

# I-THOU RELATIONSHIP VERSUS MANIPULATION IN COUNSELING AND PSYCHOTHERAPY<sup>1</sup>

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There is ample evidence that man *can* mould and structure the behavior of his fellowman according to some predetermined scheme; we need point only to such phenomena as "teaching machines" (9), Chinese "thought reform," Dale Carnegie's ways of "making" friends, "hidden persuaders," political propaganda, "subliminal advertisements" on TV screens, and, of course, the centuries-old techniques employed by women to make men see, feel, believe, and do what they want them to. The question is, "Can techniques for the manipulation of behavior, of demonstrated effectiveness in the rat laboratory, the market place, and the boudoir, be deliberately employed in the arts of counseling and psychotherapy?" It is my contention in the present paper that "behavioristic" approaches to counseling and psychotherapy, while rightly acknowledging a man's susceptibility to manipulation by another, ignore the possibly deleterious impact of such manipulation on the whole man and, moreover, on the would-be manipulator himself—whereas the essential factor in the psychotherapeutic situation is a loving, honest and spontaneous relationship between the therapist and the patient.

## NATURE AND EFFECTS OF MANIPULATION

We are beginning to get some notions of what healthy personality looks like (5, 6), and what health-yielding behavior might be. In the light of this it is tempting to imagine some such situation as a therapist flashing a light, or a smile, or a glance at the patient whenever the latter emits behavior thought to be health-promoting. If these stimuli have become reinforcing, the therapist thus will increase the rate of wellness-yielding behavior in his presence, and weaken those responses which produced and perpetuated symptoms. In fact, if such a procedure were desirable, one might construct a therapy-machine, somewhat as follows: Whenever the patient talks about subject-matter which leaves him "cold" and unemotional, a light remains off. The

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patient's job is to get the light on and keep it on. As soon as he discusses emotionally meaningful material, his autonomic responses will close switches that turn on the light. Shades of 1984! Then, the therapist can go fishing, and the patient will subsequently display healthy behavior whenever he encounters a machine. Monstrous though these ideas sound, they are not implausible. Greenspoon (3) and numerous workers (7) following his lead have demonstrated the power of a well-placed verbal reinforcer to increase the rate at which selected verbal operants are emitted. What is wrong with aiming toward the eventual control of patients' behavior *in situ* by means of reinforcements deliberately administered by the therapist?

I believe that a program of psychotherapy undertaken with such an aim is a contradiction in terms. It cannot achieve the aim of fostering a patient's growth toward healthier personality, one aspect of which, I believe, is healthy interpersonal behavior (6, p. 150). It cannot achieve such therapeutic aims purely *because* it constitutes deliberate manipulation of man by man. Such is not a healthy interpersonal transaction by criteria of which I have written elsewhere (6, pp. 180-226). The aim of rational psychotherapy is not so much that of remitting salient symptoms, as it is to alter interpersonal behavior from the range which generates the symptoms (manipulating self and others) to a pattern which generates and maintains healthy personality.

My patients have been vociferous in deploring those times when I have experimented with manipulation. I have tried delimiting my behavior to the dispensing of reflections of feelings. I did a pretty good job of it, too. I have tried imposing the fundamental rule on patients, remaining silent except for well-timed utterance of *ex cathedra* interpretations. I have, I confess, even tried deliberately to shape my patient's behavior in the therapy hour with some rather ingeniously discovered reinforcers which varied from patient to patient, e.g., the head-bob when the output was "right," looking away from the patient's face whenever he was uttering what I thought would be most helpful, and so on. The only trouble with these devices was that in time the patients would "see through them," and become quite angered at being manipulated in these ways. I am beginning to think that people, even patients, resent being manipulated. I know I do. I become furious when, for example, a salesman gives me a canned pitch which his supervisor told him "worked" in some percentage of cases. I can't stand a Dale-Carnegie smile, or any of the other de-

partures from simple, spontaneous honesty in a relationship between man and man. There is something downright degrading in being treated like a ninny, as something less than human.

What is the impact of therapy on the therapist? In our concern with what we do to clients and patients we have never asked what we do to ourselves. The "technical" therapist is striving to manipulate himself and his patient rather than respond to him. He does this by striving to be a good disciple of his master or practitioner of his technique. I have come to recognize that those who habitually strive to manipulate others in one way or another, do violence to their own integrity as well as to that of their victim. Surely behavior that does not do a bit of good for the therapist, cannot do much good for his patient. We need data on this point.

#### THE I-THOU NATURE OF THE PSYCHOTHERAPEUTIC SITUATION

If we look naively at the psychotherapeutic situation, we observe a patient talking about himself to his therapist. At first, the patient is trying to manipulate the therapist's perceptions of him. But the latter listens, seems to avoid conventional responses to what is told him, such as scolding, shock, scorn and moral indignation, and so on. Encouraged by the lack of expected censure, the patient may go on spontaneously to reveal all manner of things about himself. One gathers he had never before in his life told these things, or expressed these feelings to anyone. In fact, in the therapy situation, the patient remembers things which surprise him; he experiences feelings that never before had he even envisioned. As time goes on, he becomes remarkably free in expressing what is passing through his mind, and if you asked him to describe himself late in therapy, he would give a much more comprehensive picture of his wishes, feelings, motives, etc. than he might have earlier in the game. Outside the therapy room, people who have known him notice he has changed, in that he seems less tense, more able to acknowledge a broader range of motives, and often much more spontaneous in his behavior with others. Moreover, he seems to be much more "genuine" in his dealings with others. The absence of his symptoms becomes almost incidental in the face of the more basic changes that seem to have gone on.

What has been responsible for these changes? The man has gone through a unique experience which evidently *has* changed his behavior from responses that generated and perpetuated "symptoms" to responses which yield more valued outcomes.

This seems to be the experience of being permitted to *be*—to be himself. It is the experience of being utterly attended to by a professional man who is of good will, who seeks to understand the patient utterly, and to communicate both his good will and his understanding *as these grow*. It is the experience of feeling free to be and to disclose oneself in the presence of another person whose good will is assured but whose responses are unpredictable. Recent studies, summarized by Carl Rogers (8), have shown that it is not the technique or the theoretical orientation of the therapist which fosters growth of the sort I have been describing. Rather it is the manner of the therapist's *being* when in the presence of the patient. *Effective* therapists seem to follow this implicit hypothesis: If they *are themselves* in the presence of the patient, avoiding *compulsions* to silence, to reflection, to interpretation, to impersonal technique, and kindred character disorders, but instead striving to know their patient, involving themselves in his situation, and then responding to his utterances spontaneously—this fosters growth. In short, they love their patients. They *employ* their powers in the service of their patient's well-being and growth, not inflict them on him. Somehow there is a difference (2).

This loving relationship is a far cry from the impersonal administration of reflections, interpretations, or the equivalent of pellets. The loving therapist is quite free and spontaneous in his relationship: his responses are bound only by his ethics and his judgment. He may laugh, scold, become angry, give advice, in short break most of the rules laid down in psychotherapy training manuals. This differs sharply from the deliberate restriction of therapist behavior to some range thought to be health-fostering. Such restriction of behavior by therapists makes them the legitimate butt of jokes and caricatures—they become so *predictable*. Evidently it is only the therapist's good will which needs to be predictable, not his specific responses to a patient's disclosures. In this connection I should like to mention the beautifully written satire by Jay Haley which portrays psychoanalysis as a special case of the game of one-up-manship (4).

It is my growing opinion, somewhat buttressed by accumulating experience in my own therapeutic work, that valued change—growth—in patients is fostered when the therapist is a rather free individual functioning as a person with all of his feelings, fantasies, as well as his wits, and that the therapist who strives to remain a thinking, and only thinking creature in the therapeutic situation is a failure at promoting growth.

Martin Buber has succinctly summed up these observations with his concepts of the *I-Thou* relationship, and of the dialogue (1). When a therapist is *committed* to the task of helping a patient grow, he functions as a whole person, and not as a disembodied intellect, computer, or reinforcement programmer. He strives to know his patient by hearing him out. He does not limit his behavior to some range prescribed by theory or cook book. He does, however, retain his separate identity, and is thus able to see and understand things which the patient cannot. If he spontaneously and honestly conveys his thoughts and reactions, I believe he is not only communicating his concern, but is in effect both eliciting and reinforcing kindred uncontrived behavior in his patient. To a shocking extent, behavior begets its own kind. Manipulation begets counter-manipulation. A therapist who *is* concerned about his patient's lot eventually will be perceived as a man of good will by his patient. Any man will hide from those thought to be *not* of good will, just as a poker-player hides his hand from the other players who are not of good will, insofar as the player's money is concerned (10). In the presence of a man who *is* of good will, even the most defensive will strip themselves, so that the other will know their lot and be able to help them.

#### CONCLUSION

No patient can be expected to drop all his defenses and reveal himself except in the presence of someone whom he believes is *for him*, and not for a theory, dogma, or technique. I believe that if the therapist abandons all attempts to shape his patient's behavior according to some predetermined scheme, and instead strives to know and to respond honestly to what he has learned, and to establish a relationship of I and Thou, then he is doing his job as well as it can be done—that is, if spontaneous honesty between man and man, and between a man and himself are worthwhile therapeutic goals. Somehow, I feel that orthodox therapists—we might call them Rogerian, Freudian, or even Skinnerian technicians—are more concerned to verify their respective dogmas than to know and respond to their patients as individual persons. Techniques treat with categories and fictions. Therapy proceeds through honest responses *to* this very person *by* this very person.

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