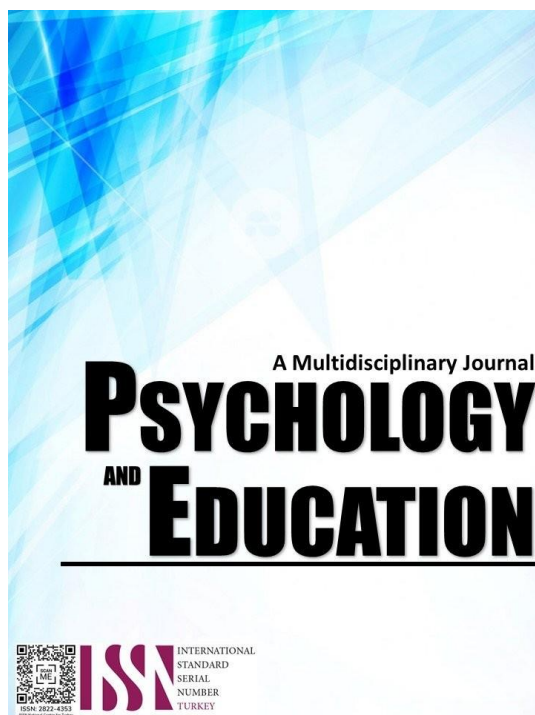


# UNDERSTANDING MARTIN BUBER’S “I-THOU” THEORY IN THE CARE COORDINATION OF PATIENTS WITH MENTAL ILLNESS



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## Understanding Martin Buber's "I-Thou" Theory in the Care Coordination of Patients with Mental Illness

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### Abstract

Care coordination among patients with mental illness can be challenging if not extremely draining and difficult because of the intellectual, social limitations, educational and emotional fragility of the population that healthcare providers must navigate during the care encounter. Both therapeutic and care coordination processes "requires some steady conception of the fully human." That a successful care coordination needs to have a good understanding of what is meant to be a human person. This is exactly what Buber's theory of the human person "offers and why his work has proven so valuable to clinicians." Custodialism has been popular and was considered as the norm for quite some time during the delivery process within the behavioral health units. However, this approach resulted in depersonalization of patients and has encouraged dependency and powerlessness. Today, the new care coordination model calls for the transformation of behavioral units into therapeutic community wherein "the person-to-person encounter is enhanced and sustained through a revitalized institutional environment." The "I-Thou" theory of Buber presents a scientific and sociological approach that has a deeper implication in clinical practice with greater emphasis on care and rehabilitation rather than control and custody in psychiatric medical treatment.

**Keywords:** *care coordination, rehabilitation, mental illness*

### Introduction

Care Coordination among patients with mental illness can be challenging, if not extremely draining and difficult, because of the intellectual and emotional fragility of the population that healthcare providers must navigate during the care encounter. Most (if not all) providers may agree that there is no formal academic research and classroom training for care coordination, but everyone will agree that successful patient coordination is experiential rather than theoretical. We learn the process through experience, and the actual delivery of care is the practical test of our unspoken and untested principles in human relationships and patient encounters. There are no psychological and philosophical theories through which care coordination can anchor its plan of care for psychiatric patients, but according to some clinical social workers, care coordination covers both case and care management (Fink-Sammick, 2011) which simply means helping patients navigate the process which could be sometimes complicated and fragmented. This process involves delivery of care, treatment (Fink-Sammick, 2011) and recovery. According to Gandré et al. (2020), care coordination is the "deliberate organization" of care encounters among healthcare providers to facilitate proper delivery of patient care that is safe, efficient, and appropriate to the needs of patients. Such delivery of care requires a transdisciplinary approach, which involves communicating the patient's needs and preferences to different providers involved in the patient's care, including the patient's family (Fink-Sammick, 2011) and another support system. And most importantly both therapeutic and care coordination processes need to understand the true meaning of the human person (Hollander, 1990). A successful care coordination needs to have a good understanding (if not a full comprehension) of what it means to be a human person. That is why the theory of the human person in Martin Buber's philosophy has become so significant to most clinicians (Hollander, 1990) and therapists alike because of its humanistic approach.

There are millions of Americans who in one way or the other are suffering from mental illness. Statistics from Mental Health America indicate that "19.86% of American adults are experiencing mental illness" (Reinert et al., 2022), which, according to the Recovery Village data, amounts to "approximately 54 million Americans each year." (Hull, 2023). The survey from National Center for Health Statistics (NCHS) indicates that in 2022, "12.5% of Americans have regular feelings of worry, nervousness or anxiety" (Schilly & Norris, 2022) and "5.0% of them have regular feelings of depression" (Schilly & Norris, 2022). Various studies cited that among the most common mental illness in the U.S. is anxiety and depression "which affects about 40 million adults or about 18.1% of the population." (John Hopkins Medicine, 2023) John Hopkins data reports that among American adults between the ages of 18-54 years old "have anxiety disorder in a given year" (John Hopkins Medicine, 2023). The mental health problem in the U.S. is truly concerning and one of the best ways to properly address this social issue is an effective care coordination approach that is both engaging and patient centric. Data from National Center for Health Statistics under the U.S. Department of Health and Human Services indicate that in 2019, "19.2% of American adults had received any mental health treatment in the past 12 months, including 15.8% who had taken prescription medication for their mental health and 9.5% who received counseling or therapy from mental health professional." (Terlizzi & Norris, 2021) According to the 2022 President's Budget (per the National Institute of Mental Health website), the United States has allocated over \$2 billion in budget for mental health, it is however alarming that there is a very low percentage of mental health patients who are actively seeking treatment and/or receiving psychiatric services from professionals.

## Methodology

### Research Design

This paper is qualitative research using hermeneutical and textual analysis of Martin Buber's "I-Thou" theory and its application in the care coordination of patients with mental illness. This approach will focus on understanding the meaning of "I-Thou" and involves the systematic analysis of textual content in academic literature to identify themes and meanings related to the theory's application in the quality and effectiveness of patient care.

### Instrument

The study involves a systematic review of existing academic literature on the "I-Thou" theory and care coordination process and protocols in mental health. The academic literature used are translations from reputable scholars of Martin Buber who have direct interactions with the philosopher himself. Other existing literature and studies are considered to gather rich data that can provide deep philosophical insights and understanding in the interpretation of the theory.

### Data Analysis

This qualitative study used thematic analysis. The textual and interpretative readings of academic literature involve the identification of patterns and themes consistent with the theory's relational and dialogical approach to human interactions. The identification and interpretation of themes involves systematic analysis of "I-Thou" theory's application in the care coordination of patients with mental illness.

## Results and Discussion

**The "I-Thou" Theory.** Martin Buber's famous book "I-Thou" (whose original title in German is "Ich und Du") was published in 1923 (Kaufmann, 1978). The first translation of the "I-Thou" into English was made by Ronald Gregor Smith, of which Martin Buber himself made "over two hundred corrections" (Buber, 1996). In a letter to R.G. Smith sometime in March 1937, Buber pointed out errors involving misunderstanding of what he has in mind (Buber, 1996). The book was later again translated into English by Walter Kaufmann who agreed to do it at the urging of Martin Buber's son, Rafael Buber in a phone call made in June of 1969 (Buber, 1996). Kaufmann's new translation of Buber's "I-Thou" was published the following year (Pickus, 2011). There has been a lot of argument related to the correct English translation of "Du" in Buber's original book, "Ich und Du." Although Kaufmann insisted that the correct translation is "You" (Pickus, 2011) which is evident in the body of the text of his translation however, he retained "Thou" in the title of the book because of the popularity of Buber's book in that title, "I-Thou" (Putnam, 2008). Kaufmann believes that "Du" refers to the pronoun that we normally use in communicating with family, friends, (Putnam, 2008) and others human so it is but appropriate to use "You" rather than "Thou" because according to Putman, the traditional use of the word "*atah*" means "you" and cannot be translated as "thou" because in doing so "we lose sight of the fact that we are supposed to address God just as we address a friend, or a parent, or a child, and not to use a special form of address reserved only to God" (Putnam, 2008). The use of the "thou," though archaic, has been "widely accepted" (Pickus, 2011) and Putman's argument and Kaufmann's insistence did not really sink in with scholars. This paper makes no distinction in the use of the "thou" and "you" in reference to the use of "Du" in Buber's Philosophy. Martin Buber's "I-Thou" fundamentally addresses and answers the question of man's existence in the world (Ravenscroft, 2017) and teaches us the significance of "relation" which is demanded of every man because absence of such, there could be no real value in institutions and systems of morality (Putnam, 2008). As Buber himself puts it, "the basic word I-You establishes the world of relation" (Buber, 1996) which emphasizes forming meaningful human relationship and this "interpersonal dimension of our existence" is what is most important because this will ultimately lead us to connectedness with God (Ravenscroft, 2017). Man realizes his full humanity only through his personal connectedness with his fellow humans, with the environment and "ultimately with God" (Ravenscroft, 2017). Man's mode of existence is twofold, the "I-It" and "I-Thou" and these modes are the two ways through which man relates himself to the world (Ravenscroft, 2017). The opening chapter of Buber's "I-Thou" speaks of duality of the mode of existence when he says, "*one basic word is the word pair 'I-You' and the other basic word is the word pair 'I-It. And these basic words do not state something that might exist outside them; by being spoken they establish a mode of existence'*" (Buber, 1996). Both the "I-It" and "I-Thou" ways of engaging with the world are important because according to Buber, "there is no I as such but only the I of the basic word I-You and the I of the basic word I-It" (Buber, 1996). Although the "I-It" and "I-Thou" are different, but they are complimentary to each other (Kellebrew, 2020). The "I-It mode of existence is equally important especially in the coordination of human activity in the world, in order to produce the materials and institutions needed to sustain biological needs, for example (Ravenscroft, 2017). Buber could not be clearer on this when he said that "without the I-It, a human being cannot live but whoever lives only with that is not human (Buber, 1996). According to Buber, human existence does not only rest within the realm of worldly enterprise whose goal is directed at some particular object rather the "I-You" mode of existence is not object-directed because You stands in relational existence not to an objectified something but to an "I" (Buber, 1996).

The "I-It" mode of existence is characterized by an attitude that is mostly disinterested. This kind of relationship is impersonal because man is not engaged with the "other" and is mostly interested in using and manipulating (Ravenscroft, 2017) the "other" or nature as an object. This is how "I-It" existence manifests itself; the action has an object, and our perception and emotion are directed to that

something. And when an act is directed at something, there exist an objectified being “*for wherever there is something there is also another something; every It borders on other Its*” (Buber, 1996). In the realm of “I-It,” our perception, feelings, imagination, and thinking are all directed at something, the expression of our want for something and our sense for something are both directed at an object (Buber, 1996). The “I-It” relation is distinctly defined by “objectification, categorization” and characterized by utility where the means shape the structure of man’s social life (Stevenson, 1963). The “I-It” existence is defined by subject-object relation, that is, man’s relationship to things as objects and man’s relationship with other men as objects of utility (Kellebrew, 2020). In the “I-It” experience, the level of engagement is detached from the “object of perception” and the subject sees the world as “measured and manipulated” where differentiation between individuals is bounded (Ravenscroft, 2017). Buber has emphasized it that human existence cannot be defined by “*the sphere of goal-oriented verbs*” nor it is understood only by some set of activities directed to “something for their object” because in that case the “I” is bounded by space and time (Buber, 1996). It is within the “I-It” mode where all types of relationships between man and the “material-vital world” and physical world exist (Santmire, 1968). In the second part of “I-Thou,” Buber describes the It-world saying that “*what has become an It is then taken as an It, experienced and used as an It, employed along with other things for the project of finding one’s way in the world*” (Buber, 1996). Although the goal of human existence is not limited to “I-It” relation however according to Buber, “without ‘It’ a human being cannot live (Buber, 1996) because it is in man’s relatedness to the world and institutions “*where for all kinds of purposes one spends time, where one works, negotiates, influences, undertakes, competes, organizes, administers, officiates, preaches; the halfway orderly and on the whole coherent structure where, with the manifold participation of human heads and human limbs, the round of affairs runs its course*” (Buber, 1996). The “I-It” therefore is a necessary mode of relating to the world but “whoever lives only with that is not human” (Buber, 1996). But how does man transition from “I-It” to “I-Thou?” This transition happens through the process of transformation where the “I-Thou invades the I-It structure” although during the process the I-It never really ceases to exist (Stevenson, 1963) but the relationship and encounter becomes an “I-Thou.” And man becomes an “I” through this relationship with the “Thou” and as Buber himself puts it “as I become I, I say Thou. All real living is meeting” (Glatzer, 1981).

The other mode of existence is the “I-Thou” (or You) encounter which can be synthesized as “reality is not myself, not the world and not God” and it is only in relating our whole being to the thou and an encounter with the “other” as thou that the “I” becomes “truly an I and reality is established” (Glatzer, 1981). This “I-Thou” mode of existence is best understood in the encounter between fellow humans where there is a personal meeting of the person as a “Thou” (or You) rather than as an “It”. This kind of encounter with the other person does not involve any utilitarian thought or how this “other” person can be useful, or how the other person may be defined (Stevenson, 1963), manipulated and objectified. In the words of Martin Buber himself, “you are not an object for men like this, not a thing to be used or experienced, not an object of interest or fascination. (Buber, 1996). This is what Buber meant when he says, “the life of a human being does not exist merely in the sphere of goal-directed verbs. It does not consist merely of activities that have something for their object” (Buber, 1996). The meaning of “I-Thou” lies in how we place value in things and people that are important to us and whether the intention of our encounter is defined by utility as we search for a meaningful existence (Ress, 2010). Buber’s thought emphasizes that in our everyday existence, we do not use the “other” the way we use an object of our satisfaction but rather engage in dialogue with the “other” through “openness, trust, readiness to speak and to respond with which we confront” our fellow human being, the world around us and ultimately God (Glatzer, 1981). In the “I-Thou” existence man encounters his fellow man “in a special manifestation of meeting in the interhuman,” a meeting “between a person and person” (Kellebrew, 2020). The distinction between the “I-Thou” and “I-It” cannot be underestimated because of its relevance in the care coordination process. The “I-Thou” is characterized by a subject-to-subject interaction whose encounter is defined by the qualities of “mutuality, directness, spontaneity, presence and openness” (Ress, 2010). Genuine dialogue only takes place in the “I-Thou” mode of existence because the “other” is not objectified and utilized (Buber, 1996). The “I-It” is marked by subject-object relationship where the other is objectified and treated as a utility to serve and fulfill the needs of the other (Ress, 2010).

The engagement of the “I” towards “Thou” (or You) comes in three dimensional encounters which is either directed towards God, nature, and human. Man realizes his full humanity only through his personal connectedness with his fellow humans, with the environment and “ultimately with God” (Ravenscroft, 2017).

**Care Coordination Process.** Care coordination of patient with mental illness is a process involving both care and case management to facilitate the smooth delivery of healthcare services by bringing together a network of mental health providers to create a cohesive and comprehensive plan to assist patients in the management of their own mental health needs (Fink-Sammick, 2011). The complexity of care plan among mental health patients are more challenging because of their “restlessness, being easily fatigued, difficulty concentrating or their mind going blank, irritability and sleep disturbance” (DSM-5-TR, 2022) among others in the case of patients with anxiety disorder. Oftentimes, (as mental health practitioner) care coordination becomes a cycle of repetitive reminders involving unanswered phone calls and emails which practitioners should not only be sympathetic but instead develop an engaging attitude so that the relational encounter with patients may be more therapeutic rather than “paternalistic” (Hollander, 1990). Care coordination involves advocating for the welfare and appropriate utilization of mental health services for clients and in doing so it requires the gift of presence which Buber calls, “the *a priori* of relation, the innate You” (Buber, 1996). According to Buber, “what man receives is not a content but a presence, a presence as strength (Buber, 1996). The dialogical approach requires on the part of the provider an attitude of understanding and willingness to enter fully into the “subjective experience of the client” (Hycner, 1993) and to be present in the here-



and-now of the patient's existence. However, the existential differences between clients' and the provider's individual experiences present an enormous challenge to the latter's readiness in understanding and appreciating the subjective situation of patients (Hycner, 1993). This misunderstanding oftentimes takes the form of racial, gender, and sexual orientation microaggression which is the result of the provider's "stereotypes, biases and prejudices" (Mio et al., 2023). The struggle to understand different yet connected human experience (Ress, 2010) which include man's cultural and class status (Mio, J., et al., 2023) are both shared by both individuals during the meeting encounter (Ress, 2010). This is what is meant by Buber in the process of confirmation which recognizes the uniqueness of the patient's experience. This relation which is *a priori* in man is only possible by being present to the other and must be characterized by "mutual confirmation, co-operation, and genuine dialogue" (Friedman, 1965). The "I-Thou" is an expression of man's "personal relationship" with other man, his surroundings, and the world (Glatzer, 1981). In fact, according to Buber, "the I of the basic word I-You appears as a person and becomes conscious of itself as subjectivity (Buber, 1996). The act of being present requires that the provider genuinely think about what the "other is wishing, perceiving, thinking, feeling, and willing (Friedman, 1985). The goal is being able to understand what the patient is going through hence it is important that providers be skilled in the process of "bracketing" which involves the suspension of all assumptions and prejudices about the patient (Ress, 2010). Genuine dialogue between "I-Thou" is only possible once the presence and relation have become mutual (Kellebrew, 2020). And this mutual confirmation of the human person is successfully realized in what Buber called the process of "making present" where both the provider and patient come together for a meeting (Friedman, 1985). This is the inherent character of dialogue – the gift of presence (Buber, 1996) which allows man to enter into a relation with other man. In this meeting, the diversity of life should not be restricted but "celebrated and respected" for man to enjoy and reflect on (Ress, 2010). Hence, during the care coordination process mental health providers' readiness to enter into the subjective world of patients requires a customized approach to care coordination which means that delivery of care is not only dependent on patient's clinical diagnosis and presentation but culturally sensitive and appropriate (Mio, J., et al., 2023). The confirmation process while making oneself present to the other requires the acknowledgment of the polarities of the here-and-now existential condition of patient. Care coordination guides patient to incorporate into the dialogical process the apparent "directionless" and polarities of client's life by not only reflecting and affirming the existential situation but confronting the trauma and what seem "painful" so that he/she can ultimately take ownership and responsibility for his/her own care. (Ress, 2010). A culturally sensitive care coordination should be tailored to the needs of the patient and should be mindful of the social, political, economic perspective of the individual (Mio, J., et al., 2023) and his/her religious and sexual orientation should not be given equal consideration as well. Whether consciously or unconsciously sometimes MH provider's "unfamiliarity and discomfort" with the cultural background of patient may result in pushing away the patient instead of building an "I-Thou" rapport (Mio et al., 2023). Several studies found that successful encounters between the provider and patient during the dialogue process have been attributed to the relationship with MH provider rather than the provider's technique (Ress, 2010).

The dialogical process in the "I-Thou" theory of Buber includes one of mutuality which means life situation needs to be addressed, that is, patient must "allow himself to be confronted by the other" (Habermas, 2015) in this case by mental health professional. During the care coordination process, patient needs to be open to the "I-Thou" by "meeting the other as a person and not as an object" (Friedman, 1992) or the source that provides everything that he/she needed for recovery - from prescription to medication and from inpatient treatment to outpatient mental health referrals among others. Both the patient and mental health professional engage in a genuine dialogue where both sides experience both the other's "side of relationship without losing one's own, bringing oneself as a whole being, accepting the other as a person - the he or she in their otherness" (Friedman, 1992). In the "I-Thou" theory, the meeting between the patient and MH professional can easily turn into an "I-It" when utilitarian principle dominates the encounter where the patient is used to benefit the provider's agenda such as "patient's admiration becomes necessary for the provider's sense of importance or status" (Ress, 2010) or job security. A similar situation can also occur when patient is required and mandated to improve to give the impression that MH professional is competent and indispensable (Ress, 2010). Mutuality in the dialogical process means that one "feels a real willingness for the other person to be what he is" (Friedman, 1992) that is, willingness of both parties in the meeting to possess and express what they feel without compromising respect and professionalism. It means that during the genuine dialogue each party must be "willing on each occasion to say what is really in his mind about the subject" (Agassi, 1999). and thereby actively involved in the treatment planning. Mutuality means that care coordination should "avoid being prescriptive, imposing onto the patient or attempting to change the patient" (Ress, 2010). Such an approach is crucial in the effective care coordination process because it facilitates self-actualization allowing patient to take ownership of his/her treatment plan.

## Conclusions

Statistics in the United States indicates that only 19.2% of American adults has received any mental health treatment (Terlizzi & Norris, 2021). What this number shows is that there is underutilization of mental health services in the United States despite billions of dollars in budget allocation from the U.S. President's annual spending. There are many literatures pointing to stigma as among the reasons for underutilization among black population and other people of color especially among Asians and Latinos, but multicultural psychology identifies other factors such as microaggression, culture, class, and language barriers. The problem of microaggression mostly affect members of the lesbian, gay, bisexual, transgender, and queer+ (LGBTQ+) community, women, and people of color (Mio, J., et al., 2023). This is mainly due the provider's failure to enter fully into the "subjective experience of the client" (Hycner, 1993). For an effective care coordination, it is necessary that the MH professional be present in the here-and now of the patient's existential condition

and genuinely think about what the “other is wishing, perceiving, thinking, feeling, and willing (Friedman, 1985). When mental health provider is unable to understand the cultural background of his/her client this may convey a negative message which may result in pushing away the patient instead of building an “I-Thou” rapport (Mio et al., 2023). Röss (2010) pointed out that successful genuine dialogue has been credited to the relationship between the client and MH provider rather than the provider’s technique. It is then necessary that care coordination should be framed within the “I-Thou” model because the patient is guided during the dialogical process in incorporating his/her stories related to the polarities and trauma of his/her existential situation, confronting what seem to be a “painful” experience so that he/she can ultimately take ownership and responsibility for his/her own care plan. (Röss, 2010). The “I-Thou” mode of existence as Buber himself puts it, “the basic word I-You establishes the world of relation” (Buber, 1996) which emphasizes forming meaningful human relationship and this “interpersonal dimension of our existence” (Ravenscroft, 2017) facilitates a genuine dialogue between man and man during the care coordination process.

The dialogical process paves the way for mutuality and the patient needs to be open to the “I-Thou” by “meeting the other as a person and not as an object” (Friedman, 1992). In this encounter it is not only the provider who is present but the client “takes an intimate and deeply personal journey of self-exploration with the provider.” And understanding the differences “in terms of race, gender, ability, religion, and/or sexual orientation” (Mio et al., 2023) is a mutual responsibility. The “I-Thou” theory as a dialogical process brings about the healing of the wounded “I” through an existential meeting with the other. That existential dialogue involves the gift of presence where there is confirmation of diversity of experience and their subsequent acknowledgment during the meeting process. When patient has been acknowledged and recognized as a subject rather than objectified as an “It” then he/she knows that he/she is being understood rather than condemned. Care coordination becomes a mutual endeavor where patient ultimately takes control of his/her treatment and recovery while the provider serves as a guide while being mindful to the specific needs of the client be it food, housing, transportation among others. The dialogue becomes relational where the provider is more “culturally responsive” to the client’s concerns and issues related to either race, religion, gender and/or sexual preferences (Mio et al., 2023). The relational aspect of the “I-Thou” serves as a great instrument in the care coordination process through genuine dialogue that addresses the mental health needs of the clients that is culturally, politically, and economically sensitive and unique to the patient (Mio et al., 2023). Henceforth, the philosophy of dialogue in Buber’s “I-Thou” could serve as an effective tool in the treatment and recovery of patients with mental illness because of its relational and humanistic approach in the care coordination process which is “not prescriptive by nature, not imposing onto the patient and not attempting to change the patient (Röss, 2010).

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