

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 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".*

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 vitaly 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 there for me. 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 there for me. She was on the phone but her voice was really close ... 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 ... 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"*.

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 that's 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 stilled 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 vitaly 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 very deep part of me - a part of me I had not felt before was coming alive*

... 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 why it was okay. Why would anybody be okay with whatever I do? I have never experienced such a thing although I have been experiencing it in therapy for the last five years! But, nevertheless, in that moment, I could never 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 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' ... 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 mismatching. 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 that 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.