

Coming Out of the Dark Age: Recognising Difference, Making a Difference

ANTHONY KORNER

What do we do when confronted by patients who act in self-destructive ways or impinge upon us as therapists? There is a tendency to blame the patient and often the term 'personality disorder' is used in that way. This often masks the genuine suffering that affects these people and those around them. One way of understanding the situation may be to look at our reaction to 'difference' in the sense of the encounter with something unknown and unfamiliar. If this is looked at as an opportunity to know more about the other person it can become a path to therapeutic engagement rather than a trigger for therapeutic derailment.

We all develop our own clinical comfort zones; the range of problems we feel familiar with, and more or less competent to deal with. Often enough, however, we find ourselves up against something unfamiliar. The experience of encountering such difference in clinical practice might be compared to hitting a wall. We don't know what's happening and the person we are with does not seem to fit into what is known and familiar. We feel disorientated, unable to act and incompetent. In particular we might feel imposed upon, with the other person seeming to have expectations that we 'fix' this unknown.

How do we manage this experience if we don't recognize what is in front of us? In a social setting we might soon be inclined to 'escape' the situation. In the clinical setting we might be pushed towards an analysis that uses labels to categorize what we encounter. If these labels satisfy our concept of illness we may make a diagnosis that directs us to act in certain prescriptive and supportive ways learnt in our years of training. When people don't fit neatly into the notions we have of illness we tend to feel even more at a loss: at a diagnostic level this is when we enter the area of 'personality disorder'.

In psychiatric training we are told that, whereas people with illness usually present themselves because they are experiencing suffering, people with personality disorder often present because of the suffering they cause to others. Inherent in such a view is a lack of recognition of the suffering of the person with the 'personality disorder'. The tendency is also to view these problems as intractable and unlikely to benefit from hospital admission. Admissions are kept brief to 'prevent the development of dependency'. A common view amongst staff is that these patients are 'not really sick' and that they are 'putting it on'. The language that accompanies this kind of view includes terms like 'manipulative', 'attention-seeking', 'malingers', 'bad not mad' and so on. In therapeutic terms the way to justify this attitude is to see it as serving a 'counter-regressive' function that places pressure on the person to 'look after him- or her-self'. However such justifications can veil a thinly-disguised hostility to such patients, and reflect an avoidance of personal encounter with the patient and a failure to engage.

If one approaches the clinical encounter from the point of view of intersubjectivity (Trevarthen, 1974) a different picture emerges. Intersubjectivity can be understood

as the actual experience that occurs between people in a space that is neither purely 'objective' nor purely 'subjective', the 'place where we live' (Winnicott, 1971), the world of experience. This realm includes the experience of self and the awareness of other selves that impinge upon and resonate with our own sense of self. The primary mode of apprehension here is empathic rather than objective. The atmosphere may be relatively calm (or at least manageable) on the one hand, or turbulent and threatening on the other. If it is the latter we have the sense of being impinged upon and there is a sense of threat to the self. Empathic reflection may lead us to understand that the patient we are with also experiences some sense of threat to the self.

When assessed from the viewpoint of pathologies of self, from an appreciation of intersubjectivity and empathic understanding, we often reach the conclusion that people who have been labeled as having 'personality disorder' often have profound disturbances of self related to backgrounds of trauma and neglect. A picture often emerges of a condition that reflects great need and where therapeutic engagement holds an important key to outcome. The paradox in the two types of assessment described is that although the *objective* mode is

based on making discriminations and distinctions, the notion of 'self' is left out and dismissed as 'subjective': hence in this account all selves are the same and there is a failure to recognize 'difference' in this field. The *empathic* mode, on the other hand, is based on a primary recognition of sameness, of common humanity that can be felt and expressed.

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However when we allow ourselves an intersubjective meeting point, or in other words to know the other as person or self, what we meet is 'difference': we find that no two subjectivities are alike and we may find profound differences in world view and experience that can challenge us at a deep level.

Making a distinction between primary and secondary intersubjectivity may help us prepare for one form of this challenge. *Primary intersubjectivity* refers to the reciprocal interactive 'dance' within the therapeutic relationship, that involves attunement and responsiveness to the other (Gallagher, 2005). *'The defining feature of secondary intersubjectivity is that an object or event can become a focus between people. Objects and events can be communicated about...'* (Hobson, 2002). In the former the dyadic relationship is central and there is a relative absence of any consciousness of any external reality. In the latter there are both dyadic and triadic forms of relatedness and a sense of space.

Dynamic forms of psychotherapy are based upon the empathic mode of apprehension and rely upon the human potential to transform experience from static, descriptive, factual events towards the realization that moments of experience have a dynamic 'liveliness' that is meaningful (Korner, 2000). Human experience has a narrative

form and the potential is there for this to be recognized and elaborated. What needs recognition for the therapist is the self of the other, and what constitutes our work is the journey we make with that self. The capacity of the therapist that may be crucial to fitness for the journey is not necessarily 'expertise' but rather what Keats termed a '*Negative*

Capability'... '*when man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason*' (Keats, 1818).

William James considered that the first, and greatest, distinction made in the mind is between '*me and not-me*' (we might say, '*self*' and '*not-self*') (James, 1890). His work is seminal to the concept of self employed in the *Conversational Model* of Meares and Hobson (Hobson,

1985; Meares, 2000; Meares, 2005) and is also notable for including a self that extends beyond the individual, the '*social self*' (James, 1890). In development those parts of the environment that are familiar will become associated with a sense of self that extends beyond the bounds of the organism: the world that is experienced with a '*warmth and familiarity*' that allows it to be owned as part of the self. Later this might be expressed by the person as '*my world*', that which is felt to be '*mine*'. The '*social self*' is the sense of self constituted by the estimations of others, the extent that we have become '*held*' inside other's minds. With the development of stranger anxiety in the first year of life it might be said that the infant begins a further differentiation between '*my world*' ('*my people*') and the '*not-my world*' ('*not-my people*').

To a large extent this form of distinction is reinforced by parents and more generally by the culture: it is considered essential for the developing child to be able to make this differentiation in order to keep safe from those with unknown or questionable intent towards the child. In many cases the cost may be that such distinctions become cemented as discriminations and prejudices against those who strike us as different or in some way strange. We no longer live in societies where it



can be expected that eventually everyone will become familiar with all the 'others' in our cities and nations, and therefore come to accept all as 'belonging' to a 'community'. Rather certain groups and individuals become marginalized, or become 'scapegoats' that serve to allow us a sense of 'justification' for our prejudices. Pogue White (2005) describes the phenomenon as follows:

'in this culture, our main defensive strategy in managing our overwhelming diversity is to split into me-notme and hate everything not-me. The main concern seems to be that embracing not-me will forever alter me-as-I-know-me-now.'

For all of us, the world is not all 'warmth and familiarity'. Indeed much of the world is sensed as 'alien and foreign'. The 'stranger anxiety' mentioned above becomes part of the structure of the mind and there is an experience of the world and others that is sensed as 'alien'. What is hard for us to recognize is that this is a part of our self-experience. This notion of the development of an 'alien self' has been explored by Fonagy et al (2002) and will be a major part of the self in cases where life has been dominated by a traumatic range of experience.

The truth is that all people are different. The natural division into 'my kind of people' and 'not my kind of people' obscures this, whichever side of the divide one is on. In therapy, recognition and tolerance of difference allows sufficient differentiation for a rapprochement, or conciliation, to become possible. An empathic approach that emphasizes the agency of the patient is most likely to achieve this end. In this article two cases are discussed that illustrate both the vicissitudes and potential benefits of such an approach. The first example is taken from an acute adult psychiatry unit and the second from the world of private psychotherapeutic practice. To protect confidentiality all case material presented is de-identified and some is composite.

The hospital setting

In the hospital setting it is common for a perceived 'battle of wills' to develop. On the one hand many patients lack the

capacity to make their needs known in a socially acceptable and articulate way. Behaviours occur that are viewed by staff as self-destructive and 'willful', rather than as communications of need. On the other hand frustrations emerge for both patients and staff that can lead to an escalating situation where lives can be endangered. There is a recreation of the developmental situation of too great an expectation of maturity at a time when the child (patient) is not able to deliver.

Emma is an 18 year old who presents frequently to the emergency department after overdoses and self-inflicted injuries including self-laceration and internal injuries inflicted by swallowing sharp objects. She has been admitted and spent a considerable time in a mental health rehabilitation setting. Since discharge the self-harming behavior has continued unabated. Looked at in an objective sense she is described as having dissociative episodes and there is debate about whether she has depression, brief psychotic episodes or factitious disorder. A plan is formulated for minimal response to self-harming gestures and to discharge her to the community once any medical problems are attended to. This plan was based on the premise that hospitalization was fostering dependence and that admission was only serving to reinforce the behavior.

There are many Emmas that I have encountered over the last twenty or so years. They test the limits of any service and it is not unusual to reach a point of therapeutic nihilism, as in this example. Diagnostic labels become therapeutically unhelpful, but serve to sanction a withdrawal from efforts at engagement. Members of the service may have the sense that 'this is all that can be done'.

Taken from the viewpoint of objective history, Emma's story is something like this:

For a time the family were together with Emma being the oldest child. Her mother and father fought frequently and her mother was often depressed, taking overdoses that resulted in hospitalization. There is a somewhat uncertain history of incestuous abuse from her father and a history of aggressive outbursts. At age 13 she is removed from the family home after a time when her mother was hospitalized. Her two younger brothers stayed at home. She lived with a foster

family for a while but then left school. Her community case manager helped find her a youth refuge. With a shift to 'adult' services, impulsive and self-harming behavior escalated with several hospitalizations. She renewed contact with her family, who again become involved with Emma although she wasn't allowed to live with them. She got the message that she would be a 'danger to her brothers'.

One of the difficulties in working with Emma is her incapacity to express herself verbally. It is still relevant, although difficult, in the face of this relative 'mindlessness' to try to grasp Emma's position from a phenomenological or first person perspective. Such an account is broken up and inconsistent with little cohesion or continuity. It might, at this point, go something like this:

'Once I was a child in a family. There was always fighting. My parents fought. I fought with my brothers. I was fighting to get what I needed. My father said he loved me, wanted to love me. Told me that's what he was doing. I didn't know what he was doing. Something was going wrong between them. Mum got so upset. Must have had something to do with me. She took tablets in front of me. How could she do that? She got taken away. I got taken away. I got a new family for a while. Then it was over, so that wasn't real. I'm really alone. I want my family back. Sometimes I feel like I'm a real daughter but then I'm not allowed home. I'm too bad, too dangerous. Not a real daughter. Not a real person. I can't stand that. I won't stand for that.' *

So far the problem of Emma, a 'difficult patient', has been approached from the point of view of the psychiatrist and staff attempting to help her. The question might be asked with regard to the hospital setting: 'What does it look like to patients?' One such account was provided by another patient, Keith, who was able to write a first person account of his experience of admission during a psychotic episode. He was a patient who did not suffer from chronic psychosis and whose problems would be classified under the rubric of 'character' or 'personality' dysfunction or disorder.

The account may provide an insight into the strangeness of the hospital milieu to one not familiar with it.

'I remember waking up thinking 'I know this place, it's familiar'. I saw it when I was little. At school I think. It looks kind of like a submarine. That's a strange thought. Those pictures on the wall ... like at kindergarten

'They think I do it on purpose, like I don't feel anything or I just want to make trouble. It hurts when I do it... they say I have 'Borderline Personality Disorder' – they don't have a clue, that's not me. I hear them ... saying 'Why doesn't she do it properly next time?' ... No-one has ever asked me why I do it. I could die and they act like it is nothing.'

... all these people around. They all seem to have different parts to play. Like members of a family. That one is doing mother and this other one, she's an aunty I think ... a lot of them are like brothers and sisters or kids at school, grandma, teachers. It's funny. Like a play. I wonder what part I'm supposed to be. How do I fit into this? Maybe it's like a test or something. Maybe I can get them to help me. That smell, I know that smell – food, soupy food that smells out the whole place and other smells like toilets, poo I suppose. Where is this place? I know it is hospital but it's like everywhere I've been, all put together. She looks friendly, I'll talk to her. I need to tell her that I have a home to go to and that I don't need to stay anymore. If I'm nice maybe she'll let me go. Those windows are round like a submarine.'

A second account relates to someone who, like Emma, had an acquaintance with hospitals in the context of self-laceration: for our purposes she can be called 'Emma 2':

'They think I do it on purpose, like I don't feel anything or I just want to

make trouble. It hurts when I do it. It's hard. And I'm always fighting to stay alive ... even when I do that. I've always been fighting. I hate it when they are rough and hurt me when they do the stitches like I deserve it or something. Then they say I have 'Borderline Personality Disorder' – they don't have a clue, that's not me. I hear them talking behind the curtain like they

don't think I hear, saying 'Why doesn't she do it properly next time?', stuff like that. No-one has ever asked me why I do it. I could die and they act like it is nothing. I'm fighting, can't they see that? Can't anyone see me?*

Both of these accounts are descriptions from people struggling to maintain contact with the world of persons, trying to make sense of the situation in interpersonal terms, trying

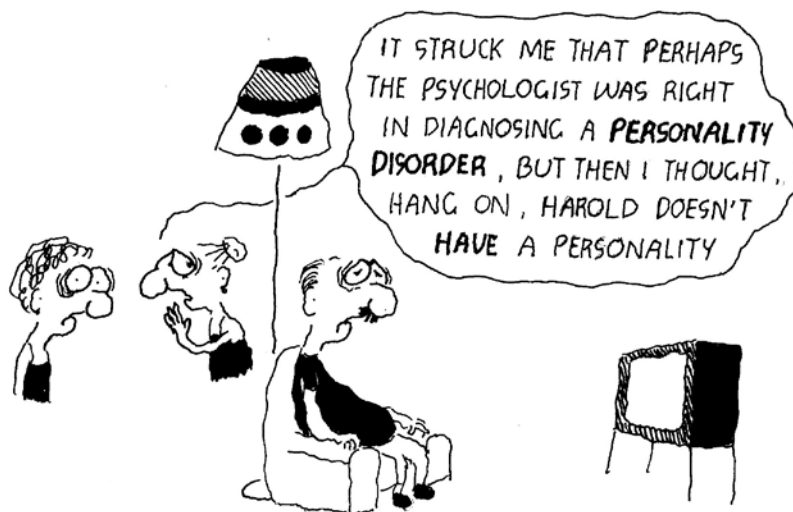
to see where they fit in, reacting against any sense of being negated as a person. There is a difference from the perception of the situation in terms of 'presenting problems, diagnosis and treatment' i.e. the primary perception is in personal not technical terms. Overall there is the sense of incompleteness in these accounts taken from the hospital milieu.

The private setting

Linda

Linda was referred for psychotherapy after a crisis involving conversion symptoms and a suicide attempt in the context of a marital break-up. Dissociative states, repetitive self-harm and explosive rages and risk-taking behaviors were identified in the course of therapy as having been present over many years. There was a history of being the middle child in a large family with a critical, 'cold' mother and a father prone to alcohol abuse and punitive, at times sadistic, physical abuse often directed against the children. Linda had mixed relationships with her siblings, identifying herself most closely with the sister next to her in age. They thought of themselves as the 'forgotten two'. There was a history of sexual abuse at the hands of a Sunday school teacher. Despite her difficult background Linda had completed a degree and had a responsible professional position.

Therapy with Linda continued over four years and was often a difficult journey. There was a gradual movement towards integration of dissociated



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states. Some passages from the second and third years of therapy illustrate this transformation. The first passage describes a more or less hallucinatory experience that dominates consciousness.

In the next exchange she is talking about experiences of 'altered states' after anxious interactions with males. In the third passage she describes a shift in self experience.

1) *'My little man came back. It was really vivid. I could see – it was way down there like distance perspective. I could see him – he was short and fat and I could see his smile and I knew what was going to happen. I said 'no, don't do that – stop it' but I knew it would happen and yes he got into my mouth – in between my teeth...then it went further, right into my head. I felt like I couldn't move, couldn't do anything – when you feel something so intensely you can't do anything. It was like something eating away inside. Really disturbing...there was something sinister...he had arms – I hadn't noticed before – behind his back ... I can see that some of the things relate to Mr Campbell (Sunday school teacher) but it doesn't feel quite – I'm really unsure.'*

2) L: *'I get this numb feeling. My hands go all scrunched up. I think I'll never come out of it ... that I want to be like that forever ... I get into a frenzy ... feel like a little child and I'll run up and down on the spot...sometimes I do other things. I find myself like this – doing things in this state and I don't know how it's started, it just has...I hit my head against the wall sometimes...I keep doing it and doing it. I keep going 'til I'm exhausted and then I just lie down. Things build up inside until I'm exploding. I'm thinking about Tom.'*

Therapist: *'You feel frightened and do something to make yourself feel better – to get some relief? (Linda nods) You keep going until you get some relief.'*

L: *'When I get sexual feelings...I don't like them...they frighten me...feel I've got to get away. It's different when I'm like that – there's more of a rhythm to it.'*

T: *'There's a rhythm to sexual arousal also.'*

L: *'When I get sexual feelings they're not like that... they're sharp...out of my control...I'm frightened ...like they're controlled by something outside me.'*

T: *'When you get frightened you do something that you feel is more under your control. The way you work yourself*

up sounds a bit violent though.'

L: *'I know how to deal with that ... I really talked about something today.'*

There was a shift that involved less acting out in terms of self-harm although at the same time there were complaints of somatic symptoms, notably headaches. Interestingly Linda felt this as a kind of progress.

3) L: *'I've been getting headaches lately. I haven't had headaches like that since I was with George (ex-husband). I used to get them all the time. When he left they stopped. They're bad – I feel really sick, I vomit and I have to lie down. I think about my father when I have headaches. When I was seventeen, I'd just started university, I had a really bad headache. I was lying down. I remember that my father sat down beside me. I really loved him then – just sitting beside me. I thought he was really caring.'*

Next session: *'I've been thinking a lot about it. I think it is a kind of progress that I've had the headaches. Like I was out of the dark ages. I hadn't thought of it having to do with relationships but when you said that it made sense. Do you know what I mean – it's been like being in the dark ages.'*

In this case progress may have been realized consciously as being able to 'contain' explosive feelings rather than discharging the feelings in action, even though pain is still felt at a somatic level.

Discussion

'When the forms of things are dissolved in the night, the darkness of the night, which is neither an object nor the quality of an object, invades like a presence ... this nothing is not that of pure nothingness. ...this universal absence is in its turn a presence, an absolutely unavoidable presence... The rustling of the there is... is horror ...it insinuates itself in the night. ...To be conscious is to be torn away from the there is, since the existence of a consciousness constitutes a subjectivity, a subject of existence, that is to some extent a master of being, already a name in the anonymity of the night. Horror is somehow a movement that will strip consciousness of its very 'subjectivity'. (Emmanuel Levinas, 1946).

The aspect of the clinical encounter that I wish to highlight is the experience of 'difference' in the sense of the 'uncanny' or strange, the alien: that

which disturbs us because it takes us beyond the zone of human comfort. As described by Levinas we are talking about an awareness within being that is unavoidable, although we may seek to avoid it. It is the horror of the night that insinuates itself into being, although in the 'objective light of day' it disappears, seemingly 'nothing'. This anonymous, impersonal presence may come to dominate consciousness. If it dominates the horror is that the person is 'stripped of their subjectivity' (status as person / selfhood).

It is this depersonalization that is presented to the therapist as an 'it'. The likely response when we are presented with an 'it' is that we apply a technical approach: we may want to remove it or disarm it with available technologies. Both patient and therapist may be motivated in this direction. The psychotherapist, however, will also approach the situation from the empathic perspective and recognize a task of re-humanizing experience.

In the case of Emma interaction with staff is dominated by behavior that demands action and there is limited verbal communication. When looked at as a condition to 'fix' there is an expectation of 'cure' from physical treatments. When looked at as communication, Emma's behaviors seem to have meaning in particular with respect to the relationship with her mother. There is, of course, a longing for the 'all-giving' mother and a reaction to the perception of the 'frustrating other' that becomes generalized to those in contact with Emma. The response to frustration is not that, however, of a 'person like any other', but rather that of someone who loses their sense of themselves, shifting into the 'horror' of being stripped of subjectivity.

The form of relatedness being sought by Emma is a relationship of persons: the 'I-thou' relationship (Buber, 1947). Ultimately this involves an unconditional acceptance of the person as person. This refers to something essential to people related to the total dependence on the other characteristic of human infancy. Of course this is felt, in the countertransference of staff members to be an overwhelming and unreasonable demand, one that tends to be resisted or responded to with either undue efforts

to fulfil the patient's need, or punitive responses that seek to 'do away with' such a troublesome interaction.

In the case of Linda we see more verbal elaboration of a story involving 'horror': an account of being dominated by experiences that have taken on the characteristics of a waking 'nightmare' invading consciousness akin to the unavoidable presence of Levinas' 'night'. In the account of subjective experience expressed in the 'little man' description we also recognize something unique to

experience, let us say Emma 3, kept self-harming and presenting as 'unsafe' with the result that she required a long period in hospital. I found myself in the role of 'container' both for the hostile projections of staff who felt admission to be unjustified and Emma's own chaotic, dangerous behavior. Prolonged containment in hospital, limited individual psychotherapeutic work with Emma and with her family were all elements that probably contributed to eventual progress. After her final

are relatively stable and that the evidence of change with psychotherapy is limited, particularly with Cluster A and C personality disorders. Interestingly the evidence is most convincing for an improvement through psychotherapy for the Cluster B group, often the patients about whom therapists and mental health staff feel most pessimistic. He stresses that therapists should have '*scaled down expectations*' and be satisfied with helping '*patients to reach a better level of functioning*'.

In the clinical examples given we see patients afflicted by the break up of self-experience into disconnected, depersonalized states. There is a basic deficit that requires responsiveness at the level of primary intersubjectivity. This will often be felt as an unreasonable demand by therapists. Empathic attunement will involve the sense of participation in the life of the other and holding an image of the other as person. However, analysis is '*not re-mothering as is sometimes imagined, since the signals upon which the ordinary, devoted, and 'good-enough' mother depends are no longer present, or are used in a distorted way. The means of connection have been lost*' (Mearns, 2005). Attunement and connection will only be possible within a framework that is sustainable for both patient and therapist.

Connection with many traumatized patients involves engagement with otherness in the sense of that which is impersonal or depersonalized and felt as 'the dark' or alien. The key to this connection lies in the area of language: the conversation. However this is not simply word-play. We will understand language as connection better if we think of language as a 'form of life' (Wittgenstein, 1963). Wittgenstein is referring to the range of human expressiveness and to language from its most visceral form, 'the cry of the infant', right through to its more abstract and symbolic forms.

If we can hold this in our minds then we see even 'acting out' as communication, and we preserve the possibility of empathic engagement with our patients. We can help our patients out of the darkness. Results will be unpredictable and at times disappointing. All relationships fail at some level. However when we are

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Linda. Through a process of conversation involving recognition and the bringing of the material of depersonalized horror into the intersubjective realm (i.e. taking it out of the purely subjective sphere) we see the beginning of a differentiation that can be sensed as real rather than being sequestered in a purely subjective space.

There is a prevailing pressure in psychiatry at present to practice 'evidence-based medicine'. Inevitably this leads to an emphasis on practices where cause and effect are relatively easily measured and outcomes are judged in terms of 'state' characteristics i.e. '*Is the depression score less?*', or '*Is the person 'functioning' better?*'. In psychotherapy literature there has often been a tendency to describe dramatic changes and psychic transformations that don't always 'stack up' when it comes to attempts at objective measures of outcome. This is perhaps understandable when literature is understood at the level of subjectivity and the drama of the inner world. As I have emphasized 'intersubjectivity' I will present some 'evidence' that is somewhere 'in between' the dry statistics of 'objective' measures and the sometimes fantastic transformations of the inner world.

One of the Emmas of my clinical

discharge from hospital I maintained contact with Emma for some months but then lost contact for perhaps a year and a half, until I met her by chance at a café. She made a point of coming over and thanking me. She did look very different from the Emma I had known and she was beaming as she showed me her new baby. Her partner stayed in the background but smiled in greeting from a distance.

The evidence in the case of Linda was less dramatic. She moved away from therapy partly because of a change of job. About two years later I was surprised to receive a phone call from Linda through the hospital where I was working. She wanted to let me know that she was still working on her problems and that she thought the work we had done had been helpful. A simple vote of thanks I guess. It seemed to me that a continuing process of healing had been established and the phone call gave me a welcome sense of ongoing connection even after such an absence in Linda's life. Outcomes like procreation or simply a sense of connection don't often figure in 'objective studies', although they are probably very significant for psychotherapists at a personal level.

In a recent review Paris (2004) suggests that many personality disorders

persistent we will find that there are signs of personal growth in our patients and we will be moved.

Buber, in commenting on the development of speech in childhood writes:

'Consider a child, especially at the age when it has absorbed language but not yet accumulated the wealth of tradition in the language ... suddenly the child begins to speak, it tells its story, falls silent, again something bursts out. How does the child tell what it tells? The only correct designation is mythically. It tells precisely as early man tells his myths which have become an inseparable unity composed from dream and waking sight, from experience and 'fantasy' (but is not fantasy originally also a kind of experience). Then suddenly the spirit is there.' (Buber, 1947).

Psychotherapists will identify with this observation: we have the experience of hearing the authentic voice of the patient, whether in the form of the cry or in more integrated forms. Sometimes we are struck by the 'newness' of a voice and have the sense of connecting with the heart of the other. Buber's philosophical analysis is that modern man has the difficulty of technological advance outstripping human adaptability. The importance of his 'I-thou' dialogue lies in the human need to turn to each other for our development and fulfilment, rather than to see technology as an 'answer in itself'. His sense of 'spirit' is non-mystical. It is rather the spirit that is evident in certain forms of heartfelt human engagement. He ascribes to the child a 'spiritual instinct ... The spirit begins ... as instinct, as an instinct to the word, that is, as the impulse to be present with others in a world of streaming communication, of an image given and received.' (Buber, 1947).

The nature of the problem Buber seeks to address is brought into relief by considering the person most readily identified as 'bad' or 'difficult' in recent history: Hitler. A recent portrayal in the film 'Downfall' (Hirschbiegel, 2005) is one of the first times he has been portrayed as human, rather than as caricature. An aspect that is highlighted is his personal relation to compassion. There are frequent references to 'fighting compassion' and 'compassion being for the weak' or simply 'compassion is weakness'. Human weakness is to be eradicated by the ruthless application of technology. The basic essentiality of the human relationship of dependence on, and participation with, others is not only denied, it is negated. In psychotherapeutic terms this might be what one might mean by 'the dark ages'.

As psychotherapists we must maintain the stance of compassion and involvement. Psychotherapy is always likely to be under threat when viewed from the lens of objectivity. We need to remind ourselves that such a lens leaves something out: the self, the world of persons. The need for shedding light on the nature of self will remain. This is the nature of 'coming out of the dark ages'.

* Endnote

The two passages marked with an asterisk are 'conscious identifications' with patients. The point of such an exercise is not accuracy but rather the holding of an image of the patient in the therapist's mind. (see Korner, 1993)

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AUTHOR NOTES

Dr Anthony Korner is Coordinator of the Master of Medicine (Psychotherapy) program of the University of Sydney at Westmead Hospital, a consultant psychiatrist for Sydney West Area Health and a psychiatrist and psychotherapist in private practice. He is also the Australian Vice-President of the World Council for Psychotherapy and chairman of the organizing committee making a bid to hold the World Congress for Psychotherapy in Sydney in 2011. His research interests are in psychotherapy and philosophy.