Dialogue instead of Medication – the Meaning of BUBER and TOURNIER for my Work

Working with people that suffer from Chronic Schizophrenia: Dialogue instead of Medication – Creating meaningful „I-Thou“ Relationships in Therapy (Empathic Therapy Conference, Syracuse NY, 13.04.2012)

Introduction:

For me it is a great honor to be with you at this conference about empathic therapy where within the medical psychological psychiatric field the human person – many mysteries included and admitted – is the central issue and not some reductive scientific biological psychological methods of influencing not-accepted human behavior. I mean methods like pharmaceutical entities (I mean pills of course) or behaviorist training methods, destructive manipulative methods that ignore the human dignity. By the way: by the word “reductive” I mean the understanding of only a part of the human being, like the biologistically thinking collegues do seeing the human being reduced to a biological system or the behaviorists seeing the human being reduced to a reflex-machine.

My main critic to modern psychiatry is as a matter of fact its reductionism, which also means a question mark (?) behind the annexation of problems and difficult behavior into the field of medical science, or the other way around a question mark (?) behind the overestimation of the giant “medical” science with its overwhelming solutions, that are also applied within the field of psychiatry – without much success. I think we all agree on that.

We observe that many problems people suffer from are even caused by this reductionism and for instance its following maltreatment with the so called pharmacotherapy. But it is not only the toxic psychiatry – a word of Peter Breggin I think – in the sense of pharmaco-toxic, it is also the whole attitude of these colleagues that mean to know everything, or if they don’t, they‘ll know tomorrow. So it is not only the toxic pills the patients get, it is also the toxic attitude of doctors that think they save the world, in the mean time benumbing or stunning the world. At the same time we must acknowledge and it also is my experience that there would still exist a lot of problems, if psychiatry would suddenly be dissolved.

The important question therefore that arises after stating this critic is: How do I explain the mentioned still existing problems, how do I meet them or how do I help people suffering from these problems?

Two Guides leading to a possible answer:

During my training time becoming a general practitioner I was very much moved by the books of **Paul Tournier**, a doctor from Geneva, Switzerland, who’s many books got spread over the whole world. Though or because of being a very modest man he started the

movement “Medicine de la personne”, the medicine of the PERSON by which he meant the whole person and nothing else. He taught, that it does matter who you – as helping person – are, it’s not only the diagnosis, the therapy, the methods you use, your pills, no, it is you as person that might help the patient, the client. At the other side the patient also is a person, he/she is not only a human being with problems, we have to solve. Of course this was in a time, in which science had many discoveries like the antibiotics and steroids, about which doctors were very enthusiastic, because it seemed then these substances could help a lot. Against this naïve scientistic background the human person with its own personal needs was forgotten.

We doctors – I must excuse us – tend to think rather naively about things. From a scientific background (I talk about natural sciences) we want to help people very quickly. Patients urge us. So if there is any promising agent we just try it, why not? I think this is the reason why we‘ve made so many mistakes with so many results of big suffering. Of course this also is behind the big failure of using tranquillizers, antidepressants and neuroleptics. We should though learn from history and start to become more critical towards any new agent, method or idea. This sounds very conservative, I acknowledge, but conservatism is not always the wrong thing. We have often forgotten what dangers new things might cause.

So I learned from Paul Tournier, that it is not lost time shaking hands with patients, asking them about their family or sharing some events. Tournier did not see the person as a mask (which is the Latin meaning of the word “persona”, the mask of an actor) behind which the doctor hides – as happens, doesn’t it?-, but rather coming from the Latin per – sonare, which means “sounding through”, which would mean, that there is a person behind the mask, who would like to meet.

The other person who influenced me a lot is **Martin Buber**. Martin Buber (1878 – 1965) was an Austrian-born Jewish best known for his philosophy of dialogue, a form of religious existentialism centered on the distinction between the I-Thou-Relationship and the I-It-Relationship. During my training as a psychiatrist I was supervised by Dr. Alois von Orelli, a student of C.G. Jung, which was again a student of Sigmund Freud just like Alfred Adler – Tom Garcia talked about yesterday. My supervisor did not agree with Jung concerning his ideas of the self. In a way Jung could not explain the core or the heart of the human being, which my supervisor found explained much better within the ideas of Martin Buber.

As I said, Buber discerns between two word-pairs: I-Thou (or I-You) and I-It. Let me quote an English article in Wikipedia: (translating Buber is too difficult for me)

For „I-It,“ the „It“ refers to the world of experience and sensation. It can be said that „I“ has as many distinct and different relationships with each „It“ as there are „It“s in my life. Fundamentally, „It“ refers to the world as we experience it.

By contrast, the word pair „I-Thou“ describes the world of relations. This is the „I“ that does not objectify any „It“ but rather acknowledges a living relationship. „I-Thou“ relationships are sustained in the spirit and mind of an „I“ for however long the feeling or idea of relationship is the dominant mode of perception. A person sitting next to a complete stranger on a park bench may enter into an „I-Thou“ relationship with the stranger merely by beginning to think positively about people in general. The stranger is a person as well, and gets instantaneously drawn into a mental or spiritual relationship with the person whose positive thoughts necessarily include the stranger as a member of the set of persons about whom positive thoughts are directed. It is not necessary for the stranger to have any idea that

he is being drawn into an „I-Thou“ relationship for such a relationship to arise. The essential character of „I-Thou“ is the abandonment of the world of sensation, the melting of the between, so that an individual stands in direct or immediate relationship with another „I“.

“It” is bounded by others and “It” can only exist through this attachment because for every object there is another object. “Thou” on the other hand, has no limitations. When “Thou” is spoken, the speaker has no thing or has nothing. The speaker yet “takes his stand in relation”.

What does it mean when a person experiences the world? Man goes around the world hauling out knowledge from the world. These experiences present man with only words of “He, She and It” with contrast to I-Thou. What this means is that the experiences are all physical, but do involve a great deal of spirituality. The twofold nature of the world means that our being in the world has two aspects: the aspect of experience, which is perceived by I-It, and the aspect of relation, which is perceived by I-Thou.

What does this mean in my words? Well, it is about meeting other persons. You can meet them in the attitude or mode of perception of needing something from them, which is – e.g. – usual between a sales clerk and a client or a customer. You don't need the whole person; you need his availability of buying something you have. This is what Buber calls I-It-Experience. The opposite of this is the I-Thou-Dialogue or –Relationship. Of course there is a lot to discuss about this difference. For instance Buber didn't mean to downgrade the I-It-mode. This is a mode on which human society builds. If I want to buy a hamburger, I-It will do, for instance. But it won't do for encounters in the doctor-patient-relationship or for instance within a partnership. Having sex with my partner in the I-It-mode reminds of abuse: I use my partner for obtaining an orgasm. Having sex with my partner in the I-Thou-mode doesn't have orgasm-goals. Let us say it in another way: I-Thou means <u>being</u> with somebody, where as I-It means <u>having</u> somebody.

As I realized the meaning of the difference between I-Thou and I-It there was the sensation of receiving a wonderful present, the explanation of the difference between two worlds. There is the doctor attitude of the patient encounter. Summarized: What kind of disease has the patient, what kind of therapy does he need, how do I teach him this, so that I am sure he takes the pills? That's the I-It-Attitude. The I-Thou-Attitude is: Here is another human being telling me about problems, showing me behavior, I don't understand so quickly, but I am willing to listen and to offer him help of finding out together how to understand the problem or his behavior.

Patients notice the difference of both of these attitudes immediately. For instance there is the problem of diagnosing the patient too quickly, being enthusiastic about it, wanting to help the patient, so that he must not suffer anymore. But I ignore the situation in which the patient feels at the same time. Instead of meeting, encountering him in a real way, listening to him, perhaps leading him into other patterns of thinking and feeling that might bring him to solutions, I confront him with my diagnosis and force him to do what I advise. You see the difference between I-It and I-Thou? The I-Thou-psychiatrist is more modest. He doesn't know everything. He tries more to understand. Of course, if you are a bit older, if you have a lot of experience, you see solutions much quicker than younger colleagues. But have you also seen that patients prefer the younger colleagues? Why? Because they are more often in the I-Thou-mode of perception!! What can we learn from this? Experience and knowledge might lead to I-It-attitudes.

Back to the concrete practical situation:

It helps a lot, if you know about problems yourself. If you want to counsel parents about rising up children, it can be useful to have children yourself. I experienced this very much during my training as a child-psychiatrist. Or even in pediatrics knowing about dealing with pampers, swaddling. This also concerns the psychiatric problems: It is good you experienced big sadness, you know about anxiety, phobia, aggression, obsessive and compulsive thoughts and acting, about addiction, about confusion, entanglements, perplexity, etc. In my website I wrote my CV (curriculum vitae), where I also mentioned my experiences as a psychiatric in- and out-patient having been psychotic and suicidal. It helps to be experienced. Of course you don't need to go into the clinic as I did. My opinion is that every empathic person is able to experience the feelings and behavior I mentioned, it is just a matter of how much.

A patient:

Let me tell you about a woman, born 1960, that I have accompanied for 17 years as out-patient, who is just in an urgent psychotic crisis at the moment, at least during the days before this conference. As in-patient she had been known under the diagnosis of paranoid schizophrenia. Let me tell you about my failures and how she taught me to learn from my failures.

I got to know her as I was working in a normal general hospital at the in-patient medicine department, which was necessary for finishing my specialist title of psychiatrist because I wanted to start a practice myself. That was the year 1995. Before I had been working within the field of psychiatry from the year 1982, 13 years always within psychiatric institutions most time in a residential context.

So I met this woman, who was sent into this general hospital, because of psychotic symptoms. She had not wanted to go as in-patient in a psychiatric hospital, because before she had been traumatized at residential psychiatric wards. She didn't want to do anything with psychiatrists, who had mistreated and drugged her terribly. There had been another trauma though. That was with the GP who did psychosomatic therapy on the basis of bioenergetics. She had been with this colleague for 8 years. The problem with him was he couldn't help her. Neither could he dismiss her out of a – now we say – narcissistic attitude. He assumed sexual abuse by her father, though she didn't remember. He thought of multiple personality disorder, though she didn't really show symptoms of this disorder. So he thought he had to provoke these symptoms entangling the patient in a symbiotic therapeutic relationship with daily contacts. At the end she didn't know in or out anymore. The reason why she was cooperating in this was her anxieties caused by having a very thin psychic skin and normal naïve ignorance. During the treatment by the GP she had real crises, got then hospitalized into the psychiatric institution of the university, where the diagnosis was paranoid schizophrenia, until we met.

My boss thought I should treat her because of my large psychiatric experience. I saw her problems of anxiety as priority, a psychotic anxiety, because of her "thin skin of her soul". She really experienced people getting through this skin causing massive fear and a lot of psychosomatic symptoms. We developed a good cooperative therapeutic relationship. I diagnosed schizophrenia simplex, the simple schizophrenia. That is the schizophrenia without voices and delusions, only showing depersonalization, derealization, dreamlike feelings like feeling the ego being dissolved and many functional disorders of the body. Remember: this was 1995, before I met Peter Breggin.. She allowed me to give her small amounts of neuroleptics. She felt well in my care. The main problem though was the dependency on this

colleague. She left him though with my help, consulted another psychiatrist after being dismissed from the hospital where I was working, waiting a couple of months until I opened my own practice.

She didn't bear high doses neuroleptics and was very convinced about this, so that I had to respect this. At the same time I was convinced she would profit from higher doses. She was psychotically handicapped. She stayed away from mobs of people because she was convinced people could look into her mind. Further she was because of her situation very sad, depressed; she also had thoughts of not wanting to live anymore. So she stayed closed within her very small world, only visiting me twice a week, traveling with cabs, year after year.

After really many years she reached a more balanced life. She didn't take any neuroleptics anymore. Because she often had sleeping problems, she sometimes takes Lorazepam 1 mg, a tranquillizer. Though she was more stable, it didn't mean, that everything was ok. No, she was glad that I could accompany her, even if she could reduce to once a week. A very big help was further her dog, with whom she trained within a special association and with whom she walked in the woods. With this dog she had successful meetings with other people in spite of her anxiety and phobia. Together with the dog she earned dog sport diplomas about which she is very proud.

Two years ago other problems began. At first she suddenly complained of massive diarrhea that even required in-patient-care, in the same hospital I once worked. She felt her body changed because of those severe bacteria. I had to assist the hospital doctors as psychiatrist. It was difficult to discern between somatic and psychiatric causes. After that she got infected by Borreliosis through a bite of a tick. The GP gave her the antibiotics she needed. Symptoms though remained, pain in her whole body especially in joints, muscles, or she suddenly lost strength in one leg. Last year it accumulated. Her GP sent her to a rheumatologist. This colleague only tried to convince her that this wouldn't be from Borreliosis. She felt not understood at all, got mad with this doc and with her GP, she dismissed after many years. I felt very invited to take all the symptoms serious. But I was just psychiatrist. So she became in-patient in a couple of hospitals. Predominant diagnosis was a threatening heart attack, though it was not. She was not able to trust her doctors anymore. Additionally she developed a phobia of cancer, because she had started smoking again. She didn't believe her ENT-doctor, who didn't find any pathology. One day she phoned from a high hill in the neighborhood, where she was with her dog. She wanted to jump down seeing no future anymore. 20 minutes later she decided to go home after believing I had hope.

It looked like a delusional thing out of massive fear from cancer. This was though the thing I was not allowed to say. So I did not. At the moment she is consulting both me and her new GP many times a week and allows me to be in contact with this GP. Without our contact he would have sent her into psychiatry. He though understands the former traumata. So we carry on being in ceaseless contact with her, not giving neuroleptics, practicing the I-Thou mode of perception, knowing not a thing, because this would be I-It, hoping time will relieve the patient from her despair.