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Buber's I-Thou/I-It Construct And Gilligan's Connected/Separate Self Construct: A Theoretical Creative Inquiry

Nancie R. Ziemke

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BUBER'S I-THOU/I-IT CONSTRUCT AND
GILLIGAN'S CONNECTED/SEPARATE SELF CONSTRUCT:
A THEORETICAL CREATIVE INQUIRY

by

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A Dissertation
Submitted to the Graduate Faculty
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Doctor of Philosophy

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1998
This dissertation, submitted by Nancie R. Ziemke in partial fulfillment of the requirements for the degree of Doctor of Philosophy from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.

This dissertation meets the standards for appearance, conforms to the style and format requirements of the Graduate School of the University of North Dakota and is hereby approved.

Dean of the Graduate School

Date

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ABSTRACT

William Heard's application of Martin Buber's dialogical theory to the practice and theory of therapy bears a striking similarity to the relational theories developed by Carol Gilligan and the writers associated with the Stone Center. Yet these two theoretical constructs have never been critically and formally compared. This study proposes to help fill that gap by critically comparing and contrasting the dialogical and relational constructs.

Seven questions will be addressed. (a) What is Buber's I-Thou/I-It construct?; (b) What is Gilligan's Connected Self construct and the Stone Center's relational construct?; (c) How do Buber and Gilligan/Stone Center's relational constructs compare?; (d) What is Buber/Heard's construct of therapeutic relationship?; (e) What is the Stone Center's construct of the therapeutic relationship?; (f) How do Buber/Heard and Gilligan/Stone Center's constructs of therapeutic relationship critically compare?; (g) What are the implications for the therapeutic relationship in light of these two constructs?
Sources for this study were the following: (a) Translations of Buber's work, works by Gilligan, and works by the Stone Center writers; (b) Secondary sources by authors who cite Buber and Gilligan in their work and others who have written on their constructs; (c) Mainstream or traditional literature reviewing the nature of the therapeutic relationship.

The study reached several conclusions. First, the Stone Center and the dialogical writers have similar though unique ways of understanding relationship in general and particularly the therapeutic relationship. Second, the traditional medical model of therapeutic relationship is inappropriate as it intrinsically objectifies the client. Finally, both groups agree that the therapist must accept and embrace his or her own vulnerability in the therapeutic process for healing to take place.
CHAPTER I
INTRODUCTION

The nature of the relationship between client and therapist is considered crucial in psychotherapy and counseling by many authors of psychotherapeutic approaches and counseling theories (cf., Rogers, 1957, 1961, 1980; Adler, F. & L. Perls, May, Yalom in Corsini, 1984; Freud in Gay, 1989; Kahn, 1991). Establishing and maintaining relationship between client and counselor is considered by Teyber (1988) to be "... the foundation of the therapeutic enterprise" (p. 8), and Heartley (1984) states, "All forms of individual psychotherapy have, as their basis, a relationship between two persons" (p. 532). Despite these assertions, the relationship, that is the "meeting" (the interconnectedness) between the client and therapist, has only rarely been the central focus of research and writing in the discipline. In this study the relationship will be the central focus. The paucity of research on this topic is emphasized by Maurice Friedman (1985), a dialogical counselor, translator and interpreter of much of Martin Buber's works, who asserts:
All therapy relies to a greater or lesser extent on the meeting between therapist and client and, in group and family therapy, the meeting among clients. But only a few theories have singled out the meeting—the sphere of the "between"—as the central, as opposed to the ancillary source of healing. (p. xi)

A second impetus for this inquiry concerns the ways in which relationship has been addressed in mainstream psychology. It is my opinion that the traditional foundation for understanding relationship in psychology and specifically in the therapeutic setting has been Western (hereafter, Western will be used in this paper to denote the following characteristics: linear, hierarchical, paternalistic, dualistic, individualistic, and autonomous) (Heartley, 1986; Miller, 1984, 1986; Gilligan, 1982). As a result of this pervasive Western influence, the statement "between two persons" in its conventional use suggests that at the heart of relationship are two persons, two selves, rather than the interconnectedness of the relationship itself.

Scientific Bias

Although traditional Western thought attributes significance to social context and relationships, these constructs are based on individuality and egocentrism
(Gilligan, Ward, Taylor and Bardige, 1988). For several centuries Western science has endeavored to objectify, and remove subjectivity from the understanding of human behavior. The assumption was that if empirical inquiry was done correctly, the laws of nature would be revealed. Recently, this assumption of science as objective, apolitical and without bias has been disputed. The depersonalization of language in scientific writing is an attempt to remove the relevance of time, place, social context, authorship, or personal responsibility. This depersonalization also contributes to the illusion that empirical data are facts of nature (Hubbard, 1990). Judith Jordan (1991a) suggests that the prevailing paradigms, such as the Baconian view of mastery over nature (control and dominance over one's environment), Cartesian mind/body dichotomy, which portrays the superiority of the mind, and Freud's theory that human behavior is driven by self-interest and self-gratification, all reinforce the hierarchical/patriarchal power structure of our Western culture. This, in turn, devalues understanding through subjective knowing, cooperation, concern for others' needs as well as one's one or even over and above one's own.

Carol Gilligan (1982) describes Freud's attempt to understand the development of the capacity to love.
Thus dividing the world of love into narcissism and "object" relationships, he [Freud] finds that while men's development becomes clearer, women's become increasingly opaque. . . . Difficulty in fitting the logic of his theory to women's experience leads him in the end to set women apart, making their relationships . . . "a dark continent for psychology." Thus the problem of interpretation that shadows the understanding of women's development arises from the differences observed in their experience of relationship.

(p. 24)

In describing adolescent development, Stern (1990) cites Anna Freud's theory that "the central characteristic of this period [adolescence] . . . [is] the renunciation of one's childhood relationships," and Peter Blo's assertion that "the adolescent['s] shedding of familial attachments . . . [is] requisite for adult involvement in society" (p. 73). Stern follows up by stating, "Indeed, autonomy has been seen not as the preoccupation of adolescents, but also as the distinguishing feature of the mature individual" (p. 74).

To carry this notion further, Jean Baker Miller (1991) not only questions whether the traditional models adequately
explain women's development, she also questions their applicability to men's development.

Modern American theorists of early psychological development and, indeed, on the entire life span, from Erik Erickson (1950) to Daniel Levinson (1978), tend to see all of development as a process of separating oneself out from the matrix of others--"becoming one's own man," in Levinson's words. Development of the self presumably is attained via a series of painful crises by which the individual accomplishes a sequence of allegedly essential separations from others, and thereby achieves an inner sense of separated individuation. Few men ever attain such self-sufficiency. . . . They are usually supported by numbers of wives, mistresses, mothers, daughters, secretaries, nurses and other[s].

(pp. 11-12)

Even Carl Rogers, who placed a great importance on the therapeutic relationship, portrays it in a manner that reflects a Western world view. Rogers' emphasis in psychotherapy was on individuality, autonomy, and self-reliance which leads towards self-actualization (Buber, 1965; Friedman, 1985; Rasmussen, 1991). In fact, Rogers' biographer referred to his approach "as American as apple
pie" (Kirschenbaum, 1979, p. 138) because of its appropriateness to the American, male culture which celebrates individuality. These examples of the over-reliance on the Western world view and the narrowness of the mainstream conceptualization of therapeutic relationship, provide a basis from which to consider an alternative paradigm for the study and understanding of relationship in psychotherapy which will be examined in this study.

Two relationship constructs which fall outside the traditional theoretical models of relationship are Carol Gilligan's Separate and Connected Self, along with the relational model developed by the writers of the Stone Center, and Buber's I-Thou/I-It construct. Unlike the mainstream relationship constructs which focus on the self in relationship (Friedman, 1984; c.f., Luborsky et al., 1983; Allen et al., 1984; Marmar et al., 1989; Frieswyk et al., 1984; Marziali, 1984), Buber, Gilligan, and the Stone Center writers all focus on the essence and the interconnectedness of the relationship as the phenomenon to be studied, not two selves in a relationship (Miller, 1984; Gilligan, 1988; Friedman, 1960, 1985). This paper will discuss Gilligan and the Stone Center writers as variants of a fundamentally similar approach to the therapeutic relationship, occasionally referring to them in connection to one another and at other times discussing them separately.
as the subject matter demands. Other writers who are associated with these women will also be quoted and referred to on occasion with the understanding that they too share common assumptions and goals. Because of the close association and shared understandings between Gilligan and the Stone Center writers, in this paper I will refer to them as Gilligan/Stone Center whenever they need to be linked together in the text.

It should be noted that Buber's ideas have been applied specifically to the therapeutic relationship by William Heard in his book, *The Healing Between: A Clinical Guide to Dialogical Psychotherapy* (1993). This paper will refer to Buber and Heard as Buber/Heard whenever they are linked together in the text.

Interestingly, Buber and Gilligan seem to share little in roots, training, background, gender, or culture. Buber's theoretical underpinnings stem from his Hasidic, existential, and phenomenological roots while Gilligan's stem from a feminist model of psychology, and her research program on moral development. Despite these diverse sources and histories, a cursory review of both relational concepts suggests that they share in their approach to relationship a focus on the "between," and posit at least two potential types of relationship. It appears that each concept may
offer insight into the therapeutic relationship from a different paradigm than that of mainstream psychology.

Although the Separate and Connected Self and I-Thou/I-It concepts have not been previously critically examined with and against one another, Sichel (1985) in her article, *Women's Moral Development in Search of Philosophical Assumptions*, suggests there are similarities.

Unlike the impersonality of men's language of rights, women's morality concentrates on personal, concrete situations. The language of responsibility, . . . stresses networks of relationships, connection, caring, interpersonal communication, not hurting others, and responsibility. Instead of being wholly individualistic, this type of moral development views the single individual as an abstraction, even a fiction. An individual acquires meaning only in relationship with others. In this sense, women's moral language can be compared with Martin Buber's (1923/1958) I-Thou relationship. . . . An I-Thou relationship takes place between unique human beings, each of whom retains his or her selfhood. When people are treated or experienced as generalized others or "Its," their uniqueness disappears. (p. 152)

Finally, Carter Heyward, (1993) links Buber's and the Stone Center's theories regarding relationship:

Martin Buber studied this quality of our most creative, liberating relational dynamic with one another, . . . this "mutuality." . . . It is a way of being in relation in which the very essence of who we are is being created, called forth, and confirmed through our power in relation. . . .

Working from a psychological perspective, Jean Baker Miller, Judith Jordan, Alexandra Kaplan, Irene Stiver, and Janet Surrey of the Stone Center at Wellesley College suggest that "growth-enhancing connection" is the basis of our psychological development and that a "mutual empathy and mutual empowerment" both reflect and generate this connectedness. To my reading, the Stone Center's work reflects a relational ontology much like Buber's, which is real and true though not always verifiable by scientific instruments. Relationships with people . . . tend to defy strict conformity with scientific rules. From a
moral perspective, this is, I believe, a very great good. (p. 231)

Heyward's summary of the Stone Center's work places strong emphasis on the interaction that occurs between the therapist and the client and its role in bringing about psychological wholeness. It also bears the assumption that traditional psychoanalytic thought and practice was working from an opposite perspective. In fact, within the last 20 years a number of off-shoots of psychoanalytic theory (Kohut, Kahn, Kernberg) have emphasized the importance of the therapist-client relationship within the therapeutic milieu. These psychodynamic theorists working from Freud's foundational concepts have reinterpreted his work into more palatable and less ego-dystonic theories. Yet the primary focus of therapy is on client change or the therapist's ability to hear and empathize with the client. This focus does not reflect a relationship of interconnectedness. Rather, in the psychodynamic construct the relationship functions as a means to an end and is not the end itself.

My thesis in this dissertation is that a broader and richer understanding of the therapeutic relationship may emerge through a critical comparison of Buber and Gilligan/Stone Center's constructs.
Purpose of Inquiry

The primary purposes in this inquiry are to (a) critically review, compare, and contrast Buber's I-Thou/I-It construct and Gilligan's Connected/Separate Self construct along with the related ideas of the Stone Center; (b) critically review, compare, and contrast Buber's I-Thou/I-It construct and the Stone Center's relational construct at the psychotherapeutic level; (c) explore the implications for the therapeutic relationship in light of these two concepts; and (d) discuss the potential merits and capability of developing a synthesis of these two constructs for understanding the therapeutic relationship.

Method

Questions

The purpose of this inquiry is to examine at Gilligan/Stone Center's and Buber/Heard's constructs by means of a theoretical creative inquiry that will first examine both concepts by answering the following questions:

1. What is Buber's I-Thou /I-It relationship construct?
2. What are Gilligan's Connected/Separate Self relationship construct and Stone Center's relational construct?
3. How do Gilligan/Stone Center's and Buber's relational constructs critically compare?
4. What is Buber/Heard's construct of the therapeutic relationship?

5. What is the Stone Center's construct of the therapeutic relationship?

6. How do Gilligan/Stone Center's and Buber/Heard's constructs of therapeutic relationship critically compare?

7. What are the implications for the therapeutic relationship in light of these two constructs?

Method of Inquiry and Sources

As the means of answering the stated questions, I will use the sources, listed below, to review the literature, to discuss my findings and conceptualizations of Gilligan and Buber's constructs, and finally to study, synthesize, and offer my conclusions.

The sources for this inquiry will include the following:

1. Primary sources which will include the translations of Buber's work and works by Gilligan. Examples of these include I and Thou (1958) by Martin Buber, and In a Different Voice (1982) by Carol Gilligan.

2. Secondary sources which will include works by authors who cite either Buber's or Gilligan's work, and personal communication with authors who are well versed and have written on either construct. Examples are William Heard and Maurice Friedman, and Lyn Brown who have written about Buber's and Gilligan's constructs, respectively. Examples of


**Structure of the Dissertation**

Chapter I includes the Introduction, the Purpose of the Inquiry, and the Method. In Chapter II, Buber and Gilligan/Stone Center theories are reviewed; the development and history of their respective theories are outlined. Chapter III articulates the relationship constructs of Buber and Gilligan. The focus of Chapter IV will be on the therapeutic relationship. The first section will review the prevailing or mainstream views of therapeutic relationship in order to establish the nature of the traditional therapeutic relationship. The next two sections will present Buber/Heard's and the Stone Center's constructs of the therapeutic relationship. Chapter V begins with a critical comparison of the relationship constructs and the
therapeutic constructs of Buber/Heard and Gilligan/Stone Center; a discussion of the therapeutic implications in light of these two constructs follows; finally, recommendations for further study are followed by a summary and conclusions.
CHAPTER II
REVIEW AND HISTORY OF BUBER'S DIALOGICAL, GILLIGAN'S MORAL DEVELOPMENT, AND STONE CENTER'S RELATIONAL THEORIES

Buber

The term dialogical psychotherapy was coined by Maurice Friedman (1985) to reflect Martin Buber's theory of the dialogical or I-Thou philosophy in a therapeutic setting. The roots of dialogical psychotherapy, specifically Buber's thesis on dialogical, or I-Thou, philosophy were expressed in his book I and Thou published in 1922. In order to appreciate and better understand his philosophy and specifically the I-Thou concept, Buber's life, both personally and professionally, will be discussed.

Although Buber did not write an autobiography he did write "autobiographical fragments" and made available nearly all of his correspondence so that several people have been able to write about his life and work. Maurice Friedman's three-volume biography entitled, Martin Buber's Life and Work (1981, 1983a, 1983b), comprehensively pieces together those fragments. Grete Schaeder, a German scholar of Buber's work, wrote The Hebrew Humanism of Martin Buber (1973) and Nahum N. Glatzer and Paul Mendes-Flohr edited The Letters of Martin Buber: A Life of Dialogue (1991). After reading these
works and others, I was overwhelmed by the authors' and editors' intricate weaving of Buber's life experiences and the development of his thought. It became clear to me in the course of reading Buber that his philosophy was never static and often so fluid that from time to time throughout his productive life he would contradict or modify himself, and at times, return to an earlier position of thought but from a new perspective. His work was not a systematic doctrine but a guiding: opening a window and pointing for others (Buber, 1963; Schilpp and Friedman (Eds.), 1967; & Vermes, 1988).

Martin Buber was born on February 2, 1878, in Vienna, Austria to parents who divorced when Martin was three years old. He went to live with his paternal grandparents and lived with them until he was a teenager at which time he moved in with his father who had remarried. Martin's grandfather, who was a noted Jewish scholar, taught his grandson at home in basic education with heavy emphasis on philosophy, theology, Jewish practices, and European languages (Hodes, 1971).

Martin Buber pointed to a number of events and persons in his life which had a major influence on his thought and person. His first and most "decisive experience[,] . . . [and] the one without which neither his early seeking of
unity nor his later focus on dialogue and on the meeting with the 'eternal Thou' is understandable" (Friedman, 1993, p. 4), occurred after young Martin's mother left him and his father, Carl Buber. As no one had informed him, he fully expected that his mother would return, shortly. He did not know until an older neighbor girl, caring for the four year-old Martin, told him that his mother was never coming back. This realization "moved him into a new situation that was to be the touchstone and testing point of every other situation into which he entered" (p. 4). Buber's notion of mismeeting, that is the "failure of real meeting . . . between persons" (p. 4) resulted from this moment. In his "autobiographical fragment, . . . [Buber concluded] '[A]ll that I have learned in the course of my life about genuine meeting had its first origin in that hour . . . '" (p. 5).

Young Martin learned many languages and as a result of his multicultural environment was immersed in German, Polish, Yiddish, and Hebrew. "Buber owed his special relation to the German language to his grandmother, Adele. She reared . . . [him] to respect the authentic word that cannot be paraphrased, the integral unity of word and thought . . . " (p. 6). Given his fluency in many languages, he knew the difficulty of translating one language to another and was acutely aware of the uniqueness of each
language which could not be fully articulated in the translation. In his play in which he had "dual-language conversations . . . he came . . . to feel the tension between what was heard by the one person thinking in one language and what was heard by the other person thinking in another" (p. 6). The roots of Buber's notion of "'inclusion'--experiencing the other side of the relationship while not losing the awareness of one's own and of the polar tension between one's own and the other" (p. 6), may be found in this childhood play.

Whereas Solomon Buber's influence on his grandson was one of a scholarly nature, Carl Buber's was one of a relational nature. Martin learned about genuine human contact with nature, plants and animals, as well as with people from his father.

Carl Buber anticipated one of the most fundamental aspects of his son's later thoughts: that the man who practices immediacy does so in relation to nature just as to his fellow man--the "I-Thou" relation to nature is a corollary of the "interhuman." (p. 10)

At the age of fourteen, Buber became obsessed and terrified by the question of infinity of space and time, so much so, he contemplated suicide. "His [s]alvation came
to . . . [him by reading] Kant's *Prolegomena to All Future Metaphysics*" (p. 17). This daunting and formidable philosophical opus quieted his angst and led him "to the view that space and time are not real properties that adhere to things in themselves but are mere forms of our sensory perception, the formal conditions by which we grasp the world of phenomena" (p. 17).

Quite different from Kant's "rationalist" mind, Buber's response to "[t]he question . . . explained as unanswerable by nature . . . took on a mystical quality" (p. 17). He began to understand eternity in a completely different realm, one of intuition.

Buber not only gained an inkling of the reality of eternity as quite different from either the infinite or the finite, he also glimpsed the possibility of a connection between himself--a man--and the eternal. Thus, in his uncharacteristic response to Kant, Buber got an inkling not only of the "I-It," or subject-object relation, but also of the "I-Thou." (p. 17)

The twenty-one year-old Martin met his future spouse, Paula Winkler, at college in Zurich at a time when women were discouraged from attending college. She has been described as having "great intellectual gifts with a
personality marked by a strong drive toward freedom" (p. 26). Of personal interest to me was her feat of "travers[ing] the Alps on a bicycle" (p. 26). Maurice Friedman (1993) in, *Encounter on the Narrow Ridge: A Life of Martin Buber*, quotes Grete Schaedel,

> It is impossible . . . to overestimate the significance of the fact that in his youthful years Buber met a woman who was equal to, indeed superior to, him in poetic gifts and power of expression and understood and spurred on his productivity to the highest degree." (p. 27)

> "Through Paula Winkler, Buber became more courageous and self-confident, stronger and firmer. This was the decisive relationship in his life" (p. 29). Paula herself sacrificed all her family connection by converting to Judaism and formally marrying Martin. Until then, as civil marriage was not recognized in Austria, Paula and Martin co-habitated and bore their children, Rafael and Eva.

Martin Buber's relationship with his children has been described as formal, cool and distant. Paula also encouraged this posture so that Martin would be free to work. I find this rather remarkable given Buber's desire and conscious effort towards "meeting." Reading the accounts of his interactions with his children, especially with Rafael,
suggests to me that Buber lacked a desire or perhaps the ability for real meeting with them. For me, it is the one tragedy of Buber's life. However, the accounts of his engagement with his grandchildren suggest this desire and connection. Perhaps, in his later years, Buber sought and addressed the young with the intention of meeting.

During his university experience, Buber studied philosophy and art. When Martin was 26 years-old, he completed a doctorate in philosophy from the University of Vienna. The existentialists and phenomenologists influenced his understanding of the classical philosophers such as Kant. This interweaving of ideas from various philosophers including Dilthey, Kant, Nietzsche, Kierkegaard, Feuerbach, Simmel, and Dostoevsky, allowed Buber to bridge seemingly incompatible concepts and to glean from them basic tenets of his I-Thou philosophy (Friedman, 1960). Several concepts are noteworthy: Buber's rejection of objectivity as the basis for understanding "Human Studies" was influenced by Wilhelm Dilthey; his development of I-Thou, the narrow ridge, and true being were based respectively on Soren Kierkegaard's concepts of God as Thou, the need to continually question rather than rely on certainties, and the "presence of true personhood" (p. 30) as a prerequisite to an encounter. Finally, the contributions of Ludwig Feuerbach and Georg
Simmel fostered his understanding that a whole person was more than just one's cognitions and that human relationship occurs between whole persons.

Although Buber was raised in a traditional Jewish home, he grew away from these religious beliefs and practices. It was not until he became involved with Zionism and then later Hasidism that his Jewishness became a major part of his person. In fact, Walter Kaufman (1970), a translator of Buber's work, credits Buber with the revival of Hasidism. Likewise, Hasidism played a major role in Buber's life and specifically in his dialogical philosophy which he began to articulate following five years of intensive sequestered study of Hasidism (Hodes, 1971).

Hasidism is described as a "story-centered culture and religion" (Arnett in Rasmussen, 1991, p. 32). Life is understood using the metaphor of a story in which one is neither seen individualistically or collectively but rather someplace between the two. The interconnectedness between the story and the characters is central to the Hasidic tradition. Characters in the story are a part of the story and the story is a part of the characters. When the story is told and retold, written and rewritten by the characters, the story is transformed. In the same way the characters are transformed by the retelling or rewriting of the story.
Therefore a character cannot be randomly assigned to another story nor a story be randomly assigned to a character without changing the essence of the character or the story. Similarly, Buber's concepts of destiny: a "call[ing] forth into being by the 'story' of which one is a part" (p. 33); metaphor of the story: "the process of uniting the many into the whole without losing their separateness" (p. 33); and good and evil: terms which are not absolutes but describe direction or lack of direction (Buber, 1953, p. 130) were derived from the mystic beliefs and practices of Hasidism.

Buber refused to see himself as a philosopher, one who appreciates ideas for their own sake. Neither would he take the title of theologian, as his interest was in revealing God's relationship with "man" and not God's nature. It was not his goal to sustain a state of relationship due to its impossibility and to its equally polar limitations; but rather Buber encouraged a state of readiness for the possibility of relationship (Vermes, 1988). It is also difficult to describe Buber's ideas because he used ideas, concepts, metaphors, examples and narratives to express his experience to others and to find meaning in his meeting with another. Therefore he did not attempt to develop a lexicon of definitions for his dialogical constructs nor attempt to define and explain his beliefs in a traditional scientific
formula using logical deductive or inductive reasoning as proof.

The development of dialogical psychotherapy stems from applying the concepts of dialogue to therapy. Buber's dialogue embraces psychological thought, and beginning with Hans Trub, a number of psychotherapists point to his concepts as philosophical underpinnings of their therapy (Friedman, 1960). Maurice Friedman is credited with bringing forward Buber's work into a distinct form of psychotherapy. A translator and scholar of Buber's work, Friedman wrote two books applying dialogue to therapy. This led to the establishment of The Institute for Dialogical Psychotherapy in La Jolla, California, where Friedman and colleagues provide research and training in dialogical counseling (Friedman, 1984, 1985, personal communication, 1989). Recently, William G. Heard (1993), a former student of the institute and a psychologist of thirty years, wrote The Healing Between: A Clinical Guide to Dialogical Psychotherapy which details the therapeutic process of dialogical therapy. Heard's work will provide the foundation for the dialogical psychotherapeutic relationship construct presented in Chapter IV.
Gilligan

As Carol Gilligan's professional efforts are primarily research oriented, she and her colleagues have not coined a term for the practice of psychotherapy using the Voice of Care/Justice or Connected/Separate Self. However, Jean Baker Miller and her colleagues at the Stone Center for Developmental Services and Studies presently use the term "relational" to describe their philosophy of psychotherapy. This dissertation will favor the terms "relational" or "relational therapy" in reference to Gilligan/Stone Center's theories regarding the centrality of relationship in human interaction.

The roots of the constructs Care/Justice which evolved into Connected/Separate Self and later "Reframing Resistance and Courage" were developed in Gilligan's first book, *In a Different Voice* (1982). As with Martin Buber, knowledge of the influences in Carol Gilligan's life provide understanding and appreciation to her work and specifically to the voice construct.

Carol Gilligan's (1982) entree into defining and presenting a relational construct emerged from her investigations on moral development and decision making. In the introduction of *In a Different Voice* Gilligan describes
the process through which she began to question the traditional model of human and moral development.

Over the past ten years, I have been listening to people talking about morality and about themselves. Halfway through that time, I began to hear a distinction in these voices, two ways of speaking about moral problems, two modes of describing the relationship between other and self. (p. 1)

As a colleague of Kohlberg, Gilligan used his construct (which was normed on an all male population) of moral stages of development and learned that often women's responses were found to be lacking. That is, the level of moral development (stage three out of six possible) at which women were measured coincided with a morality that "is conceived in interpersonal terms and goodness is equated with helping and pleasing others" (p. 18). Gilligan points out that the implication of these results was that this level of moral development was functional for homemakers but that if and when women took on traditional male activities their level of moral reasoning would rise and correspond with males.

Along with Kohlberg, Gilligan cites Freud, Erikson, and Piaget as theorists who emphasize individuation, separation, autonomy, and impartiality as key elements in human and
moral development. This corresponds with the Voice of Justice. Connection, responsibility, and consideration of relationship, which correspond to the Voice of Care, are relegated to a less mature level of moral development. Gilligan argues that this creates an imbalance between two modes of relationship which prizes individualism and devalues connection.

Far fewer specifics have been published about Gilligan's life than Buber's. Yet like Buber's, Gilligan's work has had far-reaching exposure and impact, from Hilary Rodham Clinton's Health Care Address (October, 1993) to junior high girls who after completing involvement in one of her longitudinal studies wanted "to tell them [the public] everything we said, and we want our names in the book" (Brown and Gilligan, 1992, p. 228).

Her influence has crossed the field of psychology into others, notably education. Mary Belenky, once a student of Gilligan's and now a colleague, developed a theory of acquiring knowledge by listening to women. In their book, *Women's Ways of Knowing*, Belenky, Clinchy, Goldberger, and Tarule (1986) develop a scheme that describes among others separate and connected knowing that parallels Gilligan's voice constructs. Nursing, a field similar to psychology in that it requires the practitioner to be knowledgeable in
techniques and pragmatics of their science as well as offer interpersonal care has begun to study the dimension of care more holistically (Neil-Urban, 1994).

No biographies have been written about Gilligan and the development of her theories, therefore this section on her life and development is limited in scope. Carol Gilligan was born in 1936 and graduated from Swarthmore College where she studied literature and history. I believe the influence of literature and history on Gilligan's work is telling. Her writing incorporates literature and literary criticism to develop, support and provide evidence for her ideas. Gilligan uses history to guide the reader through a hermeneutical understanding of traditional psychology and Western civilization.

Gilligan completed a Ph.D. in clinical psychology at Harvard University. She did not attempt to publish her dissertation on the "power of children's stories to influence them to cheat or stop cheating" (Saxton, 1981, p. 63) because of her discomfort at the deceptive methods she used to gain her data. Following graduation and marrying Jim Gilligan, a fellow graduate student, Carol "dropped out" of the field to have her three sons: Jon, Tim and Chris (Saxton, 1981).
Carol Gilligan notes that many events during the late 1960's and early 1970's had a profound impact on women, this country and her personally. The Vietnam war and the accompanying anti-war demonstrations occurring on college campuses provided the opening for the "foundations of knowledge" to be reexamined (Gilligan, 1993, p. ix). At the same time, the "resurgence of the Women's Movement," the proliferation of feminist thought and outrage, along with the Supreme Court decision of Roe v. Wade encouraged women to publicly question "the morality of the Angel in the House--that nineteenth-century icon of feminine goodness . . . : who acts and speaks only for others" (p. x). In so questioning, women began to become conscious of the need to speak for self, and of the danger of abdicating their voices which leads to the disappearance of themselves in relationships, responsibilities, and loss of power in society. Gilligan experienced her own loss of power when she and her female colleagues at the University of Chicago noted that while men in similar positions were granted the title assistant professors, they (she and her female colleagues) were simply referred to as instructors.

While at Harvard, both as a graduate student and later as a professor, Gilligan studied and worked with Erik Erikson and Lawrence Kohlberg (Saxton, 1981; Gilligan,
1993). She stated that following their lead, she taught psychology from a purely Freudian and Piagetian perspective. During this time she experienced her own splitting and loss of voice when women students would ask insightful questions countering these perspectives; while acknowledging the usefulness of the questions she would dismiss the invitation for discussion (see Gilligan, 1993, p. xiv).

Taking from Erik Erikson, Gilligan learned that "you cannot take a life out of history, that life-history and history, psychology and politics, are deeply entwined." (Gilligan, 1993, p. xi). Thus Gilligan's bringing women, their experience and their voice into the research domain changed psychology and history as well as the speaker and the listener. As a result of her research, writing, and her outspoken criticism of psychology's male viewpoint and voice, she has found herself in the midst of an active and lively and often contentious discussion about women's voices, about difference, about the foundations of knowledge or what is currently called "the canon," about relationships between women and men, and about women's and men's relationships with children. (Gilligan, 1993, p. xi) Gilligan cites these discussions as the impetus for rethinking and reevaluating traditional research methods, psychological assessment and psychotherapy.
In the acknowledgements of her first book, *In a Different Voice* (1982), Gilligan offers some clues to the development of her theories and research. She cites colleagues, friends, graduate students and family for their contribution to her work as well as to her "vision" and to her personally. Her research groups, which include current and former graduate students, are highly collaborative. Gilligan notes several contemporary theorists who have influenced her thinking, just as she has influenced them. Examples of such theorists include Jean Baker Miller and her colleagues at the Stone Center, Nancy Chodorow, Ruthellen Josselson, and Mary Field Belenky.

Following the release of *In a Different Voice* and related articles in periodicals, there was considerable debate on Gilligan's reworking of Kohlberg's stage theory of moral development specifically as it related to gender differences and gender bias. Although the line was drawn in the sand so to speak, it appears that Gilligan and Kohlberg are respectful of each other and their respective work. Carol Gilligan describes her colleague, Lawrence Kohlberg, as a "teacher and a friend . . . who illuminated for me the study of morality" (1982, p. vi). Lawrence Kohlberg writes regarding *In a Different Voice*: 
An important and original contribution to the understanding of human moral development in both men and women. Carol Gilligan writes with literary grace and real sensitivity to the women she interviewed . . . (sic). Her book has important implications for philosophical as well as psychological theory. (Gilligan, 1982, jacket cover)

To attend to the criticism that her research was not acceptable, Gilligan initially attempted to document and research her work in a manner that was more congruent with the more traditional viewpoint in psychology. Following this more traditional approach, her research model was empirical, mechanistic, linear, "objective," rational, analytical, quantitative and reductionistic. As she and her research team moved away from this model they initially "went to great lengths to describe their research method, both philosophically as well as practically" (Twohey, 1991, p. 211). Even as they moved into a more flexible qualitative research method as well as a more literary writing style they continued their efforts to maintain replicable and valid research by "following standard procedures of research design: experimental and control groups and standard procedures for analyzing interview data" (Brown and
Gilligan, 1992, p. 19). Eventually the team moved away from this when Brown, Gilligan, and the research team discovered that their efforts to do "good" research, at the expense of "discomfort and unease" on the part of the researchers, also brought about an "emerging underground" by the girl participants—sharing with each other information and preparing for their turn—which is a common "response to situations of inequality" (Brown and Gilligan, 1992, p. 9). Their method evolved throughout the study as they began to listen to what the girls knew and to listen to what they, the researchers, knew.

In a book review of Brown and Gilligan's *Meeting at the Crossroads*, Twohey (1993) states, "'Holding on to what one knows' is at once the most important developmental task for many women, the heart of good research, and the major task of education. *Meeting at the Crossroads* addresses all three endeavors" (p. 168). By listening to the girls and to themselves the researchers paid attention "and listened for the stops and starts, for silences and struggles" and "the complexities of voice in relationship" (Brown and Gilligan, 1992, p. 20).

Gilligan (1993) recognizes the influence of understanding voice from the work of "theater's leading teachers of voice." She cites Kristin Linklater, Tina
Packer and Normi Noel as women who have taught her the "physics for my psychology--a way of understanding how the voice works in the body, in language, and also psychologically" (p. xv). She has taken from them an understanding that voice speaks in relationship. . . . [Y]ou can hear the difference between a voice that is an open channel--connected physically with breath and sound, psychologically with feelings and thoughts, and culturally with a rich resource of language--and a voice that is impeded or blocked. (p. xvi)

In 1984, Carol Gilligan was named MS magazine's "Woman of the Year." During that year she and Jean Baker Miller, M.D., author of Toward a New Psychology of Women (1976, 1st edition) and Director of the Stone Center for Developmental Services and Studies at Wellesley College, were honored at the annual convention of the Association of Women Psychologists. Their work, although not specifically collaborative, is complementary, compatible, and has had profound impact on the other's work. Gilligan (1993) writes of Jean Baker Miller,

Coming to the study of women's psychological development from her vantage point as a psychiatrist and psychoanalyst working with women
in therapy, Jean Baker Miller observes that girls and women in the course of their development, in their attempt to make and maintain relationships, paradoxically keep large parts of themselves out of relationship. Jean Baker Miller's formulation of this paradox is central to a new understanding of the psychology of women and leads to a powerful rethinking of psychological suffering and trouble. (p. xxiii-xxiv)

Using feminist perspectives regarding the development of women offered by Chodorow (1974) and Miller, of the Stone Center (1976), along with the traditional models of human and moral development, and the data from her research, Gilligan arrived at two different modes for understanding relationships: one based on autonomy and rights and the other on connection and responsibility. In her initial research, Gilligan found that people voiced moral dilemmas in two prominent ways which she named "Voice of Care" and "Voice of Justice." These voices correspond with Connected and Separate Self constructs. Gilligan later identified two modes of self description: the Connected Self and the Separate Self. The Connected Self description naturally includes other people as part of the self. It is characterized by an understanding of relationships as the
interdependence of people and by a concern for the good of others in their own terms. The Separate Self description more formally includes other people as a part of the self. It is characterized by a view of relationships as reciprocal roles of obligation and commitment between people and a concern for considering others objectively and fairly as one would like to be considered oneself (Attanucci, 1988). For the purposes of this study, the terms Voice of Care and the Connected Self will be used synonymously. Likewise, Gilligan's Voice of Justice and the Separate Self will be used interchangeably.

Each voice/self characterizes the manner in which relationship is understood and extended to others by the speaker. In describing the Voice of Care, Gilligan asserts that relationships are understood in terms of connection, abandonment, attention, rejection, responding, attachment and detachment. The Voice of Justice's characterization of relationship on the other hand is described in terms of equality, inequality, reciprocity, impartiality and fairness (Brown, 1988). It is clear that Gilligan (1982) values both voices as necessary for living in relationship. By identifying and amplifying the Voice of Care, Gilligan attempts to balance and harmonize these two voices of relationship.
Changing metaphors, Gilligan (1982) describes the voices as one's vision and offers a binocular means of seeing relationship.

The experiences of inequality and interconnection, inherent in the relation of parent and child, then give rise to the ethics of justice and care, the ideals of human relationship--the vision that self and other will be treated as of equal worth, that despite differences in power, things will be fair; the vision that everyone will be responded to and included, that no one will be left alone or hurt. (pp. 62-63)

In words that illustrate the tension, the paradox, the need for binocular vision in understanding human experience and relationship, Gilligan offers "[W]e know ourselves as separate only insofar as we live in connection with others, and . . . we experience relationship only insofar as [we] differentiate other from self" (p. 63).

With continued investigation, Gilligan (Gilligan and Attanucci, 1988) modified her position to include further harmonizing of these two voices within one individual. That is, she found that frequently a person has both voices and uses both voices but that usually a person uses one voice
predominantly. Second, the research results suggested that while women may utilize either voice predominantly, men do not use the care voice predominantly. These results give credence to the notion that when women are not included in studies, the Voice of Care perspective drops out and is not heard.

Gilligan and her colleagues, along with Jean Baker Miller and her associates at the Stone Center, have focused on the meaning of relationship in women's lives and are reformulating what part relationship plays in the development of the self. Although they have approached the study of women and girls from different directions and are working in different ways they have arrived at much the same insight into the relationship between women's psychology and the prevailing order. A new psychological theory in which girls and women are seen and heard is an inevitable challenge to a patriarchal order. . . . Staying in connection, then, with women and girls—in teaching, in research, in therapy, in friendship, in motherhood, in the course of daily living—is potentially revolutionary.

(Gilligan 1993, p. xxiv)
Lyn Brown and Gilligan continue:

Together with Jean Baker Miller and her colleagues, Judith Jordan, Irene Stiver, and Janet Surrey [and Alexandra Kaplan], we found that an inner sense of connection with others is a central organizing feature in women's development and that psychological crises in women's lives stem from disconnections. (Brown and Gilligan, 1992, p. 3)

Thus, the work of Jean Baker Miller and her colleagues at the Stone Center will be used to complement and supplement Gilligan's constructs. Finally, although Gilligan's and Jean Baker Miller's focus is on the development and psychology of women and girls, a focus which stands in contrast to traditional developmental and psychological models, they suggest that the importance of relationship in one's life is equally salient in the lives of boys and men. In the course of her research, Carol Gilligan conducted longitudinal studies with her collaborators and applied qualitative and flexible research methods to her study. This research emphasized the development of women and girls, primarily focusing on the tendency of white, middle to upper socio-economic, American girls to lose their voice at the critical stage of early adolescence. Gilligan and her colleagues, Jill McLean Taylor
and Amy M. Sullivan (Taylor, Gilligan, Sullivan, 1995) also focused on women and girls of color, some of whom retained their voices but lost connection and relationship to others. One of their purposes was to listen to the voices of girls and women in a new way, quite distinct from the point of view offered by traditional Western psychology.

This brief overview of Buber and Gilligan's lives and theories and the theories of the Stone Center offers a foundation to understand the various aspects they hold in common. Since both Gilligan and Buber are interested in explaining the centrality of relationship in forming the self, it adds depth to their theories and work to reveal their personal histories as individuals seeking connection in community. Working from this foundation, the next chapter will consider Buber's I-Thou construct as well as Gilligan's Connected/Separate Self and the Stone Center's relational theory.
CHAPTER III
THE RELATIONSHIP CONSTRUCTS OF BUBER AND GILLIGAN

In this chapter I will explain and elaborate Buber and Gilligan's relationship constructs, beginning with Buber's I-Thou/I-It theory of relationship and continuing with Gilligan's Connected and Separate Self construct. A discussion of the Stone Center's work in relational theory, emphasizing the writings of Jean Baker Miller and other Stone Center theorists will conclude the chapter.

I-Thou/I-It Construct

In Chapter II, Buber's life was traced along with the development of his dialogical theory. The following discussion will outline three essential components of Buber's dialogical approach. These are (a) the narrow ridge, (b) I-Thou, and (c) I-It. Taken together they reveal the paradoxical nature of the dialogical encounter. Essential characteristics of these constructs are also discussed in this chapter.

Narrow Ridge

The narrow ridge provides a framework in which to begin to understand Buber's relational I-Thou/I-It construct. In Between Man and Man, Buber (1947) expounds on the phrase "narrow ridge."
I wanted by this [the narrow ridge] to express that I did not rest on the broad upland of a system that includes a series of sure statements about the absolute, but on a narrow rocky ridge between the gulfs where there is no sureness of expressible knowledge but the certainty of meeting that remains undisclosed. (p. 184)

Friedman (1960) believes that the narrow ridge is the crux of Buber's I-Thou philosophy.

Perhaps no other phrase so aptly characterizes the quality and significance of Martin Buber's life and thought as this one of the "narrow ridge." It expresses not only the "holy insecurity" of his existentialist philosophy but also the "I-Thou," or dialogical, philosophy which he has formulated as a genuine third alternative to the insistent either-or's of our age. Buber's "narrow ridge" is no "happy middle" which ignores the reality of paradox and contradiction in order to escape from the suffering they produce. It is rather a paradoxical unity of what one usually understands only as alternatives--I and Thou, love and justice, dependence and freedom, the love of God and the fear of God, passion and direction, good and evil, unity and duality. (p. 3)
I-Thou/I-It

Buber proposes two types of relationship, termed "I-Thou" and "I-It," that he suggests are necessary for all people to experience in order for growth and personhood to develop and be sustained (Buber, 1970). One can be authentic in an I-It relationship but it is not a requirement. I-It is the relationship of everyday life; the I-It relationship can be best described by what it is not as it encompasses an almost endless number of human interactions (Buber and Friedman, 1965).

What the I-It relationship does not describe is the I-Thou relationship which Buber (1970) describes as the "true meeting" of two or more people. The I-Thou is a relationship in which both persons have available to the other their entire being and, by their interaction, their meeting, and the possibility of change. Buber (1970) asserts that the I-Thou relationship is such that each person is required to change and thus this relationship is always fluid so that the I and the Thou will never again form the exact same relationship.

Buber believes that an individual could live a life devoid of I-Thou relationships but the person would remain an individual and never evolve into personhood. (Personhood is a term Buber used to describe someone who experiences I-
Thou moments and thus has evolved into a whole, authentic, relational person.) The I-Thou meeting is not descriptive of an ongoing encounter with two or more people, but of brief moments. The I-Thou relationship is embedded in the general I-It. And the I-It relationship is most descriptive of the ongoing encounter. The I-Thou relationship is created together, between the persons, and then is brought back to each person. Maurice Friedman (Buber, 1965), Buber's primary translator, offers that this "unfolding of the sphere of 'the between' Buber calls the 'dialogical'" (p. 26).

Heard (1993) states that in order to experience "continued embodiment," one must experience I-It relations throughout one's life (p. 65). That is "'without the world of It man cannot live.' Yet the person who lives with It alone has so fully missed authentic human existence that he is not human" (Friedman, 1993, pp. 131-132). The word-pair, I-It, that is the subject-object relationship, allows us the ability to analyze, compare, contrast, evaluate, calculate, imitate, emulate, own, sell, barter, observe, contemplate, comprehend, explain, defend, associate, group, generalize, rationalize, philosophize, diagnose, differentiate, reflect, reduce, deduce, induce, and act on an idea, a thing, or a person. This, of course, is not a comprehensive list but one
that quite plainly demonstrates the necessity of I-It relationships.

The contrast of I-Thou and I-It lies in the relationship and not in the nature of the other. In I-It relationships, the I knows and uses other individuals without allowing them to exist in their uniqueness and wholeness. The I-Thou relationship is one of openness, directness, mutuality, and presence. . . . The person that I meet is . . . not yet a Thou for me until I step into elemental relationship, . . . even the [friendliest, kindest,] politest forms of address do not prevent his remaining for me an It. (Buber, 1965, p. xiv)

I-It relationships, although they may be intimate, pleasurable, and gratifying, lack the presence of the mutual creation of "meeting." Although the I-Thou relationship needs to be created between at least two people, one person may be more ready or prepared to participate in the I-Thou relationship than the other. As a result, one person may have more I-Thou experiences than another because he or she is more open to the possibility of meeting and creating an I-Thou relationship (Arnett, personal communication, 1991).

Buber contradicts himself regarding the necessity of mutual readiness to have an I-Thou moment. It was not
important to Buber to have his constructs be consistent over time. For example, at times, Buber stated that the importance of I-Thou moments was in the mutuality of the relationship, at other times he posited that it was not necessary for both people to experience the I-Thou moment simultaneously. This inconsistency makes reading and understanding Buber challenging.

When a person is "ready," the possibility for having an I-Thou relationship exists. Rather than an acquisition of attributes, the concept of readiness is a synergy of preparation, openness, authenticity, expectancy, immediacy and acceptance. It is possible to possess these qualities without experiencing meeting. But it is not possible to experience meeting without being ready.

Buber's concept of I-Thou emphasizes the essentialness of relationship with regard to mental health, or as Buber puts it, "personhood" (Buber, 1971). Buber's (1965) concept of the person is based on the primary assumption that human beings are relational and not individual in their fundamental nature. Rasmussen (1991) summarizes Buber's concept:

Whereas psychology regards the psyche as the true self with relationships emanating from that self, in Dialogue the true or real self may only
be found in relationship with another. The internal self or what psychology refers to as the psyche or personality is an artifact of relationships which created it, and continually re-create it. In Dialogical [sic] theory and practice, personhood begins not with birth, but with relationship. (p. 62)

The dynamic life force is placed not within the individual but "between" persons in mutually created relationship (Buber and Friedman, 1965). This between is the I-Thou relationship.

Buber reminds us that when we meet our Thou we might not necessarily feel sustained or comforted. Instead Buber declares that we may instead confront our insecurities and vulnerabilities. We must remember that meeting is not created out of desire, behavior, or effort but by inexplicable grace. Thus the meeting--and not any associated feelings--is a gift of grace (Buber, 1970).

Summary

Buber's understanding of relationship and personhood centered in I-Thou and I-It encounters defines the self in terms of human interactions which continue as long as the self exists. Thus the center of human existence and meaning is not located within the individual person or psyche, but
in the dynamic "between" of human engagement. I-It relationships characterize most of our daily interactions with the world, where the other is analyzed, contrasted, evaluated, defended, acted on or otherwise objectified and distanced. Without such interactions, daily life and routine human encounter would be impossible. I-Thou relationships are contained within the framework of I-It: Where the It was, the Thou becomes and meeting takes place. For this to occur, there must be openness, directness, mutuality, and presence, allowing for the possibility of mutual change. The Thou encounter is the place where personhood and growth occur and develop, where two persons are available to each other in their wholeness in the "between": where "meeting" takes place. It is the "narrow ridge" of human existence, a "holy insecurity" where "meeting is the only assurance."

**Self in Relation: Connected and Separate Self Construct**

Chapter II traced the development of Gilligan's relationship model. Given the contemporary and evolving nature of her work, this section will examine the development of Gilligan's theoretical constructs. A specific consideration of Gilligan's alternative construction of self and relationship will begin the section. As a research psychologist, Gilligan and her colleagues developed a research model for studying relationship. The process of
developing the method and its description will follow. The relationship constructs of Gilligan, although not formally stated by the Stone Center writers as the foundation of their therapeutic relationship construct, have been used as a cornerstone for their theories and the development of their presentation of the therapeutic relationship. The last section will provide a description of the Stone Center relationship model.

**Alternative Construction of Self and Relationship**

More current research by Gilligan and her colleagues (Taylor, Gilligan & Sullivan, 1995; Brown & Gilligan, 1992; Gilligan, Ward, Taylor & Barridge, 1988; and Gilligan, Lyons & Hanmer, 1990) has focused attention on the development of adolescent girls and provides an alternative theoretical framework to "images of self in relationship" (Gilligan, Ward, Taylor & Barridge, 1988, p. 3). In Gilligan's (1988) essay, "Remapping the Moral Domain: New Images of Self in Relationship," she summarizes the essence of her alternative theoretical framework:

> The definition of the self and morality in terms of individual autonomy and social responsibility--of an internalized conscience enacted by will and guided by duty or obligation--presupposes a notion of reciprocity, expressed as
a "categorical imperative" or a "golden rule."
But the ability to put oneself in another's position, when construed in these terms, implies not only a capacity of abstraction and generalization but also a conception of moral knowledge that in the end always refers back to the self. Despite the transit to the place of the other, the self oddly seems to stay constant. If the process of coming to know others is imagined, instead, as a joining of stories, it implies the possibility of learning from others in ways that transform the self. In this way, the self is in relationship and the reference for judgement then becomes the relationship. . . . In this alternative construction, self is known in the experience of connection and defined not by reflection but by interaction, the responsiveness of human engagement. (pp. 6-7)

This alternative construction will be the primary focus of the following discussion.

**Development and Use of the Listener's Guide**

In the first several chapters of their book, *Meeting at the Crossroads*, Brown and Gilligan (1992) describe the development of a research model that was more conducive to
listening for and encouraging the authentic voices of the girls. At the start of their research project they attempted to construct a research design that would bear up under scientific scrutiny and at the same time be respectful to the girls, the teachers and the administration. Yet two years into the study, the researchers discovered that the girls had developed their own underground network to help each other prepare for the interviews.

Gilligan and her colleagues had to decide between carrying out a rigorous and replicable research design, although clearly unauthentic and contrived, or risk scientific criticism and design a method that would listen to the girls' voices. They chose to listen to the girls and to themselves. In doing so the researchers developed interview questions that encouraged voice and developed relationships between participant and interviewer. The "decision to listen to ourselves and to the girls led us away from standard procedures for analyzing interview data and to the creation of a voice-centered, relational method of doing psychological research" (Brown & Gilligan, 1992, p. 19).

By returning to a more clinical and literary approach to interpreting the interviews the research team developed "The Listener's Guide," a voice-sensitive method, that
"enables relationship by taking in another's voice" (Brown & Gilligan, 1992, p. 24). This structure provided the means for a relationship to develop between the girls and the researchers (also females) thus allowing the participant to embed her voice in a body and in a relational and societal context thus paradoxically allowing girls' and women's voices (and those of others who struggle to speak and be listened to within the current framework) to be heard and at least partially understood. (pp. 24-25)

A question relevant to this dissertation was addressed by the research team: "When a conversation has different meanings for the people engaged in it and especially when one of the two has the power to structure the meeting, it is important to ask whether there can be genuine dialogue?" (Brown & Gilligan, 1992, p. 25). The researchers' discoveries, as they moved their research into the realm of genuine dialogue, led them into questioning the nature of these relationships. In the research with the adolescent girls, Brown and Gilligan (1992) discovered that they were influencing and being influenced by the interactions with the girls. The nature of knowledge was changed by the interaction. As the researchers became more aware of the
impact of the research on the girls, the researchers became more respectful, willing to express care, and willing to shift power in the relationship in order to create a more mutual experience.

The Listener's Guide is a method of research created by Brown and Gilligan. Although this method is used to assist the researchers in understanding a narrative by taking in and highlighting the complexity of peoples' lives, voices and relationships, the concept has relevance to psychotherapy. The Listener's Guide offers a gateway to understanding relationship and therapeutic relationship from a stance of authenticity rather than adaptation.

Within this method, the text of verbatim interviews is read by the researchers at least four times. Each time, the text is read for a particular meaning. In the course of the readings, the readers are made aware of their own power and influence on the interpretation of the narrative and hence the participant. The first reading examines the biases, power, and judgement of the reader. The second reading involves listening for the fully present self of the narrator/participant.

Once we let the voice of another enter our psyche, we can no longer claim a detached or objective position. We are affected by that voice,
by words that may lead us to think and feel a
variety of things. (Brown & Gilligan, 1992, p. 28)

The third and fourth readings, once described as
listening for the Voice of Care and Voice of Justice
respectively, have been reframed to embrace a stance of
"resisting." That is, they involve actively questioning
what appear to be modes of relating which are embedded in
our socialization process and which are considered to be
universal truths. The third reading is about the struggles
for relationships that are authentic. The fourth reading
acknowledges the silencing of the self and resisting the
silence.

There are at least two ways that people resist:
psychologically and politically. The first is marked by
"self-silencing or capitulation to debilitating cultural
norms and values--times when a person buries her feelings
and thoughts and manifests confusion, uncertainty, and
dissociation" (p. 30). The other is marked by "times when
people struggle against abusive relationships and fight for
relationships in which it is possible for them to disagree
openly with others, to feel and speak a full range of
emotions" (p. 30).

Brown and Gilligan (1992) have proposed several
conclusions, based on the use of the Listener's Guide. The
first two are direct findings from their research. Euro-American, middle to upper socioeconomic status girls were silencing themselves to remain in relationships with others. This has been described as adaptation in traditional psychology and seen as healthy. Second, some girls of color, socio-economically disadvantaged, or both who spoke out, found themselves disconnected from others and were seen as antagonists. Frequently, outspoken girls are isolated from relationships of support and connection and from their own emotional process (Taylor, Gilligan & Sullivan, 1995). Their third conclusion is based on previous research (Gilligan, Ward, Taylor & Bardige, 1988) and postulation regarding Western culture's influence on boys and men. The Stone Center writers drew a similar conclusion. This final conclusion is elaborated below.

While both groups of writers (Carol Gilligan and her colleagues and Jean Baker Miller and her colleagues) have focused their attention on the meaning of relationship in girls' and women's lives and on development of self through relationship, both groups suggest that the importance of relationship in one's life is equally salient in men's and boys' lives. Gilligan (in Gilligan, Ward, Taylor & Bardige, 1988) describes the Western world view as, "The developmental model which equates adulthood with a justice
perspective, and maturity with separation, self-sufficiency, and independence" (p. v). Jordan (1989) builds on this:

Western science, including psychology, rests on the assumption of a primary reality composed of separate objects which secondarily come into relationship with one another. As Helen Lynd notes, "The separation having been initially assumed, the problems of relation and integration are posed" (1958, p. 81). Moving from Aristotelian logic, and Newtonian physics to quantum physics, we begin to see reality defined by relationships, continuities and probabilities rather than by discrete objects and dualities. Traditional psychological theories view "the self" as the basic unit of study and emphasize its independence, security, and separation from our selves. (p. 1)

The researchers' third conclusion is that boys, in the early years of their lives, are required to give up relationship also for the sake of relationship. The young boy, through social and familial pressures, is required to give up relating to others as a whole person and instead relate as a "man" who is self-disciplined, rational, logical, and without emotion or sentiment. Finally, all of
these ways of adapting exact a high cost, sacrificing oneself and relationship and precipitating fragmentation of one's whole person and uniqueness.

**Stone Center's Relational Theory**

Although Gilligan and the Stone Center's writings evolved separately, there are many parallels and acknowledgements of the similarities in their theories. Gilligan's approach is research oriented whereas the Stone Center's is therapeutically oriented. The Stone Center theorists (who are clinicians, clinical supervisors and educators) have written extensively on relationship and the elements that constitute and flow from relationship (Miller, 1986; Jordan, Kaplan, Miller, Stiver & Surrey, 1991; Surrey, Kaplan & Jordan, 1990; Surrey, 1987; Jordan, Surrey & Kaplan, 1983; Miller & Stiver, 1997). The focus of this section will be the Stone Center writers' construct of relationship and the elements that constitute their relational construct. Since individuals experience two sets of outcomes (i.e., growth of self and growth for the other) once engagement occurs, it is obviously artificial to talk about specific growth in each person. For purposes of this study, the Stone Center outcomes will be discussed separately. The following concepts will be addressed: diminishment of self in relationship, growth for the other,
outcomes of growth-fostering relationships, empowerment, empathy, mutuality, conflict, self versus relationship, vulnerability, and responsive initiative.

**Diminishment of Self in Relationship**

There are endless ways that interactions or lack of interactions in relationship may diminish one's sense of self. Some diminishment generally occurs to all of us early in our lives. For example, children experience and display many emotions. How parents and others respond to them affects one's development of self. Children learn through these interactions which feelings are legitimate and allowed and which ones are not. Jean Baker Miller (1986b; Miller & Stiver, 1997) posits that "diminishment of self" occurs when one does not experience one's feelings or even acknowledge one's feelings.

Diminishment of self also occurs when one refuses to acknowledge or accept one's own experiences in connection with others. Thus, when we do not feel heard or understood by the other, (or when others refuse to acknowledge their own experience in connection), we feel diminished: confused, invisible, unacknowledged, unworthy, or unimportant. One experiences disempowerment when there is an absence of mutuality. Abuses of power in relationship result in disconnection and diagnoses of mental disorders including
dependent, borderline, histrionic personality disorders (Surrey, 1987).

**Growth for the Other**

Jean Baker Miller (1986b, Miller & Stiver, 1997) believes that the ability to empathize, that is to feel the feelings and the associated thoughts of others with one's own, can be either beneficial or harmful. She states that the capacity of each of us to feel the feelings of others, with our feelings and their associated thought content is basic to everything that is potentially good and potentially bad. One may respond either by experiencing one's feelings and thoughts which are present and turn towards the other or turn away from the other. When one responds to another's feelings or perspective, one experiences a sense of connection with the other. Jean Baker Miller (1986b) describes this as "growth for the other." She states, "It is being in the flow of human connection rather than out of it, rather than feeling that you must turn away from it" (p. 12).

**Outcomes of Growth-Fostering Relationships**

Jean Baker Miller (1986b, see p. 3; Miller & Stiver, 1997) describes five outcomes that she has observed in the phenomena of growth-fostering relationships. They are as follows: (a) each person feels a greater sense of "zest"
(vitality and energy) for self or life and for relationship; (b) each person feels more able to act and does act (motivation and response); (c) each person has a more true and accurate picture of oneself and the other person; (d) each person experiences a greater sense of worth; and (e) each person feels connected to the other person and is motivated to seek connection with others beyond the original relationship.

Definitions of Empowerment, Empathy, and Mutuality

Three key terms the Stone Center writers use in the promotion of growth-fostering relationships and the development of self are empowerment, empathy, and mutuality. They offer a variety of nuanced definitions for each term and each is interwoven with the others in its definition. This leads to confusion and unnecessary complexity. Part of the problem stems from numerous authors (five primary: Alexandra Kaplan, Judith Jordan, Jean Baker Miller, Janet Surrey, and Irene Stiver) writing on a variety of subject areas that are interrelated. Each term is subtly different. Second, the Stone Center's relational theory has not been synthesized into one whole, concise theory. Third, as the authors continue to think and write, their ideas evolve. Thus, these definitions are fluid and nuanced.
Empowerment. Jean Baker Miller (1982) described power as "the capacity to move or to produce change" (In Surrey, 1987, p. 2), replacing the concept of control or mastery. Over the years the concept of power has been modified to describe personal power as inner strength, self-determination, and self-actualization. However, this notion is still grounded in an individuated-separated, autonomous self framework. There is a shift of meaning when power is experienced as shared and derived from mutually empowering one another and the relationship.

Empowerment occurs in a relational interaction in which each person feels heard and understood and hears and understands. This experience energizes and activates each participant to act purposefully. "This process creates a kind of unencumbered movement of interaction. . . . The movement of relationship creates an energy, momentum, or power that is experienced as beyond the individual. . . . Neither person is in control" (Surrey, 1987, p. 7). "The term assertiveness can be reframed as empowerment in a relational context" (Jordan, 1990, p. 4). This relational context describes a multi-directional growing opportunity for all participants that differs from conventional models of assertiveness and nurturance.
Empathy. The Stone Center writers believe that empathy is a dynamic process that evolves as a result of engagements with others which are increasingly rich, complex, shared and mutual. Empathy requires one to attune to another's affect, to perceive another's experience without losing one's own perception, to balance affective and cognitive input and processes, and to be comfortable within an interaction focused on mutuality. Empathy is described by Judith Jordan (1991b) as an activity requiring high levels of cognitive and emotional integration by which one person experiences the feelings and thoughts of another while knowing one's own feelings and thoughts.

Developmentally, empathy evolves over time as the individual engages in increasingly complex, shared, and affective interactions from which mutually informed understandings emerge. From the sense of enhancement gained from many such experiences one seeks additional mutually empathic exchanges as a primary source of growth and empowerment (Miller, 1986b). Given the complexities of empathic development, it is unlikely that empathy will emerge in a life absent of experiences that promote and encourage empathic interactions (Surrey, Kaplan, & Jordan, 1990, see p. 7).
**Mutuality.** Mutuality is an engagement in which each participant is both affected and affects the other in an emotional, cognitive, and spiritual sense. Affecting and being affected refers to one's ability and desire to be open to influence, to be emotionally available, and to express initiation and receptivity towards the other. Relationship flows from the experience of feeling understood and understanding, wanting and having an impact on the other and wanting and being influenced by the other. In mutual connection we can elaborate on our particularity but also move beyond our sense of unique and separate self. Emotional reactions and changes in one's behavior or thinking also signal that one has been influenced or touched (Jordan, 1986). Judith Jordan (1991a) elegantly captures mutuality's aspects in these words:

> When empathy and concern flow both ways, there is an intense affirmation of the self and paradoxically a transcendence of the self, a sense of the self as part of a larger relational unit (Jordan, 1987, p. 1). Whether in the joy of empathic contact, in the ecstasy of sexual joining, or in the heat of conflict, mutual relationships move us beyond self-centered control. (p. 1)
She, Jordan (1986), emphasizes that in mutual relationships not all specific interactions are mutual. What is important is that there are enough interchanges for each member to experience mutuality in the relationship. Responsibility for mutuality within the relationship by each person is required to sustain or care for the relationship. Thus, the relationship as well as the members in it are given attention, energy, and care.

**Conflict**

A reader may infer from the writings of the Stone Center that the authors idealize relationships and see relationships as utopic, causing the reader to wonder whether establishment and maintenance of such a relationship is realistic. The Stone Center writers acknowledge the difficulties that arise within relationships and suggest growth occurs in the ongoing struggle for relationship. Moreover, it requires desire, humility, commitment, courage, and persistence. Engaging in the conflictual interaction includes the following: expressing and listening to oppositional, negative, and aggressive thoughts and feelings; being aware that misperceptions and misunderstandings will arise; and being open to engaging even when it is emotionally painful and disturbing.
Conflicting thoughts and feelings in relationships need not end relationships but provide an opportunity to build mutuality and meet relational needs. In order for this to occur, each person must be willing to engage in the conflictual interaction and acknowledge and attend to power imbalances. Problems arise when there is no opportunity to engage in dialogue about the conflict.

Conflicts may arise when experiencing sameness, differentness between people, or both. Experiencing the other's sameness and differentness is essential to promoting growth in relationship. Accepting another's differentness as well as one's sameness in a mutual relationship validates each other's uniqueness and is critical to a relationship's growth (Jordan, 1991a). Growth happens as a result of one's attempts to fully understand and grasp another's experience (Jordan, 1991b). Thus, it is best to value the other's differentness and sameness. To do otherwise would distort the perception of the other. These distortions are often grounded in differences in culture, gender, class and race (Jordan, 1991a, 1991c; Surrey & Bergman, 1992; and Bergman, 1991).

Whenever there are imbalances in mutuality, there will be conflict, either implicitly or explicitly. Major barriers to mutuality include boundary rigidity and the inability to
self disclose or allow another to have an impact on one's thought and feelings. Descriptors of this rigidity include inaccessibility, disconnection, and a feeling of being "walled off" from another (Jordan, 1991b, p. 90).

Conflict within relationship occurs as a matter of course given that partners will disagree and respond differently to their own and other's experiences. Conflict is an expected aspect of relationship. It occurs as a result of engagement with another and when differences cannot be encompassed and dealt with directly. It becomes problematic only when the participants believe engagement of these differing thoughts, feelings, and actions is impossible.

Self versus Relationship

In the relational model of development, there is a shift away from the self as the primary focus and towards the relationship. Rather than a bounded, static object, the self is viewed more fluidly. The Western view of a healthy bounded self holds that one uses boundaries to protect oneself from the influences of the outside world. Both Gilligan and the Stone Center writers reframe the construct of boundaries "as processes . . . (contact, engagement, and interaction with another.) Thus we evolve from a metaphor of a bounded self whose task is to 'master' reality, to a
While the Stone Center writers do not deny an inner life, they emphasize that movement towards relationship influences, enhances, and changes the inner self. They also believe that connection is central to one's well being and that mutuality contributes to growth individually and relationally. Jordan (1989) summarizes, "A psychology of relationship goes beyond the dualities of intrapsychic versus interpersonal, selflessness versus selfishness, altruism versus egoism" (p. 2).

**Vulnerability**

When being vulnerable is seen as a weakness, demonstrating poor boundary control and an inability to be objective, one's capacity to be in relationship decreases and an increase in self-interest, a need to control and have power over oneself or others results. The Stone Center writers maintain that the capacity for vulnerability, described as "the ability to maintain oneself in a state of openness to be influenced" (Jordan, 1991a, p. 2) and the respect of the other's vulnerability are essential to mutuality. When one responds with respect for the other's vulnerability the process is mutual, affirming, and growth enhancing for each person and the relationship.
Responsive Initiative

Judith Jordan (1989) redefines the term autonomy in words that reflect an ongoing state of relatedness with others and with the world. She stresses that "the capacity to experience joy and nourishment in solitude" (p. 4) is not eschewed in this relational model.

In solitude, one can relate fully to nature, books, animals, or one's internal images, and one can expect to return to the human community. By contrast, in isolation, one feels cut off from others, wishing for reconnection but unable to achieve it. (Jordan, 1989, p. 4)

The characteristics of "initiative and responsibility," which are associated with "autonomy," are valued in this model. However the word autonomy itself connotes "freedom 'from' relational consequences" (p. 4). Jordan offers the following descriptors as a means to reframe "autonomy."

I prefer to speak about the capacity for (a) initiative, creativity, and responsiveness; (b) clarity of perception and desire; (c) acting with intentionality; and (d) effecting change. All of these capacities are expressed in a relational context where we feel active concern about the consequences of our actions for others . . . [and]
an openness to others' impact on us. Perhaps we could call this "responsive initiative." This is the dwelling place of morality, which Carol Gilligan (1982) explores, and it is at the vital core of human caring. (Jordan, 1989, p. 4)

Summary

Gilligan and the Stone Center theorists offer a model of relational engagement and personhood which contrasts with traditional Western constructs and assumptions. Whereas Western models assume an isolated self interacting as a discrete unit with other selves and evolving or growing from a point of isolation in secondary relationship with others, Gilligan and the Stone Center posit a model that defines the self in relational interaction with others. In this model, individual selves are involved in a dynamic process which puts them in touch with each others' feelings, experiences, and cognitions, and which produces change and the possibility of moving beyond the separate or isolated self to mutuality and empowerment. For these writers, the desired outcome of this dynamic process is the phenomena of growth-fostering relationships, where individuals express vitality and energy for life and relationships, are motivated and responsive, have an accurate picture of themselves and the other person, experience a greater sense of self-worth, and
desire connection with others beyond the immediate relationship.

In the first portion of this chapter, I focused on the following question: What is Buber's relationship construct? I listed the three components of his construct as the following: (a) the Narrow Ridge; (b) the I-Thou; and (c) the I-It. In the second portion of this chapter, I addressed the question: What is Gilligan's relationship construct? The components of Gilligan's understanding of relationship include the following: (a) the Separate/Connected Self; and (b) the Listener's Guide, which allows the speaker to be heard in a richer and fuller manner. The Stone Center contributes the components of growth-fostering relationship, namely, Empowerment, Empathy, and Mutuality.

In Chapter V I will critically compare Buber and Gilligan/Stone Center's relational constructs. I will attempt to establish their agreement on six points: (a) the nature of the movement from individual experience to a relational and lived experience; (b) the two basic approaches to understanding human experience: rights/fairness and connection/responsibility; (c) the discovery of the unique self in the context of relationship; (d) the change an individual undergoes as a result of a relational encounter; (e) the importance of vulnerability
(a Stone Center term) and participation in the "narrow ridge" (Buber's term) as a precondition for dialogue and change to occur; (f) the importance of individual authenticity as a precursor to meeting. Next I will endeavor to demonstrate Buber and Gilligan/Stone Center's disagreement on four points: (a) the terminology they use to articulate their views; (b) their critique of patriarchy; (c) their view of how the connected experience happens in time; and (d) the role of authenticity as a result of the connected encounter.
CHAPTER IV
THE THERAPEUTIC RELATIONSHIP

This chapter explores the therapeutic relationship from its origins in psychoanalytic theory through its development in dialogical and relational psychotherapy. Freudian psychoanalytic theory as well as more recent psychodynamic and humanistic theories represented by Kohut and Rogers respectively will be discussed. Friedman's adaptation of Buber to the discipline of dialogical psychotherapy will be examined using the more recent work of William Heard. This will be followed by material from the Stone Center writers, including Miller, Jordan, Kaplan, Stiver, and Surrey who offer their developing theories of relational therapy.

Prevailing or Mainstream Views

In Schumacher's (1993) review of the literature on therapeutic alliance, she confirms that "from a theoretical perspective, interest in the importance of the client-therapist relationship is not a recent phenomenon" (p. 53). Although the traditional psychoanalytic view regarding the personal relationship between therapist and patient was initially and for some time considered unimportant or perhaps antithetical to treatment outcome, this view has changed. From the 1940's, 50's and 60's forward, the
psychotherapeutic field has shown an interest in the therapeutic relationship. Frank and Frank (1991) dedicate an entire book to the importance of the therapeutic relationship. They compare all manners of healers from psychotherapist to shaman, medical physician to priest. Their review and analysis of the literature, as well as those of other researchers studying therapeutic alliance, continue to focus either on variables of the therapist or the client or their similar/dissimilar value judgements.

It is now generally agreed that the therapeutic relationship is crucial to successful treatment outcome. It is seen as a component of therapeutic success rather than the core of successful treatment. Thus the emphasis is on the multitude of factors that influence therapeutic alliance as well as on the complexity of the therapeutic alliance variable itself. Study and theoretical discussion have focused on the "variables that contribute to positive therapeutic alliance" (Schumacher, 1993, p. 44). In mainstream psychoanalytic theory, the therapeutic alliance is considered to be a component of therapy and not therapy itself.

**Historical Development of the Therapeutic Relationship**

Early in the history of therapy, specifically psychoanalysis, the therapeutic relationship was rigid in
regard to procedure. The therapist was to be the blank slate onto which the client projected his or her significant relationships: primarily the parental relationships during one's early childhood. This was done basically through free association and interpretation of dreams. Clearly the relationship of the client and therapist was utilitarian at best.

The person of the therapist was to be insignificant to the therapy. When the person of the therapist was engaged in the therapy, it was considered detrimental to psychoanalysis because the real work of getting at unconscious thought and experience, at inadequate defense mechanisms, and at the root relationships with primary care givers would be delayed at best and at worst impossible. Although this was the prevailing view of psychoanalysis, Freud apparently interacted much more intimately and committed many violations of what was considered proper practice.

Freud is credited with bringing the therapeutic relationship into bold relief. By observing the relationship between his friend and mentor, Josef Breuer, and client, Bertha, Freud began to recognize that the therapeutic relationship was complex and not what it appeared to be on the surface. He spent the rest of his professional life studying the nature of the therapist-patient relationship
and how it could be used to cure the patient. Yet the emphasis was on how patients engaged with the doctor. The theory was that patients were not responding and engaging with the person of the therapist but rather were unconsciously reacting and responding to the first important relationships they had in early life: their parents. These relationships become the template for all subsequent relationships.

From this framework, Freud believed the therapeutic relationship recapitulated the patient's earliest important relationships and the patient's management of them. Because patients often did not receive what they wanted from parents emotionally, they repressed these desires. He believed that people need to recreate situations and relationships that were particularly difficult or troubling in their early years because they are fixated on that experience and are driven to repeat the painful dynamics (Kahn, 1991). The therapeutic relationship was not a relationship between therapist and client but rather the client's experience of the therapeutic "relationship in light of their earliest ones, and ... [their attempts at trying] to engender replays of early difficult situations" (p. 25).

To prevent influencing the development of the therapeutic relationship, the therapist was cautioned to be
neutral, that is, cool, distant, withholding. The therapeutic relationship as seen through the eyes of the patient was considered a distortion. It was the therapist's job to help the client recognize that this distortion was a result of the patient's transference due to repression of wants and desires that had not been gratified in early relationships. This repression led to various symptoms including hysteria, obsessive-compulsiveness, depression, dependency and so forth. As psychoanalysis evolved and students of Freud's and his successors' continued to reformulate theory, many began to question this neutral or nonperson stance to relationship. Others in behavioral and humanistic approaches to therapy also questioned and modified the therapeutic relationship (Kahn, 1991).

Transference

The relationship that the client experienced with the therapist was often described as "the transference." It was Freud's (1912) belief that transference was a universal phenomenon that influenced each person's relationship with another. Due to our "unique histories, ego functioning, superego mandates, fantasies, and fears" (Strean, 1994, p. 109), transference distorts our experience of another. In therapy, Freud (1912) believed that patients' experience of the therapeutic relationship and their behavior in therapy
were driven by their earliest relationships and their need to recreate the difficult situations that had transpired in them.

Additionally, it is thought that positive transference may occur as a result of how the patient had fantasized the relationship should be. Initially, for most patients, the therapist is experienced in positive terms, as the ideal parent, benevolent, nurturing. This positive transference was expected to run its course and then, in time, a negative transference would take its place. At this time the patient would perceive the therapist as the bad parent, the tyrant, abuser, withholder of love. This is when the "real work" would occur.

It is suggested that the patient's response to a therapist's intervention is determined by the type of transference the patient is experiencing towards the therapist (Strean, 1994). Freud (1914a) believed that one of the primary responsibilities of the psychoanalyst was to shed light on the true nature of the transference. He believed that as patients are analyzed, their true nature and defense mechanisms come to light. When they became more and more aware of their motivations, defenses, hurts, unconscious strivings, the patients then would have more
genuine, honest relationships within themselves and with others.

The theory of transference suggests that the therapeutic relationship is a microcosm of patients' pathology and life experience (Kahn, 1991). More recently, theorists have described the clients' experience of therapeutic relationship as a mixture between fantasy and perception. The fantasy is the experienced transference and the perception is the personal or real relationship (Hamilton, 1990).

**Countertransference**

Countertransference occurs in the therapist. Originally it was thought that when countertransference occurred the therapist was unable to maintain neutrality, distance, and objectivity. The therapist's experiences of feelings towards the client, whether love, hatred, boredom, or joy were seen as projections of the client's feelings onto the therapist. These emotions were not engendered by the relationship between client and therapist but rather by the client's influence on the therapist's unconscious.

If a therapist was successfully analyzed, countertransference would then be experienced as the provocations of the client's transference. Thus, the therapist would be able to use the experiences as a direct
avenue to uncovering the patient's unconscious motivations and drives. As time has gone on, countertransference has taken on a much broader definition: "all those reactions of the analyst to the patient that may help or hinder the treatment" (Slakter, 1987, p. 3).

More recently, some object relation theorists have begun to regard countertransference as similar to projective identification by the patient: the "attribut[ion of] aspects of the self to objects and the . . . elicitat[ion] of those qualities from them" (Hamilton, 1990, p. 251). The patients' behavior, however unconscious, elicits in therapists unwanted emotional reactions. By understanding this process, therapists learn how patients are feeling, and then they are to respond in an appropriate manner (see pp. 238-239).

Developing empathy for clients often results from clinicians' awareness of countertransference. When therapists recognize that they are experiencing what their clients are experiencing, the therapists are better able to sit with these feelings and provide interpretations and confrontations which are without judgement or condescension.

**Therapeutic Alliance**

The term therapeutic alliance, defined by Frank and Frank (1991) as a "... confiding relationship with a helping person" (p. 40), has been used by researchers and
therapists alike to describe the therapeutic relationship. The purpose of the alliance is to encourage trust in the therapist so that the "real work" of therapy can proceed. Therapeutic alliance has been studied, measured, and analyzed using various techniques and strategies from the client's perspective as well as the therapist's. The therapeutic alliance has been studied in order to improve it (Schumacher, 1993).

Psychodynamic Theories

Currently, psychodynamic therapy's (including self-psychology, ego psychology, trans-personal psychology, object-relations therapies, and gestalt therapy) interest in the relationship between patient and therapist (doctor) is understanding the nature of the relationship and how the therapist should engage in it. The position of many is that attending to the subtleties and changes in the therapeutic relationship gives the therapist the most powerful therapeutic tool and offers a major therapeutic advantage (Kahn, 1991, see pp. 2-4). Using the relationship to promote change in the client, to encourage mental health, is the hallmark of psychodynamic therapy. Even those therapies that do not specifically focus on the therapeutic relationship, such as behavioral, cognitive, cognitive-behavioral, and advice-giving therapies, have found that therapy is more
effective when there is a therapeutic alliance (see pp. 2-3).

Recently, object relations theorists, self-psychology theorists, and transpersonal theorists have recognized the importance of the therapeutic relationship to help the client. The term "good enough" parenting or mothering is used to suggest that everyone needs important satisfying, supportive, nurturing, consistent and constant relationships. When people do not receive or perceive that they experienced this relationship during childhood, they develop coping strategies that are often ineffective or harmful to themselves and others. By reparenting (providing support, encouragement, nurturance, consistency and constancy), the therapist is able to "parent" the client into a healthier adult. Coming to terms with not having been parented "good enough" during one's childhood and learning to parent oneself as an adult are two of the goals of therapy (Kahn, 1991).

Regarding the therapeutic experience, there are two major styles of relating to patients: the first includes Kernberg's integration of ego psychology and object relations; and the second is Kohut's self psychology, a reformulation of object relations. The focus is how to best
serve the patient, that is, to promote individuation (integration) and growth (Kahn, 1991).

Kohut (1971) believed that children's basic need from parents was for empathic responses. "Through a process of transmuting internalization, they make this empathy a part of themselves in the form of healthy self-esteem and a capacity to self-soothe, both of which allow development of a cohesive sense of self" (p. 307). Thus vulnerability leading to aggression in the child is a result of empathic failures in parents and then later in clinicians.

Transmuting internalizations. Kohut (Kahn, 1991) used the term transmuting internalizations to describe how the structures of the self are formed. Kohut hypothesized that children have three basic needs that must be met by parents in order for a healthy self to develop. Those needs are the following: (a) The need to be mirrored: the communication that they are "special, wonderful, and welcome, that it is a great pleasure to have them around" (p. 85); (b) The need to idealize: the experience that at least one parent is powerful, knowledgeable, calm and can be counted upon to help the child with complex external and chaotic and frightening internal events; and (c) The need to be like others or twinship: the confirmation that they share important characteristics with one or both parents providing
a sense of belonging, such that they fit in and are not too different from the rest of the world.

No parent can consistently and perfectly fulfill these three needs. When parents do not meet these needs, an opportunity is created for the child to draw upon previous experiences when these needs were met and provide them for oneself if only initially for a brief time. The creation the child draws upon is defined as a transmuting internalization. When a child has many experiences of having its needs met and only sporadically experiences needs unmet, transmuting internalization can take place. Gradually through the process of transmuting internalization, the child will develop structures of the self, which are cohesive in space, enduring in time, the center of initiative, and the recipient of impressions. They also promote "high self-esteem, a guidance system of ideals and values, and the self-confidence to develop one's competence" (Kahn, 1991, p. 88).

Kohut understood that development and maturation was a life-long process and that throughout life people need others to meet these three basic needs periodically. Kohut believed that when transmuting internalization processes do not occur or occur too infrequently as a result of experiencing too many failures to meet these needs, the
child will not develop structures of the self sufficiently and the individual will suffer 'self' problems of greater severity.

**Person-Centered Therapy**

Carl Rogers developed a therapeutic approach called person-centered therapy. The importance of the therapeutic relationship was to provide an environment in which the client felt totally accepted, and was viewed with unconditional positive regard. In experiencing this regard and acceptance the client would then be able to develop a way of being in the world that was best for the individual (Corsini, 1984). Person-centered theory held that one's sense of self regard is influenced and altered through the conditions of self worth which accumulate through interactions with other people significant to one's life. The perception is distorted, Rogers claims, when there is a state of incongruence between the self and one's experiences (Corsini, 1984).

The person-centered therapist responds to the client with empathy, understanding the world as the client sees it. This in turn strengthens the client's self-perception that "it is okay to be me, even this tentative new me which is emerging" (Corsini, 1984, p. 163). It is Rogers' belief that as the client experiences the therapist as empathic,
genuine, and offering unconditional positive regard, the client will move toward "constructive personality change" (Rogers in Corsini, 1984, p. 175).

**Empathy**

In spite of this relatively recent emphasis on the therapist's supportive and empathic role in the therapist-client relationship, traditional psychoanalysis did not consider empathy a therapeutic tool or topic of concern. Psychodynamic theorists credit Heinz Kohut with influencing and providing the theoretical underpinnings for empathy as part of therapy and an essential component of developing a healthy self (Strean, 1994). Kohut asserts that the task of the therapist is to provide a corrective emotional experience for the patient primarily through the application of empathy (Kahn, 1991).

Others credit Carl Rogers with developing and influencing the professional therapeutic community regarding empathy (Kahn, 1991). In the 1940's Rogers proposed a fundamentally different therapeutic relationship than what was currently offered in psychoanalysis. Rather than the nonresponsiveness towards the client that was the hallmark for American Psychoanalysis, Rogers believed the most therapeutic posture of the therapist was to be empathic and to offer unconditional positive regard and genuineness.
Although it is not clear whether Kohut acknowledges Rogers' contribution to self psychology, Kahn in his book, *Between Therapist and Client* (1991), suggests that Kohut, who remained a psychoanalyst, was able to integrate the humanistic and analytic schools of therapy. The use of empathy is an example.

Empathy was considered by both Rogers and Kohut to be of central importance to the therapeutic relationship. Kohut was able to combine empathic understanding with exploration of the therapeutic relationship. In order to be empathic, one needs first to be nondefensive. From Kohut's perspective providing an atmosphere of nondefensiveness (on the part of the therapist) allows for better interpretation, analysis, and integration.

Gill, another psychoanalyst, encourages a nondefensive therapeutic presence and contends that throughout one's life beginning with one's parents, one is confronted with defended people. In turn one becomes defended, keeping one's feelings to oneself, expecting one's verbalized feelings to be met with defense, or not trusting one's feelings or perceptions. Therefore, when patients express themselves, rather than experiencing defensive countermoves by the therapist, they experience sensitive support to examine their concerns further (Kahn, 1991, see p. 15).
It is impossible for anyone to remain nondefensive at all times. When patients experience threat, the nearly automatic response is to protect themselves. This can take many forms such as fighting back, cajoling, criticizing, justifying, or explaining. When this occurs, opportunities exist for therapists to acknowledge ways they may have provoked a response from patients and to encourage clients to talk about it through reflection and exploration.

From Rogers' perspective, empathy is the imaginative entering of another's subjective experience cognitively, emotionally, and experientially without losing the "as if" quality (Kahn, 1991, see p. 41). Next, therapists communicate to clients their understanding and meaning of the experience which may be just outside the clients' awareness. In everyday experience and in traditional therapy clinicians give and receive messages that evaluate and analyze people (Kahn, 1991). "It is viewing other people's lives in our terms, not theirs" (Kahn, 1991, p. 43). When clients feel heard by their therapists, they feel understood and continue to gain self understanding, they learn to have self-empathy, and their self-esteem improves.

Kohut defines therapeutic empathy in this way, "[I]t is the capacity to think and feel oneself into the inner life of another person. It is our life-long ability to experience
what another person experiences, though usually . . . to an attenuated degree" (1984, p. 82). For both Rogers and Kohut it is the opening up of the therapist to the client's experience, the communicating of this desire to understand, and the expressing of this understanding which provides the corrective emotional experience.

N. Gregory Hamilton (1990) states that object relations theorists use "the personal relationship [to form] the context of psychotherapy" (p. 194). He offers this description of empathy:

[Empathy] contributes to the holding and containing aspects of the therapeutic relationship. [It] serves as a twofold tool for communication: it gives the therapist a means of deeply and subtly understanding the patient, and when the therapist makes an empathic comment, it performs a quietly interpretive function. A third function of empathy is its role in the personal relationship. (p. 194)

According to Hamilton (1990), regardless of the presenting concern of the client, an empathic attitude is always a basic ingredient in the therapeutic relationship.

One's theoretical orientation influences the quality and complexion of the therapeutic relationship. Some schools
discourage any sort of disclosure including personal decorating preferences of one's office, memorabilia or photographs, or even one's attire; others allow for personal interchange as long as there is a therapeutic purpose to the inquiry, or if the therapist redirects the focus of the inquiry to the client.

**Summary**

Traditional psychoanalytic theory offered the therapist a means of understanding the therapeutic relationship. Using the ideas of transference and countertransference, projection and projective identification, the analyst was able to interpret the patients' verbalizations and behaviors in the therapy sessions as acting out their first important relationships, specifically their parental relationships. Psychodynamic theory, and especially its representation in Kohut, places the therapist in the role of catalyst, creating an opportunity for transmuting internalizations to take place. Using empathy, the therapist mirrors clients' needs to feel special, to experience a reliable and calm parental figure, and to feel a sense of belonging in realizing that they share human characteristics with the therapist/parent. Rogers' person-centered therapy focuses more on the unconditional positive regard that clients have missed in their interactions with others. He differs from
Kohut in the level of involvement the therapist has with the clients' internal processes. For Rogers, the atmosphere of unconditional positive regard itself allows for clients to find their own personal direction, while Kohut, rooted in traditional psychoanalytic theory, wants the therapist to guide the process of internal change more directly. This summary of prevailing or mainstream theories forms the basis from which I will compare and contrast the dialogical and relational perspectives.

Buber's and the Stone Center's Theories of Therapy

Buber and the Stone Center differ from these traditional therapeutic approaches in at least two fundamental ways. First, they place a central emphasis on the relationship or meeting which occurs between therapist and client, as an occurrence which is necessary for healing. Secondly, they re-evaluate and reframe the role of the therapist in a way that allows for the possibility of connection or what Buber calls the I-Thou moment.

As this study critically compares and contrasts dialogical therapy with relational therapy, I intend to present the concepts of each in the words of the writers themselves. This will allow the reader to have an experience similar to the one I had in this process. Buber and his collaborators, Carol Gilligan and her colleagues and the
Stone Center theorists each write with a poetic, literary grace that is integral to their theses. Removing the style in order to improve the comprehension of their work would therefore remove the fluid and nuanced quality of their writing and the sense of "being with" the writers.

However, there are limitations in their styles of writing. One reviewer of this paper found the writers confusing and overly complex. Yet to delete or try to minimize the confusion by removing confusing phrases or simplifying the constructs takes away the attempts in demonstrating the I-Thou, the mutual empathy/connected self mystery. Mystery in this case refers to that ineffable experience that occurs in the between, in the relationship, that an analysis or a delineation of the experience cannot describe or fully bring into complete relief.

Offering exact wording of the authors allows the readers to have their own experience and compare it with mine. Both the dialogical and relational theories are embedded in relational experiences that cannot be translated into techniques or behavioral sequences or logical cognitive objectives. Attempts to compare and contrast these theories using my own words and paraphrases would lose the uniqueness and nuanced quality that my efforts to improve readability might make.
Since I am invested in these two theories, it would be difficult not to consciously or unconsciously smooth out differences or sharpen similarities in the description of these therapies. Viewed through my eyes and heard through my ears, much of the "data," the distinctiveness of the approaches, would be removed making my critical comparison in Chapter V less valid. As this is a creative critical inquiry of dialogical and relational theories of therapy, my "data" are the presentation of these two therapies in the words of their authors.

In Chapter III, I paraphrased Buber, Gilligan and the Stone Center's ideas of relationship, since they appeared less critical to the inquiry. But the crucial examination is the therapeutic theories themselves. Strictly speaking, I have contaminated the data. I have abbreviated the sections to make them more readable and have chosen what to include and in what order. I have also engaged in what seems to me minor editorializing. This contamination of the data occurs in all forms of comparison and criticism and is a limitation of this study. To maintain the integrity of the study, I have attempted to keep my interventions to a minimum. My editions were included to clarify the text.

Unless comprehensibility required a different format, Heard used both male and female pronouns alternating by topic,
theme, or paragraph. The text for the following section covering the writings of Buber/Heard and the Stone Center will be interspersed with various headings. After listing the headings I will give a brief description of the topic for that heading followed by the quoted material by Buber/Heard and the Stone Center respectively. A summary concludes each section. This will be the general format for this section.

**Buber**

Dialogical psychotherapy has evolved from Buber's philosophical anthropology which encompasses the wholeness of our lives in a manner that matches how we experience life. He contends that to understand our wholeness we must understand the nature of our being and the primordial givens from which our humanness evolves, that is, our ontology—the experience of our existence that is determined by the nature of our being as human beings. (Buber, 1988, pp. 3-10; Friedman, 1992, 127-131 in Heard, 1993, pp. 7-8)

Recently, William G. Heard (1993), a psychologist of more than thirty years and a student of Maurice Friedman at the Institute of Dialogical Psychotherapy, published the book, *The Healing Between: A Clinical Guide to Dialogical*
Psychotherapy. In the book's forward, Maurice Friedman describes the book as an introduction to and an advancement of dialogical psychotherapy furthering the "development in our understanding and application of dialogical psychotherapy beyond the pioneering work of Hans Trub, Leslie Farber, Ivan Bosormenyi-Nagy, Richard Hycner, Aleene Friedman, and myself [Maurice Friedman]" (p. xii). I will use much of this text augmented by Buber, and Friedman's work to illustrate the psychotherapeutic relationship in dialogical therapy.

The Healing Between is the first book that has "attempted to explain and illustrate the elements of "dialogical psychotherapy" (Heard, 1993, p. xiv). All but one of the eleven elements originate from Buber's theory which have been elaborated by Friedman. One element, Touchstones, was developed by Friedman himself as a result of his study, integration, and expansion of Buber's work. The element Personal Direction, which was coined by Heard, was also taken from Buber's work.

The eleven elements are the following: the between, the dialogical relationship, distancing and relating, healing through meeting, personal direction, the unconscious, inclusion, mutuality, confirmation, existential guilt, and touchstones. Each will be listed and briefly explained.
Attention will be paid to the elements which are most pertinent to this dissertation.

The goal of dialogical psychotherapy is healing or wholeness through meeting and all the elements are essential to dialogue and real meeting. For the purposes of this study, the focus of attention will be on the between, dialogical relationship, the unconscious, inclusion, mutuality, confirmation, and touchstones.

**Between**

The Between is the first element in Buber's understanding of the dialogical relationship.

The foundation of Buber's philosophical anthropology rests on the "Between." It is the first ontological given. It is defined as the new reality that is created when true dialogue occurs between the therapist and the client [and] it is in the between that healing takes place. (Heard, 1993, p. xv) The dialogical psychotherapist contends that it is in the reality of the between that the important therapeutic work is accomplished. The between is the basic element of the approach, and the efficacy of the other elements stem from it. It is a reality generated in the interaction between the partners of a
special type of relationship. (Heard, 1993, p. 10)
The mystery is that the source of the client's healing is not found within himself nor the therapist but between them. (Heard, 1993, p. 15)

This happens through grace and cannot be simply willed. Neither of the partners can generate nor manipulate this reality. Each can only attempt to create the conditions for its appearance and hope it occurs. To grasp this reality results in profound changes for those involved in the relationship. (Heard, 1993, p. 16)

Buber contended that to the extent we experience the reality of the between, we become truly human (Buber, 1988, p. 74). It is in the between, in our special relationship with another, that we find our humanness. (Heard, 1993, p. 16)

Other terms Buber uses for our humanness are "true personhood" and "unique whole person." The between may only occur when the therapist grasps the unique whole person of the client through inclusion or by imagining the client's reality.

It requires that each partner focus his wholeness on the other in such a way that the other is experienced in all of his uniqueness.
Neither sees the other as a type or category to be analyzed [or viewed as the scrutinizing other]. The other is experienced as Thou. (Heard, 1993 p. 16)

The between is the I-Thou relationship (Buber, 1958, see p. 6).

From the dialogical perspective, the healing work of psychotherapy is found in the between of our I-Thou interactions and not in our selves as therapists. Healing is not something we as therapists do to the client nor is it something the client accomplishes within himself. The source of the client's healing is in the reality between the therapist and himself, which is created by their interaction. This reality, the between, is the dynamic of the therapeutic relationship and the therapist who avoids working in it cannot be effective. (Heard, 1993, p. 18)

**Dialogical Relationship**

The dialogical is the second element. The characteristics of the element will be described along with a description of the dialogical relationship.

The special way of relating that generates the healing between is called the Dialogical
relationship. . . . It is the method used by the dialogical psychotherapist to engage the client in the therapeutic endeavor. (Heard, 1993, p. 10) Buber calls the "unfolding of the sphere of the between, 'the dialogical.'" (Buber, 1988, p. 16 in Heard, 1993, p. 23)

Whenever and wherever humans relate to one another with the wholeness of their being in an I-Thou relationship, healing may result from their dialogue. (Heard, 1993, p. 24)

Buber amplifies this distinction by placing sickness/fragmentation in the between. "The self is never sick alone but always in a situation between it [the self] and other existing beings [people]" (Buber, 1967, p. 142 in Heard, 1993, p. 24).

Friedman tells us that dialogue is characterized by mutuality, directness, presentness, intensity, and ineffability. (Buber, 1988, p. 2 in Heard, 1993, p. 24) The relationship is mutual [italics added] in that both partners share a common experience. However, the experience that is shared is greater than the sum of what either side brings to the relationship and different from the other partner's separate
experience. In fact, the experience does not have its origin in the individual realm of either partner but rather in a realm created by their interaction. (Heard, 1993, pp. 24-25)

The experience of the between comes directly [italics added] to each of the partners of the relationship without contemplation--prior to any cognitive processing. It is a knowing that is immediate without anticipation or interpretation. Its meaning goes straight to the core of both partners and alters their individual reality. It is a gift bestowed on them by the relationship. (Heard, 1993, p. 25)

Presentness [italics added] is one of the distinguishing traits of this special relationship. In these moments when the between is at work, the partners experience only the present. The experience is full and complete in itself without either of the partners needing to look backward to its beginning nor forward to its outcome. (Friedman, 1960, p. 58 in Heard, 1993, p. 25)

The intensity [italics added] of the experience can be seen in its profound influence
on each of the partners in the relationship. The depth of the experience absorbs our whole existence. In addition, this special way of relating is *ineffable* [italics added]. We may discuss how the experience impacts the partners of the relationship, but we cannot describe the event itself. We are presented with a dilemma that is paradoxical. We are talking about something that cannot be talked about without changing what it is. (Heard, 1993, p. 25)

The *I-Thou* [italics added] relation which is necessary for genuine dialogue requires the therapist to become involved with the wholeness of the client. When the therapist directs her attention to the symptoms of the client, she is no longer relating to the client and cannot expect the healing work of the between to be present in her therapeutic endeavors. The therapist must remain open to the totality of the client. . . . However, the initiation of the dialogue does not reside entirely in the efforts of the therapist. It requires a reciprocal interaction involving both the client and the therapist. (Heard, 1993, p. 26)
Yet, a part of the client's injury that brought him to therapy may be his inability to participate in such an intimate relationship. To effect a dialogue with the client, the therapist must accept and relate to the wholeness of the client, including the client's inability to enter into a dialogue. When she accomplishes this, the dialogue once again becomes a possibility. (Heard, 1993, p. 26)

**Distancing and Relating**

The third element, distancing and relating, describes how I-It relationships allow for the I-Thou to occur.

Distancing and Relating is a twofold movement that allows the therapist to set herself apart from the client and see him as a unique, whole person and relate to him as a whole rather than focusing on one trait or characteristic. (Heard, 1993, p. xv-xvi) Understanding how . . . [distancing and relating] shape us is crucial to the dialogue. The manner in which we relate after distancing determines whether we will interact with the other as an object (It) or as a subject (Thou). (Heard, 1993, pp. 10-11)
Distancing is a prerequisite for ... relating. Distancing sets the other person apart from us, making it possible for us to experience his unified wholeness without fragmentation. In this way we can relate to all of the person and not just certain characteristics or traits. This experience of relating to the wholeness of the other results in the client's inner growth. (Heard, 1993, pp. 32-33)

_Healing through Meeting_

For the purposes of this study healing through meeting will not be thoroughly discussed as it is one of the terms used interchangeably with other terms such as the between and dialogical relationship. Heard describes this element as follows:

Healing through Meeting occurs in the between, when the therapist and client are totally responsive to the new reality created between them. (Heard, 1993, p. xvi) The purpose of dialogical psychotherapy is to effect a healing [wholeness] of our relational self. (Heard, 1993, p. 41)
Personal Direction

This fifth element, Personal Direction, occurs during the Between. It will be briefly described. Heard writes,

Personal Direction is what comes from the healing between. It is unique to the client and points him towards achieving his potential. (Heard, 1993, p. xvi)

Buber defines our direction as the unique contribution that only we and no other can make to the world. It is not predetermined but discovered ever anew in each unique, concrete event [I-Thou moment]. (Buber, 1952, pp. 95-96; Friedman, 1960, pp. 95-97 in Heard, 1993, p. 50)

[The client's] direction is found in the realm of the between, where the uniqueness of his unified wholeness is encountered and he is endowed with the imagination to pursue it. (Heard, 1993, p. 51) Both the elements of inclusion and confirmation are involved in this endeavor. (Heard, 1993, p. 52)

The Unconscious

Buber's description of the Unconscious is quite different from the mainstream psychoanalytic view. It is the sixth element.
Buber attributed to the Unconscious the following three functions: the entity synonymous with one's wholeness, the guardian of that wholeness, and the locus of psychic activities that have somehow broken apart from one's whole self. (Buber, 1967, p. 155ff; Trub, 1952, in Friedman, 1985, 1991; in Heard, 1993, p. xvi)

Buber felt that the nature of our personal wholeness [italics added] is unconscious. Since it is beyond our conscious awareness, the unconscious can be said to be its guardian [italics added]. Our personal wholeness is the base of our being equal, our essence. It is what we are intended to be. It is our potential for the expression of our uniqueness. It encompasses all our manifold possibilities to which we do not have conscious access. These possibilities remain nonconscious potentials until they are called out. (Heard, 1993, p. 68)

When this occurs, they are split into their respective psychic (inner) and physical (outer) manifestations required for our conscious apprehension; they appear as dissociated phenomena since their source cannot be traced by
introspection or analysis. Their manifestation is always precipitated by a concrete event. The event that calls them out seems to exist apart from ourselves and remains so in our interaction with it. It is distanced from and stands against us, calling for an interaction with it that will result in our potential being actualized. (Heard, 1993, p. 68)

To respond to the concrete event with our whole potential is to follow our personal direction. When we do not respond to the event with our whole potential, we are left \textit{fragmented} and \textit{divided} [italics added]. We are not conscious of our fragmented parts until we are restored to wholeness. The restoration can be found only in dialogue. (Heard, 1993, p. 68)

The dialogical therapist must be able to tolerate the mystery of our unconscious functions if the client is to experience the healing work of the between. When the client presents himself for treatment, he brings a wealth of possibilities for being that have never been realized. The therapist brings the possibility of interacting with the client in a dialogue that heals the client's
fragmented and divided self and gives him access to his unique possibilities for being. (Heard, 1993, p. 68)

**Inclusion**

Another term for this element is Buber's "imagining the real." Inclusion is Buber's answer for the term Empathy, which he felt was inadequate to describe the client being embraced in his fullness by the therapist.

Inclusion is the process by which the therapist must embrace the entire being of the client, thus experiencing his pain as though it were her own. (Heard, 1993, p. xvi) Buber tells us, "Such an awareness is impossible, however, if and so long as the other [the client] [sic] is the separated object of my contemplation or observation. It is only possible when I step into an elemental relation with the other [client], that is, when he becomes present to me [becomes Thou]." (Buber, 1988, p. 70 in Heard, 1993, pp. 11-12) In order to accomplish this task, we must develop and exercise a gift that resides as a potential in our innermost being. Buber calls this gift "imagining the real." (Heard, 1993, p. 12)
In its essential being, this gift [imagining the real] is not a looking at the other, but a bold swinging--demanding the most intense stirring of one's being--into the life of the other. (Buber, 1988, p. 7 in Heard, 1993, p. 12)

Imagining the real is to experience the client's presence before you as a real person in all his unique, unified wholeness without analysis [reduction] or abstraction. (Heard, 1993, p. 12)

It involves conceiving what the other, the desired partner of the dialogue, is thinking, wishing, feeling, and perceiving. (p. 78) When this occurs the therapist experiences in the most personal way the subjective world of the client; at the same time she remains apart from the client by being fully aware of her experience as completely separate and different. (Heard, 1993, p. 12)

The initiator of inclusion, the therapist, has a presence that is in immediate and direct contact with the other, yet still in contact with her own self. In this respect, inclusion is different from identification or empathy. To the extent that she "identifies" with the other she sees only herself in the other. (Heard, 1993, pp.

...
She relates only to those parts of the other that are similar to herself. This type of relating does irreparable damage to the other's unique wholeness. The other is no longer related to as a Thou, but as an It. To the extent that she "empathizes" with the other, she experiences only the other's self and loses contact with herself, thus precluding the possibility of relating. The I is lost in the other. (Heard, 1993, p. 79)

Inclusion is necessary but not sufficient for the dialogue to occur. Inclusion is initiated by the therapist but the client must respond. Yet, the therapist initiates inclusion at some risk to herself. She must be willing to give up the relative comfort of her own being by boldly swinging over and encompassing the sick being of the other. She will be changed by the experience in ways that she cannot predict if she is to allow all of the client's impulses to affect her, and she cannot be certain of the outcome. She must, in those moments that she practices inclusion, give up control of the outcome to the reality of the between. (Heard, 1993, pp. 78-79)
The therapist is not gifted with omniscience; she cannot know how the client's fragmentation is to be fixed. She need only know that among the manifold possibilities that exist between herself and the client, there is a way to restore the client's wholeness. From the interaction of the therapist and the client, the client is able to apprehend and actualize the possibility of wholeness that exists between them. The healing comes from this meeting. Inclusion is necessary for genuine dialogue. Without a clear understanding of it, the therapist will only frustrate the healing work of the between. (Heard, 1993, pp. 78-80)

Mutuality

Heard describes mutuality, the eighth element, in the following manner:

Mutuality is the openness and mutual trust that client and therapist must have toward one another to achieve a dialogue. (Heard, 1993, p. xvi) As Friedman has pointed out, there is mutual contact: both partners experience the presence of the other in an open and direct manner, and there is mutual trust in that both partners in either
case are open and present to each other. There is mutual concern as the partners share the problems presented in the dialogue. (Heard, 1993, p. 12)

However, in a therapeutic dialogue, inclusion comes from the therapist's side of the relationship but not necessarily from the client's side. The therapist does not expect the client to imagine what the therapist is thinking, wishing, feeling, and willing in the therapeutic relationship. The focus is on the client and not the therapist. (Heard, 1993, p. 12)

The feelings that emerge from the therapeutic dialogue are assumed to be intrinsic to that particular relationship. They are not familiar feelings that have been acquired in previous relationships and brought to the therapeutic dialogue, such as in cases of transference. They are uniquely derived from the current relationship, which has resulted from the therapist's inclusion. (Heard, 1993, pp. 86-87)

There is a danger of exploiting the client when the therapist tries to speak outside of dialogue. When the therapist does his work outside dialogue, he no longer encounters the unique
wholeness of the client. The client is encountered as a set of symptoms that need to be ameliorated so she can function appropriately in the world. To function appropriately means to comply with the standards of conduct that are acceptable to our society. What is dealt with are those things that cause discomfort in the client or society in the light of these standards. There is little or no concern for the client's uniqueness or her personal direction. It is a safe and comfortable way for the therapist to conduct himself in the therapeutic endeavor. . . . Because the client risks more, the therapist's responsibility with regard to their mutual contact, trust, and concern is greater. (Heard, 1993, pp. 92-93)

The therapist must at all times be aware of his special relationship with the client and, even in the most intimate moments of sharing, must suppress his own needs and concerns and look to those of the patient. He must take care not to presume to shape the client's personal direction but leave the outcome to the work of the between that evolves from the relationship between them. In those moments when he practices inclusion, the
therapist is exposed and vulnerable to the psychic pain of the client and must remain present to his own self lest he become enmeshed in the client's problems. If healing is to occur, the client must also understand that he is a partner in the relationship and must not expect the therapist to resolve his problem. The client must take responsibility for pursuing the unique direction he discovers in the relationship. (Heard, 1993, p. 87)

**Confirmation**

Confirmation is a fundamental element in Buber's theory. Confirmation requires the presence of inclusion, though for Buber even more is expected. It is a way in which the therapist encourages the client to find his personal direction.

Confirmation involves the therapist's helping the client to find personal direction, the fulfillment of his uniqueness. (Heard, 1993, p. xvi) Confirmation . . . emerges from the dialogue and is used by the therapist to support the client in the pursuit of his personal direction, that is, to fulfill his uniqueness in the situation the dialogue addresses. It is the
method used by the therapist to support the healing changes in the client that occur in the dialogue. Often the therapist must point out to the client those aspects of his life that are not in tune with the dialogue. Confirmation is a very powerful tool of the psychotherapist and must always be directed by the dialogue. (Heard, 1993, p. 12)

Although inclusion is necessary for confirmation, confirmation is more than inclusion. Confirmation involves the therapist's struggle with the client to discover and pursue the demands of the client's unique personal direction. (Heard, 1993, p. 95)

Confirmation demands that the therapist personally join in the client's struggle to be his best, to do what is right for himself with his whole being, to pursue the unique personal direction of his life as it unfolds in continuing dialogue. To do this, she must not distance herself from the client by assuming an objective stance, but she must be willing to accept the personal discomfort associated with the demands of
the dialogue; for confirmation is not always approval. (Heard, 1993, p. 98)

It may also involve confronting the client with one's disapproval. Whether it involves approval or disapproval, true confirmation is always a product of what is created between the therapists and client's interaction and is in support of the client's personal direction. (Heard, 1993, p. 98)

**Existential Guilt**

The penultimate element, existential guilt, is very briefly described here in relation to neurotic guilt. Existential guilt can be understood as real or necessary guilt, while neurotic guilt is experienced even though the person is not actually responsible.

Existential guilt is the guilt that comes from knowing we have consciously hurt another and have thus alienated ourselves from the common order of society. (Heard, 1993, p. xvi) Dialogical psychotherapy distinguishes between two kinds of guilt, existential, in which the client is truly guilty, and neurotic, in which the client feels guilty but is blameless. (Heard, 1993, p. 13) If by his own conduct he [the client] has thwarted
the expression of another's uniqueness, he is existentially guilty. Included are acts of omission and as well [as] commission. Thus, existential guilt is a conscious experience. (p. 12) When he is the victim of an injury by another, as opposed to being the perpetrator of the injury, he may experience guilt feelings, but it is a neurotic guilt. (Heard, 1993, p. 13)

**Touchstones**

This element is Friedman's term, coined from his reading and study of Buber's writings. The two ways of experiencing touchstones, those which emerge from the dialogue and those which are brought into the dialogue, will be described by Heard.

Touchstones [the last element] are what each partner in the dialogue takes away from the experience. (Heard, 1993, p. xvi) There are two ways of viewing touchstones: those that emerge from the dialogue and those that we take to the dialogue. Throughout the client's dialogical history touchstones emerge from his dialogues to be carried with him to future dialogues. These touchstones embody the unique reality of the client, and as this reality changes, the
touchstones are constantly in the process of being altered in each successive dialogue.
(Heard, 1993, p. 13)

Our experience of subjective and objective reality . . . are consciously experienced through acts of apperception or reflection. They are mediated rather than being immediate and direct. They are always experienced after being processed by the individual and the group or the society in which we exist. (Heard, 1993, p. 112)

This is not so with our touchstones. With them, the experience is immediate and direct. Our touchstones are derived from the reality of the between and are experienced by us totally. It affects us totally and in a manner different from either subjective or objective reality. It can be apprehended but not comprehended. It is our openness to the encounter with another that our touchstones evolve and we find our unique direction. (Heard, 1993, p. 113)

When each [therapist and client] brings his touchstones to the dialogue, there is a fusion in the between that alters and creates new touchstones for each. These new touchstones would
not have come into existence without sharing in the dialogue the differences of the other's touchstones. (Heard, 1993, p. 113) If we are open to such dialogues, our touchstones are constantly being reshaped to accommodate the differences in others. The reality of the between that unfolds in the dialogue is not predictable or preordained. (Heard, 1993, p. 113)

The therapist brings her touchstones into the therapeutic dialogue to effect healing in the client. Her touchstones are no more valid than the client's, but they bring experience in imagining the real, inclusion, and confirmation. . . . It is within the therapeutic dialogue of touchstones that the dialogical psychotherapist works to heal the client's disturbed self. The therapist may have the skill and knowledge to participate but not to direct the course of the client's healing. It is a humbling experience that calls forth the uniqueness of both the client and therapist. (Heard, 1993, p. 114)

Regardless of the manner in which the dialogue occurs, the therapist must take care not to impose herself on the client. She must not
present her opinions and attitudes so as to make the client feel that she is speaking from his insight rather than her own. She must respect the client's ability to unfold in the dialogue by actually being with him as he goes through the process of becoming. It is a work—the client's authentic response to his touchstones of reality—that can be accomplished by the client only in dialogue with the therapist. (Heard, 1993, pp.121-122)

Use of the Elements to Promote Healing in Dialogical Psychotherapy

William Heard briefly describes the general process by which the elements are utilized in the therapy session to bring about the possibility of the I-Thou moment, Healing through Meeting, or the Dialogical. He goes on to outline two roadblocks to the therapeutic relationship: therapist's obstacles and client's obstacles. The role diagnosis has in dialogical therapy is then clarified. Lastly the treatment process as it is envisioned by the dialogical therapist is portrayed.

This approach may be in conflict with the past experience of the therapist who has been trained to be analytical. The skills we use to
effect analytical comprehension require a method for separating out the parts of the whole and noting their connections, but in the therapeutic dialogue we must relate to the person in her totality. (Heard, 1993, p. 126) The therapist must see the client as someone of inestimable value; for the time they are together in the therapeutic endeavor, the client is worthy of his total regard. The client's welfare is the focus of his [the therapist's] entire concern. The therapist must strive to be totally present and focused on the client's concerns. If the therapist has the ability to share himself in this manner with the client, there is the possibility of a healing dialogue. (Heard 1993, p. 126) At the moment when the client is willing to accept the therapist's inclusion and to believe that the concern of the therapist is authentic, a dialogue may take place. (Heard, 1993, p. 126)

Obstacles to Therapeutic Dialogue. In this section, obstacles which hinder the attainment and maintenance of therapeutic dialogue will be addressed. Some obstacles lie within the therapist or in his or her training and others reside within the client. Any barrier will prohibit or at
least delay the occurrence of therapeutic dialogue and thus, healing.

**Therapist's obstacles.** The following is a description of the obstacles the therapist may experience preventing him or her from entering into the dialogogical relationship.

As therapists most of us have been trained to approach our clients in a warm and personable manner but always to maintain our objectivity....

To interpret our observations we ... adopt a particular theoretical orientation that serves as a guide to show us what is important. ... The traditional participant/observer role of the therapist means that the therapist is divided in relating to the client. One part must observe while another part interacts. He [the therapist] cannot commit his whole, undivided self to the therapeutic interaction. (Heard, 1993, p. 127)

In addition, his contact with the client is not direct but mediated. He has contact with only that part of the client that has been strained through his theoretical grid. ... The more skilled we [therapists] become in the practice of inclusion and subsequent dialogue with the client, the less we tend to rely on a particular
theoretical orientation. This does not mean that the therapist must discard his theoretical orientation to practice dialogical psychotherapy. However, he should be aware that it can be an obstacle to the therapeutic dialogue. (Heard, 1993, pp. 127-128)

Realistically, what usually happens in the therapeutic process is that the therapist moves back and forth from inclusion and dialogue (I-Thou) to observation and analysis (I-It). However, the dialogical psychotherapist understands that the reality of healing occurs in the therapeutic dialogue. (Heard, 1993, p. 128)

Therapists' attitudes regarding clients "can also be obstacles to the therapeutic dialogue" (Heard, 1993, p. 128). When a client is stereotyped, diagnosed, and categorized it becomes difficult to impossible for the therapist to be fully present in the therapeutic process. This does not mean that as therapists we must be saints in our ability to tolerate our clients, but we must be pragmatic. If the therapist approaches the client with anything less than a profound grasp of his unique and inestimable worth, she is not
capable of inclusion, and thus she precludes the occurrence of a therapeutic dialogue. (Heard, 1993, p. 129)

Other obstacles to the dialogue ... stem from the therapist's inability to focus his total and undivided concern upon the client. The therapist may be too preoccupied or fatigued. He must take care to maintain himself in such a way that he is able to focus without reservation or distraction upon the welfare of the client. Anything that detracts from his ability to accomplish this precludes the occurrence of the therapeutic dialogue. (Heard, 1993, p. 129) The therapist must also be willing to undergo the exposure to the client's psychic state that comes with inclusion, even when sharing this experience is painful. There are times when the therapist, for whatever reasons, is simply not able to tolerate the pain or discomfort associated with such an endeavor. (Heard, 1993, p. 129)

On still other occasions, the therapist may lose his awareness of himself as a person in his empathy with the client and be unable to maintain the dialogue. [When a] therapist loses awareness
of himself as a person separate and different from
the client, (Heard, 1993, p. 130)

The impact of the client's experience may render the
therapist so distressed he is incapable of continuing the
therapeutic dialogue.

Client's obstacles. Below is a description of obstacles
to the between and entering into relationship with the
therapist that a client may experience.

Just as there can be barriers on the
therapist's side, the client may also obstruct the
dialogue. The client's total, direct, and open
response to the therapist's inclusion is necessary
for a therapeutic dialogue to occur. Whatever
inhibitions or limitations exist in the client
that prevent such a response become obstacles to
the therapeutic dialogue. The obstacles result
from the client's inability to accommodate the
close psychic contact of the therapist's inclusion
and to accept the trustworthiness and authenticity
of the therapist's concern. (Heard, 1993, p. 130)

The client may be frightened by the close
contact resulting from the therapist's inclusion.
He may have had very little experience in dealing
with this kind of intimacy with another. . . .
Because it is unfamiliar to him, he has no ready response to it. It may be a type of contact that makes him feel extremely vulnerable since there are no barriers, no defenses between him and the therapist's concern. (Heard, 1993, p. 130)

To place himself in such jeopardy may be more than he can tolerate. It is not a matter of trusting the therapist as much as it is trusting himself to be able to cope with such close psychic contact. We often see our client move away from the close contact of inclusion. . . . [B]ecause of his inability to trust the therapist . . . his [the client's] interactions with the therapist are guarded. . . . [This objectivity] precludes his [the client's] ability to respond to the therapist's inclusion with all of himself in an open and direct manner. (Heard, 1993, pp. 130-131)

In other instances, the client may question the therapist's concern. He may think, "Why would she [the therapist] be concerned for me? After all, it is her job to make me think she is concerned. That's what she is supposed to do, but I don't believe her concern is really authentic." (Heard, 1993, pp. 131-132)
Inclusion and dialogue will not be possible until the client is convinced of the sincerity of the therapist's concern.

To analyze the resistance of the client to the therapist's inclusion, one must deal with the client as an object. In such an endeavor (I-It relating), the therapist may be able to formulate a very plausible explanation for the client's resistance. The focus is on some part of the client that must be fixed and not on the whole person. To understand in the dialogical sense is for the therapist to experience the client's resistance as though it were his own. (Heard, 1993, pp. 132-133)

On the other hand, the client has only introspection to help him understand the source of his resistance. ... What does effect understanding and alleviation of his resistance is the meeting with the therapist in the between, something neither the therapist nor the client alone can attain. The source of the client's resistance can be explored meaningfully only in the therapeutic dialogue that the therapist must hope will occur. (Heard, 1993, p. 133)
Diagnosis

Heard distinguishes between the use of diagnosis in mainstream psychodynamic practice and its use in dialogical therapy.

Traditionally we are trained in our initial contact with the client to seek a diagnosis. This involves identifying patterns of behavior, those characteristics or traits common to a particular disorder that we perceive as persisting in the client. . . . In our diagnosis we attempt to eliminate surprises. In our desire to understand the client we enter into an analytical process that is structured to eliminate as much as possible the unexpected. (Heard, 1993, p. 135)

Dialogically speaking, the diagnosis is important because it identifies the manifestations of the client's disturbance and gives us a way of communicating with one another about the client--talking about the client as opposed to talking to the client. But it can be a means of focusing the attention of the therapist on the repetitions or sameness in the client's expression of the exclusion of his uniqueness. It is in his personal experience [his uniqueness] of the diagnosis that
the real work of therapy occurs. The dialogical therapist recognizes the importance of diagnosis but is careful to remember that a diagnostic label never encompasses the unique wholeness of the client. This is seen in the attempts of the therapist to work in the elusive area of the client's uniqueness which by its very nature is always a mystery, . . . always a surprise.

(Heard, 1993, pp. 136-137)

**Treatment Goals**

The treatment goals of mainstream therapy are contrasted with the treatment goals of dialogical therapy in this section. William Heard (1993) stated that due to the nature of the dialogical therapeutic process it cannot be explained in scientific terms. Lastly, Heard focuses on the dialogical process; the centrality of the relationship is emphasized over and above analytical and technical skills.

[T]he treatment goals of the traditional clinical approach address the identified psychopathology of the client--those psychic or mental activities that we presume have produced his disturbance. The traditional therapist assumes that the meaning of the symptom is found in its psychological causes. The treatment goals are
structured to alleviate the cause and thus remove the client's disturbance. (Heard, 1993, p. 137)

The dialogical psychotherapist contends that we cannot treat the whole client if we assume the meaning of the client's symptom is found solely in its psychological cause. We must also be concerned with its purpose, that is, what the symptom is intended to accomplish in the client's existence . . . [, such as,] to help him reclaim his wholeness, severed because of the injury he has suffered. (Heard, 1993, pp. 137-138)

However, the purpose of the symptoms is unique to . . . [the client]. It is in his [the client's] interaction with the therapist that their purpose emerges. The outcome is a mystery and cannot be anticipated since it is peculiar to the dialogue. This uncertainty has profound implications for the dialogical therapist. She must always be aware that she can only experience the purpose of the client's symptoms in her interaction with his wholeness, a personal wholeness that can only be encountered in dialogue and that cannot be encompassed in the treatment goals. (Heard, 1993 p. 140)
The dialogical approach attempts to synthesize rather than analyze the client. It is concerned with the unique wholeness of the client, which is inaccessible apart from dialogue. As the client's unique wholeness unfolds in the dialogue, the personal direction of the client emerges. It is a movement toward the fulfillment of what the client is intended to be. (Heard, 1993, see p. 141)

From the dialogical perspective, the unfolding of the treatment process is a mystery that cannot be anticipated nor encompassed in the treatment goals. . . . While it is true the dialogical provides a starting point and treatment goals give a direction to the therapeutic process, once we have encountered the uniqueness of the client our journey has only one destination: wherever the mystery of the between leads us. (Heard, 1993, p. 142)

If a description of the therapy process involves explaining how the healing of the client's disturbed self is accomplished in the therapeutic endeavor, the dialogical psychotherapist will be found wanting. From the
dialogical perspective there are at least three characteristics of the therapy process that make . . . a scientific analysis impossible. First, the healing process is not observable; second, it is unique; and third, the dynamic of the between is not subject to a natural order. (Heard, 1993, p. 151)

It is Heard's (1993) position that although one may argue that the client's verbal responses and behavior are valid indicators of his intrapsychic activities, it is conjecture. In addition, these observations take into account only the psyche of the individual and not the whole person. Because a unique event has no counterpart it cannot be compared and thus analyzed.

The healing dynamic of the dialogical process is found in a third reality, the between, which comes by grace. Its occurrence is not subject to a predictable [natural] order for there are no contingencies that guarantee its occurrences nor can its impact on the partners of the interaction be predicted or comprehended. (Heard, 1993, p. 152)

In many approaches to therapy . . . [t]he emphasis is on the analytical and technical skills of the therapist and not the dialogical process.
The contention is that the therapist does something to the client and/or persuades the client to do something to himself in the meeting that alleviates the disturbance. To the contrary, Friedman tells us, "It [the meeting] is not only the means to the goal; it is itself the goal" (1985, p. 218). Healing comes in the meeting itself and not in the application of the analytical and technical skills of the therapist. The actual source of healing comes from a reality, the between, that appears in the meeting of the client and the therapist. Each occurrence of the healing between is unique and beyond our comprehension. (Heard, 1993, pp. 152-153)

Thus, the relationship is central not ancillary--not just a supportive framework--but the nexus where real healing takes place (Heard, 1993).

**Summary**

Dialogical psychotherapy, as presented here by Heard, is thus grounded in Buber's philosophical anthropology. In this anthropology, Buber views the individual as someone coming into the fullness of existence and finding one's own personal direction through dialogical encounters. The various elements that make up the experience of dialogical
therapy, including the notions of the between, the dialogical, distancing and relating, healing through meeting, personal direction, the unconscious, inclusion, mutuality, confirmation, existential guilt, and touchstones, all express an overall encounter between client and therapist that is characterized primarily by mutual relationship. The therapeutic model of an objectified client whose symptoms are diagnosed and dealt with in a treatment plan that has built-in specific desired outcomes in the client's behavior is replaced with an encounter that exists in the realm of mystery, the between or a meeting between whole selves who are brought to an experiential knowledge of their own personal direction through dialogue. In this relationship, treatment outcomes are replaced with an experience of wholeness that cannot be dispassionately examined or controlled. What comes of the encounter or meeting is unknown beforehand.

Stone Center Theorists

The bulk of the section on relational therapy comes from the Stone Center writers, a group of feminist theorists who have been re-evaluating traditional therapeutic models since the 1970's (Miller & Stiver, 1997). This section will focus on relational therapy as described by the Stone Center writers in their "Work in Progress" papers.
As the title "Work in Progress" suggests, their writing has developed and their theories have evolved over time in an on-going conversation among the major writers, their colleagues, and other professionals who have attended Stone Center colloquia and seminars. As stated on the title page of each Stone Center Working Paper (See for example Miller, 1984), "WORK IN PROGRESS is a publication series designed to exchange ideas while they are being developed. However, unlike Heard's comprehensive synthesis of Buber's and Friedman's work, the Stone Center writers have not written a comprehensive synthetic manuscript regarding relational therapy. In addition, the "Work in Progress" papers are written to be read aloud to an audience and therefore employs a style of writing that differs from that found in other texts.

In my own research, I have engaged the work written by the Stone Center writers on the topics pertinent to relational therapy and its components. This work ranges from an early, pre-Stone Center book (1976) by Jean Baker Miller, Toward a New Psychology of Women, to a collaborative work, The Healing Connection, written by Miller and Irene Stiver (1997). Working from that literary foundation, I highlighted and collated the information written on each major construct of relational theory and therapy. Finally, I distilled the
information from its original wording down to a comprehensible yet manageable length.

The following key aspects in relational therapy will be addressed using quotes from the "Work in Progress Papers": therapy and relatedness as movement, conceptualization of client's growth in therapy, goals of therapy, empowerment and conflict, authenticity, trust and mutuality, empathy and therapy, transference, countertransference, the unconscious, relational resilience in therapy, and transformation and social change. The format will generally consist of the following: a heading, a brief introduction to the section, and the quoted material by the Stone Center writers.

**Therapy as Relatedness and Movement**

The Stone Center's focus is on relationship in the therapeutic process and how the client as well as the therapist move more deeply into mutual connection. This will be addressed in the following quoted material.

[Judith Jordan] suggest[s] that the most obvious and overlooked event in therapy is that when one brings oneself more fully and clearly into relationship, one enhances self, other, and the relationship. One increases one's capacity to be more whole, real, and integrated in all relationships; split-off energy begins to flow
back into connection. . . . [She] include[s] relationships with people, nature, material objects, and work. (Jordan, 1989, p. 2)

Changes in the therapist's attitude and understanding rather than techniques are emphasized. "These [changes] guide the practice of therapy so that the perspective shifts from one of control and self-sufficiency to one of relatedness and movement" (Jordan, 1989, p. 2).

**Conceptualization of Client's Growth in Therapy**

Speaking for relational theorists, Alexandra Kaplan (1988) contrasts their conceptualization of growth in clients with that of the traditional theorists. Kaplan writes, Mainstream theories identify growth with [higher] levels of boundedness or separation [and individuation]. [While relational theory conceives of] growth as resulting from active participation in relational processes, and . . . focus[ing] on those qualities of connection that facilitate empowerment.

(Kaplan, 1988, p. 8)

[R]elational connection [is understood] as a synergistic process in which each person is aware of her own and the other's unique experience and identity, and of the encompassing, mutual flow of
which they are a part. There ensues an expansion of self to a larger unit and, simultaneously, a growth of the self rather than a loss of self in the other. (Kaplan, 1988, p. 8)

Instead of a therapy that supports the myth of attainable self-sufficiency and individual perfectibility (self as intrapsychic island), we recognize the necessity of mutuality in the face of inevitable uncertainty and suffering. We are not "bad" and therefore guilty if we cannot control and shape our lives in some ultimate way; we are simply subject to the inevitable human limitations which create the humility upon which our interdependence and humanity is predicated. (Jordan, 1989, p. 4) In therapy the client develops the courage to bring herself or himself most fully into relationship and into creative action. (Jordan, 1992, p. 8)

Goals of Therapy

In this section the goals of therapy, mutuality and empowerment, are described and expanded. The Stone Center writers also identify experiences of disconnection and other forms of empathic failures which if worked through bring about connection.
Just as the goal of psychological development is the capacity to engage in mutual relationships, the movement towards mutuality and the deepening and expanding of the therapeutic relationship is the goal of therapy. [The goal of relational therapy is] to embrace both similarity and difference . . . and, within difference, to hold on to a multiplicity of ways of being without creating hierarchies or their resultant differentials of power and control. (Kaplan, 1988, p. 8)

What makes for growth and empowerment through the course of one's life is what fosters growth and empowerment in therapy (Kaplan, 1988, see p. 9).

The core relational goals are: increased mutuality (an interplay of initiative and responsiveness) and increased capacity to grow in connection and to contribute to the growing connection. (Kaplan, 1988, pp. 2-3) [Three aspects which expand on the goal of therapy include] the development of an increased openness to learning and growth and more capacity to tolerate tension and conflict so that movement into isolation and, hence, fragmentation does not occur . . . .
[S]uffering becomes a cause for joining others in alleviating pain and developing compassion. . . .

[R]eaching out to others "for help" and "to help" are ultimate human responses, acknowledging the ongoing interdependence of all people. (Jordan, 1989, p. 4)

The moments of disconnection and isolation are not just times of pain but contain possible lessons which both therapist and client must be prepared to take in. We learn from empathic failures. As Steiner-Adair (1991) and Miller and Stiver (1991) have noted, therapists must become sensitive to our [their] own disconnections and try to discern what is happening when we [therapists] or the other person is moving away from connection. Disconnections must be named and understood [without blaming the client]. (Jordan, 1992, p. 8)

[G]ood therapy leads toward mutuality and empowerment. Both the therapist and client are affected and moved by one another. In the interest of helping the client change, the therapist is committed to protecting client vulnerability, facilitating movement, and bringing awareness to
the relationship and to the treatment process. Both move toward an increasingly differentiated and full representation of self-with-other. It is like a dance in which the flow of mutual responsiveness sometimes obscures who is leading and who is following. (Jordan, 1991a, p. 5) The mutual need to give support, to empathize, also grows as clients move beyond the initial heightened self-concern and painful vulnerability which accompanies the beginning of treatment. Ultimately we need to create meaning and confidence in a caring human community that we are both part of. (Jordan, 1992, p. 7)

Empowerment and Conflict

In this section, a central goal, empowerment, is described. Also in this section the Stone Center writers illustrate their view of conflict as something to be embraced rather than avoided. Finally, Judith Jordan differentiates between the medical model of therapy and the relational model.

Among therapy's central goals is the encouragement and empowerment of individuals to most fully and creatively live their own truths in a way that is respectful of other's lives.
Validation of experience, which often includes directly noting the contextual factors which contribute to difficulties, assists in this process. Learning to trust that we can be ourselves, be different from one another, with the possibility that difference can lead to growth-promoting conflict, is also essential to authentic relating and creative action. We encourage clients to be more comfortable with moving into conflict in relationships by exploring the development of conflict with us. (Jordan, 1990, in Jordan, 1992, p. 8)

Judith Jordan (1991a) has a preference for an educational model of therapy as opposed to a medical model which encourages an authoritarian therapist-"patient" relationship with the "patient" taking a passive, "sick" role (see p. 5).

The Latin word "educare" suggests to "lead out," and I [Jordan] think of therapy as a process of guiding or moving into an increasingly mutual relationship where the most differentiated and full representation of "self-with-other" is possible. While therapy occurs within a protected relationship, "real" safety and growth in
relationships for adults depend ultimately on our increasing ability to develop (a) mutually empathic and empowering relationships in the world, and (b) the capacity to perceive the absence of mutuality and to protect ourselves, or to disengage from unyielding and destructive non-mutual relationships. (Jordan, 1991a, p. 5)

Given therapy's goal of empowerment, the therapist must be especially attentive to the inevitable power differentials that exist in the treatment situation. Conscious or unconscious use of the client to protect the therapist's vulnerabilities or to boost the therapist's sense of worth, whether subtle or blatant, is always destructive for the client. This can lead to retraumatization if it resonates with previous exploitation at the hands of supposedly caring, powerful others. (Jordan, 1991a, p. 5)

Therapists with a strong need to be in control may be threatened by the demand for greater emotional engagement in such therapies. The "neutral" and "blank screen" approach of many traditional therapists creates intense anxiety about disconnection, leading the client, in panic
and anger, to try to connect in increasingly maladaptive ways. The treaters may react by further distancing, imposing more and more controls, and showing signs of discomfort—sometimes frank aversion. (Jordan, 1991a, pp. 5-6)

**Authenticity**

In the following quoted material the Stone Center writers propose that authenticity, an aspect of relational therapy, evolves in a context of relationship. Judith Jordan continues with a discussion of boundaries and their relationship to authenticity.

We develop a sense of personal authenticity largely in relationship and, paradoxically, as we move into relationship, coming to know the other more fully, we also greatly expand our knowledge of ourselves. [In traditional theory, the "real self," which is bounded within, is described as having a] coherent and predetermined direction, which then becomes distorted by interactions with others. (Jordan, 1989, p. 3)

Boundaries then are understood as barriers which protect the vulnerable intrapsychic reality from external influence. In contrast, within a relational perspective, "vulnerability" can become an
opportunity for growth rather than an invitation to possible danger. And safety resides in connectedness, not separation and power. . . .

[T]here is not a "real self" which can "emerge" fully formed, but the possibility of the co-creation of an increasingly "authentic self."

(Jordan, 1989, p. 3)

Inauthenticity takes us out of real mutuality (Jordan, 1992, p. 8). [Loss of voice or an inability] to say what you see, [hear], think, feel, and need [is associated with inauthenticity.] Voice, like the notion of "real self," rather than being something that emerges fully formed from within, is contextual. . . . In real dialogue both speaker and listener create a liveliness together and come into a truth together. Dialogue involves both initiative and responsiveness, at least two active and receptive individuals. (Jordan, 1989, p. 3)

As Carter Heyward (1993) believes, one is "heard to speech."

Trust and mutuality

Trust, a necessary component of therapy, must also grow in the therapeutic process for mutuality to occur. Mutuality, or mutual responsiveness, unfolds when both
parties are open to influence. In order for a client to make use of her vulnerability in therapy, the therapist needs to be honest about his or her own vulnerability as well. The following quoted material will address these issues and the limits to mutuality will be discussed.

Therapy occurs in a context of trust; both therapist and client must develop trust for each other and for the relationship developing between them. Many clients . . . [experience] difficulty trusting others; . . . many also feel untrustworthy. It may be just as important to learn to trust clients, that the trust created be mutual. Therapy involves growth in trust of the other which . . . leads to growing confidence in our own view of reality, a process of gaining a sense of our own voice or truth. (Jordan, 1989, p. 4)

Mutuality does not mean "sameness." It involves openness to change and healing on both sides. Therapy requires mutual trust, respect, and growth. . . . [T]he two individuals, the therapist and client, join in the intention to assist the client. While the therapist exercises certain kinds of authority and the client moves into a
place of vulnerability, the attitude is one of empowerment rather than "power over. "The client's position of vulnerability is at all times respected and protected; the therapist is there to serve the client's needs. (Jordan, 1989, p. 4)

The therapy relationship should never include an attitude of superiority; both members of the interaction must be open to influence by the other. Both must risk change and the uncertainty which accompanies growth. This does not imply that both grow in the same way, or that there is no difference between therapist and client. But mutuality in therapy does rest on the assumption that real growth of an individual can occur only in the context of a real, mutually responsive relationship. (Jordan, 1989, p. 4)

One of our most important therapeutic tasks, it seems to me [Jordan], is to help clients deal with, tolerate, and make use of inevitable vulnerability and uncertainty. To do this from a position which pretends one isn't vulnerable does not seem either truthful or helpful. One very insightful client noted, "I've been to a lot of therapists. They've all been busy putting labels
on me, trying to stay at a safe distance. I don't need to see someone who's cut off from me that way. I need you to be really present . . . that means you've gotta be vulnerable too." (Jordan, 1991a, p. 6)

Real understanding as opposed to pseudo-understanding, involves constantly shifting back and forth between empathic attunement and inevitable disconnections, finding a way back into connection, and understanding together the paths leading to disconnection and connection. It absolutely has to involve both people in an open, moving, and energetic process. . . . Bearing the tension of relational flow together can often provide a sense of relatedness in circumstances which previously resulted in isolation and a sense of personal badness. (Jordan, 1991a, p. 6)

It should be stressed that this [developing mutuality] goes beyond merely undoing projections, or working through the transference; developing new relational patterns of mutual responsiveness and influence is at the core of emotional growth. (Jordan, 1991a, pp. 6-7)
The illusion that therapists have magical abilities and power will decrease as therapists demystify the therapeutic process. This may be done by therapists admitting to their own uncertainty, errors, and personal failures, and by not perpetuating the myth that they know the "magic route to the treasure but it is up to the client to find it on her own" (Jordan, 1991a, p. 7). In the same manner mutuality between client and therapist will develop (Jordan, 1991a, see p. 7).

In a mutual exchange one is both affecting the other and being affected by the other; one extends oneself out to the other and is also receptive to the impact of the other. There is openness to influence, emotional availability, and a constantly changing pattern of responding to and affecting the other's state. There is both receptivity and active initiative toward the other. (Jordan, Kaplan, Miller, Stiver, and Surrey, 1991, p. 82) . . . Rather than independence from others, therapy leads to an enhanced ability to engage in relationships. . . . Further, in good therapy I think both people are
affected. Both client and therapist grow and in that sense are involved in a relationship of mutuality. This is dialogue. (Jordan, Kaplan, Miller, Stiver and Surrey, 1991, p. 95)

"[I]n several ways it [the therapeutic relationship] is not a fully mutual relationship, and awareness of . . . these dimensions is useful" (Jordan, Kaplan, Miller, Stiver, Surrey, 1991, p. 95). There is a financial transaction involved; there is a fairly structured format that is organized primarily by one party (especially early on); there are restrictions on non-therapeutic involvement and interactions outside of the therapeutic setting (Jordan, Kaplan, Kaplan, Miller, Stiver, Surrey, 1991).

In therapy, one individual discloses more, comes expressly to be helped by the other, to be listened to and understood. The client's self-disclosure and expression of disavowed or split off experiences, in a context of nonjudgmental listening and understanding, forms a powerful part of the process. (Jordan, Kaplan, Miller, Stiver, Surrey, 1991, p. 95)
In order to facilitate this process there is a contract that puts the client's subjective experience at the center, and there is an agreement to attend to the therapist's subjective experience only insofar as it may be helpful to the client. The therapist offers her-or [sic] himself to be used for the healing. But within this context there can occur real caring that goes both ways. There is an important feeling of mutuality, with mutual respect, emotional availability, and openness to change on both sides. And the experience of relationship, of mutuality often grows with the therapy. (Jordan, Kaplan, Miller, Stiver, Surrey, 1991, p. 95)

**Empathy and Therapy**

Empathy, where the therapist enters into the client's interior world of experience yet holds on to his or her own interior experience, is expanded and discussed in the following section.

At the heart of relational therapy is the relationship between therapist and client. A return to the pain of the past becomes possible and healing because in this journey the client is not alone. Empathically present, the therapist
joins in the experience. . . . The therapist, while feeling the pain, is not overwhelmed by it. The message is, "we can bear this together." The client and therapist begin to appreciate the meaning systems that have grown around the pain and how it has shaped the person's life and understanding. (Jordan, 1989, p. 3)

Crucial to a mature sense of mutuality is an appreciation of the wholeness of the other person, with a special awareness of the other's subjective experience. . . . Empathy in this sense, then, always contains the opportunity for mutual growth and impact. (Jordan, Kaplan, Miller, Stiver, and Surrey, 1991, p. 82) Empathy allows an understanding of each other's subjective world; it involves a direct movement from subject-object relating to subject-subject relating. Here is another person I can understand, in some ways different from me, but also like me, like all people. (Jordan, 1984, p. 4) Poets have suggested that in moving more fully into the particular, we can experience the universal. It is in the paradox of empathy that we appreciate the unique, differentiated characteristics of this particular
other person, and we move past the particular to join in a place of commonality.

(Jordan, 1989, p. 4)

Not only does the therapist understand and resonate with the client through empathy, but "'both' people draw nearer each other in the empathic moment in a way which expands their sense of human community" (Jordan, 1989, p. 5).

Equally important as Kohut's (1978) assertion of "recognition of the self in the other" is the "recognition of the other in the self" (Jordan, 1989, p. 5). Self-empathy develops both out of empathy and mutual empathy through the recognition of one's own humanity, which includes having compassion for one's own failures and losses. The capacity to experience self-empathy and empathy for others is diminished when there is a suppression of spontaneous affect as a result of either curtailing or controlling one's feelings (Jordan, 1989, see p. 5).

Kaplan (1988) suggests that when the therapist understands that the client enters the therapeutic relationship trying in her own way to make contact [with the therapist] and that she is behaving as she is because she could find no response to her earlier efforts[,] . . . [the] therapist can help . . .
[by] conveying to the client her wish to understand the client from within the client's own experience, including both her fears of, and wishes for, engagement. The therapist also suggests by her actions that the immediate situation has been created mutually, and the client's reaction is a reasonable response to a shared process, not a sign of the client's inadequacy. . . . [When the client feels understood and validated, she may then be able] to explore further her fears of isolation and rejection, her expectation of being misunderstood or blamed, and the historical antecedents of these feelings. . . . The task [then] for the therapist [is] to stay connected to the client's affect and the relational process. (Kaplan, 1988, p. 7)

When we as therapists feel threatened by the possibility of having our human limitations seen and known, we may assume a defensive position, i.e., move out of connection. In potentially open and precious moments between client and therapist, we will close down--psychologically abandoning the client in order to take care of our own threatened narcissism. Our work is not simply to notice when
empathic failures occur, but to understand the therapist's contribution to the problem and, most importantly, what is happening in the relationship that would lead to such misunderstandings or disconnections. (Jordan, 1991a, p. 7)

In the following sections (Self Disclosure, Transference, Countertransference, and the Unconscious) the Stone Center writers will first discuss the issue of self disclosure by therapists. Then they will address the constructs of transference, countertransference, and the unconscious. These traditional psychoanalytic terms are redefined to fit the relational model.

**Self Disclosures by Therapists**

Traditional concerns relating to self-disclosure have been . . . [framed as] protecting the transference and maintaining control, self-protection, and "firm boundaries." . . . 

[Increasingly I [Jordan] see the prohibition against disclosure by the therapist as part of the self-protection of the therapist and his or her sense of uncertainty and possible shame. Non-self-disclosure can support the fantasy that the therapist has no problems, while making the client feel that the therapist does not trust him or her.}
The therapist can choose not to share aspects of her or his experiences with a client, but this should not be defensively presented as "being solely for the client's own good." . . . What is good for the connection should be a central concern in determining our decision to disclose or not. The therapist now has to examine the decision not to disclose as carefully as the decision "to" share her feelings or happenings from her own life. (Surrey, 1991, in Jordan, 1991a, p. 7)

Transference

[Irene Stiver (1991) posits that] transference is very much a relational phenomenon; memories of one's past relationships, with their connections and disconnections, are expressed in many ways, in "a playing out," often symbolically and without awareness. Contrary to the traditional notion that it is the "blank screen" of the therapist that allows the transference to emerge and be "worked through," we [The Stone Center Writers] believe that a genuine relational context provides "the safety" and conducive setting to attend to representations of old relational images
in the transference, in a way that can be most helpful. (p. 8)

In fact the therapist's authenticity and care provides an environment which allows for the key aspects of transference to transpire. Taking the premise that everyone plays out their life's "significant relational dynamics" in every relationship, the relational theorists contend that the therapeutic relationship is no exception. However, rather than facilitating negative transference by remaining "neutral" and "non-gratifying" in the therapeutic relationship, Stiver contends that the client's feelings, actions and reactions towards the therapist are actually "artifact[s] of this therapy model itself rather than . . . expression[s] of 'negative' transference" (Stiver, 1991, p. 8).

By withholding and not joining with, and thus not responding fully and completely with one's whole self, the therapist creates an environment which can be excruciatingly difficult for the client who reacts according to her feelings which are precipitated by this nonrelational environment (Stiver, 1991, see p. 8). This is not transference but an authentic response to a dangerous and disempowering and nonmutual interaction. Thus transference will occur in a therapeutic relationship in which the
therapist is empathically present and providing an opportunity to move towards mutuality. As the relationship becomes safer, more empowering, and mutual, together the client and therapist may examine the client's relational dilemma that is highlighted in the transference phenomena. More importantly, through mutually empathic and empowering dialogue growth occurs (Stiver, 1991, see pp. 8-9).

Additionally, in contrast to many traditional models of therapy, Stiver (1991) disagrees with the effectiveness of providing interpretations of the client's transference. She points out that frequently these explanations are received "as highly intellectualized, not very meaningful, and often as criticisms" (p. 9).

Providing an interpretation, however, empathically and empoweringly delivered may not be prudent if the movement towards mutuality and mutual empathy is not sufficiently experienced. Understanding the transference allows the therapist to experience herself more clearly in the therapeutic relationship and to engage more authentically and constructively with the client than the client has previously experienced (Stiver, 1991, see p. 9).

Countertransference

The Stone Center theorists have just begun to examine the concept of countertransference. As in other traditional
views of psychotherapy, countertransference has been conceived within "a non-relational framework. "As a result, Janet Surrey (1991) cautions that "[i]t is possible that we are still caught up in traditional views . . . that we don't see the ways in which mutuality can occur earlier and more fully" (p. 12).

In the classical sense, "countertransference" reactions come from the therapist's past unresolved experiences. Clearly, we would emphasize the importance of the therapist having a relational context which helps her to understand her own past and present life experiences. Especially when a particular therapy relationship is difficult or confusing, the therapist needs to make certain she has a growthful relational context for herself. We also emphasize the importance of an enlarged relational context for client and therapist together--through adding other therapists, groups, or consultation--not as a sign of failure but often as necessary arenas for growth and relational movement. (Surrey, 1991, p. 12)

In an ongoing therapy relationship, unusually strong or atypical responses of fear, anger,
boredom, etc. in the therapist may signify countertransference phenomena in the relationship. They can be most relevant for expanding empathic connection when shared in a non-destructive way. The concept of countertransference to describe the emotional reactions of the therapist is only a small subset of what we mean by mutuality; mutuality involves the whole movement and development of the relationship. . . . To deepen our clinical work in a relational model, we all need an empowering community which facilitates our growth and confidence in the relational mode, helps us to heighten our sensitivity and articulateness about the nuances of relational phenomena, and helps us work with our own personal and professional mutuality. (Surrey, 1991, p. 12)

I [Janet Surrey] realize in saying this that I am still saying that the therapist is not totally spontaneous, that she is still taking major responsibility for the relationship and is making many one-sided decisions based on her view of what will further the relationship. As therapy proceeds, she should move into greater spontaneity and openness. Some of this process would be true
in any relationship. We become more spontaneous, open, and trusting as we learn more about each other. The movement from major responsibility to more mutual responsibility, however, is a characteristic more specific to the therapy relationship. (Surrey, 1991, p. 12)

The Unconscious

Irene Stiver (1991; Miller and Stiver, 1997) suggests that as the therapeutic relationship becomes more mutual and empathic, that is, when both the client and the therapist experience connection: more authenticity, accessibility, safety and full participation in the therapeutic process, then memories do begin to emerge which were previously "repressed," split off, or robbed of their meanings and importance. The notion that a "correct" interpretation with perfect timing lifts the repression, and the unconscious becomes conscious, and dramatic change occurs, has not been part of my [Irene Stiver's] experience. Rather, as the sense of connection between therapist and client grows, the client becomes able to know and understand those parts of her experience which had been too painful to encompass. (Stiver, 1991, p. 10)
In the same way, relational distortions and destructive relational experiences, which may have been too threatening to even look at before, can begin to emerge when the client can trust that the therapist will be able to tolerate these experiences, responding genuinely and affectively to them. As the person feels more accepted, she can bring more and more of her whole person into the relationship, which we believe is the way she will gain access to unconscious or previously split-off experiences. (Stiver, 1991, p. 10)

**Resilience**

Resilience, originally defined from an individualistic model, has been redefined in the following section from the relational perspective. Trauma, which challenges resilience, will also be discussed.

Studies of psychological resilience have focused largely on the abilities of individuals to adapt to stress; some have emphasized factors within the person, like temperament of personality style, which protect from adverse consequences of stress, while others have pointed to the benefits of social support. Each of these approaches, however, has been based on a "separate self" model
of development. Thus they look either totally within the individual for resources of resilience or in a one-directional way from the point of view of an individual looking for support from another individual or group. The perspective put forth here suggests instead that resilience be seen as a relational dynamic. (Jordan, 1992, abstract)

Reframing our understanding of resilience in terms of a relational model has implications for both psychotherapy and social change. Therapy, then, can be understood as largely an effort to explore and enhance the capacity for relational resilience. And in moving beyond personal resilience to personal transformation and social change, the relational context is central. (Jordan, 1992, p. 1)

In several studies of resilience, freedom from self-denigration emerged as the most powerful protector against stress-related debilitation; mastery and self-esteem were also seen as important (Pearlin and Schooler, 1978). In general, women have been found to be "lower on self-esteem and higher on self-denigration than are men" (Barnett, Biener, and Baruch, 1987,
Some have gone so far as to conclude that much of psychological literature "depicts women as having been socialized in a way that keeps them from developing resilient personalities" (Barnett et al., 1987, p. 319). But as Carol Gilligan notes, girls show an advantage in dealing with stress until they reach adolescence when they become more depressed, more self-critical and begin to move into silence (Gilligan, Lyons, and Hanmer, 1990). As she writes, "For girls to remain responsive to 'themselves,' they must resist the convention of female goodness; to remain responsive to 'others,' they must resist the values placed on self-sufficiency and independence in North American cultures" (Gilligan et al., 1990, p. 11). We might well question how women's sense of worth can remain intact when the dominant culture denigrates the relational values which are at the core of our sense of aliveness and worth. (Jordan, 1992, p. 1-2)

Trauma, particularly those caused by other humans, . . . creates major disruptions in our experience of relatedness [trust, mutuality, empowerment] and thus threatens our capacity for
resilience. . . . One definition of trauma suggests that it is a "paralyzed, overwhelmed state, with immobilization, withdrawal, possible depersonalization, evidence of disorganization" (Krystal, 1978, p. 90). . . . When an abusive [traumatizing] relationship is defined as a loving relationship, the only outcome can be severe mistrust. Furthermore, there is complete disruption of self/other/world meaning systems in trauma. . . . [O]ur basic assumptions about the world are shattered in trauma (Janoff-Bulman, 1992). (Jordan, 1992, p. 6)

Trauma therefore impedes movement in relationship. When in trauma, we are inflexible, stuck, bound to repetition. Little can be learned interpersonally; we cling to those patterns that are familiar. Withdrawal into mistrust and isolation is rampant. Some have suggested that, ironically, "those individuals who are most vulnerable may be the least effective in eliciting support" (Ganellen and Blaney, 1984). (Jordan, 1992, p. 6)

In therapy we fundamentally build a relationship in which we can explore and seek to
understand patterns of mutuality, resilience, connection, and disconnection. I [Judith Jordan] will briefly point out the ways that the reframing of relational resilience can inform our understanding of therapy. (Jordan, 1992, p. 7)

Often when people begin therapy the need for safety is paramount. Dependability, respect, care, and empathic listening contribute to a sense of security. In therapy, clients learn how to recognize when they need support, what kind of support they need, how they can ask for it and from whom. Clients become aware of those things that interfere with asking for support or bringing themselves more fully into relationship—shame, pride, fear, anger, split off experiences, inability to find trustworthy partners, etc. . . . The mutual need to give support, to empathize, also grows as clients move beyond the initial heightened self-concern and painful vulnerability which accompanies the beginning of treatment. Ultimately we need to create meaning and confidence in a caring human community that we are both part of. (Jordan, 1992, p. 7)
As misunderstandings are renegotiated and empathic failures are reworked, the client slowly develops a sense of relational confidence. The very capacity of the therapy relationship to not only withstand but grow through the shared work on anger, hurt, and pain contributes significantly to the sense of relational confidence. (Jordan, 1992, p. 8)

While therapists address individual problems and personal change, we also work on developing "relational awareness" which gradually becomes as important as the kind of self-consciousness that is so prevalent, but so paralyzing, for many people when they enter therapy. . . . We engage in articulating, tracing, and getting to know relational movement from connection to disconnection and back into connection in the here-and-now. We foster an awareness of self, other, and relationship. . . . [A] relational point of view . . . emphasize[s] the need for mutual involvement and mutual empathy. [T]he need for a kind of relational competence and belonging is powerful and primary. (Jordan, 1992, p. 8)
Transformation and Social Change

The relational perspective avoids a therapeutic outcome that leads to individuation and a separate self. The following material illustrates the Stone Center's emphasis on therapeutic connection leading to social connection and ultimately to the client's involvement in social change. In this relational outcome the client engages systemic problems from the root experience of connection in the therapeutic process.

Unlike resilience, transformation suggests not just a return to a previously existing state, but movement through and beyond stress or suffering into a new and more comprehensive personal and relational integration. In the case of disconnection, discovery of a means for reconnecting, and building a more differentiated and solid connection. The movement into and out of connection becomes a journey of discovery about self, other, and relationship--about "being in relation." The importance of connectedness is affirmed, and one's capacity to move into healthy connection is strengthened. This is indeed transformative. (Jordan, 1992, pp. 8-9)
By speaking of transformation rather than just resilience we move beyond a notion of recovery from individual pain to a sense of greater integrity and integration in the human community as well. Joining others in mutually supporting and meaningful relationships most clearly allows us to move out of isolation and powerlessness. Energy flows back into connection. Joining with others is a powerful antidote to immobilization and fragmentation. It is thus an antidote to trauma. Moreover, the ability to join with others and become mobilized can further efforts towards a more just society.

(Jordan, 1992, p. 9)

As therapists, we must move beyond the dealing with individual pain; we must become part of a larger solution by joining with others to transform the social conditions that contribute heavily to individual pain. We can replace an ethic of individualism with an ethic of mutuality. As feminist therapists have been noting, the personal "is" the political. We cannot continue to pathologize individual adaptations to socially destructive patterns. Therapy should not become a
part of the problem by suggesting that the pathology is individual and that the solution is individual. We should not become a part of the problem by the reinforcing of isolation.

(Jordan, 1992, p. 9)

Patriarchy and existing power structures depend on the isolation and disempowerment of women. Women are pitted against each other in competition for men in the demeaning of women who choose to be with women. Women of color are separated from white women. Feminists are characterized as "ballbusters" and "angry bitches." Women fighting for reproduction freedom are portrayed as murderers. Those who speak up against rape, harassment, or job discrimination are seen as troublemakers, to be doubted and judged. (Jordan, 1992, p. 9)

Those involved in social change will need to find ways to be resilient and move toward transformation, in much the same way we have suggested individuals need to move. This transformation can be accomplished through extensive use of support networks, finding the places where change is possible, and finding ways
to live with those situations that are utterly beyond movement. . . . Much individual suffering could be prevented if as a culture we truly appreciated our essential interdependence and the bankruptcy of "power over" models. We might accept the inevitability of much suffering, but apply ourselves arduously to the elimination of that suffering which need not be. This is a question that faces us all in our own lives; as therapists we must help people grapple with it daily: "Is this suffering necessary?" If it is, we must support one another, develop compassion, become resilient. If it is not, we must find ways to move through it and thus to transform the conditions creating unnecessary suffering.

(Jordan, 1992, p. 9)

**Summary**

The Stone Center writers are advocating a relationship between therapist and client which stands radically at odds with traditional Western psychotherapy and which assumes a quite different therapeutic outcome. For these writers, the client-therapist relationship is based on a shared power dynamic that honors mutual trust, vulnerability, self-disclosure, and a sense of the wholeness of the other. The
therapist, contrary to traditional psychotherapeutic practice, does not operate from a premise of superiority as in the medical model, but rather remains open to one's own feelings and responses in the relationship and offers to share them with the client. The client thus encounters a whole human being, not an expert who is compartmentalizing the client's life; and, as a result, the client is better able to share his or her own vulnerabilities with the therapist. From the Stone Center's perspective, this is healthier and more life-giving for the client, more authentic and genuine, and ultimately more affirming than the "blank slate" approach typical of the traditional psychoanalytic model.

The therapeutic goal of this relational approach is to deepen and to expand the client-therapist relationship and to facilitate the client's movement towards mutuality. Mutuality implies the ability to be fully present as a whole person in relationship, to deal with difference out of that wholeness, and to move through conflict to growth (that is expansion and depth). This contrasts with the traditional view of the "bounded" self, where the expected outcome of separation and individuation is paramount. The Stone Center writers also imply that this newly formed connectedness with others (beginning with the therapeutic connection) leads
necessarily to a connection with the larger social/political community. In this expanded setting, the client continues to apply new-found wholeness to address the systemic conditions that lead to individual pain. Thus, these writers move towards social transformation as an end result of therapy—the client in responsible relationship to the larger world.

The first section of this chapter focused on a brief history of Western psychodynamic theory, beginning with Freud and concluding with the work of Kohut and Rogers. I noted a progression from the powerful authority figure in the therapist to a more benevolent, caring, and empathic helper. Also in this progression, the role of the client moved from a more or less passive receptor of the therapist's treatment to a more active player in the therapeutic process. Some consider Carl Rogers as the one who introduced empathy into the client-therapist relationship, thus providing a link between traditional psychoanalysis and today's psychodynamic perspective.

There is a break with the prevailing psychotherapeutic point of view with the advent of Buber's dialogical theory and Stone Center's relational model. In these relational theories, what happens in the relationship between therapist and patient is central, not what happens as a result of the expertise, treatment strategies, and status of the
therapist. This places the healing event in the between, meeting, or connection of therapist and patient and thus marks a significant shift away from traditional psychotherapy with its tendency to objectify the client.

In the discussion of dialogical therapy eleven elements were explained, answering the question, "What is Buber/Heard's construct of the therapeutic relationship?" These elements were as follows: (a) the between; (b) the dialogical; (c) distancing and relating; (d) healing through meeting; (e) personal direction; (f) the unconscious; (g) inclusion; (h) mutuality; (i) confirmation; (j) existential guilt; and (k) touchstones. When taken as a whole these elements mark the essence of dialogical relationship or what Buber terms the I-Thou encounter. It is in this critical human encounter that healing can and must take place.

The latter section of this chapter dealt with the question, "What is the Stone Center's construct of the therapeutic relationship? The main concepts that delineate this construct are as follows: (a) trust and mutuality; (b) vulnerability; (c) self-disclosure; (d) a sense of mutual wholeness; (e) empowerment; (f) authenticity; (g) empathy; and (h) relational resilience. These concepts are directed to a therapeutic goal which seeks to deepen and
enrich the client's movement towards relationship and mutuality.

Chapter V will answer the question, "How do Gilligan/Stone Center's and Buber/Heard's constructs of therapeutic relationship critically compare?" It will also answer the question, "What are the implications for the therapeutic relationship in light of these two constructs?" The chapter will explore the goals of each therapeutic school and compare and contrast terms such as the meaning of relationship for therapy, vulnerability, empathy, inclusion, confirmation, meeting, the between, connection, mutuality, holy insecurity, and directness. The implications of these comparisons will then be considered.
CHAPTER V

CRITICAL COMPARISON OF THE RELATIONAL CONSTRUCTS
AND THERAPEUTIC CONSTRUCTS OF BUBER/HEARD
AND GILLIGAN/STONE CENTER, THERAPEUTIC IMPLICATIONS,
FURTHER STUDY, SUMMARY AND CONCLUSIONS

As the dissertation was written and I followed my format, I realized that Chapter III and Chapter IV, although a useful division to quickly become familiar with each relational construct, was artificial in that I made choices as to where I would present concepts of relationship and therapeutic relationship. I found I spent more time in Chapter III on Gilligan and the Stone Center writers' construct of relationship and in Chapter IV, more on Buber and Heard's therapeutic relationship position.

Because I used different formats for Buber and Gilligan and the Stone Center writers, I had difficulty strictly comparing constructs within Chapter III and then Chapter IV. Therefore, for the purposes of this study, I will critically compare Gilligan and the Stone Center writers' and Buber's relational constructs as well as their therapeutic constructs taking from the entire body of this paper. In the first two sections, I will critically compare and provide my interpretations of Gilligan and the Stone
Center's and Buber's relational constructs and their constructs of therapeutic relationship respectively. I will discuss in the third section the implications for the therapeutic relationship in light of these constructs. In the fourth section I will provide recommendations for further study. Lastly, I will briefly summarize this study and offer my conclusions.

Critical Comparison of Buber's and Gilligan/Stone Center's Relationship Constructs

It is my experience, and others', that Buber, Gilligan and the Stone Center writers are challenging to read and comprehend. Buber has been found to be especially confusing and inconsistent within the theoretical framework he attempted to develop. This is not surprising, since his goal was to join with another to create meaning rather than construct a tight, concise theory of relationship. In light of this more experiential approach, he used terminology loosely and creatively and did not hesitate to use several terms for the same or nearly similar ideas. It is even quite possible that Buber would object to the word "theory" as a referent to his "pointing towards" relationship.

The Stone Center writers, in my view, tend to use more concrete language, while Buber/Heard are more abstract. This may have something to do with the historical location of each perspective and the process by which their work is
produced. The Stone Center writers are engaged in a public reading forum, writing for live audiences, and bringing their work to publication after this process is complete. Heard and Buber follow a more conventional approach to text preparation, where the work is written with more limited public engagement and is meant to be read privately.

Perhaps more importantly both Buber and Gilligan/Stone Center are attempting to describe experiences and encounters that are fundamentally indescribable and ineffable. These are events that can be suggested and pointed toward but not fully embraced and understood within the limits of conventional scholarly language. They use and create terminology to point to the shift from individual experience to that of relational experience. The writers are deliberate in forgoing an "objective" scientific style of writing as it is not suited to the kinds of ideas they seek to convey nor does it offer the experience of relationship they want to encourage. Given this context and the authors' literary background, Buber and Gilligan/Stone Center rely on metaphor and poetic imagery to point to the moment of engagement. It is, finally, a language that encourages relationship instead of distance.

Both Buber and Gilligan/Stone Center describe two modes of understanding relationship: (a) autonomy and rights and (b) connection and responsibility. The first mode of
relationship or ways of being refers to Buber's I-It construct, and Gilligan/Stone Center's Justice/Separate Self/Autonomous self. The second mode corresponds to Buber's I-Thou construct and Gilligan/Stone Center's Care/Connected Self/Relational Self. From my own reading and reflection the similarities between Buber's and Gilligan/Stone Center's relational theories are compelling.

Although both groups of writers critique Western culture's heavy emphasis on I-It, Voice of Justice and Separate Self relationships, each discusses the importance of such relationships. Moreover, both are critical that these types of being and relating have been overly emphasized to the exclusion of I-Thou, Voice of Care, and Connected Self engagements. While Buber can be understood to be more evenly balanced than Gilligan and the Stone Center authors in his appreciation of I-Thou and I-It experiences, he may also be less critical of the harm that I-It experiences can bring to the "other." It seems to me that Gilligan and the Stone Center writers are more critical of the image of the separate self which has been elevated in Western thought to a level of superiority and offered as a model of maturity and optimal mental and emotional health. At the same time engagements of Care/Connected Self and I-Thou have been pathologized and labeled with diagnostic language. The Stone Center writers have reframed the
language of traditional psychoanalytic theory to reflect a more relational context. Judith Jordan, for example, uses the term "responsive initiative" to describe aspects of autonomy that also maintain the experience of connectedness.

One ramification of this study is the way the Stone Center's feminist ideology influences the interpretation of dialogical therapy developed in the writings and practice of Buber/Friedman/Heard. For example, I believe that Buber, Friedman, and Heard, all men, have been steeped in Western culture and tradition to such an extent that even in the moment of I-Thou encounters, Western individualism flavors the experience of personal direction making it less relational than their theoretical orientation suggests. Such a critique certainly honors the groundbreaking work that these men produced, but it also acknowledges the patriarchal logic, to borrow a term from Carter Heyward (1993), that keeps them subtly attached to a more linear and individualistic ethos characteristic of white male hegemony. The men working in dialogical therapy have not been in a position to offer systemic critiques of patriarchy, nor could they have been expected to do so. It is nonetheless true that feminist social theory shines an important light on their work and reveals a subtle patriarchal bias even as they develop theories and practices that move strongly in
the direction of a more relational, and therefore more "feminist," track.

In both the Buber and Gilligan/Stone Center material, the self is understood as coming into being in relationship. Buber was quoted earlier in this paper as saying the real birth of the human person happens in relationship. For the Stone Center writers, the central organizing feature in women's psychological development is an inner sense of connection with others. When women experience crisis, it will inevitably stem from disconnection. Both Buber and the women writers associated with Gilligan and the Stone Center agree on this, and both stand in opposition to Western individualism with its emphasis on the isolated or autonomous self which interacts with others but never connects in the profound way desired by these writers.

Feminist theologian Carter Heyward (1993) contributes these words as she comments on Buber's theory of relationship: "It is a way of being in relation in which the very essence of who we are is being created, called forth, and confirmed through our power in relation" (p. 231). This is echoed in the Stone Center's theory that "a growth enhancing connection is the basis of psychological development and mutual empathy and mutual empowerment both reflect and generate this connectedness" (Jordan, 1991a, p. 1).
Mutuality, though not developed in the section on Buber of Chapter III, is a necessary attribute in preparation for relationship and I-Thou moments. This particular term, understood differently by Buber/Heard and the Stone Center writers, will be addressed later in the section on therapeutic relationship in this chapter.

Although Buber and Gilligan/Stone Center utilize their own unique vocabulary to describe relationship and the experience of meeting, they seem to be referring to a similar event. A difference may be that Buber speaks of brief moments of meeting, encountering glimpses of the I-Thou, whereas Gilligan/Stone Center writers suggest a more continuous experience, a "growth enhancing connection." This continuous, growth enhancing experience addresses moments of mutuality and connectedness as well as an overall experience of mutuality, connectedness, mutual empathy, and mutual empowerment in a relationship. The I-Thou moment lasts for seconds or minutes, while the overall experience of mutuality perseveres through the relationship. Each groups' unique understanding of the essential relational experience seems to me a key difference in these writers.

It occurs to me that this difference in understanding may be a matter of enculturated gender differences. Men in Western culture are socialized not to move towards mutuality or the between, while women are more frequently socialized
to attend to the other as well as to the relationship itself. Seeking connection and understanding appears to be a more overt goal for women then for men in the West. This may well provide a plausible rationale for the subtle differences in the two groups' orientation towards "meeting," the "between," and relationship/mutuality.

A feature shared by Gilligan/Stone Center and Buber/Heard is a common understanding of "change" as it occurs in both therapist and client. A method of "change" occurring in the therapist is offered by Brown and Gilligan. Their Listener's Guide research method provides the impetus for change on the part of the researcher as well as the research participants. Many of the Dialogical elements offered by Buber/Heard as well as the Stone Center's approach to engagement with the client provide a similar impetus for change. The "change" is a self better able to enter into the between, the relationship. This "change" in the therapist makes it possible for a relational encounter with the client to occur. Each becomes more open, more empathic, and has a clearer sense of individual self in relation to another fully present self; each person is available cognitively, affectively, emotionally and experientially. In these relational encounters, variously described as moments of meeting, touchstones, or connection, both participants are present as whole selves. In fact, it
is the very presence of two whole selves that makes such moments possible.

The changed self, proposed by Buber and Gilligan/Stone Center, is the result of a profound encounter with another. Buber/Friedman use the language of personhood, personal direction, and touchstones to describe the self transformed through relationship, while Gilligan/Stone Center speak of zest, vitality, transformation, empowerment, mutuality, and resilience. Gilligan (1988) writes of this in her essay "Remapping the Moral Domain," "If the process of coming to know another is imagined instead as a joining of stories, it implies the possibility of learning from others in ways that transform the self" (p. 6). In the same way, Buber's I-Thou dynamic life force is placed between persons in the relationship.

When Buber speaks of the narrow ridge, it is as a unity of contradictions, a paradoxical unity of what may be thought of as dualistic alternatives in terms of either-or's. This place of contradiction, paradox, and relational vulnerability is where meeting takes place. Buber thus speaks of a "holy insecurity," describing the narrow ridge, which leaves the parties in the relationship vulnerable to influence. All of this is compatible with Gilligan's radical decision to do research that listens to all participants, including the voice of the researcher, and with the Stone
Center's belief that the capacity for vulnerability (on the part of therapist and client) is critical to mutuality.

Each theory acknowledges that for mutuality, connection, or I-Thou encounters to occur, one must be fully present and open to being changed in the encounter. The result is a significant shifting of power from the isolated self to the relationship of two whole selves, fully present and open to change. In this relational setting, both selves are indeed at risk, yet such a vulnerable environment is the only situation in which real relationship can exist. This is the ground honored by both Buber and Gilligan/Stone Center.

Authenticity, a term used by both Buber and Gilligan/Stone Center, describes the quality of one's being in relationship. While Buber suggests that being authentic is one of the characteristics necessary to be prepared for the possibility of meeting to occur, Gilligan stresses that authentic relationship can only occur when there is shared power, when each participant is fully present, and when each acknowledges the other as fully present. For Gilligan authenticity is derived from the relationship; for Buber personal authenticity is necessary for the meeting to transpire. Although not parallel, these two concepts substantiate each other. Authenticity will be revisited in the next section on therapeutic relationship.
Summary

Buber and Gilligan/Stone Center agree on six points, as defined in this section: (a) Both are attempting to describe the ineffable movement from individual, autonomous experience to a lived experience that is fundamentally relational; (b) Both agree that there are two modes of thinking about human experience: individual rights/fairness and connection/responsibility to others; (c) Both agree that the unique self of each person is called forth in the context of I-Thou/Connected Self relationships; (d) Both agree that each person engaged in an I-Thou/Connected Self encounter is changed as a direct result of this encounter and this change occurs in the "between"; (e) Buber's "narrow ridge" and Gilligan/Stone Center's understanding of vulnerability provide the opportunity for dialogue and thus change to occur; and (f) Both agree that authenticity in each person is a necessary component for meeting to happen.

There are also four issues on which Buber and Gilligan/Stone Center are not in full agreement: (a) Buber's language tends to be more abstract and tied to his goal of joining with another to create meaning rather than constructing a tight theory of relationship, and Gilligan/Stone Center's use of language tends to be more concrete; (b) Gilligan/Stone Center are clear in their critique of patriarchy while Buber and the dialogical
writers seem unable, perhaps due to their gender and historical location, to offer such a critique even though it follows logically from their understanding of human relationship; (c) Gilligan/Stone Center view the connected experience occurring both in moments of time and as part of a continuum of connected experience while Buber sees the I-Thou moment occurring in a moment of time with mere glimpses of connection on a continuum; and (d) Buber understands authenticity as a pre-condition for meeting while Gilligan/Stone Center see authenticity not only as a pre-condition but also as a result of the connected encounter.

Critical Comparison of Buber's and Gilligan/Stone Center's Therapeutic Relationship Constructs

Both Heard and the Stone Center writers utilize language in which terms are defined with overlapping meanings, creating a sense of confusion for those who undertake to read their material. It would appear that this lack of clarity regarding terms is due in large measure to the kind of reality they are attempting to delineate and discuss. The circularity observed in their writing as well as in my critique may reflect their shared resistance to the traditional analytically based approach to therapy, or it may also reflect the tension resulting from their efforts to put forward these more experiential constructs in a traditional context. Heard also has tried to use many of
Buber's terms in discrete definitions, when Buber himself crafted these terms with nearly identical meanings. Examples include the following: I-Thou, narrow-ridge, meeting, the dialogical, and the between.

A metamorphosis seems to exist in the history of psychoanalytic thought and practice that moves from the supposedly objective therapist, rooted in the psychoanalytic model with its doctor-patient, power-over, "objective," and distant ethos, to the more involved therapist represented by the work of Kohut. This movement also parallels the movement of physics: shifting from Newtonian physics to quantum mechanics and chaos theory. By the time Gilligan/Stone Center arrive with their own goal of mutuality and empowerment, the metamorphosis is fairly complete. If one accepts the theoretical basis of Gilligan/Stone Center and Buber, the distant analytical or medical model simply does not work well; the selves cannot be changed nor the relationship flourish, these writers conclude, in an objectified, Separate self, I-It relationship. This is the fundamental critique of traditional and even psychodynamic therapeutic practice and theory offered by Buber/Heard and the writers surrounding the Stone Center and Gilligan.

Both theories question the traditional therapeutic stance on the importance of objectivity in relation to the client. Objectivity has been a requirement in most
mainstream therapeutic practice and theory. Both Buber and the Stone Center writers, on the other hand, insist that for real relationship to occur, the therapist must be vulnerable and emotionally open to the client even to the point of being profoundly affected by the client. Compassion, feeling heard, and connection preclude the judgement, "I, the therapist, have the answers." When a therapist takes on the expert role of assessing, diagnosing, and judging the client, there is a lack of respect for the personhood and dignity of the client. Currently our culture seems to be more critical and less accepting of authoritarian models. Perhaps the dialogical and the Stone Center therapeutic approaches to therapy are coming at a time when partnership and trusting one's own experience are becoming more valued.

In dialogical and relational therapies, both client and therapist are being asked to be more responsible and accountable. The client does not enter therapy to be fixed, but rather is invited to participate fully. The therapist does not hide behind authority and role as therapist/expert/judge but rather brings the whole self into the therapeutic relationship. As far as possible, given the circumstances of the situation, client and therapist enter into the therapeutic relationship as partners with a common concern: the client's welfare and healing.
Both Buber/Heard and the Stone Center emphasize that the therapist must embrace the totality of the client. Buber/Heard use the terms totality and uniqueness, while the Stone Center uses the terms wholeness, subjective, and the client's own experience. Not only do both groups of writers insist that the therapist embrace the totality of the client, but the therapist must bring him or herself directly into the therapeutic relationship. The therapist must be prepared to be surprised by the client's uniqueness. This way of relating to the client is very different than what most mainstream analytic schools of therapy would teach, namely a model based upon analysis and diagnosis, defining a client's area(s) of difficulty in functioning, and determining goals, objectives, and strategies to address the client's concerns. These professional behaviors fragment the client and provide a means of distancing for the therapist. They also keep the client in the position of the generalized other.

Similarly, in traditional therapy the individual is considered the point of reference for judgement and understanding; both Buber/Heard and Gilligan/Stone Center concur that when there is a connection or an I-Thou experience, the relationship is the referent. The self is known in the experience of connection and is defined not by
reflection but by interaction, a process of responsive human engagement.

The Stone Center writers' notion of bringing oneself more fully and clearly into the therapeutic relationship, thus enhancing self, the other, and the relationship, correlates with Buber's term wholeness or personhood. They agree that wholeness is found in the between or in the connection which is facilitated by the client's and therapist's interactions. Buber/Heard offers this explanation: One's wholeness encompasses all that a person is and all that a person can be which cannot be apprehended until it unfolds in the concrete event. Even so, wholeness is not a once and for all experience. It occurs as the client brings one's whole self to a specific situation; in that moment wholeness is experienced. When all aspects of one's existence are integrated, the client experiences a coherent whole self.

Mental health is literally created in this experience of integration. Conversely, when various aspects of existence are not integrated, the client is left fragmented and dysfunctional. Since the client's personal wholeness is realized only in one's relationship with others, it is the responsibility of the therapist to assist the client in approaching wholeness. Although the writers of the Stone Center use different language to describe the co-creation of
connection and thus wholeness and mental health, the engagement between client and therapist and the resulting outcome parallels Buber/Heard.

Buber/Heard do not specifically address power imbalances in the therapeutic relationship although it is implied. In order for the possibility of meeting or movement towards mutuality and empowerment to exist, therapists must shift the power away from themselves and instead place it in the relationship (that is the between). This shift enables mutuality to develop and the possibility for meeting to occur. Similarly, abuses of power in relationship result in disconnection between therapist and client—a dynamic which maintains the I-It relationship. Redistributing the power imbalance allows for the possibility that the client will experience empowerment and mutuality.

The concept and goal of therapy for both Buber/Heard and the Stone Center are, in my assessment, analogous. Jordan speaks in terms of relatedness and movement, while Buber/Heard use the image of the meeting. Alexandra Kaplan, of the Stone Center offers a similar definition of the therapeutic goal. For her, it is "the movement toward mutuality and the deepening and expanding of therapeutic relationship" (Kaplan, 1988, p. 8). In both theories of therapy, connection or "meeting" is the means to the goal as well as the goal itself. Both propose a shift from
individuality, isolation, and disconnection to relatedness, movement, and connection. The Stone Center writers believe that through mutually empathic and empowering dialogue growth occurs. Buber and Heard agree with this assessment but would use the terms "through meeting" or "in the between."

In dialogical terms, healing for the client and the therapist takes place in the meeting, the between, the dialogical relationship, or the I-Thou moment and not by applying techniques and strategic interventions during or outside the therapy hour. Instead of techniques, a change in the therapist's attitude and understanding are emphasized. This is also strongly supported in the Stone Center's construct of healing. For these writers, dialogue involves mutuality, initiative, and responsiveness, an approach also supported by dialogical theory.

According to Buber and Heard, when meeting occurs, the client finds personal direction, encounters his or her uniqueness, and experiences touchstones to carry and to share. Meeting brings the client out of fragmentation and fosters wholeness in both the client and the therapist. The Stone Center, developing their own images and language for wholeness in the client, posit that the basic goals of relationship which are increased "initiative and receptivity" (Kaplan, 1988, p. 8) and "increased capacity to
grow in connection and to contribute to the growing connection," (Jordan, 1989, p. 4) together constitute mutuality.

The Stone Center writers speak of being more whole and integrated in all relationships. In the same way, Buber/Heard speak of healing, wholeness, personhood, and being fully present. Carter Heyward (1993), in her book, *When Boundaries Betray Us*, integrates the understanding of healing in relationship found in the writings of the Stone Center and Buber when she states that "Healing is not a 'cure' but a meeting" (p. 200). She writes, in therapy there may be

a moment of actual encounter--in which person meets person. It is in such moments that the actual therapeutic value of therapy resides, for the real healing happens here, in these irreducible moments of meeting across the Professional/Patient divide. . . . Breaking through one's sense of being inherently flawed or sick into a sense of one's wholeness as a person is precisely what any good therapy promises.

(Heyward, 1993, p. 200)

Both Buber/Heard and Gilligan/Stone Center submit that the therapeutic relationship is different than a mutual or egalitarian friendship. There is a monetary transaction; the
therapist, at least initially, controls the structure of the therapy hour; and the focus of the therapy is on the client's concerns. In a therapeutic relationship the clear purpose of the encounter is to help the client. Yet both groups of writers assert that the therapist must not anticipate what that help might be.

Vulnerability holds a prominent place in relational therapy and is implied in dialogical therapy though it is not offered as a formal element. Buber/Heard embrace the vocabulary of contact, openness, directness, imagining the real, holy insecurity, and the client having an impact on the therapist. Judith Jordan (1991a) describes vulnerability as, "the ability to maintain oneself in a state of openness to be influenced and still have respect for another's vulnerability" (p. 2). Although presented in different formats, these words and phrases describe similar experiences. The general concept of vulnerability, whether depicted by the Stone Center or by Buber/Heard, is necessary for connection or meeting to occur. Jordan's understanding of vulnerability also suggests parallels with the notion of mutuality, dealt with by Buber/Heard as well as Jordan. Mutuality will be discussed later in this section.

In spite of the similarities between the two groups on the issue of the therapist's vulnerability, the Stone Center writers have taken this notion to a level only implied in
Heard. Reading the Stone Center material makes one reader reflect on a noticeable silence on the part of the dialogical therapists regarding the therapist's vulnerability. Certainly, the dialogical therapists are arguing for genuine relationship between therapist and client, but may be working too closely to the traditional model of therapy to be totally free of its influence. The Stone Center writers, on the other hand, seem freer to push the vulnerability issue, since they have publicly repudiated the traditional psychoanalytic model as a helpful construct for the therapeutic relationship.

The Stone Center's definition of empathy resembles "imagining the real" and thus is similar to inclusion. Jean Baker Miller speaks of empathy as an interpersonal engagement in which cognition and emotion are highly integrated allowing a person to experience the thoughts and feelings of the speaker while being cognizant of one's own feelings and thoughts. Inclusion/imagining the real requires the listener to imagine with one's whole self the speaker's actual experience without losing one's own perspective. If the other responds to the act of inclusion or empathy, dialogue may occur. Gilligan's Listener's Guide, in fact, provides a template for therapists to listen to their clients in a manner that facilitates imagining the real/inclusion. Although originally developed for the
researcher, this approach would aid the therapist in learning to hear the client from the four perspectives so that the full impact of the client enters the person of the therapist.

Buber/Heard use the term empathy very differently than the Stone Center writers. Whereas Buber/Heard are critical of the term empathy, it is a central concept in the Stone Center material. For Buber/Heard, when therapists empathize with clients, they experience the clients' thoughts and feelings as their own and thus may become enmeshed with their clients because the therapists did not retain their own thoughts and feelings. The Stone Center's definition of empathy, on the other hand, asserts that therapists retain their own thoughts and feelings as well as those of the clients. While experiencing empathy towards clients, the therapists do not get lost in the clients' pain and suffering. Although they develop it as the element of inclusion, Buber/Heard certainly utilize the concept of empathy as understood by the Stone Center. Thus, empathy and inclusion appear to be parallel constructs for these writers.

While relational therapeutic theory anticipates that the client, in time, will be able to offer empathy, confirmation, and inclusion, dialogical therapeutic theory has no such expectation. It is a mark of the relational
therapist's level of commitment to the mutuality of relationship that they respect the client's role in the process as much as the therapist's. In fact, it is for them an indication of the client's healing that the client would be able to participate in the relationship as a whole person, present to the other. Dialogical therapeutic theory regards offering inclusion and confirmation as attainable goals for the client in other relationships, but it is reticent to see them practiced by the client in the therapeutic encounter itself. This seems related to the more traditional understanding of the roles of therapist and client held by the dialogical therapists as well as the tendency of the relational therapists to progress further with the implications of relational theory.

The relational theory of therapy does not seem to contain a direct corollary to the dialogical term confirmation. Confirmation identifies the engagement of the therapist with the client as the "new reality between them" or what comes from the experience of inclusion. The therapist engages the client in a manner otherwise unavailable to the client. In this engagement the therapist struggles with the client to help the client pursue the unique personal direction of his or her life. In relational therapy, when therapist and client experience connection, both participants are able to move and be responsive in ways
that had been previously unavailable to them. It seems to me that the process of relational movement, of moving from connection to disconnection and back into connection again, may describe one facet of Confirmation. In this scenario, conflict may arise in the moment of connection itself, perhaps leading to disconnection. The process of moving back into connection may include a discomfort similar to that found in confirmation when the therapist struggles with the client to help the client find personal direction in that concrete event.

While authenticity as defined by Gilligan/Stone Center is not synonymous with the element of Personal Direction offered in Buber/Heard, I believe they do have strikingly similar meanings. These terms share a common understanding: personal authority arises within mutual relationship and not in autonomous isolation. In both of these concepts, we come to understand ourselves more fully as the other becomes better known to us in the process of relationship. Once again, it is in the between that personal direction, a person's unique contribution to life, is discovered and brought forth. It is also important to note that personal direction/authenticity is not limited to the client alone. In the dialogue between client and therapist, each encounters the unique wholeness of the other and thus
creates the necessary condition for the mutual discovery of personal direction.

The idea that the therapists may discover their own personal direction during the therapeutic interaction is a characteristic of authenticity as delineated by the Stone Center writers; however, it is problematic from the point of view of dialogical therapy. Although there is obvious tension between the implications of the dialogical encounter in theory and Heard's deference to traditional professional ethics, Buber and Heard seem to prefer a greater degree of professional propriety on the part of the therapist at this point. It is certainly possible within the philosophical and therapeutic framework developed by Buber/Heard for therapists to find their own personal direction in the dialogical encounter. However, this is not specifically addressed by Heard.

Mutuality is a term that both groups of theorists use to convey similar ideas. For the Stone Center writers, mutuality, and by implication growth, only occur in an environment of trust. Mutuality requires that we become vulnerable to "change and the uncertainty that accompanies growth" (Jordan, 1989, p. 4). Conversely true growth develops "only in the context of a real, mutually responsive relationship" (p. 4). In mutuality "there is an openness to influence, emotional availability, and a constantly changing
pattern of responding to and affecting the other's state" (Jordan, Kaplan, Miller, Stiver, and Surrey, 1991, p. 82).

Mutuality, in the sense presented by Jordan, is certainly similar to Buber's "between" or "meeting," the relationship inherent in the "I-Thou" moment, and Buber's general understanding of dialogue. William Heard states that "mutuality is the openness and mature trust that client and therapist must have toward one another to achieve a Dialogue" (Heard, 1993, p. xvi). Due to the nature of therapy, both Buber/Heard and the Stone Center writers agree that there cannot be complete mutuality between client and therapist. Because the client comes to therapy for help there is a potential for abuse. Therefore, it is up to the therapist to empower and protect the integrity of the client.

According to Buber/Heard the unconscious functions in three ways. First, Buber/Heard interpret the unconscious as "the potential for the expression of our uniqueness" (Heard, 1993, p. 68). In its second function, Buber/Heard treat the unconscious as a guardian of the nature of our personal wholeness. The third function of the unconscious corresponds to the meaning developed by the Stone Center, where parts of the whole self are fragmented through an inability to engage in an encounter with one's "whole potential." Buber/Heard calls these fragmented parts "the locus of psychic
activities that have broken apart from one's whole self" (Buber in Heard, 1993, p. xvi). Stone Center writer, Irene Stiver (1991), describes the unconscious as "memories that are repressed, split off, or robbed of their meanings and importance" (p. 10). These memories are brought forward when there is mutual connection through genuine dialogue. Although this "locus of psychic activities" may not specifically refer to memories, the idea that those fragmented parts of oneself may be integrated during the I-Thou moment or mutual encounter is present in both Buber/Heard and the Stone Center writers. It is also evident that the definitions of the unconscious put forth by these writers are less pejorative and sinister than the traditional descriptions found in psychotherapeutic literature.

Buber/Heard's definition of the unconscious appears to be more global than that presented by Irene Stiver of the Stone Center. Heard expands it to encompass all of the potential that has not been previously called forth in dialogue. Since the unconscious encompasses both psychic as well as physical potentialities, we never fully experience it.

The Stone Center writers believe that in a safe, authentic, empathic, and mutually enhancing relationship, transference will be profound. In this safe environment the
therapist and client, together, are able to explore it consciously. However, examining the relational dilemma that the client is experiencing does not mean that the therapist offers an interpretation. The Stone Center has found that even the most gentle interpretation is not very meaningful if mutuality and mutual empathy are not fully present. Buber/Heard believe that in dialogical therapy transference does not happen in the between, the dialogical, or the I-Thou moment because these are moments of real relationship. Healing takes place in the moments of real relationship; transference is not real relationship and thus it is not an issue for them. However, the therapist may use the dialogical element, confirmation, to confront the client's fragmented self if that is what is called out in the therapist to do during the moment of I-Thou.

Both therapeutic approaches address the issue of client resistance. Buber/Heard discourage therapists from analyzing the resistance of the client. The Stone Center writers, while not addressing resistance directly in this paper, also discourage therapists from analyzing and offering interpretations of the client's transference. In both these situations, when therapists analyze and provide interpretations clients become objects to be studied and their unique wholeness is lost. In lieu of such objectification, therapists are asked to experience the
client's resistance or transference as if it were the therapists' own. In his development of the dialogical therapy model, Heard suggests that diagnosis has a part in the therapeutic setting. This is one indication that Heard appears more comfortable with the traditional, objectifying role of the therapist. Heard posits that diagnosis is a useful concept when one is talking analytically to colleagues about clients and remains helpful in discussions about client similarities or when there is a need to group clients together. However, it is impossible to experience the client as a whole person when this type of objectification is permitted, even to the limited degree that Heard seems to allow.

While dialogical therapy generally accepts the traditional notion of diagnosis, the relational therapists have taken a stand against diagnosis in principle, since it is based on the perception of an objectified client. From their point of view, such a client is not in relationship with the therapist in any meaningful or therapeutically helpful way. The Stone Center theorists understand diagnosis as a labeling mechanism that places the client at a distance and allows the therapist to abdicate the responsibility of really encountering the client person to person.

Fundamentally, the traditional psychoanalytic model precludes relationship. In dialogical therapy there is also
a very strong emphasis on suppressing one's own needs and concerns in order to look to those of the patient, indicating again that Heard, contrary to the implications of dialogical theory, tends to hang on to certain presuppositions characteristic of traditional therapy. Heard, following Buber, appears to be more individualistic and oriented to the autonomous self than his theory might suggest. The sentiment of focusing attention and the therapy hour on the client and his or her needs is congruent with responsible ethical therapy. Nevertheless, I believe it is unrealistic and even inappropriate for therapists to expect that they are able to forestall any and all needs they may have in the therapy hour. In addition, when clients pick up on therapists' concerns it is disrespectful and condescending to pretend the concerns are not present. This, however, does not condone taking advantage of the situation or utilizing the therapy session to meet one's own needs, but to acknowledge that the therapist's needs will be present in the therapy session and cannot be willed away. Thus, it is my understanding of the Stone Center's work, that there is strong implication that the needs of the therapist are to be dealt with directly, honestly and with the realization that they do affect the therapeutic relationship.
For both groups of theorists, it is important not to direct the therapy. Heard emphasizes that the client must take responsibility for pursuing the unique direction he or she discovers in the relationship. Still, Heard seems always aware of the danger of imposing his own expectations and demands on the client. "[T]he therapist . . . must remain present to his own self lest he become enmeshed in the client's problems" (Heard, 1993, p. 87). Heard unwittingly reveals in the above quote the discomfort towards enmeshment felt by psychodynamic Western thinking, which acknowledges that at times there needs to be I-It relating (subject-object) during the session or at least that it will occur; however, healing takes place only within I-Thou moments. My reading of the Stone Center material leads me to conclude that the same logic may be applied to the issue or question of enmeshment. Thus, like the I-It relationship, enmeshment or the losing of the self (the I in the Thou) may take place in the therapeutic encounter, but healing occurs only in the I-Thou experience.

It is my opinion that the Stone Center writers argue for a complete change of theory and praxis which is necessary to accommodate a relational approach to therapy. It seems to me that this change of theory and practice is rooted in the moral and ethical principles governing human relationship which is violated in the objectified
therapeutic setting typical of the medical model. It is not enough, in this view, to simply alter a few surface details to encourage relational encounters in therapy; rather, a thorough paradigm shift is required.

This paradigm shift contrasts sharply with what I see as Heard's much softer position regarding the traditional therapeutic model. He seems to allow for the retention of this model even as he reaches for genuine relationship between therapist and client where therapists may hold on to their traditional theoretical orientation while practicing inclusion and generating dialogue with the client. In Heard's delineation of the process, the therapist moves alternately from inclusion and dialogue to observation and analysis, weaving in and out of these quite distinct therapeutic paradigms. For me, the question is raised whether therapists who intend to engage in dialogical therapy need to be trained in the prevailing or mainstream paradigm at all. When observation and analysis is allowed to become part of the healing process it weakens the possibility for total commitment to the relationship on the part of the therapist, whose attention is necessarily divided between objectifying the client and relating to the person as a human being with all the accompanying implications of genuine relationship. I believe it would be useful in this context for dialogical therapy to complete
the paradigm shift and develop a theoretical framework consistent with its claims for the centrality of meeting.

I believe that the Stone Center writers, more than the dialogical theorists, move from the isolated individual apart from relationship, to the individual in healthy relationship as a result of therapy, and finally to the relational self applying the principles of healthy relationship to the social pain caused by systemic injustice. The Stone Center writers define the engagement with systemic injustice, at the political level, as a therapeutic outcome. They adhere to the feminist axiom: the personal is political. This axiom is to be understood as a result of the groundwork laid by these writers, especially as it relates to their work on transformation and social change (see p. 166 in this text). Heard/dialogical therapy does not seriously take this final step, but leaves the therapeutic outcome at the level of the relational self. The Stone Center writers move from the relationship to systemic social pain and join with others in social transformation. Dialogical theory stops with personal direction which is important to the "human cosmos" as each of us is uniquely created and is encouraged to act in one's own distinct way.

**Summary**

Both relational and dialogical perspectives are oriented towards a process of human growth, relational
process, and mutual change which leads away from the fragmented self to a more fully relational and whole human being. This is brought about in the context of a therapeutic relationship. Apart from relationship, or what they variously term "meeting," "connection," or the "between," there is little chance for change, growth, or healing to occur.

The terms used by these writers appear congruent at most fundamental points. Vulnerability, described by Stone Center/Gilligan as an openness to be influenced, is referred to by Buber/Heard more vaguely with terms such as "holy insecurity" or "directness." Empathy, a relational word, meaning imagining, hearing, and feeling the other's experience while maintaining one's own experience, is discussed as "inclusion" by Buber/Heard. The same pattern is true of the dialogical "Confirmation" ("Connection" for the Stone Center writers) and the Stone Center's "Mutuality" ("mutual openness and trust" for Buber/Heard). Both challenge the traditional psychoanalytic model of therapist as objective professional healer and client as patient. The Stone Center, in particular, calls for a thorough paradigm shift to a relational model not only at the individual therapeutic level but also in the social/cultural realm.
Implications

My study in this dissertation allows, I think, for a number of possible implications for the therapeutic relationship in light of this critical comparison of the dialogical and relational constructs and against the mainstream view of therapeutic relationship. At one level I would like to see a collaboration between the authors that would bring them together in various manners to advance their constructs in the spirit of mutual meeting and dialogue. There are three areas of collaboration that I believe would be fruitful: among the Stone Center writers themselves, between Gilligan and the Stone Center writers, and the larger collaboration between Buber/Heard and Gilligan/Stone Center. On a more personal level I would like to moderate a public forum in which these constructs could be presented and discussed. I have outlined this idea in more detail on page 211 of this text.

As I look ahead to a possible realization of my projections, however, I want to move beyond being simply a moderator between the dialogical and relational perspectives, which is too passive for the vision I see. My real desire is to encourage and actually make happen a genuine collaboration leading ultimately to an integrated theory that weds the strengths, experience, and depth of both therapeutic views. I believe that the best chronology
for such an outcome begins with a moderated dialogue among these writers, which I would like to facilitate. There may be a need for several such conversations though these events should, in my opinion, result in a working document that would form the basis for an integrated theory.

One of the problems with the current, more tangential relationship of these perspectives is the confusion of terms and concepts. This problem would be eliminated in the course of several conversations. I see my role as facilitator and editor. Though it might be easier to formulate my own integrated theory based on their work, it makes more sense to involve these theorists (so committed to relationship and therapeutic collaboration) in a conversation that leads to an integrated theory that is derived from their own struggle with confusing, conflicting, and parallel ideas and concepts. I might be able, after moderating and being a participant in these discussions, to offer through papers or perhaps in an eventual book, my own proposal for a workable integrated theory. However, it is my view that the chronology leading to an integrated theory, whether they propose it or if I do, proceeds best from my initial gathering together of these writers in conversation and subsequent conclusions. I'm not convinced that they, or certainly I, could provide an integrated theory without first entering collaborative discussions.
I would like to see the Stone Center writers develop a comprehensive model for relational therapy. At the time of this writing Miller and Stiver have written a book, *The Healing Connection: How Women Form Relationships in Therapy and in Life*, which was released in September of 1997. This publication may begin to put forth a more concise synthetic theory of healing relationships in and outside of therapy. Following a cursory review of the book, it is my opinion that the strong voices of Jordan, Kaplan and Surrey although present are not as pronounced as they are in the "Work in Progress" papers. It appears that Miller and Stiver take a more conservative approach to changes they call for in the therapeutic process.

Relational theory is actively evolving and moving away from traditional theory. As this perspective gains momentum and acceptance the need for these writers to follow or even defend their point of view over and against the mainstream medical model should lessen. They may then be able to take more risks and move towards a deeper and broader discussion of mutuality. As they do this, they may need to develop a consensus regarding definitions and basic premises of relational therapy and theory, taking into consideration that there are a number of women writers involved who hold nuanced understandings of the material.
In addition, I would like to see Gilligan and her colleagues join with the Stone Center writers for a collaboration designed to produce a synthetic rendering of relational theory and therapy. Central to this synthesis could be the incorporation of Brown and Gilligan's Listener's Guide as a form of therapeutic training, acting as a kind of template to prepare for the possibility of mutual and empathic relationship with the client. It would further strengthen this developing relational model if the discussion were joined by practitioners such as Dana Crowley Jack, Catherine Steiner-Adair, Annie Rogers, Miriam Greenspan and others who are at the forefront of feminist therapy. Another helpful voice in this conversation would be the theologian, Carter Heyward, who writes about her own experiences in traditional therapy in order to challenge and move it towards a more developed and mature relational dynamic. In this synthesized model each person's experience would be unique and particular rather than generalized while each individual human voice would be heard from his or her point of view with an attempt to make contact with it. The Listener's Guide is central to such a synthesis.

I envision a collaboration between Heard and the Institute for Dialogical Psychotherapy and Gilligan/Stone Center. Although there are a few significant differences between these two constructs, I believe it is possible to
forge these differences into a synthesis that is even stronger than either of these models possess by themselves. Following the chronology above, the next step as I imagine it would be a presentation at the National American Psychological Association Meeting with myself as the moderator in a discussion between William Heard representing the dialogical perspective and Janet Surrey or Judith Jordan of the Stone Center representing the relational view. At some point I would like to collaborate with others on a book, perhaps with Heard, Surrey, and Jordan, basing the material on this discussion and other discussions, conversations, and similar encounters. One of the questions that might be addressed as an element in this collaboration relates specifically to gender: Is there a difference in how men and women move towards wholeness?

Part of my vision is to see a joining of these two theories. One example of this synthesis would be to come to terms with the concepts of empathy, inclusion, and imagining the real. My opinion is that dialogical theory needs to move beyond its description of empathy as an experience of feeling the other person's thoughts and feelings while losing sight of one's own and to move towards a description of empathy comparable to that offered by the Stone Center. The view of empathy embraced by the Stone Center assumes that the therapist will experience the client's thoughts and
feelings as well as the clinician's own. This definition has the advantage of being the one most widely accepted by psychotherapy, and its definition also corresponds with the dialogical terms, inclusion and imagining the real. Yet there may be nuances of these concepts that I have missed in my study. Hence, discussion concerning these concepts, empathy, inclusion and imaging the real will clarify their similarities and differences.

Finally, I believe that it may be time to examine the ethics of engagement at the American Psychological Association level. In reviewing ethical standards, one of the questions that needs to be considered is whose needs are being served: the client's or the therapist's. An example of this may be found in client-therapist engagement outside of therapy, generally considered undesirable because it tends to create dual relationships. The potential risks need to be weighed against the potential benefits. It is possible that the answer to the question for one therapeutic relationship may not be generalized to another. Therefore, guidelines may need to be put forward for parties involved to determine together.

Further Study

One of the questions that I see growing out of a reading of the Stone Center writers, whose work focuses primarily on the stories and experience of women, is the
applicability of relational theory to the experience of men. Heard and the dialogical therapists, primarily men, could enter into a helpful conversation with the Stone Center writers to address this issue. One male Stone Center writer, Stephen Bergman (1991), has offered a relational perspective on men's psychological development and goes some distance to integrate relational theory with male experience. It is my view that further work in this area would be both important and fruitful.

Though both Buber/Heard and the Stone Center implicitly reject the traditional medical model which has been the basis for the therapeutic encounter, there may be settings when this model actually functions more appropriately than the relational/dialogical model explored by these writers. It may be that dialogical and relational theory cannot allow for the objectification of persons in any circumstance, but more study is needed to clarify legitimate uses for the medical model or to justify the elimination of this objectifying model in therapy.

As I have pointed out, there are a number of similarities between dialogical and relational therapy. Each approach also possesses its own unique vocabulary and theoretical constructs which can profitably be explored to discern the areas of contrast and comparison more clearly. It seems to me that an investigation of these two theories
of therapy among their authors (in the format I stated earlier) would allow them to fully untangle dissimilarities as well as key analogous constructs which define these unique models of therapy. In doing so the strongest aspects of these two approaches would be put forth and perhaps a single synthesized model of therapy would emerge as these distinct qualities and likenesses were explored and then integrated into a whole.

Buber/Heard use a vocabulary which includes a number of terms discussed in this paper: the unconscious, the mystery of the between, distancing and relating, personal direction, touchstones, confirmation, preparation for surprise, and imagining the real. Gilligan/Stone Center, on the other hand, identify the terms resilience, transformation, social change, vulnerability, movement towards mutuality, mutual empathy, mutual empowerment, conflict, authenticity, self-empathy and self-disclosure. The relational theorists have also questioned the appropriateness of the current use and descriptions of diagnosis as it objectifies the client. The concepts identified above are at the cusp of relational therapeutic thought and their incorporation into a synthetic whole would complete this paradigm shift and move the discussion into a new and exciting realm. In addition, the concepts that are mutual to dialogical and relational
therapy would be the foundation for the development of a new synthesized, integrated model of therapy.

What might this mean in a working therapeutic situation? As the therapist in an adolescent girls residential treatment program, I have wondered how the relational approach may be studied in this setting. The opportunities to engage girls are numerous as I often eat with the girls, participate in their community meetings, interact with them on the unit, respond to verbal and physical escalations, participate in activities, and counsel them individually, in a group setting, and in family therapy. Multiple relationships are evident and opportunities are endless for the girls to see me, the therapist, in situations in which I may be unaware of the impact of my presence on them or in which I am challenged, distracted, or exhausted. A qualitative study exploring the therapeutic relationship as well as the other relationships the girls experience with the therapist would be enlightening. In addition, this is a population which may not be often studied: disturbed teenage girls in a residential treatment program. Studying people in similar situations in other treatment facilities or psychiatric hospitals in which relationships between therapists and clients are more diverse would be potentially fruitful as well.
The pastor-parishioner relationship also is diverse. In the introduction to William Heard's book, *The Healing Between*, he suggests that the book would also be appropriate and useful for pastoral counselors. Carter Heyward, a theologian and the author of *When Boundaries Betray Us*, speaks about the spiritual pastoral situation. The pastor-parishioner relationship would seem at first glance to be an ideal paradigm for the study of relational processes within multiple settings and contexts. Unfortunately, in many seminaries today the traditional therapeutic model is being presented as normative, though with some flexibility, for the clergy-parishioner relationship. Those preparing for a profession which places pastors in the most intimate moments of other's lives are being taught that proper boundaries are essential, that friendship is incompatible with a pastoral relationship, that office doors should remain open and a secretary nearby when counseling or meeting with persons of the other sex, and that days off are to be rigidly observed in the interest of self-care. The role of the pastor is being emphasized over against human relationship and real contact. This has come about for many reasons, including the more complete acceptance of mainstream psychology and the incumbent pastoral variant of the medical model by professors of pastoral counseling. But perhaps the main reason is the spate of legal cases against the church for
non-mutual sexual encounters initiated by clergy. These cases are documented in the press. Because of the confusion and the change that legal charges and corresponding "corrective" measures are producing in the ministerial profession, studying the ministerial relationship as currently practiced and taught may be less enlightening and fruitful. However, traditional models of ministry as well as specific ministries which place relationship at the core of the work would be extremely useful models to explore in order to glean further insight into the healing dynamic of the relational process.

Conversely, Gilligan/Stone Center and Buber/Heard have much to say to the area of pastoral counseling and the growing discipline of spiritual direction. Therefore the work of Heard and the Stone Center writers along with Gilligan's work (especially the Listener's Guide) would offer guidance in these areas and allow for the necessary tension when providing authentic pastoral care if introduced into classes on pastoral counseling and spirituality, pastoral development groups, clinical pastoral education, and supervised pastoral fieldwork. The pastor in these settings would be encouraged to experience and develop authentic human relationships in terms of relational and dialogical theory instead of moving more deeply into the pastoral role.
Final Summary and Conclusions

I have attempted to explore and describe the relationship between Buber's theories as they apply to dialogical therapy and the work of Carol Gilligan, including the parallel work of the Stone Center writers as they continue to work out their notions of relational therapy. Chapters II-IV delineated the theories of both groups, beginning with biographical profiles to frame the discussion of these writers/theorists in a more relational context. Chapter III examined the notion of relationship found in each group of theorists, while Chapter IV proceeds from a consideration of the mainstream psychological theories of therapeutic relationship to a concluding section which reviews dialogical and relational therapeutic relationships. In Chapter V, I critically compared the constructs of relationship according to the perspectives found in dialogical therapy and rooted in Buber's writings with the separate/connected self and relational therapeutic approaches found in the work of Gilligan and the Stone Center writers. Implications of this study were offered and I suggested a number of related topic areas that would benefit from further study.

In the course of this work I have drawn several conclusions. First, the Stone Center and dialogical writers have similar though unique ways of understanding
relationship and therapeutic relationship. Their uniqueness is found in the areas of terminology, writing style, and research methodology while their similarities are more fundamental. Beneath the dissimilar terminology lies an essential agreement about the meaning of relationship and its impact on healing, and a general consensus about the necessity for mutual interchange and the development of a connection or "I-Thou" moment in the therapeutic encounter. Second, the medical model which has been the foundation for traditional therapy is not appropriate because it intrinsically objectifies the client and thus precludes genuine relationship from occurring. Given this state of affairs it is necessary for mainstream therapy to continue crossing this bridge and embrace the paradigm shift to the relational model. Finally, both groups agree that the therapist must accept and embrace his or her own vulnerability in the encounter for any genuine healing connection to take place. This is implied by Heard but more completely and explicitly discussed by the Stone Center writers.

There is certainly room for fruitful discussion pertaining to the issues I have raised in this paper. I have already noted the need for more research to explore existing relational settings where healing is the desired outcome. Nevertheless, I believe that if my conclusions, as I have
expressed them, are adopted by the psychotherapeutic community, the opportunity for healing within the therapeutic encounter will be greater.
REFERENCES


