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**THE THERAPIST AS 'OTHER':
The Patient's Search for Relatedness**

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INTRODUCTION

In the practice of psychotherapy, philosophy and psychotherapy are intimately intertwined. Therapeutic interventions are guided as much by a therapist's philosophy as they are by an understanding of psychology and psychotherapeutic principles. Both philosophy and psychology attempt to address the question of what it means to be a human being. One gravitates toward certain philosophical assumptions in large part because they address fundamental personal, subjective themes in one's life. From a psychological perspective, one's philosophy can be seen as an artistic and abstract description of one's subjectivity. From a philosophical perspective, one's psychology can be seen as an embodied, personal expression of some of the various universal themes which philosophy is dedicated to articulating.

Perhaps a description of my development as a psychotherapist can illustrate the interplay of personal psychology and philosophical interests. My professional interests have been shaped by my life-long struggle to overcome a pervasive sense of isolation and disconnection in my life. My struggle to come out of isolation and to allow intimacy, to touch and be touched, has been of central importance. I was initially drawn to humanistic therapies--especially gestalt therapy--because of what I witnessed in the therapeutic relationship; the gestalt therapists I first met were intensely present and engaged. I saw in their willingness really to 'meet' their patients, person-to-person, an emotionally intense encounter, some hope for salvation from own emotional impoverishment and isolation.

In fact, I first discovered Martin Buber's philosophical anthropology when I studied gestalt therapy. The relationship gestalt therapy is said to be predicated on Martin Buber's philosophy of dialogue. It is the only school of therapy I know of that has purposely placed Martin Buber's philosophy as a cornerstone of its theory, although it is only recently that elaborated description of the dialogic philosophy in gestalt therapy has emerged (Hycner 1985, Jacobs 1989,).

I was immediately drawn to Buber's ideas. He spoke elegantly to my deeply felt yearnings for genuine engagement with others. His ideas helped me see my own personal struggles in the broader framework of universal human themes, thus reducing my sense of alienation from the world of other humans. Also, he asserted that strivings for genuine relatedness were something that could contribute to the well-being of others, whereas I tended to think of my yearnings and strivings as anathema to others .

My abiding personal interest in relatedness has fueled an abiding professional interest in the therapeutic relationship as a curative factor. This has led me to Gestalt Therapy, with its emphasis

on direct meeting, and to modern psychoanalysis, with its continuing refinement of the notion of transference as in part the search for new relatedness, and of the subtleties of empathy. Since I read Buber, my studies--be they humanistic or psychoanalytic--are integrated with the guiding principles of 'healing through dialogue.'

In my opinion, most clinical theory is moving inexorably toward the fundamental concepts of Buber's philosophy of dialogue. They do so slowly, carefully, from a more 'scientific,' as opposed to philosophical position. Not many of these theories trace their development directly to influence from Buber's philosophy, but Buber's philosophy is part of a general "weltanschauung" that definitely affects the development of new ideas in psychology.

I have already referred to Gestalt Therapy--representative of the humanistic tradition--as fertile ground for the philosophy of dialogue. Turning to the psychoanalytic tradition, a group of modern psychoanalytic theorists known as "intersubjective" theorists (a branch of self psychology) are attempting to influence psychoanalysis to renounce its natural science origins in favor of a so-called "human science" perspective. They in turn are influenced by a German philosopher, Dilthey, who draws explicitly upon Buber's philosophy:

According to Dilthey, the human sciences are to be distinguished from the sciences of nature because of their fundamental difference in attitude toward their respective objects of investigation: The natural sciences investigate objects from the outside whereas the human sciences rely on a perspective from the inside. (Atwood and Stolorow, 1984 p.2)

From a natural science perspective, observable behaviors such as interactions with others are studied. From a human sciences perspective, the meanings to the experiencing subject are explored. In a description closely allied with Buber's notion of 'inclusion,' Stolorow and Atwood assert that within the human sciences, one attempts to understand another from a perspective within the other's frame of reference. In fact, Dilthey (in Atwood and Stolorow 1984), drew a parallel to Buber's thinking. The mode of relatedness in the natural sciences is the I-It mode of subject-to-object. The mode of relatedness in the human sciences is the I-Thou mode of subject-to-subject.

Self psychology and intersubjectivity theory, assert, with their 'selfobject concept, that one's self comes into being and is maintained as a self-with-other. They also emphasize empathic inquiry as the foundation of psychoanalysis. The intersubjectivists have developed and refined a listening stance which, in my view, is the embodiment of inclusion.

Buber defines "inclusion" in therapy in this way:

"The therapist must feel the other side, the patient's side of the relationship, as a bodily touch to know how the patient feels it. n (1967, p. 173)

It is a concrete imagining of the reality of the other, in oneself, while still retaining one's own self-identity.

In dialogue, there is a special insight or illumination in the personally experienced confirmation of oneself by another, which occurs through inclusion. Confirmation means that one is apprehended and acknowledged in one's whole being (Buber, 1965). The act of confirmation requires that one enter into the phenomenological world of the other without judgment, while still

knowing one's own being. In my opinion, this is precisely what happens when an intersubjective analyst engages in sensitive attunement to the patient's emotional experience, or engages in empathic immersion in the inner world of the patient.

The modern psychoanalysts draw, in part, on exciting new findings in infant research studies put forward by Stern (1985) and Lichtenberg (1989). Both of these researcher/clinicians use infant research studies to argue that from birth infants are interacting with an 'other.' The other may be only vaguely defined and perceived as an other, but evidence of rudimentary differentiation between self and other from birth is ample. Another exciting discovery is that the infants' sense of self and their self-regulation (even regulation of physical states such as sleep and hunger) are patterned by the reciprocal, mutual interactions between caretaker and infant.

These studies demonstrate that healthy self-development requires a sensitively attuned emotional responsiveness from the caretaking surround. The emotional attunement establishes both a mutual system of physiological and emotional regulation, and also embeds the infant in a web of relatedness, without which a sense of personal selfhood cannot form.

The two themes--of sensitive attunement to the inner world of the other, and embeddedness in relation--are obviously compatible with Buber's dialogical philosophy. They are major steps along the way to developing a theory which appreciates the central importance of engagement with otherness for self development. But they remain incomplete, in that their focus is on the caretaker's responsiveness to the infant, and they do not explore fully the implications of the child's engagement with the 'otherness' of the other.

Intersubjectivity theory brings these two developmental themes into the psychotherapy process. First, they emphasize that the therapist's task is to establish an attuned, empathic grasp of the patient's inner world. Second, their interpretations focus to a great extent, on understanding the patient's experiences as emergent phenomena of the quality of relatedness which exists between therapist and patient. Thus, the patient's experience of the therapy relationship is seen to be codetermined by the patient's previously established ways of being, and also by input from the therapist. They further assert that the therapist's experience is also codetermined by the therapist's predisposition, and by input from the patient. They conceptualize the therapy relationship as an "intersubjective system of reciprocal mutual influence." (Stolorow et al, 1987) The implications of such a fluid, 'dialogic' view are not yet fully articulated in the evolving literature of intersubjectivity theory, but in my opinion they will be moving closer still to Buber's philosophy of dialogue.

At the present time, intersubjectivity theory makes a strong case for reliable affect attunement as the means whereby the affect integration necessary for self-development occurs. From a dialogical perspective, another dimension of relatedness is central to self-development, and that is the "interhuman meeting." In the interhuman meeting, attunement, a centrally important embodiment of inclusion, is accompanied by the therapist's presence. The therapist is first and foremost a human being. And as Buber insisted, for a genuine meeting to take place, the therapist must be present as a human being who endeavors to meet the patient, from the depths of one vital center to another. To touch--and thereby to heal--the roots of the patient's being, a therapist must:

Step forth out of his protected professional superiority into the elementary situation between one who asks and one who is asked. The abyss in the patient calls to the abyss, the real, unprotected self, in the doctor and not to his confidently functioning security of action. The analyst returns from this paradox . . . as one for whom the

necessity has opened of a genuine personal meeting between the one in need of help and the helper. (Friedman, 1976, p. 190)

Presence involves bringing the fullness of oneself to the interaction. Therapists must be willing to allow themselves to be touched and moved by the patient. One is present when one does not try to influence the other to see oneself only according to one's self image. While no one is free of pretense -- the desire to be seen in a certain way -- presence must predominate in genuine dialogue. For instance, a therapist must give up, among other things, the desire to be validated as a "good therapist" by the patient. When a therapist "heals" primarily in order to be appreciated as a healer, then the dialogic process is interrupted. The other has become an object, a means only, not an end also. Therapists' love for healing must be "uninvested," must not occur only to suit their needs for a certain self-image.

In therapy, presence means also that the therapist is willing to be open to a kind of contact in which the patient can touch the therapist's subjective experience, both directly and indirectly. Quite often this occurs indirectly. But at crucial points in the therapy, for instance in efforts to address serious disruptions in the therapy relationship, or at certain developmental thresholds, the patient may be intensely interested in, and require, access to the therapist's experiencing. Self development proceeds not only through the experiences gained through sensitive attunement to the patient's otherness, but through the experience of that attunement coming from a discernible, personal other.

THERAPIST AS "OTHER"

The remainder of this paper is dedicated to exploring the therapeutic implications of practicing therapy from a stance which holds that the therapist's presence is as much a necessity as skills, typology, even as much a necessity as is the practice of inclusion. I am especially drawn to understanding two related concepts, 'presence' and 'otherness,' in the therapeutic relationship. These notions find a welcome reception in the humanistic therapies, but they are often poorly understood and misused. Meanwhile, they are approached with a great deal of caution and timidity by psychodynamic/psychoanalytic therapies. I wish to be able to elaborate on the place of presence and otherness in the therapeutic process in such a way as to render the concepts attractive and practical for a broad range of therapy theories.

I believe that Buber's philosophy cannot be transported wholly unmodified into the consulting room. It must be reexamined from a psychological perspective if it is to serve the purpose of calling forth from patients their unique, personal existence rather than a model of who they should be, even if that model is a dialogical one.

Therapy as one-sided inclusion

In a previous paper (Jacobs, 1989) I detailed how a therapist might integrate Buber's "elements of the interhuman" (Buber) into a dialogical approach to psychotherapy, specifically gestalt therapy. The elements, inclusion (and confirmation), presence, and commitment to the dialogue (or the "between"), are to be embedded in the specific context of the therapeutic relationship. In the therapy relationship, the therapist listens and engages with the patient from a stance which I have termed a "dialogic attitude." From the stance of the dialogic attitude, I am committed to meeting the patient, to surrendering to the currents of the dialogue, to practicing

inclusion, and to bringing my presence forward, and yet I do not expect a reciprocal intention from the patient. Buber describes the healing relationship of psychotherapy as a particular form of dialogic relation (1965b, 1970). It is a necessary tragedy of helping relationships that, unlike friendships, they cannot be fully mutual. (1965b, 1970). Buber contends that while a therapist may at certain moments experience full mutuality with the patient, therapy, by the nature of its task, involves a limited relationship.

The therapist must feel the other side, the patient's side of the relationship, as a bodily touch to know how the patient feels it. If the patient could do this, there would be no need of therapy and no relationship. (1967, p. 173) (underlining's mine)

It is possible that in order to make his point clearly, Buber exaggerated the difference between therapy and a more fully mutual dialogue. Certainly, some patients are capable of fully mutual inclusion with the therapist. But even these patients would not be serving their own best interests by engaging in a predominantly mutual therapy relationship. The task of therapy requires that the focus be primarily on the patient, not on the therapist.

The therapy relationship is limited because of the nature of the task. Buber describes the therapy relationship as a "one-sided inclusion" rather than mutual inclusion (1970). In one-sided inclusion, the helper strives to imagine the reality of the other, but the reverse does not ordinarily happen and is not intended. If the relationship is mutually inclusive, then it cannot be therapy. The essential difference between mutual inclusion and one-sided inclusion is not based on an assumption that the person of the therapist is different from the person of the patient. The difference comes from the fact that the task sets the two people in different relations to each other and to the task. The therapist has willingly set aside personal investments in order to serve the learning of the patient. Patients are invested in their own learning, not that of the therapist. At moments of the I-Thou relation, such role definitions are irrelevant, but the alternation between the phases of I-It and I-Thou occurs within the context of the one-sided dialogic attitude. If a fully mutual dialogic relationship develops, then although the relationship will be therapeutic for both participants, the therapy contract no longer exists.

In therapy, the inclusion is one-sided, and confirmation is largely one-sided as well. The therapist confirms the patient, but not vice versa, except in rare moments. In essence, it becomes the therapist's responsibility to establish the conditions for dialogue (Friedman, 1985). The therapist must do everything possible to come fully to the relationship: be present, engage unreservedly in the dialogue, and practice inclusion.

Therapy along a 'narrow ridge'

Therapists conduct therapy along a peculiar 'narrow ridge.' On one side of the ridge is our commitment to, and faith in, exploring and articulating experience as fully as possible. This includes, most importantly, patients' experiences of relatedness, and the myriad meanings relatedness holds for them. On the other side of the ridge is 'the ineffable.' No matter how thoroughly we explore meanings, motivations, the drama of relatedness; no matter how richly patients come to articulate their world of relatedness; there comes a point where one has a concrete sense that there is more to the relationship than one is able to describe. We find ourselves thinking--or we hear our patients saying--"there is more here. But there are no words. But it is something primal, fundamental, that cannot be further 'reduced.' It just is."

It is easy to get lost trying to follow this narrow ridge. Some therapists lose themselves on the side of meanings. Sometimes their patients come away knowing a great deal about certain dimensions of relatedness and self-experience, but they are in a profound way diminished. For relationships are only understood as serving certain needs and functions for the patient. That which is ineffable has not been acknowledged, and patients may now believe that the self-regulating or narcissistically relevant elements intrinsic to all relatedness is all that there is to relatedness.

On the other hand, some therapists may so revere the ineffable that they do not help their patients to understand that which can be known and grasped about their relatedness. These patients may leave their therapy feeling vaguely at a loss and guilty about just how much of their relatedness does involve their narcissistic needs. They may try to purify themselves of such rewards of relatedness, until isolation becomes their only mode of being that does not demean the ineffable quality of relatedness, which it has become their duty to protect.

In the dialogue of which Buber writes, all living is a meeting. There is no "I" which stands alone, but only the "I" of "I-It" and the "I" of "I-Thou". There is an alternation between those two modes of existence. The I-It mode is vitally necessary for living, the I-Thou for the realization of personhood. As Buber stated,

Without It a human being cannot live. But whoever lives with only that is not human. (1970, p.85)

The I-It mode can be considered the "ego" mode (Farber, 1966). It involves such functions as judgement, will, orientation and reflection (Farber, 1966). It also involves self-consciousness and the awareness of separation (friedman, 1976b). It is in the I-It mode that a person orders living in time and place. Importantly, ideas and feelings, and attempts to make oneself understood to others, all comprise the world

In contrast to the necessary separation of I-It, the I-Thou relation is integrative, and affirms one's wholeness:

The basic word I-You can only be spoken with one's whole being.
The basic word I-It can never be spoken with one's whole being. (Buber, 1970, p.54)

When two people surrender to the "between"--called "existential trust"--the possibility of I-Thou relation emerges. But it will always be a temporary state. Both will return to the world of I-It, necessarily. Existence in either mode is an evolving process in dynamic relation to the other mode. Each alternates as background for the other. The hallmark of creative and healthy living is finding the proper balance between these modes in one's life (Hycner, 1985).

In actuality, the ridge between these two dimensions of relatedness--the I-It and the I-Thou--is not a solid ridge. It is more like netting. Buber says of the I-Thou relation that it is lived in both "actuality and latency" (1970, p. 69). This is important, because although most attention is given to the momentary experience of an I-Thou relation, I-Thou refers both to this special moment and to an underlying process. This distinction, while relatively unimportant to understanding the phenomenon and significance of I-Thou, is of particular importance to the practice of therapy, for much therapy is conducted in an I-It mode, with I-Thou in the background. Thus, while Buber makes no formal distinction between the two, I distinguish between the I-Thou moment, and a more on-going dialogic process.

Trub described two major phases of psychotherapy, the dialectic and the dialogical. In my experience, even in a more dialectic process during therapy, the ground which makes the therapeutic dialectic possible, is the one-sided inclusion--a dialogic process--which the therapist practices throughout the therapy. There are two paradoxes here. First is the fact that the I-Thou relation is also self-enhancing. From a psychological perspective, the I-Thou relation serves narcissistic, or self-regulating functions. As Buber describes:

For the inmost growth of the self is not accomplished, as people like to suppose today, in man's relation to himself, but in the relation between the one and the other, between men, that is, preeminently in the mutuality of the making present--in the making present of another self and in the knowledge that one is made present in his own self by the other--together with the mutuality of acceptance, of affirmation and confirmation. (1965, p. 71)

Meanwhile, when a patient is truly able to allow themselves to use me as an 'It'--for their emotional or self-esteem regulation--and when I am permitted to be helpful to them and can surrender to it wholeheartedly, the intimacy of such a reciprocal event touches us both profoundly. We may have started at some distance from each other, and they may need to use me more as a means than they can relate to me as an ends, and yet we move into fundamental relation to each other, speaking from center to center. At such moments the line between I-It and I-Thou becomes non-existent: at least from my side of the dialogue.

Curiously, it is through careful listening to and engagement with the patient's experiences on the other side of the ridge, the side of meanings and functions, that I develop a feel for when "the ineffable" is upon us. For example, I have worked for four years with a woman who relates to people largely as means towards an end for herself. When others do not serve the functions she needs them to serve, she spirals into a well of despair and self-loathing. About 2 years ago, at the end of a very intense session where her despair was palpable to us both, she said to me she was amazed that I hung in there with her. She also said, "I love you." I suggested that perhaps she was grateful to me. I also suggested that her 'I love you' was a way of saying 'I need you'. I thought perhaps she was guilty and afraid of censure for saying, so baldly, 'I need you', because she was supposed to be mature and loving, not selfish and needy. She agreed at the time, and began to be more open with me about self-regulatory needs of me.

Her therapy has progressed, and recently she has been able to break free of a long pattern of enmeshed involvement with her adult children. This was accomplished in part by a growth in her capacity to experience me, herself, and them as independent centers of initiative (I will discuss this issue in her treatment later). This shift in perspective now permeates the quality of her relatedness with all others. Recently she ended a phone conversation with me saying, "I really love you, Lynne. I know you think that means I need you, but I love you too." I said we will talk more about it at our next session, that I thought there had been a shift which changed the meaning of her statement to me. It is my sense, at this time, that her 'love' does carry more than 'need.' Certainly she experiences herself as being confirmed by me in her otherness (which includes a strong attachment to me), and she is confirming me by allowing me to have helped her. Perhaps we are in the realm of the ineffable here.

PRESENCE and 'OTHERNESS'

Therapy is, in large part, a developmental process. At different points in the process, different qualities of otherness are sought and required for the patient's growth, or for the patient's healing. One of the arts of therapy is the attempt to bring your presence forward in a way that addresses the patient's current particular relational need. A developmental perspective on dialogue would assert that there is a natural developmental thrust towards dialogue. If the therapist can provide the ground by being available for various kinds of 'meeting' as new developmental sequences emerge, then the full-bodied turning-toward-the-other will emerge.

In fact, confirmation, which is intrinsic to dialogue does not come about simply through the act of inclusion. The inclusion is Meaningful because it has been voluntarily proffered by a separate other. And yet, the dimensions of 'otherness' which the patient may seek relation to will differ over time. Initially, in fact, for some patients, any sense of the 'otherness' of the therapist may be experienced as a burdensome impingement on them. These patients feel compelled to attend to the narcissistic needs of the other at the expense of their own needs. Their only safety lies in a relation to a therapist who will quietly, and without protest, keep his or her 'otherness' lying fallow in the background for a sustained period of time. In this case, the therapist's presence is manifested through a dedication to providing a necessary background, a culture in which the patient may begin to grow without conscious awareness that such a culture is being provided.

The developmental thrust of relation to 'otherness' is described in a recent popular song, "Wind under my Wings." The lyrics describe a woman looking back, grateful to a friend who stood in her shadow and provided the 'wind under the wings' so that the protagonist might fly. At first the protagonist took the friend for granted. Only as the protagonist matured did she realize the gift which her friend had given her by quietly and gently supporting her (Robert Stolorow, personal communication).

At times the most loving, therapeutic presence the therapist can offer in therapy is a genuine, gentle willingness to provide a background against which the patient emerges, as in this statement by Hycner:

In a genuine dialogical approach it seems to me that the therapist is a "steward of the dialogical." By this I mean that in a very profound sense, the individuality of the therapist is subsumed (at least momentarily) in the service of the dialogical, which is the entire therapeutic gestalt and includes the individuals in it.... It assumes that genuine uniqueness arises out of genuine relations with others and the world. Individuality is but one pole within an overall rhythmic alternation between our individual separateness and our participation in something larger than us, i.e. "Being". (1985, p. 33)

We know that patients come before us having been thwarted in their desires for genuine meeting. They often feel hopeless and despairing of ever relating genuinely and deeply with another. And we know that such genuine meeting is not possible unless the patient has a genuine "other" with whom to meet. And yet, if the therapist aims at bringing him or herself to the patient as an "other," instead of aiming at meeting the 'otherness' of the patient, then the inclusion has been violated. For therapists, their "otherness" must always emerge in relation to the on-going inclusion in which they are immersed. It is through this process of inclusion that the developmental strivings of the patient can best be grasped.

One of the most common mistakes made by dialogical therapists is a tendency to impose their presence on their patients. For one's presence to be a part of what heals the other, it must be delicately balanced against the patients' readiness to encounter an "other." Therapists often bring their presence forward willy-nilly, rather than measured in response to the call from the patient. This imposition becomes justified as an expression of genuine dialogue. But it is an encounter lacking in an inclusive understanding of the patients' needs and readiness .

In my opinion, presence and inclusion exist in a dialectic relation to each other. Through the practice of inclusion we arrive at an understanding of how our presence is being experienced by the patient. We also come to understand what kind of 'otherness' the patient seeks. We can adapt our presence to be relevant to the patient's emergent developmental needs. The constant vacillation between inclusion and presence, and the ever-shifting adaptations of one's presence are all played out in the 'between.'

Self-Disclosure as Revelatory of 'Otherness'

One obvious dimension of therapist presence is that of therapist self-disclosure. Sometimes self-disclosure is a disciplined response to being called out as an 'other' by the patient. Sometimes it is an enactment of the therapist's narcissistic needs. Sometimes it is a surprising moment of spontaneous reactivity. In any case, it is a moment in the therapy process where the patient is brought face-to-face with the otherness of the therapist. I offer some examples below from my own work which I hope will refine our understanding of how patients experience our presence, and how our use of our presence intersects with both the patients' defensive needs and with the developmental readiness for, and ability to assimilate,

One thing I have found is that when a therapist describes his or her own experience in the therapy relationship, it can have a quite a different impact, depending on a variety of factors. Obviously, a self-disclosure is a complexly motivated intervention. The patient, based on their characteristic way of organizing their experience may be more affected by certain of the motivational factors, and relatively unaffected by others. The patient may respond--to the therapist's dismay--to what, in the therapist's mind is either a relatively minor motivation, or one that is a source of embarrassment to the therapist (e.g. a narcissistic need). Other factors which will influence how a self-disclosure is received is the patient's particular developmental or defensive needs at the time, and his or her developmental readiness.

1. 'Otherness' in the quiet background

I am reminded of a patient I work with who is deeply ashamed of herself and considers herself to be inherently and irreparably defective. She also often believes that no one else in the world has the same problems that she has. In the first few years I was so pained by her sense of shameful isolation, that I twice told her things about myself which were similar to problems she was describing. In both instances she became severely distressed, felt impinged on, and insisted that I not ever do that again. She said she needed me to be a "whole", not defective like herself. Similarities between us were organized by her as a sign that I too was defective and therefore could not offer her any hope of wholeness for herself (in a painful paradox, she was also deeply humiliated by our perceived difference, as that meant I was a different class of person than she was, and could only feel contempt for her defectiveness). Currently four years later, she tentatively seeks a connection to my inner world, warts and all, as she begins to feel herself more and more a part of the planet. She now thinks that if I have problems and can function as well as I do, than maybe she

can too. My presence over time with her has shifted as we both find our way in this evolving developmental relationship. I started out imposing myself too strongly on her, crushing her sense of herself as having her own mind. Then she experienced me as providing the water she could learn to swim in. During that phase I brought myself to her largely through systematic immersion in her world as best she and I could describe it. Now I am more active in bringing in my personal, particular personality, and she is revelling in the experience of engaging deeply as two distinct personalities. She never knew before that we could be different people and yet share same passion: commitment to her development.

2. Defining the field of experience

For some patients, a therapist self-disclosure helps them to define and delimit their own self-experience, as well as determine the interpersonal field for which they are responsible. For other patients, the self-disclosure is experienced as a requirement for them to come to the aid of the therapist, and respond to the therapist's narcissistic needs.

a. presence in the service of self-delineation

An example of the former is my work with a patient with whom I wrestle with seemingly intransigent countertransference difficulties. Unfortunately, this woman's characterizations of me when she is disappointed in me confirm my worst fears about myself as a cold and heartless person. I react to what I experience as a humiliating exposure by withdrawing psychologically, thereby compounding her sense of my destructive (to her) defectiveness. Recently this recurrent pattern brought us to a point of impasse. I had, by this point, admitted to having countertransference difficulties, and I was working to lessen their impact on the therapy, although without much success. In agony, she sought a consultation with a colleague of mine. She was in an excruciating bind. She was very attached to me, and could not imagine surviving without me. On the other hand, this pattern was also "killing" her. The consultation proved useful for both of us, in underscoring her desperation. I decided to tell her more about what I knew of my countertransference difficulties. I told her that I felt humiliated, and dreaded that her characterizations might prove true of me, and my defense against the humiliation was withdrawal. That session was transformative for both of us. By articulating my experience, directly with her, I am less dominated by my dread of humiliation. My patient was deeply moved, and relieved in that by my admission of my own agonizing self-doubts she was freed of the burden of trying to "work around" my problems. Now they could be addressed directly and empathically as they occurred. She no longer feels responsible for pushing me away, although she is saddened that this particular pattern has been so painful for both of us. I cannot describe in words the increased intimacy, humility, and depth of relating which has occurred between us, but it is quite palpable to both of us.

b. presence as an annihilating impingement

On the other hand, when I disclosed a countertransference problem with another patient, in the same hopes that it would help her to define her own experience and not be responsible for mine, the patient experienced it more as a usurpation of her experience. This particular patient knows a great deal about my life. She seems to use the knowledge as a way to stay in touch with me as an anchor in her life. She knew I had suffered a painful loss, and it stimulated her own grief regarding her father's premature death many years ago. She averred that my recent tragedy was the stimulus for the mourning which she entered into for the next several sessions.

One session I could not bear the intensity of my own grief which was being stimulated by my patient's mourning. I defensively distanced myself from her experience. She noticed the subtle change in my demeanor and asked what had happened. I explained what I was feeling and she became upset and angry. She said she felt undermined in her grief, as if I was telling her my grief was more important than hers, and that she should now abandon herself to shore me up. I was surprised. She knew I was grieving. I thought my speaking of it would create a meeting of greater intimacy between us. Only recently we have begun to understand some of the roots of her experience of the interaction; her mother used to be abusive to her, and then later apologize, saying she was just having a bad day. My patient heard her mother's "confession" as a plea to forgive, and most importantly, forget the injury my patient had suffered. My patient worried I wanted the same thing. For my part, in retrospect, I do think I was turning to her to meet my need for comfort and solace. This is a patient for whom I feel great fondness, and a desire for more closeness. Thus, I think there was a confluence of her fear of usurpation, and my intrusion of my neediness into her session.

3. Empathy for the 'other' as a new dimension of relatedness

Meanwhile, I have another patient who is reluctant to inquire as to how I am faring in my grief, even though she cares deeply for me, and would like to offer support. She is afraid of intruding on my privacy, and on my sense of professionalism. She was also cruelly exploited in her childhood, and she feels terribly vulnerable when she shows tenderness toward others. In our latest session we were talking about her relationship with her infant son. We thought, based on a dream she reported, that the overpowering tenderness she felt towards her son might be paving the way for the risk of being tender with adults. At the same time, she rued that she is unable to believe that she is giving anything positive to her son. His calm, sweet disposition is attributed to his genes, or to the housekeeper, but never to her. She has a longstanding belief that she is toxic to others, and has nothing positive to offer people.

She mentioned her concerns for me, and consequent embarrassment, late in this session. It seems to me that my genuine desire to have her know of my grief, and how consoling it is for me when she inquires, is an example of where my presence might provide for her a new relational experience. She might be able to have her tenderness toward another adult be welcomed, she might see it contribute to my own healing, and she might not be exploited. All this remains to be seen, but I think it is a distinct possibility. In this case, the relevant "otherness" of the therapist is as an other who can benefit from being in her presence!

4. The address of the 'other' as permission to expand

Another use of the "other" may be as a guide to the range of permissible expressiveness or affectivity in the relationship. This was brought home to me recently in a session with the woman I mentioned above who has recently begun to enjoy getting to know me as a flawed person. She made reference to something which was a painful reminder of my recent loss. Unable to contain myself, I started to weep, and choked out a few grief-stricken words. My patient was shaken to have had such a powerful effect on me by an almost offhanded remark. Then she herself began to weep, and spoke of the deep sadness which is her constant companion. This patient rarely cries, as for her, tears are a humiliation.

The next session this patient felt lost and flustered, saying she wished she could push a button to recreate the feelings of closeness between us at the last session. She was angry and disappointed. She sees me as in charge of our intimacy. I can either offer it or withhold it. She is powerless. Her anger and frustrated disappointment carried over into our next session as well. In this session she was finally able to trace that the closeness for her began with my tears, and then had continued into her tears and my interest in them. It finally dawned on both of us that my tears were permission for her to have her own tears. Her parents had been rigid and highly controlled people, who demeaned her and disapproved of her emotions. What we came to realize was that although we had often talked together about her being able to more freely show her emotions, the talking about was similar to her parents. She was looking for me to concretely set the boundaries of permissible affectivity between us, by what I did, and she desperately hoped I would be more expressive than her parents were. This emerged from the same woman who for years had insisted I stay as anonymous as possible so as not to crush and disappoint her. The end result of this exploration was a realization that the 'other' determines the range of acceptable emotional expression, and she is required to stay within the boundaries which the other person establishes.

Another similar example comes from a case described in a case conference. The patient seemed unable to directly speak of herself in relation to the therapist. She would use words like "people", and "others" when she seemed to be expressing her own needs. Then the therapist asked if she might tape record their sessions. The therapist clearly stated it as a desire of hers. In the same session, and for the first time, the patient directly stated a wish of her own.

5. Meeting 'otherness' as an affirmation of existence

Some patients may search out the therapist's otherness overtly. The therapist's otherness serves the developmental aim of affirming the patient's existence by being able to be affected by the patient. For instance, a patient may need the therapist's emotional reactions as a sign that the patient is relating to a spontaneous other who has a vital center of his or her own. These patients often had parents who usually said all the right things, but were hidden behind a facade. The patients were never truly met, and they grew up feeling dead inside, expecting to meet others who are dead at their cores.

Another patient may seek otherness as a boundary against which they can feel their own uniqueness. Someone else may use otherness as a way to discover the subjectivity of others, and also the relativity of their own subjectivity. Thus, I have a patient who, after many years of therapy, has begun to ask me how I feel about certain life dilemmas I may have, how I feel in certain life situations (such as differences with my lover). She seems to be attempting to make room for her own fears, vulnerabilities, etc., by finding out that everyone's internal world is different, and that if one looks cool on the outside, it does not mean they have no vulnerabilities on the inside.

6. Defensive search to possess the other

Sometimes patients overtly seek the otherness of the therapist for defensive reasons. I have a patient who insists that I acknowledge every anxiety that I experience in our relationship, and every defensive moment, and every moment of self-doubt and vulnerability. He watches me carefully, and is relentless when he spots a vulnerability of mine, until I can provide him with a satisfactory accounting of it, including a description of the relevant character limitations. Once I give such an accounting he is generous in spirit, compassionate and accepting. But it has become clearer to both

of us that, among other things, this patient is defending against terrible feelings of mortification by exposing me. His reasoning goes something like: if I expose her as having frailties, she will not be able to scrutinize my own because I will be able to point to hers as proof that mine are not so bad. He lives in a world of dominating, brutal-critical "others", in his view, and domination of others is his only defense.

Another patient of mine interprets my possible motivations whenever she experiences me as failing to be fully present and open to her. Recently I admitted to some irritation with her. In her usual fashion, she made some guesses about my vulnerabilities and defenses. She asked for corroboration and further elaboration from me. I hesitated to do so, telling her I did not feel open to such exploration with her. I told her I felt rebellious in the face of what I experienced as her attempts to control me. As we engaged further in this painful dialogue, it emerged that she believed that if she pointed out to me just what my psychological conflicts were, she thought she might be able to prevent them from impinging on her in the future. From this emerged a lack of faith that I would have the maturity, willingness, and skills to do the work I needed to do to provide the developmental climate she needed. Needless to say, this led back to stories of her parents and how woefully inadequate and immature they were when it came to providing a psychological climate conducive to her growth throughout her childhood. Interestingly, I never did tell her the nature of my countertransference problem as I understood it. We had several tense sessions where she waited with baited breathe to see if I really could take care of the problem without her help. When she saw that I could, she became emboldened to break free of some stultifying merged relationships with her adult daughters where she was "helping" them so much they did nothing on their own and everyone was resentful. This is the first patient I mentioned, whose relation to my 'otherness' is expanding into greater capacity for love and gratitude towards me. The difference to me is clear: at first she "loved" me in order to regulate her self esteem and soothe her painful feelings of despair and shame. Now she loves me for my dedication to her well-being. Her self-esteem is being greatly enhanced by the newfound experience of loving another as part of the on-going stream of relatedness. Rather than aiming at feeling better, she is aimed at relating. Not surprisingly, her shame and despair are abating as her esteem rises.

CONCLUSION

In the cases described above, I endeavor to show that patients seek relatedness in differing ways, depending on their past experiences and their current developmental needs. Dialogical therapists must tailor their presence to the developmental readiness of the patient. The readiness of the patient is often discovered through systematic practicing of inclusion. The therapy process becomes a fluid dialectical process of alternation between inclusion and presence, as differing types of relatedness are sought by the patient at different stages in the therapy process.

There is an on-going dialogue between Buber's philosophy of dialogue and the psychology of therapeutic dialogue. In that process, therapists can continue to refine their abilities to engage in a dialogue with their patients which is both sensitive to their developmental needs, and evocative of their richness as human beings.

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