

What Shall We Do Without Us?

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Introduction

In this paper, I shall discuss Levinas's dimension of height, and why it is essential for therapy with schizophrenic clients. Contrary to the commonly-held yet contradictory ideas that a therapist is "above" the client, or that both therapist and client are "equal," I propose that the responsibility of the therapist is to provide an ethics of inequality by placing the schizophrenic Other above herself. The patent inequality between schizophrenic client and clinician means that they rarely if ever meet the criteria for Buber's I-Thou interaction. However, this relationship can be a Levinasian Us. I shall examine the unique qualities of Us, which is formed by two separate human beings with two asymmetrical, irreversible relationships to each other. This interaction forms an arena for creating new therapeutic meanings which neither person could have imagined alone.

The Meaning of Separation

The World of Things

The various angles of therapeutic height are complex. They have been debated by philosophers, theologians and psychologists. However, the Levinasian dimension of height in psychotherapy is literally a world unto itself: Levinas's height implies *separation*. The alterity of the world of things is a mere formality, because things are forms which become "mine" as I perceive and enjoy them. When I perceive things, I consume them in consciousness.

No one else can experience my experiencing of my internship clinic, even if the president of the company holds the title to the building. I can comprehend the building as I walk around it, get lost inside the twisting hallways, and finally inspect a floor-plan that tells me where I am in relation to my schizophrenic client waiting patiently in the lobby. This building is within my world of things, and so it becomes mine as I comprehend its form. At first glance this seems similar to the idea of monism, which has become quite popular in recent years in the justification for exclusive self-interest.

"Oneness" and Transparency

Neale Donald Walsch, for example, advocates that we are "all one." Humanity, animals, and everything both animate and inanimate are quivering pieces of the God that Walsch calls "All That Is." The reason that we have relationships with anyone or anything, according to Walsch's *Conversations with God* (1996), is because "All That Is" wishes to experience itself more fully. "For the soul to experience perfect love, it must experience every human feeling. How can I have compassion on that which I don't understand? ... *The purpose of the human soul is to experience all of it—so that it can be all of it*" (p. 83). Thus each experience is chosen, whether overtly or in the subconscious, in order for "All That Is" to become enlightened and compassionate toward the unity that is itself.

This serves to illustrate two important reasons why Levinas is not a monist. The first is that of separation from the Other. Levinas wrote that the most phenomenologically apparent thing about Us is our differences. One of the keys to Levinas's idea of Otherness is that what I intend to say is always different from what the Other understands, for every Other has a unique framework for constructing meaning. Together we are Us, not ego and alter-ego. This is so

basic, so much a part of our natural attitude, that we often do not realize its importance until it is gone. In his book *Invitation to a Beheading*, Nabokov describes a world in which everyone is "transparent." They have such similar minds and meanings that each immediately knows the whole of what another means to say as soon as the first syllable is spoken. The protagonist, Cincinnatus, is not transparent. He is an individual with a vast interior beyond the face he presents, and is painfully lonely in this one-dimensional world. He writes that others "understood each other at the first word, since they had no words that would end in an unexpected way, perhaps in some archaic letter, an upsilamba, becoming a bird or a catapult with wondrous consequences" (1959, p. 26). *Upsilamba* is a nonsense letter that Nabokov invented; possibly a combination of *upsilon* and *lambda*. In the context of the story, it seems to symbolize a sense of playful progress that one can only obtain in conversation with a true Other.

The perception of "oneness" or "transparency" frequently happens for schizophrenic individuals. For example, one of the members of my "Coping with Schizophrenia" support group, Chris E, has described his first devastating experience with schizophrenia: he believed that You and I were not Us, but One. Those around him not only spoke inside his head, but his own thoughts were those of other people. Chris was deeply upset by this and tried to "outrun" his own brain. Eventually he could not even say the first thing that came to mind, because it had *come to his mind* from someone else. He was transparent to them, one with them. As his mental state deteriorated he tried to speak without thinking of his words. This was his way of attempting to make sure his words were his own: to draw a boundary that distinguished him from everyone else. Deprived of his otherness and separation, Chris was chased out of his own thoughts. That is what the removal of Otherness and basic separation—real-world monism—meant to this man. Oneness was abhorrent to Chris because it negated his sense of self.

The Myth of Gyges and the "screen"

Screens have permeated the paradigms of psychotherapy since its beginning. Freud believed that the therapist should surround herself with a blank screen to prevent interference. He even went so far as to put the patient on a couch with her eyes closed. This was ostensibly to benefit the patient, but the Victorian version of the screen also kept the therapist "safe" by providing the idea of invisibility at worst and a the idea of camouflage at best. The therapist imagined himself as a silhouette among many projected shadows. Either way, he was "hidden" from the patient and did not have to face her.

It has been established for decades that a therapist is not a blank screen onto which a patient can project images of a lost father or emotionally unavailable mother. However, popular thought now holds that a therapist is a technician who is called in when a computer throws up error messages. "Clinical staff complain that the 'actual' patient has been replaced by a 'virtual' patient" (Donald, 2001, p. 433). The digital age has shifted our concept of the "screen" onto the patient. This can tempt therapists to avoid "facing up" to our nakedness before an Other human being, but the mechanism of a machine is more subtle than Freud's erected screen. It is increasingly popular in American culture to imagine the brain as a computer. The two appear at first glance. Both store information. Computers come with pre-set "hardware" and customizable "software," which, if applied to the "nature vs. nurture" debate of the brain, seems like a comfortable compromise. Yet this comparison to a computer is insidiously dehumanizing. According to this paradigm, a therapist appears for a brief interval carrying a standardized tool-kit to administer efficacious treatment in the most efficient manner. Unfortunately,

schizophrenia is not cured by defragmenting a patient's hard drive. A schizophrenic person is not a computer with something gone wrong. Even at his most psychotic, he does not present me with a screen which reads "This program must shut down. Do you wish to submit an error report?" We must remember that a schizophrenic person-- even a catatonic, alogia person-- is an Other human being who looks back at a therapist.

To our credit, real-world clinicians do not tend to enjoy "virtual" patients. However, it is tempting to distance ourselves by thinking of ourselves as technicians and the flat affect of a schizophrenic person as a "crashed" computer screen. If this is the case, a therapist may fall into this new myth of Gyges and tell herself that when facing a schizophrenic client, she is not visible as a human being responsible for another human being. In fact, it is perhaps more accurate to call this phenomenon "The Delusion of Gyges." The story of a magic ring that made a person invisible was an honest myth with its own meaning and lesson to learn. Meanwhile, believing oneself to be invisible while interacting with another human being is nothing short of a comforting delusion. There is no room in this solipsism for an Us.

My client does not see me for who I am. However, I have nowhere to hide from my essential *responsibility* to him; neither a concealing screen around myself nor a digital-age screen that dehumanizes the patient by reducing him to a malfunctioning machine that I, the technician, can "fix" without an interaction that changes both of us.

A Meaningful Interaction

A Completed Interaction

Edward K is a 45-year-old, Caucasian male, divorced with three children. Eddie hid his paranoia since he was a teenager, so while he received sporadic treatment for depression, he received none for the underlying problem of paranoid schizophrenia. At the time of previous treatment he'd been a successful businessman and reported that he did not want anyone to think there was anything wrong with him. He had several sales jobs, but quit each one in succession because he believed his co-workers were plotting against him. "People follow me with recording equipment," he told me. "They're trying to catch me making mistakes." His entire life was structured around proving to those he felt were scrutinizing him-- with malicious intent-- that he was successful. During our first session Eddie told me that he wanted not only to overcome his paranoia, but also to have meaningful relationships with others. Throughout his life he has sought normalcy in his life through female companionship and even marriage. Yet this was rarely a "completed" interaction, for he withdrew from anyone he began to trust. He believed that if he let down his guard, they would harm him.

Eddie has admitted that he used most of his previous relationships to his advantage. For example, "I only graduated high school because I made friends with the smart kids. I made them like me so I could use them." He was doing to others what he perceived they would do to him, that is, each person tries to use the other to get ahead. I have considered the possibility that Eddie believes he is "using" me. After all, I am a "smart kid" who (among other things) is providing him with strategies to help get his life in order. If this is true, is ours a meaningful interaction? Schizophrenia has been called a disease of isolation, so much so that Gendlin (1964) felt the need to clarify his criteria of positive interaction for a therapist and a schizophrenic client. "I do not mean by positive 'good' or 'nice'... Rather, I mean *completed as an interaction between two human beings*" (pp. 176 - 177). If you and I complete an interaction, we are Us. Gendlin felt that even dysfunctional behaviors—far more dysfunctional than

Eddie's—can initiate a positive interaction as long as both human beings are participating.

In the past month, Eddie engaged in a similar pattern as he had with his previous relationships. When he became aware of his level of trust and engagement with me and other SMH staff, he withdrew and missed medication monitoring, as well as several therapy sessions. Fortunately, by that time he was aware of this tendency and, instead of breaking ties with the clinic, he returned for a session in which we discussed what had happened. I had quite a bit to say about the matter, but I also had a lot of listening to do. Both elements are critical in order for a therapist to avoid falling into *rhetoric*, especially a therapist who works with patients who are “dysfunctional” or “hallucinating” or “paranoid.”

Both Participate

While dialogue means approaching another human being with curiosity about his point of view and a willingness to learn about that point of view, rhetoric is the opposite. Rhetoric is any form of speech that tries to persuade another person to come to one's own point of view; that tries to make the Other the Same; that totalizes. Rhetoric is not a completed interaction between two human beings because rhetoric is only interested in getting its own way, whether that means persuading the public to vote a certain way or becoming embroiled in a conflict with Eddie over whether or not there really are people who follow him around with cameras.

The intended purpose of rhetoric is to persuade people to buy into an advertised lifestyle. A therapist probably will not try to persuade a schizophrenic patient to buy a condominium time-share, but she might try to “help” a patient toward a life that the therapist considers to be better. After all, what would be wrong with spending sessions trying to make Eddie K see his paranoia is groundless? Or pushing Chris E to resume the job he left during his psychotic break? Eddie's life would certainly be “better” if he did not worry about being recorded. Chris would be a more productive citizen if he were earning wages. Yet in steering clients toward my imagined goals for them, I could totalize them just as much if not more so than a time-share salesman would.

Therapy driven by rhetoric becomes a crystallization of viewpoints. I am right, my client is wrong. It also becomes a polarization of power, for a therapist has an authority conferred on her by society to “help” with life's problems. “We think that if we can only say what is wrong, we will have done our work. But the objective is not to know what is wrong, or to know anything; the objective is to aid the person” (Gendlin, 1974, p. 270). *Dialogue* comes from the Greek διά, through, and λόγος, words. Meanwhile, *diagnosis*, διά γνῶσις, means “treatment through knowing.” This carries the implication that the therapist knows better than the patient what is going on in the patient's psyche. Within the paradigm of rhetoric, I am the lecturer who knows what is going on, while my client is the listener who needs my knowledge. That is at best. When rhetoric is at its worst, I am a technician who performs a diagnostic test, then reprograms the dysfunctional mechanism.

Rhetoric, with its static establishment of power over the listener, is the opposite of the irreversible nature of height and the conversation that results from keeping this height in mind. Thus therapy with a schizophrenic client is *not* to be approached as if we a therapist is “simply accommodating a rather perfect product to unfortunate necessities, but are being afforded an opportunity to gain some perspective” (Wachtel, 2002, p. 204). The intersubjective space of the Levinasian Us will not work if a therapist's world and methods are so rigid that she refuses to allow any change, any more than it will work if the client is completely disengaged.

The objection to this is readily apparent. How can a person give a therapist a greater perspective if that person is hallucinating? Bertrand Russell once said that “A hallucination is a fact, not an error; what is erroneous is a judgment based upon it.” In other words, the person’s experiencing of a hallucination is his true experience. In that, a hallucination is factual. I do not know what he is seeing or what this means for him until I ask. However, just because a schizophrenic person has a unique visual or auditory experience, this does not mean they should act upon it. Chances are, life will be better for them (as it is for us all) if they speak with someone else and gain a different perspective.

Chris E put it more simply when he advised the other members of my Coping with Schizophrenia support group, “When the voices start to get overwhelming, the best thing you can do is check in with reality. Talk to a friend or your therapist or case manager.” Lloyd S, another member, said, “When you start feeling bad, the worst thing you can do is isolate. You might feel like staying inside away from everyone, but it’s much better to talk to people.” Roger T agreed, “There is never a time when you don’t need friends.”

In a true conversation, that is, a dialogue in which both participants are trying to gain greater understanding of *the matter in question*, in this case the matter of the client’s world and being, both of their viewpoints undergo changes. Neither participant ends the conversation where he began it. By the time they part, both are able to see something new. Conversation is not a mere tool. Nor is it a train that carries information from point A (the lecturer) to point B (the listener). A conversation arising from irreversibility is a fluid and dynamic space in which new meanings are created.

Qualities of Height in Dialogue

The Worrisome Idea of Equality

An ethical therapist, especially the sort of therapist who prefers to call hallucinations “unique visual experiences” and schizophrenia “an extreme state of consciousness,” may be bothered by the patent imbalance of power between herself and her client. What are the ethics of a relationship that is fundamentally unequal no matter how “high functioning” a patient is? Further, where are the ethics in a “helping” relationship between a schizophrenic client and his relatively sane therapist? Are we equals? If I tell myself we are, who am I fooling? Who am I *trying* to fool? For if I admit that we are not equals, what sort of a person does that make me in a country founded on the principle that “All men are created equal”?

Buber and Rogers agree that one should *not* look upon a patient simply as “sick while I am well.” They agree that the crystallization of these viewpoints is not ethical. However, I believe that Rogers might say “Let me interrupt at this point” to clarify that this states one thing, and one thing only: what he and Buber do *not* mean for the client-patient relationship. Both Buber and Rogers view patients as people, not illnesses or machines, but do not stop within the confines of this one statement. Once a therapist has determined to know the schizophrenic patient as a person with a unique perspective, what then? What sort of a relationship is this?

Rogers feels that the relationship is one of equals, or more accurately, a relationship in which two people affect each other equally. He refers to points of transformation as “the moments in which perhaps the relationship is experienced the same on both sides” (Friedman, 1960, p. 175). In other words, a therapist must be willing to speak with a patient in I-Thou terms

in order for true healing to take place.

Buber, meanwhile, does not count the patient-therapist relationship as an I-Thou. He contends that although both client and patient are people, “You are not equals, and cannot be” (Friedman, 1960, p. 172). He means that there are two distinct sides to the patient-therapist relationship. A person has come to the therapist for help. The therapist is willing to “hold” the patient’s emotions, problems, charms, etc. exactly the way they are (and there Rogers and Buber agree) but the patient is not able to do this for the therapist. Nor would the patient want to. If he did, he would not be coming to receive help.

A therapist should respect the validity of her client’s world. The key here is that this is my role, not the patient’s. When a paranoid schizophrenic woman at the shelter where I used to work as night staff told me I was “A-ok, a smart girl,” I accepted her compliment with genuine *gravitas* but her words still had more implications for her and her experience than they did for me. I tried to recall what I might have done to brighten, even for a moment, her deeply suspicious affect. Looking back, I saw that my only previous interaction with her involved recognizing her and calling her by name. What did it say about her perception of the world that this small recognition had such an effect? As Rollo May (1983) wrote, a therapist is “a human being who happens, at that hour, to be concerned not with his own problems but with the understanding and experiencing as far as possible the being of the patient” (p. 156). Before I knew of Buber or May, before I began my training to become a psychotherapist, I was trying to be both by my own side and by hers. Now that I do therapeutic work with schizophrenic clients, I still try to understand their “being” while keeping one foot anchored in the land of the well.

Martin Buber captures this mentality when he explains to Carl Rogers that the patient “comes for help to you. You don’t come for help to him. And not only this, but you are *able*, more or less, to help him. He can do different things to you, but he cannot help you. And not this alone. You *see* him, *really*” (Friedman, 1960, p. 171). It is important to note that Buber qualifies this by adding that it is certainly possible for a psychotherapist to be mistaken in what he sees, but that the therapist sees more of the patient than the patient does of the therapist.

Buber’s I-Thou deals not with the one-sided *giving* of one person but with mutual understanding. I respect my schizophrenic client’s world and try to explore it with him instead of explaining to him all the ways he, “a relatively sick person,” differs from me, a “relatively well person” and what he can do to become “correct.”

A therapist should allow a schizophrenic client to teach her, certainly. She should turn her face toward a dialogue in which both she and the client are changed. Providing significant, accurate insight does not mean simply sitting back and telling a patient what is going on inside himself. In the absence of monism, listening to the client himself is the only way to learn of their experience, which is the matter at hand in this conversation. To expect I-Thou with a schizophrenic client for the entirety of each session is unrealistic. In fact, Eddie K has admitted to me that he has trouble even *thinking* about engaging with another human being for the famous “50-minute hour” of therapy. He anticipates interactions with his court-ordered group with visceral dread which makes his heart pound and his stomach hurt. Sometimes he asks for strategies to overcome this. Sometimes simply sharing his fears with an empathetic listener is enough for his stomach to settle and his breath to slow. Eddie has often said that the mere realization that he is not alone makes him feel better.

The therapist is able to “see” from her own perspective and from the patient’s, while the patient is entangled in his own context. “You are at your side and his side at the same time...” says Buber. “He cannot be but where he is” (Friedman, 1960, pp. 171-172). How intense a mental contortion does it take to believe that my client and I are exactly equal at all times? If I persist in trying to make the world conform to a demonstrably false idea in order to avoid an uncomfortable truth, I come ironically close to a delusional reality. This is no place for a therapist to be if she is to help anyone. Buber is correct and refreshingly honest in his declaration that this is an unequal relationship.

Asymmetrical

Levinas wrote that “intersubjective space is not symmetrical” (1987, pp. 83-84) and this aspect of ethics is remarkably suited for psychotherapy. It is tempting to get caught up in the argument over who is powerful and who is weak in the therapeutic relationship. One could say the therapist is the powerful one for all the reasons discussed above. However, one could make quite a strong argument that the schizophrenic client holds power over the therapist! My client can choose to open up and give me a tour of his crystalline world, if I promise not to touch anything; or he can fold his arms, look away, and refuse to let me on the porch. He might not even show up for his appointment, whereas I have an obligation to be at my clinic day in, day out. The very language used by my particular clinic implies this. The lead clinician explained to me that those who use our services are referred to as “clients” and not “patients” precisely because they are here of their own free will. It is meant to be “empowerment language.”

It is sometimes difficult for Eddie to keep his therapy appointments, which makes sense in light of how he sees the world. If other people are out to get him, chances are he will not benefit from sitting down with another person and revealing his weaknesses. I regularly leave cajoling messages in his voicemail. He employs a service for his phone that does not allow unidentified callers even to leave a message, so I must carefully navigate a robotic menu to reach a voicemail box that will eventually allow my recorded words to reach his ear. After a couple of messages, he comes in for his appointment. Our relationship is one of constantly-shifting asymmetry.

Irreversible

Levinas neatly undercuts the debate over who holds the “power” in the psychotherapeutic relationship, for in addition to being asymmetrical, his dimension of “height” is also irreversible. The relationship between Us is radically separate as I and the Other are to begin with. The Levinasian Us is not comprised of one unilateral relationship, but two distinctly different ones. “I – Other” and “Other – I” do not go into each other *at all*, let alone reversibly. The dimension of “height” is also non-polarizing. For Us to have a conversation, we do not need to decide once and for all who is powerful and who is weak. The dimension of power in Levinas’s height is unique in that it is not a struggle for domination, but a call to responsibility. The Other needs something from me as a patient needs something of his therapist, and just as we are not equals, a patient and therapist do not expect or need equal things of each other.

My client is at his most “powerful” not when he controls the therapeutic relationship, but when he needs the most from me in his weakness. “The powerlessness of the face renders an absolute command as the ‘please’ of supplication” (Burggraeve, 2002, p. 98). This amorphous sense of authority may be paradoxical, but it lines up a great deal more accurately with the reality of therapy than a problematic idea of equality or a totalizing exertion of power. My client does

not wish to respect and explore my world. Nor do I expect him to. More importantly, he seldom allows me to come inside his, however much I might wish to.

My schizophrenic clients do not mind if I acknowledge this. Quite the contrary, in fact. One day when Eddie K's eyes unfocused, I said that he looked "as if your gears are whirring at 90 miles per hour. I'll bet all kinds of things are going on in there. I don't even *know*, do I?" Eddie blinked, focused on my face, and his usually-serious expression dissolved into a chuckle as he said yes, he'd been distracted by several tangents at once, but chose not to elaborate. I do not know what he was thinking in this instance, for my trying to see from both sides is just that, "trying." My client has his own unique world, and there may not be room for me inside that rigid, fragile place. At least, not most of the time.

Later during this session he decided to tell me about some of his paranoia and how overwhelming his terror sometimes became. He was markedly cautious about how much he said, but it was a beginning. After sharing some of his burden, and receiving some counseling about it, Eddie admitted, "That wasn't *terrible*," and smiled a little. Skirting the borders of a schizophrenic person's carefully-guarded reality, only being allowed on the porch or into the coat-room, is not a Buberian I-Thou. However, this asymmetrical, irreversible relationship can be a Levinasian Us.

The Levinasian Us

The Role of the Therapist

We have established that the therapist's role is not to ask rhetorical questions to further her own end of "treatment through knowing better." Nor should she conform to a delusion in which both she and the patient are equals. What, then, is the role of the therapist in the Levinasian Us? It is true that the roles of therapist and client are not equal, but this inequality can only be established if ethical inequality is established by a therapist who places the Other above herself. Despite the fact that the Other comes from "on high," he is not more powerful than I am. "The other is, for example, the weak, the poor... whereas I am the rich or the powerful." (Levinas, 1987, p. 83). According to Levinas, this is exactly as it should be. Not only clients, but all Others exert a command over the I not by virtue of their power, but by their weakness. However, this command in no way means that the therapist is passive in such a relationship.

Play

Instead of I-Thou, or a static polarization of power and weakness, height in the therapeutic relationship is perhaps better compared to Gadamer's notion of play. Play is a process, a back-and-forth motion. Gadamer's play does not imply "against," but a "to-and-fro movement." (2004, p. 104). Play, as it relates to the therapeutic situation, is both give and take, active and passive. It is passive in that I respect the fact that I do not have the entire truth and that the client has a vital piece of it, i.e., her experience. However, I do have opinions and knowledge and wish to engage the client with them.

The quality of such an engagement is realistic for therapy with a schizophrenic patient in that two people who do not meet on equal terms can play together. In other words, play also does not have to imply Buberian reciprocity. I remember the supervisor at the shelter where I used to work, engaging in a spontaneous dance with one of the clients. This client detested physical contact, so they danced three feet apart, hands up, palms facing each other. They played by the client's rules. No, it was not I-Thou. My supervisor moved fluidly while the client was

tentative, but it was beautiful to watch them play together. “I’m going to spin you now, is that ok?” My supervisor lifted her hand, her fingers curled as if holding a Christmas ornament. This client, very slow and dignified, raised her arms above her own head and spun in a tight circle. Gadamer would have given them both a round of applause. After all, he wrote that his word for playing, *spielt*, came from *spiel*, which originally meant “dance.”

Both Buber and Rogers make excellent points. However, I believe that it is more realistic to think of therapy as a back-and-forth play rather than a constantly dazzling radiance of equal understanding, especially since such radiance would most likely terrify a shy schizophrenic person. Mutual, relative understanding is a wonderful thing when it happens, but it would be somewhat naïve (and unfair to the client) to expect it all the time. Popular opinion tends to view separation between Us as alienation at worst and a necessary evil at best. However, a therapist endeavoring to respect the client’s Levinasian height is better served by accepting separation as a normal human state. Separation provides the space for inspiration. If unity were ever achieved, not only therapy but all conversations would be pointless. Indeed, Nabokov’s protagonist Cincinnatus is so dejected by the transparency and uniformity of others that he walks out of the world of the book in order to find Others who are like him in their very dissimilitude. The end of the book is the beginning of his quest to find those whose words are *not* instantly comprehensible, but who must hear each other through and investigate deeper meanings which produce the unexpected.

The important thing is for a therapist to see the highlights that spring from unexpected understanding between two separate beings and allow them to touch her, for Rogers is correct in saying that those transformative moments are powerful for both therapist and client. In other words, neither equality nor complete comprehension are prerequisites for therapist and client to form a Levinasian Us.

Creation vs. Exploration

I do not mean to cast therapy as something frivolous or casual. To play in the Gadamerian sense, or in the sense of professional musicians, requires a great amount of attunement and effort. Gendlin (1974) likened diagnostic concepts and knowledge to thin lines on a map, while the experience of therapy is that of both client and clinician on the ground negotiating “not yet charted terrain” (p. 271). While this analogy gives respect to the client’s rich, uncharted interior world as opposed to “treatment through knowing,” it falls short in one important aspect. It implies that these meanings are already there, waiting to be discovered by whoever happens upon them. Client and therapist travel side-by-side down an unknown but pre-existing road. The sort of “play” that I mean is not a Socratic exploration of the pre-existing, which implies that one person could make these discoveries if he thought long and hard enough. If this were possible, then what would be the purpose of therapy?

When at last Eddie showed up for his appointment he told me in so many words that he did not see how talking to another person would aid his recovery. Fifty minutes and several tissues later he looked up and sighed, “Yes, this is important. I don’t know why, but I feel better.” In that moment, feeling better was enough for him. However, in our next session, he wanted to know *why* speaking with another person this way was important. It was a reasonable question for anyone, and an important question for a person used to perceiving others as dangerous. What were we doing together that he could not do alone?

Levinas held that when two people communicate, “the face does not awaken me to something already slumbering within, but teaches me something completely new” (Burggraeve, 2002, p. 93). Gendlin used the analogy of a map and terrain. I prefer that of music.

The Levinasian *Us* plays in a similar way to that of improvisational musicians. Instead of two people moving through pre-set parts that run alongside each other like train-tracks, such musicians listen to what the other is doing in the moment and play off of each other, spontaneously creating something new. This is closer to Stern’s (1983) interaction, in which “meaning becomes creation, not discovery” (p. 72). This sort of music—and therapy—requires willingness to experiment, to surrender, to trust, to shift roles, and to expand on new themes and meanings as they are created. Yes, it requires the dimension of Levinasian height, which transcends the traditional polarizations of power. It also requires Gadamerian humility, for if the therapist asks a question she must be willing to truly attend to the client’s answer instead of falling into the rhetorician’s habit of asking a question as a means to further her own end. The creative interaction not only creates something that was not there before, but also something that *could not* have come about without the effort of two people. This is what Nabokov meant by *Upsilon*: conversation that can springboard both participants to new heights.

It should now be apparent that the sort of “play” I mean is not careless. It requires two people listening intently and attending to subtle cues. Anne Rogers summed this up eloquently. “He is my patient and I am his therapist. Yet from the beginning, different as we may be, we are engaged in a powerful human drama, a drama that neither of us can play out (or even imagine) alone” (1995, p. 8). The aim of conversation is not to cement your own opinion but to discover what is true about the subject matter. This means questioning one’s own opinions, which can be frightening for someone accustomed to a rigid, paranoid structure. Yet the schizophrenic client is not alone in facing this unknown. Both of *Us*, client and therapist, are brought into question through this interaction. This means the therapist is not sitting comfortably as a “master” who tries to bring someone around to the perspective she already sees. While the patient does come to the therapist for help, the therapist still ought to be willing to see something new, that is, to attend to the client himself instead of to her own theories and goals.

Solipsism

This is the answer to Eddie K’s question, what can two do together that one cannot do alone? We move through an ego-centric world. As soon as we move into a new part of the world and apprehend it, we “conquer” it in that it becomes a part of us. We apprehend the knowledge of it and assign meaning to it. We carry ourselves and our perspective with us wherever we go. No matter how much we might desire something different, we alone simply cannot *go* outside of ourselves. An individual is walled in on all sides by his very being, yet is always yearning to peer over the walls. “The fact of being ill at ease [*mal a son aise*] is essentially dynamic. It appears as a refusal to remain in a place, as an effort to get out of an unbearable situation” (Levinas, 2003, p. 58). This is true for Nabokov’s unwilling protagonist Cincinnatus C. At the very beginning of the book he attempts to escape his prison, walking out of his cell, out of the prison and through the streets of his town. Yet at the moment of greatest anticipation a prisoner can imagine, that of returning to his own home, “Cincinnatus ran up the front steps, pushed open the door, and entered his lighted cell. He turned around, but was already locked in. O horrible!” (Nabokov, 1959, p. 20). Even the greatest pleasure imaginable, such that it promises to transport someone outside himself in a fit of ecstasy, lasts only for an

instant. It is over as soon as the threshold from anticipation to the event is crossed, and the escapist is “ashamed to find himself still existing” (Levinas, 2003, p. 61). The only thing that breaks a person out of their solipsistic world is the face of the Other. This is true for any person, but is profoundly so for a schizophrenic person.

One morning while working on stress reduction with Eddie K, I told him that if he wished to he could learn to recognize the typical scripts and signs for “self talk” that would upset him versus “self talk” that would build his confidence. I used the example of road-signs that let him know where he was headed, whether for the mire of paranoid isolation or the expanses of the sort of life he had told me he would like for himself. If he chose, he could break the cycle, affirm his progress and lower his stress level.

Eddie stared at me. His eyes were disconcertingly green and he looked into mine for such a long time that I began to think I had offended him. “You mean,” he said at last, “I don’t *have* to give all my thoughts equal weight?”

“Exactly so.”

He broke eye contact to look down at his hands, which rested on his knees. “I never knew that,” he said softly. “How come I never knew that?”

I have already mentioned that Eddie deliberately hid his paranoia because he did not want anyone to think something was wrong with him. It appeared to him to be the best course of action and made sense for someone who thought that maleficents were lying in wait for him to make a mistake. Unfortunately, this meant that his way of seeing the world became the *only* way of seeing the world. “The ego has only the brutality of its existence in sight, which does not pose the question of infinity” (Levinas, 2003, pp. 55 - 56). All any one person can see is his own solipsistic viewpoint, and if he is to provide the illusion of infinity for himself, he must treat every thought as others might treat the information of the senses.

That is, a schizophrenic person who isolates himself *in media res* must take for granted that his every thought is the truth. It is a heavy burden to be the sole arbiter of meaning in the world. If everything is equally true, then one’s perception of the world is flattened equidistantly into a sort of *trompe l’oeil*. The eye may be fooled, and the mind may forgive the perpetual angle of shadows even when the sun has moved on, but the world of schizophrenic solipsism takes on an air of unreality. Flattened figures slide over the surface of a void. Mental health professionals are all too familiar with the depthless quality of schizophrenic perception,¹ as well as the sort of rigidity that is willing to throw the solar system out of alignment.

It is relatively easy for a schizophrenic person to brush away those who say “You are wrong,” especially if others seem to be “out to get him” anyway. So what if the shadows do not match the sun? Eddie had become so used to perceiving the world this way that he *did not* perceive it. His paranoia was not paranoia to him, but an assumption so basic that it had no conscious meaning. It was flattened into the familiar scenery along with everything else.

¹ Note that the schizophrenic person tends to *perceive the world* as two-dimensional, and that only when he is in the isolation of solipsism. He himself is *not* two-dimensional. He is an Other with an unknowable interiority for me, but he is unable to be Other for himself.

Yet in our conversation, aspects of “the scenery” that had been worn flat leaped into sharp relief. When Eddie realized that not all of his thoughts were automatically true, that there was a gap between his perception and the rest of the world (as there is for us all), his eyes filled with tears and I wondered, “What have I done to this man?” My business is not “reality-checking.” I do not harbor the illusion that my reality is the gold-standard, nor do I wish to replace someone else’s perception with my own. So what *had* I done?

Alterity

Gadamer and Buber prize *presence* and authenticity and hold, rightly so, that these are necessary for a true dialogue. Mosher (2004) and Stevens Sullivan (1989) advise “being with” clients as opposed to “doing something” to them. Stevens Sullivan argues for authenticity when sitting across from any patient. Mosher contends that schizophrenic clients especially need someone to be with them during their ordeal of psychosis rather than to dictate treatment.

Eddie wanted to believe that the world was a better place than he had known thus far, but that meant venturing into intersubjectivity. The alterity that must provide the arena for such intersubjectivity was an untrustworthy unknown far bigger than the one person sitting with him. Eddie was staggeringly brave in that like Cincinnatus, he chose to take a step out of the world of two-dimensional, “transparent” phantoms (Eddie has since admitted that he used to do a lot of ‘mind reading’) and into the world of Others. He soon realized that with this wider perspective came the power both to direct his thoughts and to collaborate with Other people in the creation of new meanings. Of course, this was a single step in a long journey which will he will continue long after our time together is finished.

Obsidional Extradition

It would be both arrogant and inaccurate to say this interaction leaves the “relatively well” therapist’s “correct” world unchanged. This is a relationship in which both are affected, and “correct” does not have much to do with this aspect of Us.

While Gadamer’s unknown tends toward the playful, Levinasian height can be frightening. While Gadamer requires that the issue be broken open by the question, Levinas insists that that the I itself is broken open by the presence of the Other. Nor do I have a choice in the matter. Levinas compares this presence to “burglary,” (1978, p. 145) or more intrusive yet, “obsidional extradition” (143), that is, giving up a guilty party during a siege. Burglary is an act of sneaking in while I am unaware. Extradition under siege is more accurate for Levinas in that the Other meets me face to face and accuses me, draws me forth from any protecting barriers I have imagined for myself. I am guilty before the other, My face is exposed to the Other, “without excuses, evasions or alibis” (p. 143). Again, height means a separation that provides the arena for intersubjectivity; it does not provide a screen between Us. This “sheer visibility [*patence*] of our being” calls us to responsibility through our shame of being seen (Levinas, 2003, p. 64). According to Levinas, our baseline state is that of responsibility. If we are visible to an Other, this means were are responsible to him, by default. This does not mean that the schizophrenic patient sees us for exactly who we are. It means that we are
...exposed to assignation in responsibility, as though put under a leaden sun without protecting shadows, where every residue of mystery vanishes, every mental reservation through which evasion would be possible. This exposure without anything held back is the very spot where trauma is produced... it breaks the secret of Gyges, the subject that sees without being seen (1978, p. 145).

My client does not have to see me for who I am, or even be able to string together a coherent sentence. The Other does not have to speak to me at all in order for this phenomenon to take place. His face accuses me with the unarguable truth of its existence. The disruption of my familiar world by another human face is what Levinas terms the *saying*. “Sincerity is not an attribute of the saying; it is saying that realizes sincerity” (1978, p. 143). In other words, sincerity is not a qualifying aspect of the “saying.” One does not see the sincerity of the other person and then know by that sign that “saying” is going on. For Levinas, an abstract quality does not take precedence over the reality of the human face. Rather, the “saying” of the face brings the abstract of sincerity into the realm of the real. The face of the Other confronts me with a disruption of my solipsism simply by “being there,” and I cannot cover or hide these things.

Levinas helps a therapist understand a schizophrenic client’s anxiety when facing others. Yet the dimension of height in the Levinasian Us goes both ways, and the therapist is also traumatized by her patient. Even as I pulled Eddie (harder than I meant to) from his solipsism, he pulled me from mine as well. His presence as an Other who comes from on high exerts a command, a “please of supplication.”

In Conclusion

A therapist should not welcome her patient into a rigid, delusional world. This ought to go without saying, but the world of mental health is fraught with paradigms that diminish Us. Maintaining separation between therapist and client is key, for this space allows Us to collaborate and create new meanings for the past, present and future. While the Levinasian Us is separate, it is not a divisive polarization of power. The balance of responsibility constantly shifts from one to the other. It is a mistake that borders on the delusional to believe we must always (or ever) be equal to create meanings this way. However, if the therapist sets herself above the patient she will fall into rhetoric. This is not a completed interaction but a lecture, or worse, a new version of the Myth of Gyges in which the schizophrenic person is a computer with something gone wrong, and the therapist is a technician looking at a screen instead of into the Face of the Other who issues a command for the therapist’s responsibility to him.

References

- Burggraeve, R. (2002). *The wisdom of love in service of love: Emmanuel Levinas on justice, peace and human rights*. Marquette, WI: Marquette University Press.
- Donald, A. (2001). The Wal-Marting of American psychiatry: An ethnography of psychiatric practice in the late 20th century. *Culture, Medicine and Psychiatry*, 25: 427-439.
- Freidman, M. (ed.) (1960). Dialogue between Martin Buber and Carl B. Rogers. *Psychologia-- An International Journey of Psychology in the Orient*, III (4), 166 - 184.
- Gadamer, H.G. (2004). *Truth and method*. London, U.K.: Continuum.
- Gendlin, E.T. (1974). The role of knowledge in practice. In G.F. Farwell, N.R. Gamsky & F.M. Mathieu-Coughlin (Eds.), *The counselor's handbook*. (pp. 269-294). New York, NY: Intext.
- Gendlin, E.T. (1964). A theory of personality change. In Worchel, P. & Bryne, D. (Eds.), *A theory of personality change*. (pp. 100 - 148). New York, NY: Wiley.
- Levinas, E. (2003). *On escape*. Stanford, CA: Stanford University Press.
- Levinas, E. (1978). *Otherwise than being*. (A. Lingis, trans.). Boston, MA: Martinus Nijhoff Publishers.
- May, R. (1983). *The discovery of being: Writings in existential psychology*. New York, NY: W.W. Norton & Company, Inc.
- Mosher, L.R., Hendrix, V. (2004). *Soteria: Through madness to deliverance*. Bloomington, IN: Xlibris Corporation.
- Nabokov, V. (1959). *Invitation to a beheading*. New York, NY: Vintage Books.
- Rogers, A.G. (1995). *A shining affliction: A story of harm and healing in psychotherapy*. New York, NY: Penguin.
- Stern, D.B. (1983). Unformulated experience: From familiar chaos to creative disorder. *Contemporary Psychoanalysis*, 19 (1), 71-99.
- Stevens Sullivan, B. (1989). *Psychotherapy grounded in the feminine principle*. Wilmette, IL: Chiron Publications.
- Wachtel, P.L. (2002). Psychoanalysis and the disenfranchised: From therapy to justice. *Psychoanalytic Psychology*, 10, (1) 199-215.
- Walsch, N.D. (1996). *Conversations with God*. New York, NY: Putnam Adult.