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„PSYCHOTHERAPY WORKS… BUT NOT IN MY CASE". A CASE STUDY OF CHANGE PROCESS DURING LONG-TERM CLIENT CONTRIBUTION ORIENTED INTEGRATIVE PSYCHOTHERAPY[1]

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client-oriented integrative psychotherapy
change mechanisms
effectiveness of psychotherapy

Summary

Objectives: Psychotherapy is a method of treatment for mental disorders of empirically varied effectiveness. In some patients clinical improvement does not occur. Research on psychotherapy should be focused on recognition of determinants of success and failure in treatment. The goals of the study are: 1) a description of the process and results of long-term client contribution oriented integrative psychotherapy with patient suffering from obsessive-compulsive disorders (OCD), who had enduring difficulties in beneficial participation in psychotherapy; 2) a psychological analysis of change mechanisms and factors influencing the improvement.

Methods: Case study of psychotherapy process.

Results: An example of clinical effectiveness of the therapeutic interventions based on referring to the patients' experiences of self-effective involvement in psychotherapy and provoking such experiences A positive coincidence between patient's experiences of shaping the process of therapy and the results of treatment was recognized. Psychological analysis of change mechanisms was done from the integrative perspective.

Conclusions: The recognition and intentional activation by the therapist the patient's personal potential for change can increase effectiveness of psychotherapy of persons with enduring obsessive-compulsive disorders, eating and depressive disorders.

Introduction

Research on the outcomes of psychotherapy which has been conducted in the last decades has undeniably proved that psychotherapy is an effective tool for personal change stimulation [1–5]. At the same time it is generally known that some patients never improve in the course of therapy and their functioning can even deteriorate [6].

Thus, the attention of researchers has recently become more focused on answering the question concerning the conditions and forms of therapy which have the most effective impact on the patient and the kind of person they might influence best [1, 7, 8] as well as the ways in which premature therapy drop-outs can be prevented [6, 9].

The extremely vast and continually growing variety of therapeutic treatment – which undoubtedly proves the vitality of this kind of medical intervention – keeps challenging scholars, trainees and patients themselves. It is also one of the reasons why the integrative approach, which becomes more and more significant, should be further elaborated on [10].

Especially since an important target of observation and research on psychotherapy is devoted exactly to the mechanisms of its influence [7].

According to Jan Czesław Czabała [2], one of the leading representatives of the integrative approach in psychotherapy, clinically substantial changes can be interpreted as such thanks to the presence of therapeutic factors, among which the most important ones are: the quality of the therapeutic relationship (or of its equivalents), providing patients with adequate conditions necessary to gain new types of experience and knowledge of oneself and the environment, as well as space for experimentation on taking actions differing from the usually undertaken ones. Czabała perceives psychotherapy as a process of learning to solve problems which arise on several basic levels of human experience. However, difficulties may emerge in the process of adequate recognition of patients' aims (patients might not know what they need, or what they want to achieve), recognition of the ways to fulfil needs or realize goals (patients do not know how to attain goals and to meet their own needs), recognition of the possibility to make use of specific ways to reach goals (patients do not know what and how these might be available), as well as the assessment of the consequences of one's actions on the road to goal attainment (patients do not know which actions were effective and, therefore, cannot plan future actions) [cf. 11].

Czabała, as a representative of the integrative approach, deems that a valid and useful procedure in the subsequent phases of the therapeutic process would be to stimulate the various mechanisms of change which are appreciated in the more traditional paradigms of psychotherapy. Another important trait of such an approach is the emphasis put on patients' agency, since they should not be perceived as mere consumers of "therapeutic services" but the co-authors of change, both on the goal-setting level, its realization strategies, as well as the assessment of their effectiveness. It is concurrent with the state of contemporary research on the discussed issue [12].

The author of the present study [13] points to the possibility of a practical integration of the above-mentioned way of understanding and application of psychotherapy with elements of the existential approach which underline the pivotal role of patient contribution to the process of change, as the one proposed by Viktor E. Frankl [14, 15], as well as logotherapy, creatively promoted on the Polish psychological ground by Kazimierz Popielski [16, 17]. Among the techniques of logotherapy focused on an active contribution of the patient one should mention paradoxical intention and dereflection. The essence of the first one is based on encouraging the patient to do or desire the exact thing that fills them with fear. On the other hand, dereflection means consciously redirecting the patient's attention from the activity they are deeply absorbed in and, as a consequence, excessively motivated to keep carrying out. It needs to be accentuated that logotherapy techniques are not underscored by mere persuasion or suggestion, but set out to activate patients' subjective agency – their capacity for self-transcendence and self-distancing [18, 19].

The results of meta-analyses on the determinants of psychotherapy effectiveness suggest that the factors connected with the patients' participation in the therapeutic process, including their engagement in the therapeutic alliance, are the most significant indicators of treatment effectiveness [1, 12, 20]. According to Bohart [21] the recognition of the active agent in the patient, who subsequently makes use of the therapist's actions to introduce change, explains much of the contemporary research on psychotherapy effectiveness (an example of that may be

the fact that patient assessment of therapy outcomes correlates with psychotherapy results to agreater degree than therapist assessment). Thus, one of the more pressing challenges lying ahead of scholars today is a more profound scientific exploration of this issue. And it is exactly this stipulation that the present paper refers to, being a clinical study of the change process in a patient during long-term client contribution oriented integrative psychotherapy conducted on the basis of the assumptions discussed above.

Case study

Ms M.[1], a single, 29-year-old university graduate, came to me with intense obsessive-compulsive symptoms and prevalent obsessive thoughts and ruminations (F42.0). When interviewed, the patient was additionally diagnosed with recurrent depressive disorders of mild to moderate intensity (F33.0–1), as well as eating disorders in the form of atypical bulimia nervosa (F50.3). On arrival, the patient admitted to 10 years of experiences connected with receiving various forms of psychiatric treatment. She had individual symptoms of anxiety and OCD dating to as early as childhood, but it was not until late adolescence that they developed to an extent which made the patient seek treatment. Ms M received initial therapeutic and psychiatric help as a first-year university student. After the second year of her studies, she applied for a yearly sabbatical leave, having experienced intensified difficulties in her normal functioning. Ever since that period, the patient has been repeatedly changing types of administered medicine and kept undertaking many attempts at psychotherapeutic treatment. She has tried a variety of therapeutic approaches (NLP, psychodynamic therapy, CBT) and forms of psychotherapy (individual, group, out-patient and in-patient treatment), all of which she deemed of scarce assistance. The result she mostly appreciated was the possibility to relate to other patients undergoing similar difficulties – a fact which made her feel less stigmatized. Due to the lack of expected therapeutic effect as well as various objections expressed towards psychotherapists themselves, the patient would normally quit treatment prematurely, which in the end led her to believe that psychotherapy – in general – is ineffective.

Course of psychotherapy

The patient sought help in my private psychotherapeutic practice, informing me on the outset about her intense OCD symptoms and other anxieties (e.g. fear of darkness). In that period, the patient was active in her career which allowed for her personal and financial independence. Ms M denied any difficulties as far as interpersonal relations were concerned, with the exception of lacking experience in partnership relations. Additionally, she has not complained of any difficult relations in her family of origin. Apart from discomfort regarding the symptoms of her disorder, Ms M complained also about her professional environment. She did not feel comfortable at work since – in her opinion – professional and ethical standards in her work place were far too low.

Having analysed the patient's problems, as well as her expectations, a contract was concluded for individual psychotherapy in the integrative paradigm. Already from the initial sessions, Ms M expressed objections to the course of therapy and its logistics, inquired about

[1]Data which would enable patient identification has been altered. The patient's written consent for publishing the present case study has been obtained.

its assumptions and the validity of applied treatment, and concentrated on the limitations of the therapist. After several sessions, the patient expressed her worry connected with not being able to meet the costs incurred in the course of therapy. During our 12th meeting, after which several weeks of break were envisioned (connected with the holiday season), the patient announced her plans of terminating psychotherapeutic treatment, despite the lack of any significant improvement. Having taken into account Ms M's therapeutic experience to date, her announcement was interpreted as an indicator of a fixed difficulty with establishing and maintaining therapeutic alliance, which was previously manifested in frequent drop-outs.

The therapist was fully aware of the fact that the therapeutic relationship is acted out by the patient in a control conflict schema and her reservations regarding treatment fees were most probably a form of rationalizing camouflage of such tendencies. Unfortunately, any attempts at discussing the patient's behaviour and announcements were strongly opposed to every time. The therapist was thus confronted with a dilemma whether to keep insisting on frustrating the patient's need for excessive control of the situation (inherent in the profile of her disorders) and, as a consequence, risk another, highly probable drop-out attempt on her part, or whether to find another solution. In this context, the therapist decided to seek advice within the existential paradigm which accentuates individual subjectivity of the patient in therapy [16, 17]. He acknowledged the fact that the patient, despite the limitations connected with relating to other people (which is typical for the kind of disorders she manifested) can still communicate from the personal level; namely, she can be "heard" by the therapist. On the basis of these assumptions, the therapist decided to address the patient's objections regarding the ways the therapeutic process is to be financed and suggested continuing NHS-refunded form of psychotherapy. He also informed the patient that in such circumstances she has the possibility of being qualified for group therapy, which, as she previously stated, was judged relatively helpful by her.

Thus, after several weeks of holiday, Ms M appeared at a state mental health counselling centre for adults. After three sessions there she was qualified for a heterogenic out-patient therapeutic group led by her current therapist. Group sessions were process-oriented with elements of Morenian psychodrama, held every week for two hours.

From the very start, Ms M found it difficult to take part in group work. She has very quickly assumed the role of an outsider. She refused to participate in exercises which would facilitate self-presentation in the group and during sessions she would often stay silent, manifesting symptoms of psycho-physical tension. She missed the meeting twice. Despite her formal consent to continue working in the group for at least 10 months, after 12 weeks she announced her intention to terminate the contract and leave the group. As an explanation she informed of her plans to undertake post-graduate studies and not to be able to tolerate any further "time wasting" activities connected with group sessions. She upheld her decision and realized it, ignoring the encouragement to remain in therapy, including offers of logistic help formulated by other patients.

Even though Ms M quit group therapy, she expected individual therapy to be continued and the therapist agreed. After two individual sessions, the patient once again manifested intense difficulties with establishing therapeutic alliance. She avoided discussing her own problems and kept inquiring about the therapeutic workshop, despite obtaining detailed explanations each time. The therapist felt that the patient expects him to assume full

responsibility for the course and results of treatment. In the face of being repeatedly ineffective in his attempts to establish therapeutic cooperation, the therapist informed Ms M of his own "helplessness" and the sensation of having exhausted any possible future therapeutic assistance. At the same time, he communicated his readiness to conduct three more sessions after which – should no "breakthrough" appear in their mutual therapeutic relations – he would terminate the therapeutic contract. The patient gave her consent to the conditions delineated by the therapist.

During the last of the three planned sessions, a clear change in the behaviour and level of openness presented by Ms M could be observed. She started to express her more personal ideas in an emotionally coherent manner. The patient declared her will to engage more fully in the process of further psychotherapy. She asked for the contract to be prolonged, a request which was accepted by the therapist.

The situation described above proved to be ground-breaking for the subsequent course of treatment. For several months to come, the patient frequently attempted to introduce her own personal life experiences and examine them together with the therapist. Techniques based on psychodrama turned out to be extremely useful for the progress of the therapeutic process. The therapist often encouraged the patient to externalize her internal roles with the use of psychodrama, challenging her to use dramatic dialogue as a form of communication between the various perspectives of her internal "I". During one of her monodramas, Ms M symbolically enacted and reflected her own position in the family of origin, which would later become the blueprint for her subsequent assessment of experiences and life opportunities. She also enacted a dialogue with her OCD symptoms on the psychodramatic stage. During the enactment, the patient disclosed painful, embarrassing circumstances of the appearance of such symptoms in the period of adolescence – experience which she, so far, had kept hidden.

Monodrama work enabled the patient to confront and modify significant elements of her experience which were impairing her current functioning, and as a consequence – allowed her to open up to new attitudes to herself and the environment. With time, Ms M began to change her own image, enriching it with new forms of self-presentation, i. e. her clothes and make-up. She made an effort to attempt new communication behaviour, including a more active search for personal and intimate relationships. In was in this period during the course of therapy that the patient confronted some of the more important experiences she had in the psychosexual sphere. The therapy was accompanied with visible positive changes in the quality of Ms M's engagement and the level of her openness during sessions. A significant reduction of clinical symptoms was also in evidence, which inclined her to discontinue the use of medication.

Also in this period, however, the patient continued to realize a "strained", perfectionist schema of modifying her own behavioural patterns, which she later recognized as "self-abuse" (she tried to be perfect working out at the gym, going on an appropriate diet, and fulfilling her professional duties). After the initial improvement, the patient went into crisis, which was manifested with a significant intensification of depression. She pointed out her experience of an impasse and the inability to overcome it. She stopped working for several weeks to – in her words – "take care of herself". After discussing things with the therapist, Ms M decided to accept the offer of a renewed participation in group therapy, aimed at enabling her a more effective work on experiencing herself in relation to others.

This time she managed to be consistently present at sessions during which she would introduce her own experience connected with current life events, as well – to a smaller extent

– the relations with her family of origin. Unlike the previous attempt at group therapy, Ms M was actively participating in the therapeutic work of other patients; among others, she accepted requests to act out an auxiliary ego in protagonist psychodrama scenes. In the course of group therapy, her depression symptoms disappeared and the spectrum as well as the intensity of bulimic episodes decreased. The patient worked on developing spontaneity in the group, expressing her attitude to others openly and managing conflicts. She also pointed to the importance of intimate and sexual relations issue.

The last stage of treatment took the form of a yearly individual supportive psychotherapy, with meetings held every several weeks. During subsequent sessions, the patient recounted her experience of introducing important changes into her personal and work life. She has made the effort to engage in an intimate relationship; to a significant degree she has accepted the limitations and opportunities connected with her principal employment; she has engaged and reflected on the style of functioning in new professional roles; she has made up her mind about buying a flat and put it into life. During some of the sessions she informed the therapist of her experience connected with introducing changes to relations with the members of her family of origin. The previously rigid, disadaptive beliefs and internal roles of the patient were greatly modified: among them the role of the abandoned, "inferior" child, passively observing life, or a person bereft of opportunities and misunderstood by others.

In this period the patient considered therapy as an occasion for reflection and discussion of undertaken actions. Therapeutic interventions applied were focused on strengthening her agency by appreciating her attempts at introducing new behavioural patterns. In the meantime, the patient acquired further experience allowing her to reaffirm the conviction that she had an actual influence (though not unlimited) on the level of her own psychological needs gratification, including the ones concerning intimacy in interpersonal relationships. An important element of the therapeutic relation on this stage were the discussions on the possibility of accepting failures and obstacles in life, as well as the negative consequences of various choices.

Another subject under consideration was the relationship with the therapist, including the evolution of its quality and the content of therapeutic alliance. On this occasion, the patient expressed her appreciation of the skills and determination of the therapist when it came to providing her with psychological assistance.

Psychological analysis of the change process

In spite of the initial difficulties with establishing therapeutic alliance, the course of psychotherapy depicted above can be deemed successful. Such assessment is supported with the evaluation of its objective effects, i. e. a significant reduction of clinical symptoms and a wide spectrum of personal change introduced by the patient, as well as her subjective conviction of the benefits obtained in the course of therapy. Bearing in mind the patient's previous attempts at treatment, being frequent and judged as having little effect, an intriguing question concerns the determining factors of the success achieved in the discussed therapeutic process.

What comes to the foreground is the patient's paradoxical and ambivalent attitude towards psychotherapy and the person of the psychotherapist. On seeking my help, she was aware of having attempted 10 (sic!) unsuccessful (in her opinion) forms of such treatment to date. Therefore, the first significant undercurrent introduced by her was mistrust and resistance

towards another recommended therapist. It seems that an important element of sustaining the therapeutic relationship in that period was the fact that the therapist managed to contain these, mainly unconscious, needs and attitudes.

On entering yet another therapeutic process, the patient reactivated the schema of "unsuccessful therapy" and an "ineffective, formal, therapist indifferent to her world". During sessions, Ms M behaved in a competitive manner, putting the hypotheses introduced by the therapist in question, and simultaneously safeguarding access to the more profound personal experiences, which, in practice, made working based on insight impossible. It can be assumed that her criticism of the quality of provided assistance might have been a form of testing the therapist's credibility and determination.

The suggestion to alter the form of therapy from remunerated to free could have provided existential ground for the patient's subsequent corrective emotional experience. One can reflect on whether introducing Ms M to group therapy was premature, taking into consideration her further resistance and the consequent partial drop-out. Qualifying her for group treatment, connected with her previous, relatively positive experience of such a form of psychotherapy, additionally based on the patient's pronounced consent, was designed to (among other things) facilitate her non-defensive reception of feedback given by co-patients, which is postulated by some clinicians [22]. Ms M's conscious consent to change the form of therapy has not, however, removed the significance of unconscious factors, e.g. interpreting the situation as connected with being abandoned by the therapist (parent).

Observation of the patient's functioning in the group was a source of additional data enabling the recognition of her rigid, anxious, control-based patterns of establishing interpersonal relations. The patient withdrew as soon as group cohesion increased and the possibility of establishing symmetrical, open relations with co-patients became inevitable.

Even though the patient left the group, she expressed the need to continue individual therapy. The therapist, aware of the character and level of her difficulty, interpreted the expectation expressed by the patient as an immature, albeit real, attempt at maintaining the process of treatment. Thus, he has given his consent; however, what needs to be stressed is his sensation that he was moving dangerously close to the confines of non-therapeutic asymmetry as far as co-determination of the shape of treatment is concerned.

Being attentive to this aspect of psychotherapy lay at the foundation of the decision to mark the boundaries of the relation in an open and firm manner, which indeed took place during the subsequent session and had the form of the therapist's announcement about his experienced sense of helplessness and the plans to terminate co-operation due to the lack of effective intervention outcomes to date. An open discussion of the problems concerning therapeutic alliance, verification of the contract by means of reducing it to three "last chance" sessions, resulted in the exposure and deconstruction of the relation schema based on the roles of an ineffective professional (inadequate parent?) as well as the "insignificant" and rebellious child.

During the last of the planned sessions, the patient has decided to share responsibility for the change process happening "here and now". After many months of strife, arguments with the therapist and avoiding focusing on herself during therapy[2], the patient decided on a more

[2]This is how the patient commented on this after several months of subsequent therapy: "Back then I had no experience or awareness that I could concentrate on myself at all; the process of change is education for me,

profound, effective therapeutic work – in the first instance concentrating on reducing anxiety (including the fear of change). Experiential procedures (psychodrama) proved most supportive in the process as facilitators of the patient's free self-expression in symbolical space. They can be interpreted as a type of therapeutic provocation enabling familiarization with anxiety inducing experiences, and helpful in overcoming the impasse emerging in the therapeutic process [cf. 23]. As the treatment progressed, the patient kept undertaking bolder attempts at moving beyond the rigid behavioural patterns based on the compulsion to control her surroundings. The changes she managed to gradually introduce were grounded in the realistic experience of her own agency in gaining more access to the previously "muted" aspects of her own identity (e.g. sexual needs), including their introduction in the process of communicating with others.

It can be assumed that the experience of safe emotional intimacy gained in the course of psychotherapy, which was connected with the patient's undertaken attempts at a more profound exposure as well as the therapist's transparent and non-directive style of intervention[3], helped Ms M while trying to establish close relationships.

In the patient's assessment, the attentiveness of the therapist wassignificant in the process of improvement, especially when he examined the circumstances of the emergence of intensified OCD symptoms which remained unexplored in previously attempted forms of psychotherapy. This, in her own words, has "won" her trust. Ms M has also pointed out the supportive aspects of the therapist's attitude, who, in her opinion: "conducted a dialogue with the patient, not sticking strictly to one route". At the same time, the patient felt that the therapist "has never avoided discussing the so-called everyday life", instead of being focused only on symptoms and psychopathological mechanisms[4]. It can be also supposed that the treatment based on the trust in Ms M's intuitive knowledge of the conditions necessary for change, contributed to the modification of the improvement obstructing belief, namely that as a result of psychotherapy she would "lose herself" and become someone else. In the course of therapy, the patient was relieved to discover that she is "recognizable in the change" and that she remains her own self.

The decision to participate in group therapy again gave the patient an additional space, this time brought to effective use, to confront the strategies of managing competitiveness and the ambivalence concerning one's motivation to protect oneself and relate with others. As the patient put it later: "Having experienced intensified symptoms of depression and going through an impasse after I've joined group therapy for the second time – I have begun to explore my

too; learning that I am important and that focusing on oneself is an obligation one has towards themselves. I associated concentrating on myself with something negative. Today I can take pleasure in focusing on myself, being closer to my own needs and being supportive to myself (I am still learning)".

[3]The therapist always tried to provide such working conditions for the patient that would facilitate freedom of self-expression; he would give feedback in the form of suppositions and encourage the patient to practice an open-minded reflection on her life experiences. The patient kept a journal for the whole duration of psychotherapy.

[4]Reflecting on the process of her own change, the patient stated, among other things: "Previous therapists would >manically< question me about my family and I was so far removed from myself I had no strength to talk about family. And you, by letting me take care of what was at the core of my life back then and what I was building my self-esteem on, you allowed me to construct myself in a way (discover/notice/come close to myself)".

existing friendships anew and started to care for them. I also allowed myself to make use of my friends' help. Before, even though my friends have approached me with help/initiative, I wanted to just make it on my own above all else".

The last stage of Ms M's psychotherapy was based on interventions which consistently strengthened her agency and self-trust. The therapist "cheered" her changes, simultaneously providing consultation regarding her independent attempts at looking for and trying out new strategies for solving personal problems.

Among the many factors determining the process of change depicted above, the evolution of the form and sense of agency in the patient is definitely worth mentioning. At first, Ms M experienced her own subjectivity in a form reduced to contestation, rebellion and anxiety-driven withdrawal from the intimate relations with her surroundings, which were compensated by an obsessive need for control. In the subsequent stage of psychotherapy, the patient had a chance to experience her own strength and efficacy as far as influencing an important object – the therapist – was concerned. Frequent confirmation of the patient's rights, emphasised by the therapist, the possibility to co-define the character of mutual relations, as well as sharing responsibility for the process of change, resulted in the formation of a specific groundwork for the symbolical "play space" — as Winnicott expressed it [24] — thanks to which the patient was able to experiment with new patterns of interaction with her surroundings in a creative way.

In the next stages of psychotherapy the patient expanded and consolidated the new schema of experiencing herself as a person having an influence, facing challenges, recognizing her own potential and limitations. The process resulted in the patient gaining an increased level of distance towards herself and her surroundings, which was directly connected with the development of tolerance, respect and kindness towards her own person. It additionally promoted newly discovered feeling of being competent enough to take responsibility for her own life.

Conclusion

The course of treatment presented above, as well as its exploration, is rooted in the integrative psychotherapeutic approach, which is a combination of change with the effects of the learning processes, additionally stimulated by the therapeutic situation. The above paradigm was applied in the existential approach, according to which the therapist provides help taking into account the subjective potential of the patient.

In the discussed therapeutic process – facing a serious risk of the replication of the patient's previous, negative therapeutic experience – the therapist decided to include interventions facilitating the conditions that enabled her to gain and increase the experience of subjectivity and agency. These included: enabling the patient to have a significant (though limited) influence on the conditions and course of psychotherapy, introducing a dialogical style of communication during sessions, expressing understanding for the patient's difficulties (including asking for help), as well as providing a clearly defined form of therapeutic relation, with attention both to clinical and everyday aspects of her life experiences and, finally, adjusting treatment to particular stages of the therapeutic process. All of these procedures, enhanced with techniques deriving from Morenian psychodrama, proved crucial for the effectiveness of the treatment introduced.

The above findings are concurrent with the observations of Bohart [21] who deems the following procedures helpful in the process of subjectivity activation in a patient: creating an empathetic environment during sessions; having a constructive, exchange-based dialogue with the patient; introducing structured activities which allow patients to explore the conflicting aspects of their subjective experience in a secure way.

The therapeutic change which emerged in the case of Ms M can be interpreted from various theoretical facets, pointing to different types of mechanisms and conditioning. The obvious option is to provide a description from the psychodynamic perspective, which would be to a great degree based on the analysis of the character and quality of change within the patient's defence mechanisms. Among them, one might point to: the tendency to stabilize anxiety by means of an intensified control of the relationship with the environment; affect isolation; intellectualization; denial; reaction formation as well as repression of past trauma-oriented content. A thing worth mentioning also is the passive-aggressive transference relationship with the therapist characterized by competing for power. Additionally, the patient manifested an intense fear of being controlled (which she demonstrated in the form of difficulties concerning complying with the framework of the therapeutic contract, as well as her fear of therapy-induced change interpreted as enforced, reductive and occurring against her will). Therapeutic interventions including attentiveness, patience and concessive attitude manifested by the therapist were the most probable reasons of the reduced self-defence pressure, decreased tension and embarrassment connected with the incapability of meeting the overly high self-expectations additionally projected on the therapist. The patient needed both time and subsequent experiences to modify her punitive, self-deprecating attitude. Even though Ms M "let the therapist down" on several occasions, he was consistently interested in providing treatment. The sequence of introduced therapeutic procedures has most likely given the patient an experience different from the previous forms of exercising influence – going beyond the schema of manipulating the object towards a dialogical relationship with the significant Other.

In spite of the fact that none of the logotherapeutic interventions proposed by V. E. Frankl were used (in a strictly formal sense) in the above therapeutic process, the change achieved can be most certainly interpreted in the light of the approach elaborated by this renowned Viennese psychiatrist. In the course of psychotherapy the patient experienced internal processes which can be explained with the categories essential to the logotherapeutic procedures of dereflection and paradoxical intention [19]. She focused on developing the previously ignored positive aspects of her personal life, intentionally approaching anxiously suppressed sexual experiences and open relationships with others. Many of the therapeutic interventions, pivotal for the change process discussed above, stem directly from logo- and nootheoretical theses on the fundamental significance of the patient's capability for self-distancing and self-transcendence [25].

Another interpretative possibility in the described case of change is to refer to the concept of spontaneity and creativity elaborated by the founder of psychodrama – Jacob L. Moreno [26]. The patient began therapy imprisoned in a cultural conserve. Initially, her self-expression was reduced to compulsive repetition of the previous, ineffective forms of relating both to herself and her surroundings. Unconventional interventions introduced by the therapist to meet the patient's needs might have been crucial for her change stimulation. They were aimed at overcoming resistance by means of a "warm-up" – in psychodramatic terms. They assumed

providing space for spontaneity, experiencing oneself in the state of free activity (status nascendi), and appreciating personal and life creativity manifested by the patient [27]. Engagement-inducing procedures allowed Ms M to effectively bypass blocks resulting from her inclination for exaggerated verbalization, rationalization and experience concealment.

The analysis of the change occurring in the patient in terms of the transtheoretical approach proposed by James Prochaska and John Norcross [28] allows one to indicate, among other things, the significance of consciousness raising, self- and environmental re-evaluation, catharsis, processes connected with an increased freedom of choice-making (choosing, self-liberation, social liberation) as well as the therapeutic relationship.

A separate, equally important issue to be considered are the reasons for the low effectiveness of the earlier therapeutic interventions – originating both from the patient's and the therapist's actions. For obvious reasons, they would be difficult to identify *ex post*. However, one can assume that conflicts with the therapist, conspicuous in the change process described above, might also have dominated the previous therapeutic attempts, making the development of therapeutic alliance impossible. In the patient's opinion none of the previous therapists (with the exception of one) were able to provide conditions allowing her to "relate" in a therapeutic situation. This factor might have been connected with the strength of Ms M's transference reactions. Subsequent therapists were given in the role of bad mother, symbolically deserving punishment for not being tender, attentive and caring enough, or the roles of overly restrictive fathers. On the other hand, some of them, at least, might have been too dependent on the label of "a difficult, not promising patient" – which undoubtedly would have negatively affected their perception of the therapeutic situation, sense of competence, and future treatment effectiveness. One of the defences against the discomfort connected with the looming therapeutic failure might consist of hiding behind the mask of a "technical expert", a measure taken additionally to protect the therapist from the effort of facing the rigid, passive-aggressive and anankastic communication patterns manifested by the patient.

The above-presented clinical data provides arguments sufficient to support the stance of the practical usefulness of therapeutic anthropology, which treats the patient as a subject of change, rather than an object of its influence. Anthropology of this nature is a postulate of existential psychology and psychotherapy and the significance of this paradigm in the course of constructing an effective psychotherapeutic relationship is judged obvious by many researchers and therapists who are its representatives [29].

The therapist who notices and appreciates the patient's subjectivity, for instance in the context of their agency, the right to choose or their intuitive knowledge of which directions or conditions should be taken into consideration in the process of introducing constructive change, gains an additional tool for greatly increasing treatment effectiveness and preventing therapeutic failure. Of course, this might be of special significance in the case of patients experiencing persistent difficulties in the course of psychotherapy. Therefore, the above-raised issue should, and without question, be explored further in the future.

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