OTHER-ORIENTATION VERSUS SELF-ORIENTATION IN PSYCHOTHERAPY

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Among the goals a therapist has while working with his patient, there is one in particular which is much emphasized no matter what school the therapist belongs to: namely that the patient explore, recollect, and describe *his* feelings, *his* needs, *his* frustrations; in short, that he talk about *himself*. While talking about oneself in therapy is necessary and generally very helpful indeed, the writer should like to consider here some consequences of this procedure which have perhaps not received enough attention.

First it is suggested that this self-orientation, or self-preoccupation (to use a stronger term), may lead to a further decrement of the patient's already underdeveloped social interest. It was originally Adler (1), of course, who proposed a want of *Gemeinschaftsgefuehl* or social interest as the central characteristic of the mentally ill individual and, in fact, of all human shortcomings. More recently a number of writers have expressed similar views, such as: Nikelly, "There is much evidence that good adjustment depends upon and varies with the amount of social interest" (16, p. 149); Suttie, "Mental trouble is fundamentally merely an abnormality of social feeling . . . " (20, p. 146); Allport, "True neuroses, we know, are best defined as stubborn self-centeredness" (2, p. 173).

From a common-sense point of view it seems likely that such self-centerdness will only increase as the patient comes to pay more and more attention to himself. If social interest is conceived of broadly as a genuine concern about the welfare of others, one necessary condition for its development is an awareness of other people and their needs and, thus, a giving attention to *them*. This giving attention to others, both intellectually and emotionally, is what is meant by other-orientation.[1]

LIMITATIONS OF SELF-ACCEPTANCE

At this point, however, many therapists will interject that, in whatever degree a patient pays attention to others, the crucial question is whether or not he can accept and respect them as fellow human

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[1]The terms other-orientation and self-orientation as used in this paper are not related to Riesman's (18) distinction between the other-directed and inner-directed social character.

beings; this, it is assumed, he can do only insofar as he accepts and respects himself. Thus he has to learn to accept himself first, and this learning involves again paying attention to himself.

But the assumption of a close relationship between self-acceptance and acceptance of others has not received strong support from research evidence; while the correlations are positive, they tend to fall well below .50 (8, 9, 17).

More relevant are studies such as Worchel and Hillson's (22), for example, who reported that criminals have higher self-acceptance (a more favorable self concept and a smaller self—ideal discrepancy) than the normal person who does not engage in antisocial behavior. Similarly, Foulds (10) found psychopaths to be more accepting of themselves than they are of others in comparison with normal people. In view of such findings it appears difficult to postulate high self-acceptance as a *sine qua non* of other-acceptance and, therefore, as a fundamental basis of social interest.

Yet even if the above postulate is maintained, further questions arise. Once a patient has achieved greater self-acceptance, will he spontaneously show more social interest? A nondirective therapist and many adherents of the man-is-basically-good school in general would answer yes, an orthodox Freudian, presumably no. Setting theoretical biases aside for the moment, it seems reasonable to contend that some clients, in any case, do need more explicit help in order to develop other-orientation and a sense of social responsibility.

For instance, the writer recently observed a youngster's struggle during the therapy hour about returning a quarter he had borrowed from her for coin flipping. Several times he slipped it into his pocket, only to dig it out again and place it angrily on the table, where he finally left it. During the next session there was more coin flipping, and now the therapist put the conflict into words and expressed her understanding of his wish to keep the coin. This is more or less standard procedure but something must have gone amiss: this time the youngster left *with* the quarter.

Perhaps one might wonder to what extent we sometimes in fact influence the patient in the direction of asocial behavior outside the therapy room. If we ameliorate his guilt feelings about antisocial impulses by sympathetic understanding but fail to strengthen his concern for the welfare of others at the same time, are we not actually teaching him that self-oriented and even selfish behavior is alright as long as he can get away with it?

The results of therapy-outcome studies by a psychoanalytic institute indicate that this question is not idle speculation. Mowrer reported that, essentially, analysis was found to have one of two outcomes: either it is unsuccessful and the patient continues to be neurotic, or "the analysis is technically successful . . . but the patient then develops a 'character disorder' and begins 'acting out' " (15, p. 235). Such an outcome is certainly not in accordance with our professed belief that "the psychologist's ultimate allegiance is to society" (3, p. 7)!

THERAPEUTIC CONSEQUENCES OF OTHER-ORIENTATION

But greater other-orientation is defensible not only from a social perspective; it also has direct therapeutic consequences for the patient himself. In general, mental health and happiness appear to require a good measure of other-orientation and self-transcendence. "Hell is yourself," wrote Tennessee Williams, "when you ignore other people completely, that is hell;" salvation is found "when a person puts himself aside to feel deeply for another person" (4, p. 53). Psychological literature too is replete with similar statements. According to Ellis, "Humans tend to be happiest . . . when they are devoting themselves to people or projects outside of themselves" (7, p. 39). Or, as Mowrer said, "man can survive physically *and psychologically*, only if he becomes his 'brother's keeper,' concerned, compassionate, generous, helpful, related" (14, p. 418).

More specifically, greater other-orientation may be beneficial in those areas of human experience which seem to be particularly troublesome today. One such area is the search for a meaning or purpose of life. To the extent that a person is oriented toward others or toward some task outside of himself, he will hardly experience his existence as meaningless.

Another such area is "the quest for identity" (21). "Only through, in, and with other selves does one gain one's own self" (12, p. 270). "The road of man to himself leads across the world; man finds himself nowhere but in another"(11, p. 94).[2]

Again, there is the problem of loneliness and unrelatedness. Exaggerated self-orientation leads to an increased consciousness of oneself as separate from others, as solitary and isolated. The other-oriented person is more inclined to identify with people and to have a sense of belonging, a feeling of being part of the human community. Then, too, in his caring, he will reach out to others and meet them

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[2]Quotation translated by the present writer.

halfway. Shoben stated, "loneliness is a function of an underdeveloped capacity for love. It is as much a symptom of one's lack of loving as it is one's lack of being loved" (19, p. 22).

As a last thought the writer should like to submit that diminished self-orientation would lessen one type of anxiety the American value system seems very prone to arouse, namely, the anxiety about failure. In comparison with other cultures, in this country there is an over-personalizing of achievement and, hence, of failure. According to Hsu, for example, the American's "only security must come from personal success, personal superiority, and personal triumph" (13, p. 228). But where personal success is of such importance, failure to achieve it means degradation and is extremely threatening. Besides, this point of view strongly emphasizes competition; being out "for myself" means here being "against you," and the self-oriented person rather expects the same treatment from his neighbor — a further source of insecurity and anxiety. In contrast, the other-oriented individual's sense of worthiness and significance derives mainly from his contribution to his fellow humans, and he can expect being accepted and valued by them.

Although the conception of a mentally healthy person as someone who is committed to the human venture through genuine concern and socially constructive work cannot boast of clarity, this area is by no means devoid of encouraging research. Berg's (6) study is especially congruous with the thesis of this paper. He hypothesized that early in treatment, clients are preoccupied with themselves and that, if the treatment is successful, they move in the direction of more empathic caring for others. He tested this hypothesis by making frequency counts of self-oriented words (such as I, me, my, myself, mine) and other-oriented words (such as we, our, they, us, you, your) in an eight-interview protocol of a case published as successful by Rogers. He found that the use of other-oriented words indeed increased with succeeding interviews while that of self-oriented words diminished.

CONCLUSIONS

In summary, the thesis of the present paper is that the current stress on self-orientation in psychotherapy has some undesirable consequences for both the patient and his environment. A movement toward greater other-orientation would seem beneficial and also in agreement with mental health conceptions of many therapists as well as laymen, with theoretical propositions about the goals of therapy as well as with our democratic social philosophy.

In actual practice such a movement could be achieved, for instance, through reinforcement of other-references; through doll play, psychodrama, and other role-playing techniques which permit the therapist to direct the patient's attention toward other people and to help him understand them and their needs; and through a more extensive use of group therapy situations, particularly those in which primary patient, close family members, and therapist(s) work together as a group. In other words, by taking the reality of social living into the therapy room we would prepare the client better for his ultimate task—his comfortable and constructive functioning in his interpersonal world.

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