subsequently discussed the issue where I acknowledged the feelings and pointed out her strength.

This incident was followed shortly after by her announcement that she wanted another baby. Aware of my recent mistake, I voiced my concern with extreme gentleness ensuring I was still confirming her but my eyes must have mirrored my confusion. I was falling into the trap of assuming her to be more cohesive than she was - she had come a long way but she still had a long way to go. I queried with her how much she felt she had learned about herself and her strengths and likewise how much I believed she had grown. She understood where I was coming from but advised me that she only wanted to use Pieter as a *"sperm bank"*. Although I undoubtedly could have handled my initial reaction in a better manner, it did result in us exploring the practical realities which she had failed to even consider. I shudder when I read her response to this: *"In turn Cathy expressed that she felt afraid for me and questioned her own assessment of my progress in therapy when in a similar incident I said I wanted another baby and Cathy looked very shaken. I had not meant to upset Cathy in any way"*. I certainly did express concern which could well be interpreted as a fear and the last thing she should have been concerned about was upsetting me. My belief that one has to allow the patient to make their own choices and decisions had been trampled under my concern. Again I was too focused on the practical as I recalled all the abuse she had experienced in the last pregnancy and currently was still living with. I really believed she was in too fragile a state at the stage to have another child.

Subsequently, she has mentioned that she wishes to have another child despite Pieter's problems. She showed no trepidation when she gave me this information and I was calm and understanding. I feel that she is making this decision from a completely different space - she is not rushing in thoughtlessly but has explored this issue carefully. The fact that she is more integrated makes this a more sensible decision.

The above has highlighted a few important points for me as a therapist.

1. The boundary between guiding a patient who has few skills and becoming too practical is a fine one. One must be aware when one is becoming too involved in the process and failing to be enough of a detached presence.
2. At the time of the above mentioned mistakes I was ill and over-tired. It was near the end of the year and I was too close to burnout. This is not fair to patients as one is definitely not as alert to the process and it is easy to fall into the trap of not hearing the patient. I did not wait and allow Rachel some space to share her feelings and explore the issues. I failed to bracket my own assumptions but blundered in cutting the dialogue short. In not suspending judgement I did not hallow her experience (Buber, 1958). This could have had very negative consequences. Fortunately it did not. It certainly indicated that I am fallible.

Finally, psychotherapy is NOT just what happens in the sessions but how the patient starts to live life between sessions. What is mirrored and learned in the psychotherapeutic relationship has meaning for the interactions in the outside world. Kruger's (1988) words highlight Rachel's psychotherapy process as he states that it is a "gradual process of becoming what she already was" as she discovers that "the meaning of her life can only be revealed not explained" (p. 200). Rachel perceives the relationship and process as primarily successful because *"you chose to join me in my hell"*.

FINAL ANALYSIS:

The purpose of this study has been to explore the value of the psychotherapeutic meeting between the patient and therapist in the healing process of the patient. The argument is that the phenomenological and dialogal approaches provide a solid foundation for grounding the healing process in the **relationship** formed between the therapist and the patient. From the healing psychotherapeutic relationship, the patient is able to step back into a larger world of human relationships.

As the patient in question suffered from psychotic episodes from early childhood, this work began its journey with the exploration of how psychosis has traditionally been viewed and treated over time. There have been changes and attempts over the centuries to treat the mentally ill person in a more humane manner. Since the advent of psychology with Freud in the late 19th century, various schools of psychology have developed which have treated the human being with more respect. Sadly there has also been much development in the medical model approach advocating quick-fix techniques and short-term solutions. Despite their usefulness as an added tool to the overall process, these approaches have tended to further objectify and dehumanise the individual. So, despite considerable progress in many areas of mental health treatment, people diagnosed with the more severe mental disorders still tend to be treated as objects to be medicated and controlled. There are still too many situations where there

is no attempt to understand the individual as a whole human being connected to a context in the world. The soul of each individual is largely ignored in the search for quick fix answers and all too frequently they are institutionalised. This may be necessary in certain cases but it is not the only solution to helping disturbed people.

Society still plays a powerful role in the definition of mental illness or psychopathology. This in turn affects the understanding and attitudes of mental health service providers as well as the average man in the street. As long as the societal attitude is one of condemnation or judgement, people struggling to deal with psychological and emotional problems will remain anxious about seeking help. Anyone more profoundly disturbed tends to be viewed as something to remove from the public eye to avoid embarrassment. There is little attempt from society to understand the patient in his world. If the person does not adapt to the prevailing social norms then his individuality is judged as pathological behaviour. I agree with Friedman (1985) who states that "our society is itself sick" and that what is required is "a community that confirms otherness" (p. 218).

Hospitals and institutions are hampered by financial constraints. This is particularly true in South Africa where staff numbers at large mental hospitals are reduced as posts are frozen, new staff are not hired and even sections of hospitals are being closed down due to financial problems. Halfway houses which provide assistance to people requiring a support system in order to function adequately in the world are struggling to remain viable and rely more heavily on the private sector to survive financially. Due to these financial difficulties and the sheer numbers of people to be helped, the short-term quick fix becomes an attractive alternative to governments and health services.

But what of the individual involved in these objectifying, quick solution situations? Something has to be sacrificed in the process. Sadly it is usually the very humanity, realness and uniqueness of the individual that is lost or trampled on. This study has attempted to show how a person can be reconnected to a meaningful and yet still functional world whilst preserving the integrity and uniqueness of the self. The question of whether the patient is healed or not will differ as to whether the standard or definition of healing is based on a concrete societal norm or a humane and more realistic one. The definitions of success are widely differing as stated earlier. Has healing occurred when the symptoms have been reduced or removed ? Must this include change and, if so, how long lasting should the change be ? Should the change be at behavioural levels only or include deep, long-lasting growth which alters the person's whole way of being-in-the-world. Does healing mean fitting into the current societally acceptable values and norms ? Or does it mean coming to terms with one's own uniqueness in a space that is comfortable for each individual ? Is Rachel capable of normal functioning after six years of psychotherapy ? These are diverse and difficult questions to answer.

The phenomenological and dialogal approaches advocate that success in psychotherapy has been attained when the person is able to live and relate with other people in the whole context of his particular world. For Buber (1958), confirmation of the person as a human being is at the core of healing as this allows for some restoration of the damaged central core of the person. This leads to a unity of body and mind in health which he views as indicating the more unified soul of the person. Buber

(1958) states that the healthier the soul, the more able it is to guard that wholeness and unity of body and mind. This suggests that these approaches view change as a long-lasting and continuous way of being.

The above indicates that the goal for success is not a static, pre-defined objective to be reached. Psychotherapy is not just what happens in the sessions but how the patient starts to live life between sessions. This has significance and meaning for how the patient will cope for the rest of his life. The goal is to assist the human being to live in a more authentic manner. As stated, psychotherapy is a "gradual process of becoming what she already was" as the patient discovers that "the meaning of her life can only be revealed not explained" (Kruger, 1988, p.200). No-one passes or fails. Even if this improvement is minor and assists the patient to live more effectively and comfortably with himself and his world, some success has been attained.

There are key aspects of dialogal therapy which are considered to be fundamental and necessary for the healing of the patient. This chapter has discussed in detail the variables which contribute to creating the psychotherapeutic relationship. There are certain points which have not previously been sufficiently researched which are felt to contribute to healing. These are highlighted below and are deemed to be particularly pertinent to the current study and may be of considerable use in working with patients in general.

If we are to create a genuine, deep, respectful, sound and solid psychotherapeutic relationship in which cohesion of the self and growth can occur, the key elements discussed are necessary factors. It is essential for the therapist to interact authentically as a human being in the encounter. This requires the therapist to give his whole self in the interaction in order to provide the basis for a healing environment. The therapist must be present in a confirming manner and be open and listen with curiosity and wonder (Stern, 1983) as the patient unfolds his story. It is only possible to meet the patient as a whole human being if this is done. This meeting the patient as a Thou, a worthwhile, separate and unique person, requires the therapist to be a human being first and a professional second. Buber's (1958) principles thus stress the connectedness of two people in a real and authentic manner. Allowing the real self to meet another may feel risky and create a sense of vulnerability in the therapist. However, it is believed that it is an essential factor if there is to be any real, deep, meaningful growth and change in the patient.

The therapist should thus allow the patient to experience his whole attitude as open, flexible, caring and non-judgemental. This means accepting the uniqueness of this person and not changing him but allowing him to be authentic and real and to become what he already is but has had to suppress through fear of annihilation. The therapist should indicate that he has faith in the patient's capacity for growth and encourage him to live HIS life without justification. This means accepting the negative and positive aspects of the patient and helping him grow through the fear of a new, freer existence and what that offers. The patient should be helped to realise that the answers lie within himself despite the fact that life is unpredictable and uncertain. By unfolding the meaning structures of his existence and getting to know himself, he can confront all that speaks to him in his world. By assisting the patient to take responsibility, he learns

commitment to his own struggle and growth and can reach his own potential.

Part of teaching the patient to have faith in himself is having faith in one's own self as the therapist. This is a largely unresearched factor. This study highlights how the therapist acquires a sense of faith and trust in his own intuition with experience gained over time. If the therapist can trust his intuition, the gain can be enormous as this allows one to move more intuitively and deeply into the unknown with the patient. Intuition is a useful addition to the complex factors that make up a good-enough therapist. By intuitively having the faith and trust that Rachel's essence was good and that she would never harm her child, she was able to process the violent images in her mind more completely. Had she experienced a strong fear from me she would harm him, the process would have been slowed down and the issue might possibly have never been fully resolved.

With the key qualities present, the therapist can be open to the world of the patient with curiosity and wonder. Then the therapist is more likely to be invited into the magical world of mystery that is the patient's life. If one is honoured by being invited into the patient's world, it is vitally important to listen to and respect the patient's experiences and perceptions. This has been clearly highlighted throughout Rachel's psychotherapy. I accepted her so-called psychic experiences as the truth. Ultimately, labelling is destructive. The key to Rachel's recognition and understanding of her own hallucinatory experiences was that they were never labelled by me as hallucinations or spoken of as abnormal or pathological.

Most importantly, dialogal therapy stresses the need for confirmation of the person in order for growth to occur. Confirmation validates the patient and allows him to accept himself as a whole, incorporating both his positive and negative qualities, without self-criticism and judgement. Thus, the patient can be real and authentic too. This confirmation and authenticity assists the patient to make decisions based on his own choices which allows a sense of some control of the self in a world that has been chaotic. Freedom and choice are particularly pertinent in Rachel's case. Having had little control due to her fragmented sense of being and the powerful influence her mother had over her, this has become a major issue for Rachel. Without doubt, confirmation and acceptance have been the major factors involved in Rachel's healing.

In Rachel's case some factors played a larger role than others. Perhaps one of the most powerful contributors to her progress in psychotherapy has been her intense level of motivation and commitment to the process. She is determined to live and cope with her world at almost any cost and to be in an authentic relationship, fully connecting with her own self as a separate human being. She also strongly desires to feel authentic, deep and meaningful connections with other people as she has never achieved this. The closest she has come has been with her son Mark with whom she has experienced the incredible value and joy of relating in a real and healthy manner.

In November 1999, Rachel wrote the following about what she had gained in psychotherapy thus far. Minor editions have been made to clarify the understanding she is attempting to convey:
"What do I feel I have learned about my life and myself i.e. how do I interact now? I

have been able to see how frantically uncentered I was in the past. I mean my feelings were so uncontrollable. Not only did I not know where my feelings were coming from or why this 'not knowing' also randomly disconnected me from my feelings. Sometimes I did not feel what I was feeling. The 'I' that was supposed to be feeling what I was feeling, was not there in a form I could recognize or even relate to. I could not 'have' (own) what I was feeling. I could not earth it, ground it or bring it home to me that what I was feeling was what 'I' was feeling. This suspension of 'I' led me to a sense of pseudo-feelings almost like what I was feeling was not what I was feeling because I was not I. I could not grasp, realise or hold what I was feeling. I can now !

I was unconscious that there was even an 'I'. I understood my 'I' to be what happened to me. That was me. My thoughts that happened to me, the events that happened around me, the people that saw me and how they saw me – that was I. That was me. How people saw me – that was me ! It was terrifying and so very confusing and painful. I was not inside me. I was outside me. I was looking at me from the feelings of approval or disapproval I got from even complete strangers. Not anymore ! I am no longer beside myself, outside myself or somewhere or someone else. I am I. I am what I am. I am that. I am. What's more I do not mind anymore if a person approves or disapproves of me. I approve of me ! I am in the process of learning to understand myself and to be kind to myself.

I have been able to see how my mode of being made things very awkward and painful for me in relationship to others. I had no gradient of self exposure. It was all or nothing. Not anymore ! I'm starting to enjoy the art of living gradiently ... drop the 'g' and that is where I am heading ... living life radiantly upon the safe shores of discriminating self disclosure. I no longer think that people can read my mind. I have claimed my mind. I am claiming myself for myself – not for others.

I am in the process of learning that my particular way of being came as a result of abuse. I survived by getting out of the way, by getting out of myself – so far out of myself that I had to find someone to show me home to myself. I found Cathy. I have learned that I am not bad. I see a lot of my fears and feelings come from having been treated badly, very badly. I am learning to trace the bad feelings by connecting them to their origin which is not myself but someone else's self acting badly. I am learning to discern myself.

I am starting to interact now with more discernment. I am feeling more comfortable with myself among others. I can converse on levels that make communication very light and I now enjoy it ! I am learning to protect my core self that I am finding is very, very rare. Others may have fragments of what I have. I am no longer the fragment of others.

I am learning that the conditional expectations of behaviour within my family are actually unrealistic. The expectation of conformity among family members makes one potentially very vulnerable. I am reducing my vulnerability. Consciousness should be the measure of closeness not title. The self, that marvellous instrument that everyone else has to their own unique and varying degree and quality of awareness, is what I am learning to discern".

The above quote highlights the growth in Rachel. She has learned that she is a whole, separate person and not simply a reflection of others' expectations and demands. She has come to understand that she is not fragments of other people but a unique human being. She has discovered her self and found it to be worthwhile and not "bad" as she had always been led to believe. As stated earlier, this sense of worthiness still fluctuates and she considers this to be her *"illness"*. There has, however, been good progress in this area. The knowledge of who I is has allowed her to accept herself with all her vulnerabilities and foibles. More importantly she is able to identify and own her feelings as being a real part of her being. At last she has begun to view her own reflection in the mirror. In this process Rachel has also learned how to protect herself to some degree and not be overwhelmed by the opinions and beliefs of other people. This has freed her to make her own decisions which brings a sense of control into her life. She can make the choice. This has lessened the high expectations she has had of others, especially family, which have resulted in extreme damage to her core. In moving from the fragmented, lack of a cohesive self to forming a powerful sense of self-identity, she has reduced the terrifying sense of isolation which paralysed her ability to interact effectively. This has brought her to an important part of her journey - entering the outside world of communication and relationships with a more stable sense of self and thus an ability to interact with her real, authentic being rather than only satisfying what she perceived other people to require of her. By being authentic, she has learned to be in relationship with more comfort and congruence.

The fact that Rachel improved despite a poor initial state of adjustment indicates that healing is possible at most levels to some degree. This stresses the need for the therapist to be open to working with fragmented and disturbed people. Although this is obviously not always successful, the therapist needs to set a realistic goal in his mind and work with the attitude than any forward progress is worthwhile. At the very least the patient will have had the experience of relating with someone who shows respect for his world.

Many psychological theories, if followed too stringently, can limit one from exploring the broader philosophical principles of a general manner of relating to man. Phenomenology and dialogal therapy are not schools of psychological thought or theories, but rather perspectives that broaden one's general knowledge of man. These approaches provide an incredibly worthwhile understanding about basic values from which we could all learn to incorporate into daily interaction as well as in the psychotherapeutic setting.

The dialogal approach states that the psychotherapeutic relationship creates a dialogue which allows for exploration of the patient's experiences in order to address the issues and heal the self. The basic condition for forming the psychotherapeutic relationship is the meeting of the patient in an I-Thou encounter which provides the potential for healing and relating to the world. In the dialogal sense, I appear to have provided Rachel with an experience that is unique, meaningful and confirming. The current study has clarified that the psychotherapeutic relationship was the basis for healing in Rachel's case. Thus, it has been adequately shown that the principles of dialogal therapy have provided a solid foundation for the 'healing through meeting'. This has led to her re-entering the world in a manageable manner whilst still being authentic and

honourable to the core of her real self.

Garfield (1992) states that large sample studies may be of statistical but not necessarily clinical significance. In those studies there is often little of practical use gained that will assist the therapist in being with the patient in his world. Although many studies do provide valuable information, one must not allow the results of statistical research to hinder the discovery of what factors assist therapists in meeting patients as real people. Each patient is an individual and must be met as such. Research can provide us with essential and valuable generalities to guide us in understanding but one must meet each individual as unique and provide him with the same opportunities for growth regardless of the diagnosis. Although this study is based on one patient's experiences and growth in psychotherapy, it is sincerely believed that the information gleaned can be broadened to the wider world of disturbed patients in general. As stated in the introduction, the information gained was clarified in discussion with the patient to ensure that the understanding of her experiences was correct. Discussion in psychotherapy sessions around issues and interpretation also guaranteed that the validity of statements was addressed. By asking the patient to write specifically about her psychotic episodes, experiences in psychotherapy and the growth she believes she has attained, the attempt was made to ensure that the meaning of her experiences was clearly illustrated. Thus, the description and understanding of the meaning of the events for her was not simply the researcher's interpretation. The therapist and patient's qualities were rated against and compared with the variables discussed in chapters two and three. Feedback from other cases about process and the therapist's qualities was utilised to substantiate the information given about certain facets in this case. A further strength in this study was that the patient was sufficiently well-adjusted to be able to articulate her experiences and the meaning they had for her. This enabled the researcher to obtain a clear description of what her world was like. From this it is possible to gain an idea of the general themes and link them to the phenomenological and dialogal therapy theory. The process and therapist interventions were queried and what were perceived as being mistakes were discussed.

A weakness in any single case study is the fact that interpretation depends solely on the therapist in question. Although the attempt has been made to ensure that the reliability and validity factors of this study have been adequately addressed, there is always the possibility that other therapists would have interpreted the case differently. One of the aims in this study is to encourage questioning and further exploration of the issues involved.

The above discussion of Rachel's case and contributions offers new insights and verifies much of what the previous research findings revealed in chapters 2 - 5. The findings support that many of those factors are of value and primary importance. But it also highlights that the therapist needs to be open and flexible to explore possibilities and new ways of being with patients.

The question of whether Rachel is capable of normal functioning after six years of psychotherapy can now be addressed. Rachel may not be totally adjusted according to society's standards but she has a strong sense of a cohesive self and clearly functions better and with more strength in the interrelationships of her own lived world.

It does not require a leap of imagination to state that the phenomenological and dialogal therapy principles can be effectively used in working with other fragmented and disturbed patients. Ideally the principles of meeting the patient in an I-Thou relationship based on respect should be the basis of all psychotherapeutic relationships regardless of the therapist's theoretical stance.

APPENDIX A

PSYCHOTIC EPISODES

These episodes are a direct quote of Rachel's wording with only minor changes to ensure confidentiality and correct spelling.

First incident:
Rachel states that her first recollection of experiencing her life in a different manner was just before the age of one.

I could speak another language. I had other conversations, like memories in my mind and I could see myself as another person fully conversing in a language known to me and to those with whom I conversed. I was understood. I could communicate in this language. I could understand the language communicated to me and I had the distinct awareness that my own feelings and thoughts, I could communicate in return and be understood. The language was like a memory of me communicating. I recall my Mother and Father talking to me in a strange language. It was not long before I understood that I was supposed to learn their language and communicate in their language. It was then that I recognised that I had no power over my mouth or tongue muscles. I wanted to talk as fluently as I knew how to them and show them that I could talk ! I knew that it would surprise them and possibly shock them because even then, I received a form of guidance that this was not supposed to happen. I was comforted in my struggle with my tongue and mouth that because it was not supposed to happen, it could not and would not. I felt quite desperate and continued to struggle to communicate in my own language. My effort was blunted by my Mother laughing at me when my efforts came out garbled. Her affections did not penetrate into the awareness that I just might be struggling to say something.

I became aware of my consciousness familiarising itself to the new language. The energy was going into a direction of learning. As this happened I was gaining control over my tongue and mouth muscles. I became aware that the energy to learn was leaving my memory of my strong knowledge of another language. The knowledge of the other language was fading. I felt desperate. I decided that use of the energy to learn was going to erase my memory altogether of the language I knew. I did not want this to happen. The memory was fading fast, as my awareness increased into the existence and stimulation and encouragement from the life around me. I decided to look at my Mother and hold her eyes to try to communicate via my awareness. She did not see. I was treated as a baby. I was not a baby. She did not see my awareness. I could not communicate my presence in another language. My memory was slipping of the language. I knew I would lose all recall so I decided to try to hang on to at least one word ! A word I could bring to the world as proof and recognition that what was happening to me was exactly the reality that I already knew would be denied in the world. I was determined. I had the word but then the stimulus from the outside world started to eclipse my memory even of that word. I was very sad that this effort was so hopeless and I could do nothing to prevent the slipping away of my language memory. I remember being so sad and unhappy about this that I decided my protest would be to not learn the language spoken to me and even as I learned it automatically, I decided I would not speak it.

I think my decision went against a certain law. I did not care. I was going to hold out in despair of great truth being lost even if it impaired me in new language. I felt without any objection or concern a presence that came to me and said this was not okay to do and I argued my position. I was given the agreement from this presence that the word in the language could not be given to me and that it too would fade. I was given the accord that I would be granted the memory only that I knew and was able to fully converse in a different language before I gained control of my body muscles as a baby. It was a small consolation. One that I did not accept too happily. The word faded and all I had to go on was the consolation given earlier. I knew I could trust the consolation as an absolute but I also realised that the task ahead would be more difficult to establish in the unaware world into which I was growing. This made me sad so I decided to use my skill in language to learn the language not as a baby but as a full awareness in a unintelligible world. I wanted to express my awareness of language by mastering the language as I heard it in the world. I thought that this may have helped but it was only a small effort placed in this regard because as I mastered the language and managed it into sentences, I received applause and laughter that I could do such a thing and not once did the awareness of those around me,

look deeper at the deeper significance of my effort. This result quickly erased my efforts.
I recall the colourful rattle toy my Mother draped across my pram. I recall she looked at it with much happiness and enjoyed it more than me. I remember her telling me to look at it and she played with it as if to show me what to do with it. I distinctly remember thinking how stupid this was and asking myself what it was for. I remember thinking, if only she knew, if only she could be aware that I am not the age or awareness of the body I was having to learn to master. That I knew with every effort to apply my energy into learning control over my body, my memory would slip. My Mother physically showed me what to do with the toy to make it rattle and move and I recall thinking, how stupid, so that is what it is for. When I tried to lift my arm and reach out to the rattle, I remember how difficult it was to control my arm and the delight from my mother that I was trying. The joy my Mother expressed made me feel quite hopeless in my effort to express my thoughts and knowingness that were fading as I gave in to the effort I required to master my body.

When finally my memory and language and the word in my language were erased, I knew it was gone. I decided to hold onto the knowledge that it was gone, that something was gone and not to forget ever. That was the gift that I received and decided to hold onto that was given in consolation towards my effort. Though I have lost memory of the language, the words, the grammar, the very form of the language, I do recall that it was very different from English. I recall the vibrations of the words and the texture of the language but have no recall of even one word that will give me a map to the languages of the world against which I could trace the language that I could speak within my mind when I was a baby with no control over my body. I have not one word with which I could seek out and find my language and be 100% certain of identification. I am aware, to this day, of this loss. That this is the form which was decided and given to me as a baby in which I would retain this experience. I had no choice and this is a gift, a consent.

Rachel's reaction:
I was quite anxious at first because I wanted to communicate to others. It felt like I was ignored because I could not communicate to my parents and their friends. I did not understand the language I was born into. I felt ignored because I could not speak and I wanted to change that. As I realised that my muscle control was not efficient and that I could not articulate my tongue to say the words in my mind, I felt frustrated. I wanted to talk in my language even if others did not understand. I felt sure, someone would recognise a different language and the feeling of being ignored would then be removed and they could then understand a lot more. There was only very little comfort when I was made aware that I could not change things, that I was not supposed to change things as they were. I felt in the presence of higher beings who gave me this advice and who tried to comfort me. They did not succeed but they did say there would be more and I would open the dimensions to connect with the earth dimension of consciousness, in time. They did not say this to me in this way, but I was assured I would connect, not fully though, the passage way between the two dimensions, worlds. I felt like I was given, in recognition of my sorrow before such unawareness and knowingness that I could understand and converse in a language, I was given a kind of reward. I would have a thread, like a single thread, in the future, only when I was grown up, to connect the two worlds. It was not enough. I was still angry that I could not reach out and be understood. I do recall that I was very upset so I asked if I could have just one word which was denied. I was very unhappy that this too would be taken. I felt sure, that with one word, I could prove my language as soon as I could linguistically articulate it. Again in recognition of my despair, I was told that I could do nothing about it but struggle, and struggle I did.

I recall losing my last word. I could not get it back. It was gone. I tried and tried but it was gone. I remember the day. I woke up, and it was gone. At first I was able to hold onto a whole story and then it became a sentence and then a word and then nothing. It was gone. I knew I could not get it back and there were other things to concentrate on like growing and using my effort to develop muscle co-ordination and vocal co-ordination. I did remember that my language was gone. I did remember that there had been a body of persons advising me and watching over me. It was not them that stopped me from speaking, it was the condition of the human body I had in infancy that obeyed other laws that could not be broken even though I tried. I was not alone because I did have the advisers and comforter but my will was even against their will and the laws of the human condition and in this I felt betrayed even by the spirit council. This spirit council was like a group of elders in spirit wisdom. They were not visible but I felt them and received their presence as if they were behind me. Even lying down in the cot, they

were mentally behind me in my mind not in physical reality near the cot but behind my mind behind my consciousness.

I felt the spirit council presence as if I knew them and they were familiar to me. I felt them with acceptance but with anger when they would not break the rules of the human condition and the laws governing lives here in this world. They said they could break the rules but that would be breaking higher rules that I was not aware of and that would not be good and it would have very wrong consequences for all. This would include those to whom I wanted to communicate and I did not want that to happen because I wanted them to be enlightened not harmed. This is what made me acquiesce. It was this argument. When I asked about the higher rules I was not informed. I was told. It was not for me and that my direction was human life. I was prepared to die to bring the knowledge to the earth, but that was not accepted. I said I would give my life. It stalled the spirit council and bought with it sombre and deep tones. It felt like resonating with such great love it hurt them. I could feel this from their communication to me when they came back to me, but even that did not change the rules to ***allow me to speak from the crib!***

Second incident:
This occurred at three years of age in the garden at home.

My older sister and I were outside in the garden. She was in front of me at some distance. I stood up to walk over to her and felt myself being thumped very hard from behind on my left shoulder. It was a powerful thump that sent me flying. I fell but did not hurt myself. I started to cry, not because I had hurt myself, but more from the shock of being thumped so hard. I did not know why I had been thumped and that was also a shock. I looked at my sister and thought that somehow she must have been the one who thumped me. My Mother ran out of the house and picked me up. She was in quite a state. I accused my sister and she said "no" it was not her. My sister looked surprised and concerned. My Mother said she did not know what it was that thumped me so hard but it was not my sister as she had seen what happened.

Rachel's reaction:
Before being thumped I felt a presence that was gathering force like a ball of energy waiting to explode. I was concerned and wanted the presence to go away. It just got bigger. I could not see anything but I could feel where it was and that it was like a ball getting darker and darker. Rather like seeing a person go from calm to very angry until they hit something. I was really scared. Firstly, I felt being thumped and it was hard and a real knock. I did not enjoy the suddenness of the thump nor the force with which it threw me and that it actually hit me. That was shocking. That it actually hit me and I was doing nothing but playing in the garden. That it was not my sister who knocked me made me feel even more scared because my Mother had not seen anything hit me so she could not defend me from something she did not see. This made me scared and anxious. It worried me for a long time. It was not the first time I had felt being touched but it was the first time I had been knocked over very hard. I had been touched before but it did not hurt or worry me. It was like little pats that did not worry me because they did not hurt even though I could see no-one touching me. It was just something that happened that did not worry me until I got a huge clout. From then on I did not want to be touched, patted or knocked over again. It felt like all the pats were just a build up to a huge knockout and I did not want any part of it and I did not want it to happen ever again. It did not. The earlier pats took place only over a period of a few days on and off before the big thump.

Third incident:
This occurred at the age of eight in Rachel's bedroom and is the incident in which she believed she connected with 'aliens'.

I woke up and saw people in my room. They were adults and they were talking among each other. The room was filled by their presence and there were about four or five of them. I then noticed that they had noticed I was observing them. One of the men came over to my bed side. He crouched down to bring his face to eye level with mine. He had bright green eyes and his face glowed light from inside him. He smiled at me but it looked all too glary bright and out of the ordinary because the lights were off and the

room was dark. I looked at his face and his jersey was of a most unusual knitting pattern. His smile and eyes just seemed to glare brightness at me and seemed to penetrate into my own beingness with intensity that I shut my eyes and started to feel very frightened. I said to myself that I would shut the sight out by closing my eyes. I was so afraid I could not even move my body. Hoping he had gone away, I opened my eyes just a fraction to look, and was shocked that even with only barely opening my eyes again, his full face and smiling menacing glare came full into view. He said he would not go away and would come back again. I was terrified. I then, with great resolve, managed to turn my body over to face the wall. It was then that I went to sleep, determined to sleep and find safety there to shut out the images in my room.

The next day I had full recall. I tried to tell my Mother, but she brushed what I said aside and said it was a bad dream. That night I was terrified to go to my room to go to sleep again and insisted that the door to the room be open and a light outside in the passage be kept on. I got into bed and in terror began to watch the room for the people who had been there last night. Then it happened. I was petrified to see forms taking shape out of the safe form of the door handle, a larger form of substance grew out of the shadow shape to the door handle and grew into the presence of a person. I was horrified. The room again became full of people. They were having a serious discussion. What they were saying was of a theme of secrecy and urgency. There was the same man who came over to me and again with his face very near to mine, with the same light in his face and menacing smile, he looked into me again. I went into a cold sweat, shut my eyes tight and said I could shut him out and I would not see him. I again was very frightened and willed myself to sleep.

The next day, I told my sisters how scared I was to go to sleep in the night. That in the day, all was okay but night time filled me with terror. My Mother and Father insisted again that I was having a bad dream. My Father said I should pray the Our Father if I saw the people again. That night, the appearance of the people again came about before I could go to sleep. There was a speed of appearance this time, as if they all knew I could see them and their appearance was without restraint. Only this time it was very different. The conversations became loud and fierce and then a fight broke out. One of the adults drew a knife and stabbed the other man who fell. They dragged him across the room. I was so afraid I started to pray the Our Father, at which point a small white light appeared right in the centre of all the goings on. It grew into a small white angel of intense white light that was not of a kind that extended itself into the room. It was white self contained light. At that moment the passage light went on and I could hear someone coming out of my parents' bedroom. The images scurried for cover with one of the men coming to hide right behind the dresser next to me. He saw me observe him and commanded me to "Shhh" then disappeared. When the room had returned to normal in the few seconds, I dived out of bed and ran to the passage, throwing the door open where I saw my Father, fully dressed in his day clothes coming out of his room. I ran into his arms crying and explaining the people were in my room. He held me in his arms and asked me if I had prayed. Yes I said feeling certain that was why he had come out of his bedroom on his way to the bathroom just when I needed him ! He encouraged me that all would be alright. I told him what I had seen and he said all would be fine now and I returned to my bed and went to sleep feeling better.

The next day I was in happy spirits that my Father had been there at the precise moment I needed him and that the people had not come back. My parents did not inform me then, that my Father had not come out of the room and he only asked me what he was wearing. I told him and that was the end of the discussion except for the fact that there was a scratch across the room where I had seen the people drag the body. I pointed it out to my parents to make them believe what I had seen. They did not believe that part and I was puzzled. The mark on the floor was there. I had not put it there and I had seen why it had appeared. My Father, I was later to learn, had no recall of coming out of the room to comfort me. I was sure it was my Father who came out the room and even as my Father said he did not remember, I knew that my Father came out his bedroom and I had seen him do so. He asked me what he was wearing and I explained. That he had come to my rescue was all that mattered to me whether he could remember or not. The people then went away after that night and no longer appeared to me. My Father had not come out of his room that night, and my parents decided that the house was haunted and we moved to another house as a consequence to another incident that made me scream in such terror I frightened my eldest sister who recalls the incident. I was not to know that my parents had decided to move from the house due to these events until some ten years later when the event by casual discussion

came into our conversation. I was quite astounded by this news because at the time, my insistence of the event was treated as if I was dreaming bad dreams.

Rachel's reaction:
It is disturbing in its lack of explanation to this day, as to why I say a man get stabbed and dragged across my bedroom floor. The experience of seeing people in my room began with the sight of a man at eye to eye level very close to my face with his whole face glowing brightly in front of me even if I just squinted my eyes open to peek a look. What frightened me was that his whole face appeared in front of me which was not as in the normal law of seeing. If you squint, you only see partially. That was not the case with seeing the glowing being whose face was close up to mine and smiling a row of many white teeth that appeared rather intimidating to me because smiling was so rare in my life. The glow from the face was not normal to life either and this also unnerved me. My fear was due to the unnatural to life appearance and experience of seeing fully even when I wanted my eyes to see partially. This caused the terror and fear because I could not relate this to my family with any hope of understanding or appreciation. That the experience took place at night when everyone was asleep further removed the credence of the experience and this also made me feel very unprotected.

When I saw the angel preceded by a few flickers of white points of light, one at a time to only then disappear, I concentrated my fervour in prayer and the angel appeared like a white flame. I was very happy and felt only then that something had come to protect me and to save me from the terror I was feeling. I felt happy and very content and then the passage light went on.

Fourth incident:
This occurred in her sister's room when Rachel was eight year's old.

My older Sister, my Mother and I were at the swimming pool. It was a sunny day. We were at the pool side and I had left my towel behind. I was too afraid to go and get it by myself as the people in my room had been appearing to me and I did not want to be alone in the house. I asked my older Sister to come with me and she refused. I needed my towel and would not go alone into the house. My Mother told her to go with me so, with a sense of security and safety, we went off together to get it. When we got to the entrance of the house my Sister said she would wait for me outside. No I insisted starting to feel afraid. She was very kind and said nothing would happen and that there was no need for her to come into the house with me. I insisted but she assured me and said I should run in, get my towel and run out. I was almost sure something was going to happen but she was not and was not going to come into the house with me. I took a deep breath, ran into the house, into my room and grabbed my towel, turned and walked quickly out. Passing my Sister's room, I got the fright of my life ! There in her room were red gnomes with one of them with his head in her beach bucket. They were only playing, I knew, but it was not right that I should see them. I was so instantly shocked, I let out a scream of terror and ran with all my strength to get out of the house. My Sister heard my scream from outside and by the time I reached outside, I was crying from terror. She was quite shocked and said she was sorry she did not come with me into the house as I explained what I saw and promised never ever to go into the house alone ever again. I was crying and Mother came to see what was happening. I was so distraught that my Sister explained to my Mother what I had seen. I was very frightened. Mother took me in her arms and calmed me and we returned to the swimming pool after she assured me she would tell my Father and they would do something about what was happening.

Rachel's reaction:
I felt ready to die. I was so unhappy and I felt so sure that I would not be believed. There was comfort in my older sister's concern that I looked as white as a sheet when I ran out the house but that did not remove the terror that I was the only one getting to "see things". No-one could comfort me that I was seeing things and this was very distressing.

Fifth incident:
Rachel was fourteen years old when this event occurred in her bedroom at home.

I had decided to enter the school diving competition. I had only two dives that I could do to some extent. I needed to have a third dive for the competition. The only one I could think of doing was a dive I had

never done before and that was complex and dangerous to perform. The dive was done by taking three steps down the spring board, taking the jump and then reversing the direction in mid-air to go backwards down into the position. The danger was that one could seriously hit one's head. I was encouraged by my teacher to enter the competition as my two dives were in good form for the competition. I was quite anxious about the fact that I had decided to go ahead and enter with a mind to perform the dangerous dive for the first attempt in the competition. I felt that in a way I was doing the wrong thing. I struggled with my decision after having taken it but was determined to see through my choice. The competition was to be held on that Saturday. I was unaltered in my plan.

On the weekend before the competition I was riding my bicycle and had a thought enter my mind that something bad was going to happen to me. I had a thought that I might harm myself in the diving competition but I put the thought out of my mind. Yet still, I had a most vivid thought that said something bad was going to happen. I prayed to God, as I cycled along, that nothing would happen to harm me. The thought came into my mind that something bad would happen because I was good. That really did not make any sense to me and still the thought went on to explain that I should not worry, that what was going to happen, was not because I was bad and that I was being punished. The thought ensured that I was good. I did not understand my own thoughts and pushed them aside. I was puzzled.

On the Thursday night, I woke up in the middle of the night. I woke up gently, not sleepily, but clearly and gently. There at my bedroom door stood a beautiful golden glowing person in a long molten gold to the floor garment. I could not discern whether the person was male or female. The person's face was also golden and the features were chiselled and perfect. What a beautiful sight. The hair was thick and gently wavy in thick locks of golden brown shoulder length in a glow of light. Standing at the door, the person said, "Do not be afraid." I was instant in my response, "How can I be afraid ? You are so beautiful !" The person smiled, and as if my reply had given the person the way to now come near to me. Smiling, the person came right up to my bedside and crouching down to face me, told me not to speak, but to talk with my thoughts so we would not wake anyone. I was happy and excited to feel the radiance of the being with me. I was very happy. The being said to me that there was news for me. I was at once curious. I was told not to be worried. That God did not want me to think I was bad because an accident had to take place in which I would be slightly hurt. I asked why such a thing had to occur feeling quite worried in that very instant. The angel person asked me to remember the diving competition. "Yes ?" I answered. Then it was explained to me, that my decision to dive at the competition was going to lead me to do the dive in front of all the people. I was shown, as if on a movie in my mind, that my dive would result in a head injury in which I would be killed. I was very stunned and the angel person then continued to say that this was not what God wanted for me and so I had to be in a small accident to prevent me being part of the competition.

I understood, and then basked in the Angel radiance and presence of happiness and goodness again and said I did not want her/him to go. The Angel said, with a smile, that she/he had to go now. Then with great anxiety, I asked if I would remember the visit when I woke in the morning. "No it is not for you to remember" I was informed. I begged to remember because of the exquisite beauty and happiness and joy I felt. I was informed again that that was not the plan. I begged and then the Angel said that I would be given a small reminder but I would not be given anything to remember in the morning. Then the Angel said goodbye, smiled, told me she/he liked me very much and left. The room returned to darkness and I fell asleep.

The next day, true to the words spoken in thoughts, I did not recall anything. The day was usual. I went to school on by bicycle. On the return journey home after the day's school classes, I was riding together with a few friends. A boy in my class, rode up next to me, which was somewhat unusual. He said a few things and I exchanged comment and then he did a most extraordinary thing. He lifted his leg up and kicked out his foot against my bicycle handles and sent me flying in somersault over the handle bars at full speed. I went crashing to the ground. my face hitting the tar road and in that instant I blacked out !

In the blackout, I had full recall of the Angel visit ! As I returned to conscious I felt the urgent need not to let the memory go. I had to struggle. I knew I had to remember ! Returning to consciousness, I had to force myself to concentrate on the memory I received in the blackout long enough to keep the memory

and be able to return to it at a later moment. Blood was all over my face and school uniform. I had to be taken to the hospital to receive stitches, but that was the minor incident. The main most important thing had happened. I had remembered!

I did not tell anyone. Then, when my parents came to find out what had happened to make me take such a severe fall, my Father went into a rage. He was going to sue my friend's family for every penny they had, he said. The assault was without provocation and it truly was without provocation. Even at the time, I felt it most strange that he should do such a stupid, uncalled for action to make me fall and hurt myself. As my Father was serious about taking the boy's family to task, I felt I had to somehow tell my parents to back off because what had happened was the event to save me from death in the diving competition. I quietly told my Mother to tell my Father not to harm the family. That provoked my Father into a deeper rage because he then told me that my choice of boyfriend was totally incorrect. This boy was decidedly not my boyfriend and so I had to explain further, regarding the visit of the person I saw in golden garments.

At first I was quite cautious about explaining because my Father said he thought I was trying to protect the boy. Eventually, I had to become quite forthright about the incident and, with great clarity, I told both my parents that God did not want us to hurt anyone. That my accident had been created to protect me from a diving accident. I told my parents about my decision to do the dive I could have attempted that would have placed my life in danger. I was very forthright about God not wanting us to hurt anyone. This succeeded. My Father did not pursue legal measures even after he had threatened the family of such action. Nothing was said again of the matter.

Rachel's reaction:
I was not going to say anything to anyone because I was so used to hearing "Yeah yeah" response. It was only when my Mother said that my Father was going to punish the boy's family that I felt I was now duty bound to prevent a court case. I had to convince my parents not to do such a thing because I was spared and they had to not be angry with anyone. It was very important to stop them. My Father said I was just too scared to go to court and that I was making up a story and that hurt. There was some comfort from my Mother who was not so quick to disregard what I was saying and she took up my cause and won on religious grounds and persuasion. I had said I would have no part of any fight in court. To go against my parents was not comfortable, but what had happened with my Angel visit had happened and there was no getting past that. It happened and bad could not come of it. It just could not. I could not.

Sixth incident:
This occurred in her bedroom at the age of sixteen.

I woke up. I felt something was about to happen. There was an intensity, a frequency of some kind that I could feel. The room was in a natural soft dark shadow. It was night time. Something was going to happen. I could feel it. Something imminent was about to happen. I felt a white being at my right shoulder. I was comfortable with the sense of the being in white light at my side. The presence of the being seemed to be quite natural and comfortable. I felt it communicate to me to be unafraid that yes something was about to take place and at no stage would the being leave me. Then I saw it. It was a purple light. It had a life of its own. A cobalt purple light that appeared in a dimension all of its own I noticed. It appeared as a small spot of light appearing out of a great distance while yet against the cupboard door that was near to my bed. The light had its own dimension and was imposed against the normal regular dimension of my cupboard distance from my bed. This was the first strange thing to me. I reached back in resistance to turn to the being at my side and received the communication not to look at the white being at my side. That the being is my guardian and that all would be well. I looked at the light and sensed a velocity of speed as it was in high speed as it travelled into view and grew in size. When it arrived fully in my room, it was a ball of purple light that took on a solid form of a small little beast of a blob of animal but not animal appearance. It had a long snout and black eyes that glinted at me as it seemed to see me. It just looked at me. Pretty harmless, I thought. So, now what I thought. The being next to me informed me to pray the Our Father. I did so and as I uttered the words, the little, strange looking thing let out a huge scream. It snarled and its mouth curled back over its teeth. The white light being said I should keep praying and as I did so, I noticed that the words of the Our Father

seemed to be killing it. It could not come near me and it went backwards into the ball of light and reversed back over the same path which it had appeared in my room. Then it was gone. The being of light was still with me. So. What was that for I asked. I felt safe and was informed that the prayer I had said had been my protection. I knew I was safe and wondered at the intense frequency I had felt ahead of the thing coming into view. I felt sorry for it because it looked as though the prayer had strangled it and like it was in intense agony as it reduced in size and vanished. I had also noticed its intent to harm me if it had been able to attack me in defence but it was unable to harm me as the white being had assured me. That was the only remotely scary thing about this event and the frequency of speed of an approaching dimension was the scary part. I felt throughout the incident that I was safe and in no way did I feel that I was in danger as I was assured that the prayer would protect me and that the being of white light was near to also help were it necessary. I was quite puzzled after the event. I noticed that I was not so scared and that was a comfort. I was disturbed that there was a dimension that had made itself visible to me and that its intensity was greater than the intensity of the regular world. It had interfaced over it like a live hologram.

Rachel's reaction:
I had felt protected from the very start of this experience. I felt rather puzzled as to the meaning of the experience in the first place other than to convey the power of the prayer the 'Our Father'. It left the question in my mind ... was I going to need it in the future? That was disconcerting to feel I might be alone in the future where the only thing I have to hold onto is the prayer 'Our Father' where even my protection would be removed. I felt worried but not too worried because I had felt protected through a very bizarre experience.

Seventh incident:
This occurred in Rachel's bedroom where she had seen the purple light described in the previous incident. She was seventeen years old.

I woke up with an instantly fresh and alert mind. I had for some months been doing yoga meditation. This was done in my room alone and the feeling I got from the meditation was simply a feeling of my body becoming very heavy and then like a concrete cask. During the meditation I had become aware of a cloud like vapour above my head. Like a dark rain cloud. I was disturbed with it and did not like the feeling of it being over my head. I could not see it. I felt it. Rather like if you have to walk under something and you see it and even while looking away, you know it's there. You know it. Like that, only I could not see it. I knew it was there and I did not want it to be.

Over the days, the grey thing above me grew. I was perplexed. I sought to be in a state of goodness and went through my conscience with a fine tooth comb. I could not find any error or guilt in me. I knew if I were to die, God would receive me, yet this grey thing persisted. It started to worry me. I was seeing a 72 year old Swami at the time on weekly visits. He was a holy man and I went to him to listen to him and be in his presence. I asked him about it and he told me not to worry.

The night that I woke up, suddenly, fully awake and clearly conscious, was the night of the evening when the grey cloud above me had moved away from me, off centre to above my head and in the corner of the room. It was quite large by now and still bothered me. It did not disappear from my awareness, but continued even after that night I woke up and saw, in a yoga lotus position, a beautiful sight of a beautiful looking man in a bright orange tunic and turban. His eyes were large brown and he had a wide and generous forehead. He looked very beautiful and was levitated off the ground in the centre of my room just away from the spot I usually sat to meditate. As I looked at him, he looked into my eyes and I realised that if I as much as blinked, he would vanish. I regretted this knowledge as his appearance was very beautiful, especially as he was levitated about eight inches off the ground and his face and eyes were soft and good, filled with warmth, seeing and connection with awareness of him. He knew I saw him and it was as if he was there to be seen and I was to see him only for a second. I panicked that I would not remember this, so I quickly scanned his face for a feature that I could remember in the morning. I took in his eyes and forehead, and then blink, he was gone. What a pity ! He was so welcome. The sight was too brief I felt. I felt only sorrow that he had not stayed and that he was lost in a blink !

I was to recognise a photo of this Yogi when I was in London the following week on my first holiday in Europe with my parents and younger sister. In the three months ahead of the holiday, I had planned with great excitement to visit the Swami at the Ashram in London, the very first day of my visit. I would spend my pocket money on books from the Ashram and then read them in the exciting hotel lobby my Mother had described with great excitement. My parents were informed about my plans on my first day in London and I was looking forward to this highlight. The cloud had not gone when the time for the holiday at last came. All went well and according to my plan. I went to the Ashram in Hollard Street. There I was made welcome and as I waited for the Swami to come, I was left in a room where some photos were on display. In the photo album I saw the picture of the Swami I had seen in my room in the blink of an eye. I asked who he was. The Swami who received my question was curious because I had singled this photo out from the many different pictures of Indian looking people pictured in the album. I told him I had seen him. He asked me when. I did not want to go into any detail so I answered simply, about a week or two ago. The Swami replied with a gasp, "Oh strange, he has been dead for over one hundred years" ! I felt embarrassed so I said, well I had seen him in a dream and remembered what he looked like. The Swami asked if I was sure. I affirmed yes, and then he returned to me with a book all about the Yogi I had recognised. The Yogi, in his life had been a very holy man and his book is highly regarded about his miraculous, holy life. I bought the book and was quite thrilled to read about him in his Autobiography of a Yogi.

On my return to the Hotel with my new books and a mind to enjoy them in the hotel lobby, I felt again the grey cloud. It angered me. Why ? Had not what had happened been the end of the cloud ? I felt very perplexed and wondered what God was doing. I knew that my soul was in a state of goodness and yet this contradiction of a grey cloud following me was more intense than ever. Walking back to the hotel I was in conversation in my head to God. I was angry now and then, out from the sidewalk an unshaven, scruffy looking man appeared and walked up next to me and started a conversation. I looked at him and saw him to be rough in appearance. I spoke to God in anger and said to him I would not trust him again as I was told I was safe and now look. This man was definitely not safe to be with and he had attached himself to me and walked next to me on my way. I was furious with God and in answer to my thought that I would not trust God again I asked what God expected me to do. I was, in thought form, advised to be polite to the man next to me. I was appalled. It didn't make sense. I quickened my steps and my thoughts advised me to hurry to the hotel and that once inside I would be clear of the man who would not follow me into the lobby looking the way he did. I quickened my steps and as I got to the hotel I rushed inside and there saw my younger Sister. I rushed to her and said I had been followed by a terrible man ! I insisted she come with me to the hotel room as I did not wish to risk being alone with him possibly following me at a distance. My Sister asked me to point out the man. I looked around and could not see him. My Sister said he had gone and that all was okay so I said okay and that I was going to sit down as I had intended to do and read my new books. I went over to sit down. I put my two heavy plastic bags of books down and noticed a brown package tucked under the chair next to me. I had no concern for it and as I glanced up, I saw the man again, who had followed me. I felt a sharp rush of panic and dashed up off the chair, grabbing my bags, and running across the foyer looking for my Sister and heading for the lifts. I found her and, not wanting to go without her, I grabbed her arm with force and insistence. I explained I had seen him again. Where, she asked. I looked again and saw him. "There" ! I almost screamed, and not really worrying if she saw him or not, as the lift doors opened we both hurried inside. As we got to our floor we got out the lifts to go to our room. As we were opening the door a huge explosion went off. We rushed into the room shutting the door and rushing to the window to see what it was. We saw the people on the street below as if they were frozen in their tracks for a split second before turning to run like mad people screaming in the opposite direction.

My Sister and I did not understand. We decided to go and see what happened and as we opened our bedroom door, a thick blanket of grey smoke like a wall met us. Sixty four people had lost their lives in the first IRA bomb attack on a London hotel in the Hilton lobby where we were staying. The brown package I had seen moments ago, I think must have held the bomb that was so devastating to cause the glass windows to shatter glass across two highways in front of the hotel. I had not trusted God. I had said so. I was very sad at this realization. No-one in my family had been hurt.

Rachel's reaction:
The build up of grey cloud that I felt over my head but could not see, was very worrying. I did not know

what it meant at all. I felt guilty yet I could find no reason to feel guilty. I could not relate the grey cloud to anything pleasant or worthy. It was not something I wanted in my life. So it was very upsetting and it would not go away. I could go away from it by aiming my awareness to daily life but it would not go away from me. It would make itself felt in quiet moments of reflection and contemplation that were part of my meditation exercises that I was doing daily. The cloud got bigger and seemed to have a life of its own, quite removed from my will for my life to be cloudless. There it was. In my conciseness and it was going nowhere, just getting bigger.
I was very concerned because I could not see the run up of events that were to take place in London that would occur and save my very life. I could not see the future and if I could, I would fight not to be there even though I would be unharmed.

Eighth incident:
Rachel married at this stage and this event occurred in her bedroom in Italy at the age of twenty two.

I was missing my husband dreadfully. It was a most stressful period of my life as he was working in Libya three months at a time with two week breaks back in Rome where I was staying with my Mother and Father-in-law.

One night I dreamt that my husband was slouched over the steering wheel of his car with a dagger in his shoulder. I felt the pain in my own shoulder that made me recall the dream and consider it meaningful. When I woke up the following day I recalled the dream and pondered the feeling it had left in my emotions. My shoulder was feeling the pain. It was distinct and as I thought about it I felt a presence, in a dark shadow form, stand before me and ask me if I was willing to let my husband go. I thought about it and said no.

He returned from Libya early with an injury to the same shoulder I had seen wounded in my dream. He explained that he had received a powerful electric shock that had been so strong as to throw him off his feet into unconsciousness. He only survived due to the quick thinking of a colleague who unplugged the machine that was carrying the voltage that tore the nerve endings in my husband's shoulder. It took four months before he was fully recovered.

My husband returned to Libya and again, some several months later, the shadow presence came to me asking me whether I could let my husband go. This time, I had no dream of any danger or harm that my husband was facing. I questioned the presence and was informed that if I was to say yes, that I wished to be released, he would die. That was too much for me to contemplate his death and yet I was informed that he would die as I requested release, in that moment ! I said no. When my husband returned he told me he had gone fishing and had swum too far out to sea. It was dark and he started to sink under the water. He explained that a good feeling came over him as he drifted down under the water. I was amazed ! My husband had never before or since, explained any such supernatural type feelings. I did not tell him of my experience. I found out that it happened at the same time as my husband felt he was drowning. He said he desired the peace he felt in the experience that lasted the few minutes that the presence was with me asking me if I wanted release. When I said no the presence was gone with the affirmation that my husband then lives but only upon the strength of my prayers. At that time, my husband then experienced a vision of me under the water with my arms open and calling him. I had prayed for nothing to happen to him after the presence had left me and felt the urgency needed in my prayer for his safety. I was most concerned, but after a while, I knew all was well.

The shadow presence came to me again after my husband and I had returned to South Africa. I was asked by the shadow presence whether I needed to suffer more as there were heavenly beings that were most caring of me and my situation. My marriage was a brutal experience. I felt the compassion and knew that outside my normal vision there were numerous beings that cared about me. I felt the truth of the shadow presence and the concern. Once again I was asked if I could let my husband go. I knew by now that this meant his death so I argued that it was not Godly to say yes and so be the cause or desire of anyone's death no matter what my suffering. The presence did not leave but stood, as if held in sorrow for me, and again asked me if I was now ready to let my husband go. I thought about it and then took a most bold step. I answered with my arms open wide in image of Christ the crucified. " May the will of God be done, I embrace my destiny." I did not know if I was the one who was going to die after

I affirmed my final answer. Aware of this, I was most conscious of the events in my life and the time that lapsed.

The shadow presence was not something I saw with the naked eye. It was a presence felt and can only be described as a shadow presence that does occupy a place and form that is felt not seen. Some three months later, my husband was killed in a tragic accident.

Within the three months before the death of my husband, I was to meet a most wonderful human-being who was to greatly assist me with my hotel and air arrangements to Rome where my husband was buried. This wonderful person had his own travel agency in Rome and he instructed his friends and colleagues to ensure my security and safety in all ways possible. The Italian hospitality, care and generous attention I received due to my new acquaintance and his friends, during those sad circumstance in Rome surpassed all the times I had experienced in the three years I had lived in Rome.

Rachel's reaction:
I was in an urgently unhappy relationship and marriage. I felt such pain when my husband died but I was so grateful that his passing had not been my decision. I would have felt like a murderer. The absence of such a feeling only gave more space to feel the devastation of his death without cramping self guilt. A hopeless utterly destroyed incoherent space of soul. His life in my life was pain. His death in my life was pain. A double-edged sword. What for ?
I felt his presence for many years after his death. I only felt released from him when a Mass was said on the anniversary of his death for the intentions of his soul and his relatives by a very good Priest friend of mine who opened the Mass with the powerful invocation to God - "Oh God, if thou shouldst mark our guilt, who could ever stand before you ?" That Mass gave me tears of joy. I felt pure joy in the core of me radiating into my bones and flesh leaving me trembling all over. I knew my husband had ascended from my mind and thoughts that his soul was earthbound. I felt so happy for him and for the first time I felt free from pain and loss.

Ninth incident:
Rachel was 34 years old and this occurred in her bedroom at a London hotel.

I woke up. The room was in darkness. It was night time. I did not wake up suddenly or uncomfortably. I drifted into wakefulness. The bed was comfortable and I was in a safe environment. I lay still and allowed myself to fall back to sleep. That did not happen. Instead, I entered into a different, altered state of awareness of myself inside myself in the region of my head. The first thing I recognised was that there was a tall being of white light at my right hand side guiding me in walking towards the centre of my own self. I wanted to look over my shoulder at the being, but was told not to look as it was not necessary or wished that I do so.

I then became aware of 360 degree inward sight. It was a most extraordinary experience. It lasted a while and confirmed that I was seeing inside me, not outside. Then I experienced myself as a person walking with the guide behind me again. I doubted that I was inside my own self and in that same instant, again, the 360 inward sight returned in confirmation that I was not experiencing outer awareness. I enjoyed the experience of this kind of sight and made mental notes to recall the thrill of such an experience.

As I continued with the guide behind me, we came to a faceted obelisk metal structure right in the centre of me. I did not understand why it was there or what it was. As I realised my own blank at that point, the guide encouraged me to take steps to approach the structure. As I took a few steps forward I became aware that the structure was "all powerful" ! I was quite stunned as I contemplated this and felt that it was communicating to me that it was the power that created the planets and systems of the universe. I was quite amazed. It called me to approach it and with the awareness of what it was, I started to think that I could share its power. I felt what it was like to create a planet and to reverse it into non-existence. I was awed at the thought that this was inside me and to approach and merge would erase me as I knew myself in the outside identity of my experience of my own life. I was unable to move forward and share the power of the structure and, as I decided this, veils started to fall. First one, then another. I regretted not merging with the structure and felt the desire to be at one with it and felt my deep regret and urged

the white being to allow me another chance.

The veils lifted. I took two steps forward and again felt the power, the greatness that again overwhelmed me and I could not go further. "God" I acknowledged. "Yes" was the most subliminal response. The veils fell again, and this time I was very sorry I had not been able to go forward. I pleaded again for a chance to go forward. I was denied but at my urgent insistence, compassion again let me try. Even before the last veil was lifted I knew I could not of my own strength approach God. I accepted. I was sad. The white figure next to me of a shaft of light, said I was not ready.

I re-entered my awareness of the room I was in and had full recall of what had just taken place. God was with-in me ! I saw. I knew and experienced inward sight with no question of a doubt ! I had not even the imagination to have created such an experience or dream. I was awake. I was exhilarated ! Thrilled, excited and very happy.

Rachel's reaction:
I was sad with myself that I was not strong enough to go forward and merge as I thought would have happened if I had stepped forward. I had been invited to do something and I could not. I wanted to, but I could not. I did not have the fearlessness. That was what stopped me in my tracks. I felt sad at myself but not in a reprimanding way. It could not be helped. I simply was not ready and there was no punishment attached.

I have since been advised, in 1998, by a person who I consider to be very spiritual with whom I shared the experience, that if such an experience should ever happen again, I can equip myself with the precursor of whatever is to follow by saying, "For the good of all Mankind only".

Tenth incident:
This occurred in 1990 in Rachel's Cincinnati apartment just before dinner one evening.

I was really not expecting anything. I was having my dinner in my safe secure Cincinnati apartment. The view was lovely and I was about a third way into my dinner when I felt a presence over at the window. It was unavoidable. It was felt and I could shake the feeling had I wanted to. That was an option. I asked the presence why it had come now in such poor timing. The timing was not poor it said. I had just finished praying, as is my custom before I eat.

I just felt like the presence would go away if I chose. I did not want to be inconvenienced either. Reluctantly I got up and went over to the window where I felt it to be standing. I got the feeling that it was in a large gray orb. I have since discovered that the reason I felt this was that the gray orb was a veil to the presence's intense light that would otherwise harm me to see into it because it is so bright. I am comfortable with that explanation that came to me some years after the event.

When I went over to the window, the presence said I should take off my shoes as I was standing on holy ground. The ground referred to was the ground immediately in front of the presence and not the ground of the apartment as such. The presence said I should pray and so I began. Then it interrupted me and said I should pray as I knew how. How I asked ? Then the memory came to me of how I really do pray for all people I have known, who have known me. Then I pray for all that they know and continue in a great circle to include all people north and south and east and west and all those who came before me and who will come after. As I prayed like this the presence said to me in a stunning thought - I should pray for Judas - the Judas that had betrayed Christ.

I was stunned. The presence did not feel to me to be unholy. On the contrary. The thought of doing such a thing went far against all I had been taught. The presence gently said that what was wrong in the world is that Judas is still not prayed for or forgiven by us, mankind.

I felt a huge excitement come over me and through me. It made such sense and I had never considered this before. The presence asked me to get a pen and paper and write down a prayer. I was to give this prayer to the priest. That was the very hard part. The prayer was dynamic in terms of everything I had ever conceived of in religion - but to pass it on that was really very hard. I had not written it. How could

I explain any of this ?

I was in conflict. I did not want to put myself into any question. I did not want to have to do what was asked of me. As I wrote the prayer down I was thrilled. It felt like a huge holy revelation. I was so very excited and happy and I felt very humble and amazed. The presence left as these feelings took over. I could hardly continue to eat my dinner. I had the prayer in front of me as I continued to eat. I never tasted anything ! It felt like I had been shot in the arm with a kind of uplifting drug - not that I have ever - but if I imagine what it was like for a person who has never experienced this kind of thing before. There was just excitement, thrill and responsibility to pass on the prayer.

The prayer:
Eternal Father, I offer Thee the wounds of Our Lord Jesus Christ -
to heal the wounds of souls and for the conversion of the Judas soul.

My Jesus, pardon, mercy, love, the unity of the Holy Spirit, merit of your blood
Most sacred new and everlasting covenant - have Mercy.

Lord God, heavenly King, Almighty God, Lamb of all ages
From East to West, gather your people for the perfect sacrifice of
all saved and non-lost Glory to your Name Creator of all."

Eleventh incident:
This occurred within the year before Rachel started psychotherapy.

When this happened I was at the height of my career and the depth of despair. I felt like a I had nothing. Yes, I had the material comforts and security but love was missing and I felt awful.

I had read in the Bible of a time when Christ came across a blind man and asked the man what he wanted. The man was blind but he had to ask for his sight. Feeling filled with poverty I stripped down and got down on my knees. I started to pray. Look at me I pleaded. I have nothing and I am so sad. It was in this state of prayer that a I felt a presence come to me and standing above me said to me ... what do you want ? The question was not audible nor the presence visible. It was felt. The question was felt in thoughts that I did not think out. The thought came to me. It was like telepathic conversation. Subtle. Prayerful. Sad. I answered that I did not know and that I wanted to be helped out of my sorrow and loneliness. The thoughts came back to me in the form of instruction. I was crying my heart out so when the thoughts came to me to stand up off my knees and go and do something, I felt like a control in the right direction was being given to me.
The thoughts said I should get some wine and make a sign of a cross on both entry and exit points over all the doors in my apartment. I did not know why but it came to me that from that moment on my apartment would be blessed and no-one would come or go who was not screened by this watching presence. I obeyed. As I did this I was relieved because it felt like something constructive. It felt like I was being saved from a terrible fate as I recalled that the ancient Israelites had to put lamb's blood over the entrance of their homes to guard against being killed when the angels of death flew over their homes.

APPENDIX B

WHAT HAVE BEEN MY EXPERIENCES OF THE QUALITIES, BOTH HELPFUL AND UNHELPFUL, OF CATHY ANGUS AS MY THERAPIST ?

I made this request to Rachel in January 1999. I asked her to write honestly and gave her no more information than the above question. I wished her to write spontaneously from her own experience without any sense of structure. Only minor changes to ensure the understanding of a comment and spelling mistakes have been altered and these have been approved by Rachel. A few of my comments are written in brackets to clarify issues.

"Let me begin by saying that this request can not be answered adequately enough with so few pages. To do so would require writing my observations down on record after each therapy session. Had this been possible only then would I have been able to express the scope and meaning. The following expresses only a few percent of what the request asks.

I believe my first experience of therapy began over the telephone. Cathy's answering machine answered my first call. That's when I first felt what therapy could be like. The sound of Cathy's voice held a tone of kindness but was also very 'together'. This was a person who was professional. I did not think then that I deserved to have anyone 'professional' waste time on me and also I was scared. Cathy's voice did not scare me. The tone of discipline and astuteness scared me. I was in a real mess emotionally. I did not think I deserved help. I could not help myself. That much I knew. (She did not leave a message).

The next call to Cathy, I also got her answering machine. This time I left a message. I was suicidal and very scared. At the pit of despair I imagined I had killed myself and allowed myself to experience what could happen after my death. My consciousness showed me the agony, of my mother particularly, and the utter confusion, denial and pain to everyone I knew. That pain was greater than the pain spurring me to suicide. That awareness made me terrified because I was beginning to feel I could not control my impulse to suicide. That was when I called Cathy. When I first spoke with Cathy on the telephone I was crying and talking to a complete stranger. It still makes me choke at the depth of feeling even as I write about it now. Cathy was 'there'. That is what makes me have the feelings well up inside me. Not that I was suicidal. Cathy was and felt as though she was <u>there for me</u>. She was on the phone but her voice was really close. It felt as though she was really close. Not in a physical sense but in a conscious sense. Conscious of <u>me</u> - right there in my pain <u>with me</u>, conscious of me and telling me how to manage what to do next.

Cathy gave me an authoritative number of options. She knew how to manage my situation and she shared with me the choices I had. She made no decision for me. She asked me to tell her what decision I felt okay with. That approach gave me some power in a hopelessly powerless feeling I was experiencing. The options Cathy gave me were to wait and then come and see her at her next available appointment the next day at 10 o'clock. Cathy said if I felt I could not survive that long then I could call (her doctor and arrange for) an ambulance and they could come and fetch me. I said I thought I would make it to the appointment without doing anything to harm myself between time. It was like I had an agreement now, with a decent human being to hold onto. I could do that.

When I got to the appointment, I felt my case was hopeless and now Cathy, a complete stranger I felt, would have to decide my fate. If she could pull me through, good enough. If not, tough luck, I had tried. I had heard of psychologists who were 'no good' exploiters. I had no idea about who Cathy was save from the very good person who referred me to her, which gave me hope. I did not want to commit suicide but things had got out of control. I felt bad about how I looked and even worse about how my emotional crying had stopped on the surface. I was still crying inside. I felt uncomfortable to get to Cathy's door and met a 'together' person. Cathy on the phone was one thing. Now Cathy in person was another level.

When I first saw Cathy, she came across as an intensely astute consciousness. Her eyes spoke and showed awareness. Maybe someone at last would be able to see me as I felt. I did not know what was

to follow. I was there as the last straw. I said so. That was to introduce the next experience I was to have of Cathy. I asked Cathy up front if she could handle losing me to suicide if I went that way after being with her in therapy. I did not want her to feel responsible for failing in any way. For my part I had decided to be as honest as possible. Honesty was a smaller pain to bear than the one I felt would happen before and after suicide. So being as honest as I could was my part I would give to therapy. I did not know what kind of psychologist I was talking to so I did not want to feel guilty if I was talking to the wrong kind, ie., someone who would say something to push me over the edge. I was on the edge. It needed only a breath in the wrong direction.

Cathy answered my question in exactly the right way. She paused as if pondering my 'challenge' which it wasn't (and was not experienced that way for me). The pause seemed to contain a lightning passage of thoughts in Cathy. She looked away for an equally lightning fraction of a second. That pause helped me. In looking away I felt safe. I felt that Cathy was not questioning me. It was a breath of a pause and look away, but it carried enormous weight. When Cathy looked at me again with her answer, her eyes carried incredible intensity. I could see she had committed herself.

Cathy answered me by saying, 'yes'. Cathy told me that she would be all right if she lost me to suicide. Her eyes spoke another reply. Her awareness and conviction in her eyes reached into my soul and said that 'yes' meant that Cathy would (not in a literal sense) go with me right into suicide if that is what was going to happen. Her eyes said that with eyes open wide to the experience of suicide, Cathy would go there with me, with commitment, by choice and with visible conviction. (What she is stressing here is that I had no intention of abandoning her). Tears well up as I write this part because what this meant for me then was that I had a chance. It felt like a small chance. But it was a chance! I can still see Cathy's eyes in my memory of that moment. I was to experience that wonderful expression in her eyes many times afterwards especially when she was to tell me that I was not bad. I did not know that then. I did not know that I was not bad and I did not know that I would ever see that look of conviction and choice again. I said okay. We met again the following week.

In the first session Cathy asked me some questions and she wrote down the answers. It felt pretty routine. Nothing special other than what I have written above.

The weeks that followed were weeks I had now decided to commit to. This was in addition to my commitment to be honest no matter what. I was not there to kid myself. I still did not know if Cathy was going to kid me along.

It was only much later that I shared with Cathy, in an off-the-cuff sort of manner, what it was like for me at an intellectual level when I asked if Cathy would be okay if I committed suicide. This disclosure was to give rise to a wonderful gift back to me from Cathy. At the intellectual level I told Cathy that the moment when she said 'yes' she would be okay if I committed suicide, it felt like a hand reaching down to me in a very dark underground cold place and the hand was white. Not white in a skin colour way but white as a light shaped in the form of a hand that reached me and took hold of me. I can still see this impression today that came to my mind then when I expressed this to Cathy. I can still see it because it was not lost. Cathy saved it for me because she gave it great meaning. She was stalled in her seat. Her face showed her mind going inwards to some place I could not follow. Her words were the indication. As she looked at me her eyes showed horror. She said she never knew that it felt like the way I described it to her. Cathy, by showing and saying to me that she had no idea, gave me a sense that I was with an honest person and a caring person. Cathy was not covering up her feelings over this issue. In my experience, Cathy went from being the intense listener to the vulnerable person. She was not covering up. She was showing me what it felt like to feel. This gave me the space to remember this experience. It was so wonderfully liberating. I was seeing what it must feel like to feel. I explained some more. I said I only saw a hand. Not an arm or face or anything else. Only a hand and it seemed very natural not to see anything else.

Cathy's response carried enormous meaning and depth. In this way Cathy gave my pain a kind of livingness that enabled me to feel it also in an atmosphere of deep respect. I felt like I was not dead inside anymore. I was starting to feel my pain. I was starting to experience it through another human being. Cathy. My pain was being held, seen not admired, but respected with care and deep

compassion. This feeling was to be one of many steps in the climb away from suicide. Cathy gave my pain tremendous value. I felt it and I was very surprised at the experience.

I had never felt what it was like to have a person respect my pain. The little I was feeling of my pain, Cathy was able to magnify for me like no-one ever had. It felt good. I was only saying what I felt on the verbal intellectual level. Cathy was listening. And in that moment when I said something very significant, Cathy pulled it into reality by responding. In that way I could start to feel what I was feeling. Feeling what I was feeling was a huge and highly rewarding step for me. It felt so wonderfully good.

Up until that moment when Cathy gave feeling to my expression of her hand reaching down to me in darkness, I could not really connect to what I was feeling in any emotional way and it was very self-defeating. It made me doubt myself terribly to be able to articulate what I 'felt' was going on inside me and not to fully connect emotionally to the feeling. I felt like a contradiction. I felt dishonest and worthless. This state of being was extremely hard for me. It had brought me to the suicide 'solution'. Also my experience of not being heard before I met Cathy did not help. Can you imagine how I felt after so long of not being heard and then feeling like I was being heard for the first time ever with no vested interest following any of my discussions afterwards ?

Talking to Cathy felt like what I said was being heard with absolute clarity without any rose tinted glasses. Cathy was not questioning my honesty or experiences. That was so vitally refreshing. Cathy was hearing me. I really truly needed to be heard. I could not even hear myself. I needed someone to do that for me. Cathy did it. This was no small issue. It was a deep life experience! It felt very good. I started to look forward to going to therapy. I started to feel the influence of therapy. I was starting to feel better and the feeling was being felt in a very deep part of me - a part of me I had not felt before was coming alive. The feeling stayed with me a while even after therapy. It was great ! This was a very new experience of well being - something that is becoming quite familiar I am very happy to say, through therapy.

The next memory I have is when I started to include in my vocabulary the terms 'Dear and Sweetie'. I tried this new style on Cathy. She took exception but not right away when I first used this language to include her. That Cathy did not express her indignation right away was meaningful to me. This made me feel that I was not being rebuked. It meant to me that Cathy had thought about how to tell me that she did not approve of my using such language in reference to her.

I still felt awkward when Cathy asked me why I was using such endearments. That was how Cathy approached the matter. I was relieved that Cathy asked. I was able to tell her that it felt good to me when I had recently heard a person in my work place use the endearing terms to me. Cathy explained to me that it did not have the same effect on her at all to hear me call her 'sweetie'. She explained that such language was reserved for the appropriate relationship. I felt she was very adamant and that hurt. I felt hurt because I was trying to show Cathy appreciation. It felt like I had lost Cathy. It felt like she was not there with me. I have never used the casual endearment language inappropriately again not because I felt bad but because I learnt something. I realized that words have meaning and should be used accordingly. Trying to show appreciation to Cathy by calling her 'sweetie and dear' was not doing the job. So I thought of other ways. A card. Respect. Consideration.

Cathy did not leave my hurt feelings unattended. In the following session Cathy asked me if I was feeling hurt by what she had said to me in the previous session. She explained that she sensed I was hurt. This felt like Cathy was seeing that I had been hurt and was returning me to myself. She had not changed her position about not wanting to hear me call her sweetie. Knowing that it was hard for me to experience a boundary, Cathy gave me the sense that she was back with me. Her kindness was back. She was listening and hearing my pain. We were not even talking about boundaries at that stage. It is only in hindsight that I can assume that Cathy was seeing my response to boundary setting. I could not handle it very well. A few more boundaries and I can assure you, I would not have survived. I needed to be heard. I needed to learn to hear myself. More than that was beyond me.

The next boundary I felt (nearly five years after the above incident) was when Cathy asked me to take my used tissues and put them in the bin before I left a session. This 'boundary' felt very different. When

I apologized and said I was not aware of leaving my tissues behind and how awful of me, Cathy said she knew. I knew she knew. She was with me. It did not take the next session to grasp that. I did not feel abject remorse or deep pain. I felt exposed but not uncomfortable. I knew and felt that Cathy knew that I would never consciously do such a thing as to leave my used tissues on her table where her next patient was to sit ! That I had done this repeatedly and unconsciously did not make me feel bad about myself. It made me feel a small sense of humour towards myself that I had not felt before. I could feel this only because Cathy again confirmed me by saying she knew that it was unintentional. She said this with meaning, awareness and kindness towards me. That gave me the opportunity to experience myself in a humorous loveable light. I was not being punished. I was not being demoted or made to feel less worthy.

My 'tissues' experience happened at the close of a session at the end of 1998. There is just no comparison between how I felt about my tissues and my endearment language 5 years ago! Cathy hears me. It has been a process to experience being heard - a process of great joy and fear at thinking at several stages that I would lose this wonderful experience for some reason or other. Going through those fears with Cathy hearing me and being supportive of me creates for me the opportunity to learn to not only hear myself but to believe what I hear - to believe myself. This experience has given me life. Learning to hear and then to believe myself because someone else is - gave me my life and is giving me a growing sense of wellness in each and every session with Cathy.

I loved and still love what is happening to me inside through therapy. In the beginning I had never felt feeling well to last so long. I had been to Church every day and felt healed but it never lasted longer than 15 minutes after mass. Therapy healing by contrast was lasting. What a huge find ! What an awesome privilege! Therapy with Cathy has been like an experience of the most eloquent religion imaginable - healing, Holy sanctity.

Cathy validated my pain. Her listening to me was not felt to be passive. It was felt to be very intense. I had a lot of talking to do. There was so much I did not understand. I did not look to understand it in the beginning. I just needed to say it. In the first few years of therapy Cathy said very little. What she said was very important. It was like I was fast forwarding on a video tape. When Cathy spoke, it felt like she had pressed a pause button that only required a fraction of a second. What she said I felt to alter the course of the fast forwarding in that it gave me a new perspective. Her statements validated me. I cannot recall exactly what she said. I recall the feeling. Whenever Cathy said something it gave me a deep sense of healing. The urgency of having to say so much more was never interrupted by Cathy. Eventually after several months, I started to feel bad that I was being heard with such focus by a complete stranger.

I am not saying here that it would have made me feel better if Cathy had given me information about herself. Doing that would have made my work of getting better very difficult if not impossible. I did not need to have to process things about learning about someone else. Cathy assured me and affirmed that it was okay. It was okay to talk about myself. I did not feel bad about it after Cathy heard how I felt. She was not in opposition. She heard how I felt and so I felt okay to continue.

I have not done justice to the lightning perceptions that Cathy gave to my conversations at the beginning. Her statements eventually became something I looked forward to experiencing. I started to hold onto them after therapy. They went with me into the world. I started the work of changing my perspectives to ones I had direct experience of being more comfortable with in therapy. The feeling I got when Cathy spoke was amazement. She chose to comment about the deepest issues I was fast-forwarding over. That is where I got the sense that Cathy was listening with acute focus and not casual interest. I got the sense of Cathy being an incredible consciousness that had skills I could not define. What or how she was giving me a deep sense of reality and comfort I did not know. All I knew is that she was. Her awareness and input together was really helping me at a very deep level.

On the precious and rare occasion that Cathy shared with me a personal experience, I felt it to have been expressed only to help me. Cathy was not sharing anything of herself for any other reason. That helped immensely. I was not in therapy to get to know Cathy. I was there to get to know myself. It was a long hard haul and I felt like Cathy was there for me. That felt good. It was a new experience for me.

When Cathy shared anything of herself with me it became precious to me. It started to feel like I had a friend - a really professional friend. I started to feel like I was experiencing the highest order of friendship. I had never had a friend or experienced what a friend was like outside of therapy. The feeling of friendship that I was getting in therapy became a role model for me. I started to learn what being and having a friend should be like. This was an immensely healing experience for me that arose out of Cathy and her astute ability, not only to hear me, but to reach me.

The people who I had felt very hurt by, I brought with me into therapy discussion. These people had been very significant in my life. They included my late husband, my employer and a 'friend' who was a Professor. These people I discussed with Cathy and I received clarity on how to see them myself. I will never forget that Cathy commented that my ex- boss, by the way I was describing him, was a 'convoluted' person. That terminology was so accurate. It was not a word in my own vocabulary. It stood out from a clean, clear observation from Cathy and it was liberating. I have not forgotten it since.

The other people were likewise expressed in therapy and Cathy again validated my pain and gave me her view based on what I was explaining. Cathy showed anger and indignation on occasion towards many of the things I expressed. Her indignation and anger were not at me. That helped. It gave me a sense of what was okay to be feeling. I had lost touch with feeling anger and indignation. Cathy showed me that it was okay. She felt what it was like for me at a level I had lost touch with. Cathy joined up my consciousness with my reality. Cathy became like an angelic surgeon. There were times that I really felt stitched and bandaged up after therapy.

Then it became, to my mind, an embarrassing and awkward situation because I felt like Cathy was doing such a good job but I kept coming into therapy bleeding. What use was it if Cathy was binding up a dog that kept coming back wounded. I did not feel like I was a dog. I felt worse. I felt far worse and less valuable. Cathy reassured me. She said she would not ever abandon me. She assured me that everything was as it should be. She did not mean that my wounds were as they should be. She meant that my wounds should be bound and healed. That made me feel very good. It made me feel that there was value in getting the sense of healing and help that I was feeling. It gave value to my inner wounds in a very healing way.

There were several times when I felt that I would have to discontinue my therapy -my lifeline, due to financial constraints. Cathy was extremely considerate. Again Cathy met me at my level. She heard me and she gave me a huge benefit of not increasing my fees. At one point she did not charge me for a whole month of therapy. This act of great kindness and generosity and being on my side in a very deep sense, gave me yet another role model. This is what love should feel like. In both instances of feeling what friendship should be and what love should be, Cathy did not personify herself at a personal level. I never felt that Cathy intended herself to be the focus of my need for love and friendship. Cathy offered nothing of herself at a personal level. I still did not know Cathy. She was an example. Her example gave me hope that I could experience love and friendship outside therapy one day. I was feeling it as a reality in therapy and that gave me an exciting and wonderful feeling of hope and journey towards this goal.

The healing process in therapy was a process. It could never have been a quick fix. I had to become aware of things. This could only happen over time. That is another point I would like to mention. Sometimes I felt like I was not getting to the goal fast enough. Cathy validated me, and still does, where I am in the moment. This has been very important to my experience of self-acceptance. It has been vital. Cathy reminds me, and still has to as I meet new levels of my own awareness, that it is 'baby steps'. 'Oh ! Even here' I sometimes catch myself thinking ! Cathy is with me, where I am, in my moment not hers and this experience has been beyond words. I feel my eyes start to well up again as I write this. The experience has been so breathtakingly healing and wonderful. There can be no value placed on this experience. It is beyond any price paid for therapy. It is priceless and exceedingly valuable! It is the value of life. How wonderful the therapy I am experiencing is because of Cathy - because of her work, her knowledge her skill, dedication and commitment !

Cathy never told me what to do. That has been so essential to my experience of getting in touch with me. On the occasions that I asked Cathy what to do, Cathy has encouraged me to take baby steps or

just hold the pain like a little bird close to me. What has been a new experience for me is to simply do that and not do anything about anything else. It was such an empowering feeling to know that it was okay to do 'nothing' but hold the pain. I could do that. It gave me a sense of myself. Another very important answer that Cathy has given to me when I ask her a question is 'I don't know'. When Cathy has answered me in this way she does so with awareness open wide and utter perception in her eyes. Seeing that and experiencing another human being as aware by choice and still not knowing the answer gave me incredible advantages. I could see it was okay not to know. I could see that not knowing did not in any way diminish consciousness. I could experience appreciation for Cathy because in not knowing Cathy was the same Cathy. She did not cringe or feel bad and her self-esteem appeared to remain constant. Her awareness did not flinch. At the same time, Cathy also gave a sense to me of being with me and not wavering for even a fraction of a second ! For me, that would have required an enormous effort and acting skill, but for Cathy it really looked real ! That is what helped ! Cathy showed me it is okay not to know something and just ***be*** *there in that space. Experiencing it by seeing it achieved by another person has helped me to find myself more and more.*

Regarding my psychic experiences - Cathy has been wonderful. Cathy made my experiences not something I had to cut off from myself because they were unacceptable to Cathy. Cathy again was there with me in my experiences. What has been so extraordinary for me is that Cathy did not make me feel like I had to amputate my experiences from my own acceptance or sense of reality regarding how my psychic experiences made me feel. My experiences made me feel a whole variety of feelings and Cathy did not cause me to think I had to be ashamed of any. Again, Cathy is there for me.

Cathy shows genuine interest in what I say. The interest is not felt to be personal, it is felt to be professional. This makes me feel like someone knows what is going on. Regarding my psychic experiences, I feel Cathy also shows curiosity. This feeling is very complimentary. I feel good about it because it gives me an emotion of curiosity through which I can look at my own experiences that have been riveting and unexplainable in any logical way. I have felt very threatened because some of the things I have experienced can not be accepted logically. I have been able to stand back from my experience of being threatened by having the opportunity to talk to Cathy about my experiences. So I have been able to separate and feel the beginning of healing the threat by Cathy hearing me. Cathy in no way made me feel threatened. She listened and helped me by telling me what she thought it must have felt like for me and that gave me great support. It gave me a handle on what it did feel like. It is no easy matter to have had experiences that cannot be shared without making me feel less safe because of the experience. Cathy did not make me feel less safe. She made me feel safe because she did not look threatened or afraid for me. Cathy did say she would have been terrified if what happened to me happened to her. That gave me a feeling that I was not wrong to feel terrified myself.

Yes there are psychics and persons who explore the paranormal, but they are not in my circle of people near or dear to me. No-one ever told me it was okay to respect or trust someone. It followed that I could never choose someone to trust. I also had a distrust of such phenomena even though I was experiencing it first hand. Cathy helped me to trust myself regarding these issues. At several times she so very kindly and gently affirmed that I (may) have psychic qualities. That was so wonderful. It is really not easy to have psychic qualities. Again, Cathy showed acceptance and I could experience her stability with acceptance. This became a very powerful feeling of terra firma under my consciousness that really swivelled around not knowing how to handle inexplicable experiences. Feeling accepted I was able to be okay with experiences I could not explain.

When I first came into therapy, I always felt as if people thought I was lying and so I felt I had to prove everything I said. Cathy never made me feel as though she doubted me and that was because she handled what I was saying as if it were the truth. It was awesome to experience this. I had never felt this before. It gave me a way back to myself not because I was not telling the truth, but because someone 'out there' was believing me without question. At one time Cathy had her practice door spoiled with graffiti (violent, aggressive language) and Cathy said she suspected two or three people. I can't remember if it was two or three. Anyway, Cathy said one person had come into session and was cold to the fact that the door was carrying such an ugly graffiti. (My recall is that she enquired and showed concern as a number of patients did and I commented briefly about being uncertain and one patient's strange reaction - but I knew it was not that patient). I could relate exactly ! I had been the same way

in my mind before coming to therapy. I would have thought 'she thinks I did it. I cannot prove I did not'. (She shared these thoughts with me). Those would have been my surface feelings and now they are not. I could feel for Cathy and I could feel how I might have felt if it happened to me. Cathy told me why she could not suspect me because I showed horror immediately and, of course I know by now after some years of therapy, that Cathy knows me. (She had seemed disturbed so I reassured her that I knew it was not her).

Regarding my dreams. Cathy has been able to be a wonderful source of upliftment and light. Some of my dreams have been very painful and have left me with a sense of that pain that I could take into therapy. Cathy never diminishes the pain. She is with me there, with the pain. That is how I have been able to see an alternative view of myself. I see how Cathy handles it and then I know it is possible.

Cathy has been able to take my dreams and give a very positive viewpoint that is so acceptable to me because she does not alter my dream or my experience of my dream. She takes a positive viewpoint and shares it with me. She does not devalue me in doing this either. She tells me what she sees from her point of view - a wonderful experience for me. In this I have been able to get out of the feeling of being held captive to pain or captive to the way I see and experience things. Cathy gives me an alternative way of looking at things in a way that does not diminish or devalue me. It is quite extraordinary to experience this. It allows me to absorb a new way that feels so much better. Cathy does not rush me on this either. Cathy is affirming of my own time. So it feels as if Cathy is okay to take baby steps with me - even though she is a giant ! She is not trapped in any of my own issues.

Cathy has expressed that she is not okay when I get hurt or abused. She shows horror and indignation and has taught me that it is okay for me to feel anger also. This gives me another positive sense of my own value that I explore and put to the test and then go and talk about it with Cathy. I have not been able to master being angry as I would like to but Cathy is reassuring that it is natural not to be able to master anything at the first attempt. Baby steps !

Cathy is not a psychologist. Cathy is a Great Psychologist ! She has really been able to help me feel better and to experience a sense of well-being that was unattainable outside of therapy.

Regarding sex. I really had some very sensitive issues regarding sex. Cathy never made me feel bad about how I felt about myself even though I was out of control. Cathy explained, very gently and sympathetically that my sexual behaviour arose from my seeing myself in others, rather like looking into a piece of a mirror. Cathy did this in a very accepting, gentle but at the same time matter-of-fact way that made my feelings of revulsion and hatred for myself experience something quite different - compassion and authentic understanding. This direct understanding expressed compassionately to me by Cathy felt like a blanket of understanding over a very cold self hate. The comparison was that I felt warmth for the first time - warmth that was so absent in any of my sexual encounters. Intelligent explanation that was presented with compassionate understanding gave me the experience of compassion and I could then start the work of trying to feel that same compassion for myself. That was the work I had to do and Cathy returned me again and again to how she saw me as being a piece of a mirror. The aim being to draw those pieces together. This effort is ongoing as I grow in the consciousness of myself.

I could say that therapy in my experience is a practice of growing consciousness. That I have taken five years in therapy to come to my present state of awareness is starting to give me a new awareness that others may also not be conscious of certain things that do not necessarily become clear even if said. Also expansion of my conscious has not been based on what Cathy knows, but on what Cathy has helped me to experience and that, as a consequence, brings me to the start of my own knowingness. For example, Cathy will not talk about 'boundaries' at a purely conceptual level. With the feeling of pain that I have suffered by not having or even knowing about boundaries, Cathy takes my experience, and relates to it. My experience gives me the handle to rise up out of my pain into understanding and into the direction opposite to being the victim. I am feeling less and less like the victim as I continue in therapy.

Sex was a way I tried to obtain approval and affirmation of myself. I did not know that was what I was doing and I did not know how to stop either. I have come a long way from this point of feeling so very

lost and worthless because therapy gives me a completely different experience of myself. The experience of myself through therapy makes me briefly at a time, glimpse and experience myself as being very precious.

There have been times when I felt afraid to go into therapy. The fear I am realizing is a fear of what I will feel from within myself and not because of anything Cathy will do or say. I did not want to tell Cathy that I had decided to stay at home and not get a job. Cathy was afraid for me and she was concerned. In the next session Cathy again expressed this concern. What came across to me was rejection, disapproval and failure. It was not coming from Cathy, it was coming from inside me. That is very awful! I have however started to distinguish this. What was great is that I could identify these feelings in myself and explain that this was so like the feelings impaled in me by my Mother. In turn Cathy expressed that she felt afraid for me and questioned her own assessment of my progress in therapy when in a similar incident I said I wanted another baby and Cathy looked very shaken. I had not meant to upset Cathy in any way.

Cathy said I could say whatever I wanted to say and do whatever I wanted to do and it would be okay with her. That really made me not understand something. Cathy allows me great listening space to talk my feelings out and so I could ask her <u>why</u> it was okay. Why would anybody be okay with whatever I do ? I have never experienced such a thing although I have <u>been experiencing it in therapy for the last five years</u> ! But, nevertheless, in that moment, I could <u>never</u> have guessed the answer even if my life depended on it. The answer Cathy gave me was spoken with what I sensed to be great balance in Cathy and she answered, 'Because I care' said with neither any vulnerability nor any sense of making me look inadequate. The consequence of this answer and tone spoken was to bring into my consciousness the following that I thought and still remember thinking: 'Ah! So <u>that's</u> what it means to care' ! I felt my mind leap up to grasp, so that is what it means to care ! And tact ! Cognition ! Now I know ! Now I know what was missing !

So you see, my therapy has been a wonderful privilege of learning to <u>be</u>. Thank you Cathy. The wonderful, holy and awesome process continues.

In conclusion please be aware of the following three points:

a) *Although this report may appear to have been written to favour Cathy Angus, this was in **no** way my intention. Rather, it was my intention to be as true to my own experience of therapy regardless of the interpretation of Cathy as a consequence.*

b) *I feel that with continued therapy I shall feel more comfortable about the distance I feel between my emotions and intellect.*

c) *The way I have expressed myself in this document could not have been articulated with the same substance or clarity earlier in my therapy. Therapy has improved my ability".*

The following addition was written by Rachel on 10th February 1999 as she felt it to be an important insight. I believed it to emphasise the authenticity and the manner when occasionally one is merely relating like a normal person in a psychotherapeutic relationship:
*"My latest insight came when I told Cathy that I was experiencing the most lewd and sexually explicit words that would come into my mind to express my indignation at something. It was embarrassing for me because I have never had this experience before ... I did not enjoy it but it did express my core feeling even though expressed in a way I do not prefer. Cathy asked me to give her an example. It was embarrassing to give her one example. I was feeling sensitive and embarrassed. When I gave Cathy the example, Cathy burst into laughter and said it was funny, apologised for laughing, then laughed again before saying she would never have thought it possible for me to express myself in such a way. This was a great affirmation for me. It was the combination of gaiety in a really light pure and funny way with affirmation of me that gave me a terrific new way of seeing things. It was Cathy's humour and lighthearted response with affirmation of **me** that won for me an incredible sense of **relief**. Cathy gave me a new slant on how to see. With relief I then felt able to take the next step like a breeze to assimilate what Cathy explained next which was not new to me. Cathy reassured me again that my emotions came*

as a result of my earlier experiences with my Mother and Father which were surfacing and, in having to deal with them, extremes can be expected before balance achieved. When next the explicit terms came into my head ... I returned in my mind to my experience with Cathy and I could apply my new understanding of the direct experience of sexually lewd words coming into my mind and how to express myself. This was a fantastic experience for me because I now felt in charge ! I could either ***choose*** *to say the words or not - and with the sense of humour that Cathy had transferred to me, I was no longer afraid. I was no longer lost in the dark of not understanding myself at all. I* ***had*** *to tell Cathy this ... I felt I had made progress and I had really achieved something. Cathy always makes my achievements feel special and she strengthens them for me in order to make it real, valuable and something* ***I*** *can claim....".*

Rachel's latest comments about what the psychotherapy experience has meant for her came from a book she is currently reading (September, 1999). The author, Walsch (1995), wrote "Conversations with God - an uncommon dialogue" as a result of receiving answers to questions he had posed to God. He states that he asked the questions and was guided to write the responses. Rachel believes the following quote accurately describes the psychotherapeutic relationship and process as she has experienced it: "... all life arises out of **choice**. It is not appropriate to interfere with choice, nor to question it. It is particularly inappropriate to condemn it. What **is** appropriate is to observe it, and then to do whatever might be done to assist the soul in seeking and making a **higher** choice. Be watchful, therefore, of the choices of others, but not judgemental. Know that their choice is perfect for them in this moment now - yet stand ready to assist them should the moment come when they seek a newer choice, a different choice - a higher choice ... **Allow each soul to walk its path**" (p. 47).

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