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DIALOGUE IN GESTALT THEORY AND THERAPY

(first published in: The Gestalt Journal. v12,1, 1989)

Hycner (1985), in a thoughtful and stimulating article on the concept of dialogue in Gestalt therapy, asked for more public discussion to clarify the implications of Martin Buber's philosophy of dialogue for Gestalt theory and practice. His article is the impetus for me to contribute my thoughts on the matter. * * Hycner described clearly and simply the basic premises of Buber's philosophy of dialogue. I shall elaborate on connections between the philosophy of dialogue and the theory and practice of Gestalt therapy.

*This paper represents my early thoughts on a subject which is still evolving. Although some of my thoughts have changed since I wrote this paper, it become clear to me that if I wait to become current with my own thoughts I will never publish anything.

I am deeply grateful to Richard Hycner, Ph.D., and Gary Yontef, Ph.D., for their thoughtful and thorough criticisms of this paper. I am solely responsible for the content.

**The majority of this paper is taken from my doctoral dissertation, I-Thou Relation in Gestalt Therapy, California School of Professional Psychology, Los Angeles, 1978. See also Enright, 1975; Friedman, 1985; Hycner, 1985; Kempler, 1973; Naranjo, 1975, Yontef, 1975,1976; Zinker, 1975.

There are two major foci when describing the nature of the relationship in any therapy: the role of the relationship in the overall therapy process (the importance of the relationship as a curative factor vis-a-vis the other curative factors, as well as the extent to which the relationship per se is a focus of therapy), and the characteristics of the relationship in that therapy (the range of permissible and valued therapist behaviors, and the structure of the patient-therapist relationship).

The relationship in Gestalt therapy is not clear cut and simple to describe; while there does seem to be widespread agreement on the characteristics of the relationship, full understanding of the role of the relationship is still evolving. In keeping with existential values, the characteristics include a non-hierarchical structure and an emphasis on full and genuine engagement between patient and therapist. But there has been little attention to the role of the relationship in the literature, and rather a wide range of opinions on the subject in the oral tradition. In the past there appears to have been two major emphases: one, exemplified by Isadore From and the Polsters, which focused on contact; the other, represented by Perls, Hefferline and Goodman (and more widely publicized), which focused on awareness work. In my opinion, when the implications of the catch-phrase "I and Thou, Here and Now" are fully apprehended, one will find that the restoration of awareness of which Perls et. al. write can only occur when the therapy operates from an I-Thou context in which the process that Buber describes as "dialogue" is encouraged and developed.

In the dialogue of which Buber writes, all living is a meeting. There is no "I" which stands alone, but only the "I" of "I-It" and the "I" of "I-Thou." There is an alternation between those two modes of existence. The I-It mode is vitally necessary for living, the I-Thou for the realization of

personhood. As Buber stated,

> Without It a human being cannot live. But whoever lives with only that is not human. (1970, p.85)

The I-It mode can be considered the "ego" mode (Farber, 1966). It involves such functions as judgment, will, orientation and reflection (Farber, 1966). It also involves self-consciousness and the awareness of separation (Friedman, 1976b). It is in the I-It mode that a person orders living in time and place. Importantly, ideas and feelings, and attempts to make oneself understood to others, all comprise the world of I-It.

In contrast to the necessary separation of I-It, the I-Thou relation is integrative, and affirms one's wholeness:

> The basic word I-You can only be spoken with one's whole being. The basic word I-It can never be spoken with one's whole being. (Buber, 1970, p.54)

The I-Thou relation has the qualities of immediacy and directness, presentness, and mutuality (Farber, 1966). It is a full-bodied turning-toward-the-other, a surrender to, and trust of, the "between." The I-Thou relation is seen:

> ... not as dimension of the self but as the existential and ontological reality in which the self comes into being and through which it fulfills and authenticates itself. (Friedman, 1965a, p. xvii)

When two people surrender to the "between" - called "existential trust" - the possibility of I-Thou relation emerges. But it will always be a temporary state. Both will return to the world of I-It, necessarily. Existence in either mode is an evolving process in dynamic relation to the other mode. Each alternates as background for the other. The hallmark of creative and healthy living is finding the proper balance between these modes in one's life (Hycner, 1985).

Before I describe the implications for the practice of Gestalt therapy, I will describe how Buber's philosophy of dialogue meshes with the concepts of contact, awareness, and the paradoxical theory of change.

I-Thou and the Theory of Contacting

Essentially, the I-Thou relation, or dialogue can be seen as a specific form of the contacting process. Contacting is a process common to all organisms and all types of activity. I-Thou is a specific form of the contacting process between two people, through which each person realizes most fully their distinct humanity. For one's humanity is manifest only in dialogic relation to others. It emerges from, and requires, self-awareness, a uniquely human characteristic.

This specific form of contacting requires certain "elements of the interhuman" to be present for the dialogue to inhere (Buber, 1965b). These elements, presence, genuine and unreserved communication, inclusion and confirmation, will be described later in the paper.

Buber says of the I-Thou relation that it is lived in both "actuality and latency" (1970, p. 69).

This is important, because although most attention is given to the momentary experience of an I-Thou relation, I-Thou refers both to this special moment and to an underlying process. This distinction, while relatively unimportant to understanding the phenomenon and significance of IThou, is of particular importance to the practice of therapy, for much therapy is conducted in an I-It mode, with I-Thou in the background. Thus, while Buber makes no formal distinction between the two, I distinguish between the I-Thou moment, and the dialogic process.

Hycner (1985) prefers the term "dialogue" to describe and differentiate I-Thou process from the I-Thou moment. I worry that the term "dialogue" is used so commonly in our language that Buber's specific meaning may be ignored. But I agree with his need to differentiate the two uses of I-Thou, and his preference for de-emphasizing the "peak moment" in favor of a discussion of on-going process. So I too shall use the term dialogue.

In the prologue to I and Thou, Kaufmann asserts that there are many modes of I-Thou (1970), p. 16). The writing in Buber's I and Thou focuses largely on the most intense and exalted moment of I-Thou (Kaufmann, 1970). But some of his later writings, particularly on education, pay more attention to the process - to the variations where It and Thou are intermingled (Buber, 1965a, 1965b).

A teacher whose students are the means for gratification but who also cherishes the unique development of each pupil engages in I-Thou relation. One who asks directions of another with the genuine courtesy that comes from appreciation of personhood has permeated means with I-Thou relation (Kaufmann, 1970). When one is used as a means, with full respect and appreciation that one is an end also, then there is I-Thou (Kaufmann, 1970).

I-Thou Moment

The I-Thou moment is a special moment of insight or illumination wherein the participants confirm each other in their unique being. Such moments occur at various times during genuine dialogue, and are often culminating points of the dialogic process. The I-Thou moment is the most intense moment of what Polster and Polster (1973) call a contact episode. Any experience of an I-Thou moment is a confirmation of the possibility of integration and wholeness, a confirmation of the healing process by which one can restore one's relation to the world.

Sometimes this moment of illumination occurs between a therapist and patient who engage so unreservedly with each other that the essential being of both persons is touched. In Gestalt terms, such a completed contact episode is the realization of the Gestalt formation process within the special context of what Buber calls an interhuman event. A clinical vignette from my own experience will illustrate this:

> The patient was argumentative and critical. She claimed to be desperate for help, but disparaged my attempts to understand her and to be helpful. I tended to react with unaware defensiveness by taking a particularly superior, authoritative stance toward her. The meeting -- the momentary I-Thou -- occurred after I realized that I was defensive, and decided to be more attentive to my own defensiveness.
>
> The next hour, I found myself again reacting defensively. I began to

> "disclose" this to the patient, while still operating from my defensive, authoritative stance. Suddenly I realized that at that moment I was still protecting myself by pushing against the patient. I brightened and exclaimed, "See! Oh my, I'm doing it right now! Damn it, E---, you are just too good. I give up!" I began laughing at my own absurd attempts to coerce the patient. The patient, surprised, also laughed heartily. She admitted she was very good at what she was doing, and enjoyed it, although she always left feeling bitter and dissatisfied. What ensued was our first authentically cooperative exchange of ideas. Both of us had gained a renewed respect for the anxieties that had driven us into defensive styles at the expense of presence with each other.

In the above example, the contact episode moved into an I-Thou moment. This was possible because in an instant of immediate, spontaneous awareness, I experienced a full acceptance of our being-in-situation, that is, my own and the patient's defensiveness. This acceptance, and then the patients's willingness to be affected and to respond with her acceptance, allowed both of us to be who we were, fully.

There is another way the I-Thou moment enters therapy, and that is when the patient's saying "Thou" to the therapist frees the therapist to enter I-Thou relation. The strand of Gestalt therapy which emphasizes encounter between patient and therapist encourages such moments. For me, these moments often happen when I am stuck in my own defensiveness or frustration, and the patient recognizes this and points out what is happening, with the attitude of, "It's too bad we've gotten so messed up here. What can we do?"

Once recently a patient said to me, "I can tell when you are on your guard with me. You become sarcastic. Have I done something that pushed on you just now?"

I felt relieved to be able to pull back for a moment. I realized I had felt pressured by her conflicting messages to me, and was trying to coerce her into being more straightforward so that I would not feel pressured.

As Poister and Polster (1973) said when talking of contact episodes,these moments "endow the therapy with substance and drama." They are the critical moments that bring the whole process together, render it meaningful, and release the possibilities for its participants.

Farber's idea that the I-It "ego functions" provide grounding for the I-Thou moment parallels the Gestalt therapy view that the directed and willful actions of the middle state of contact are important for the successful resolution of a contact episode (Farber, 1966; Perls et al., 1951, p. 402). This usage does some injustice to Buber's concept of I-Thou, in that not all contact episodes are dia-logic episodes. Dialogic episodes involve the further "becoming" of two people. Contact episodes which involve, say, realizing one's hunger and satisfying it appropriately, do not involve the development of one's person, and so are not dialogic processes. But the references to I-Thou can be seen as an attempt to capture the flavor of this particular moment of contact:

> The lively goal is the figure and is in touch. All deliberateness is relaxed and there is a unitary action of perception, motion and feeling. The awareness is at its brightest, in the figure of the You. (Perls et al 1951, p. 402)

The I-Thou moment has some of the terrors of the impasse. There is a danger of symbolic death. In the impasse this occurs as one gives up one's self-image in order to contact one's emergent sense of self. In the moment of I-Thou, the danger is that one's boundaries will permanently dissolve. There is a softening of one's boundaries, and sometimes the intensity of the moment feels explosive. But both Buber and Gestalt therapy assert the faith that surrender to the experience will take one through symbolic death into symbolic rebirth (Brown, 1977; Farber, 1966).

In Gestalt therapy, contact has the polarities of isolation and of confluence. The danger in meeting is confluence. The risk of moving toward contactful engagement is that one will become engulfed by union with the other. In addition to this fear of being entrapped in confluence is the fear that after the compelling, rending intensity is over, one's loneliness and isolation will be even greater than before. A person who has settled for the ,'security" of isolation fears dialogue as a disruption of this state. For such a person,

> The I-Thou relation is not an unqualified good. In its lack of measure, continuity and order it threatens to be destructive of life. The moments of the Thou are "strange lyric and dramatic episodes, seductive and magical, but tearing us away to dangerous extremes, loosening the well-tried context, leaving more questions than satisfaction behind them shattering security." (Friedman, 1976b, p. 60)

Farber (1966) points out that the more alienated one is, the less one can rejoice in either I-It or I-Thou (p. 148). When split off from the I-Thou realm, the I-It world is impoverished, lonely, and so divorced from its dynamic relation to I-Thou that it provides no support for entering into dialogic relation. The danger becomes that a moment's grace in dialogue will leave one all the more profoundly lonely when the moment is gone. Farber points to the most obvious and painful example of the schizophrenic, who has no continuity and order and cannot assimilate the "lyric and drama" of I-Thou. These intense moments tend to send such a patient into further retreat, further isolation, and further despair.

Thus, the two dangers of isolation and confluence await on either side of the I-Thou moment, the moment of fullest contact of one being with another. The problem is that contact cannot be made static. The boundaries of self and other shift, and there is mutual influence which cannot be predicted. If one wanders too far too long, one is in danger of becoming so far removed as to lose sight of the way back. Or one's boundaries may disappear in the merging with the other, or may explode from intensity. One can never know the balance in advance, but following it allows one to live fully in the present, and to come to know one's own possibilities.

The importance of contacting for one's identity as a human being - what makes it so compelling and also so complex - is the way it is different from contacting among all organisms. The interhuman contacting process is the process by which we come to know ourselves and others,to apprehend our human existence and that of others. From Buber's perspective, contacting takes on importance not only for organismic self-regulation, but also for our specifically human ontology.

All individuals have an urge toward growth. In Gestalt therapy this is described, under holism, as the "press for closure" whenever Gestalten form. When a contact episode is begun, the individual is motivated to finish the episode in the most growth-producing manner, given the current conditions of the organism-environment field (Perls et al., 1951). 1 think this same principle motivates the individual toward dialogue. The contacting that occurs within the dialogic relation involves more of

the being of the person than does any other kind of contact. The I-Thou moment is a moment in which we are totally absorbed with another, which paradoxically puts us profoundly in contact with our humanity, with the knowledge of being; in this moment the meaning of human existence is revealed.

Dialogue establishes the ontological significance of contacting. Contact is the means by which we feed ourselves, by which we understand, orient, and meet our needs, but cast in the light of I-Thou, contact also stands at the ontic center of the psychological and spiritual development unique to our human exis-tence. For Buber stressed over and over again that only through dialogical relation can one come to know the uniquely human aspects of one's self (Friedman, 1976a), and that genuine dialogue between persons is most central to realizing the full potential of the person (Friedman, 1976b, p.61).

I think that many Gestalt therapists operate from an appreciation of the ontic significance of contacting, and in fact most of the clinical - as opposed to theoretical - literature on contacting focuses on contact as it occurs between persons (Latner, 1973; Polster and Poister, 1973, 1976). Compare the following quotation from Polster and Polster with Buber's statement that the moment of "meeting" in the dialogic process is "ontologically complete" in simultaneously knowing and being known by the other, and that in such a moment the "inmost possibilities" of the person are released (1965b, p. 71):

> Contact is not just togetherness or joining. It can only happen between separate beings, always requiring independence and always risking capture in the union. At the moment of union, one's fullest sense of his person is swept along into a new creation. I am no longer only me, but me and thee make we. Although me and thee become we in name only, through this naming we gamble with the dissolution of either me or thee. Unless I am experienced in knowing full contact, when I meet you full-eyed, full- bodied, and full-minded, you may become irresistible and engulfing. In contacting you, I wager my independent existence, but only through the contact function can the realization of identities fully develop. (Polster and Polster, 1973, P.99)*

The dialogue that Buber describes is also a transcendental process. Thus, when contacting is in the form of dialogue, the contacting process becomes itself an evolving, spiraling developmental process. For Buber this development toward the higher reaches of existence was a product of his basic trust in the sphere of the "between." He had faith in the dialogic relation as it developed and deepened. In the language of Gestalt therapy theory, as the contact process unfolds, one must have faith in one's "coming solutions" if the contacting process is going to resolve itself well. In both cases there is a surrender to

* Both Erving and Miriam Polster are widely regarded as model "dialogical" therapists. But in their writings they refer to "contact" to describe the existential patient-therapist relationship. in fact, some of the surge of interest in dialogue in Gestalt therapy can probably be traced most directly to the influence of their book, Gestalt Therapy Integrated (1973) which deals extensively with contact issues. Interestingly, a later article of theirs (1976) refers only to contact: awareness is not mentioned at all. the forming moment, rather than an attempt to control what will happen next. When the contact

episode is an interhuman event, then trust in one's "coming solutions" translates into trust in the between. Contact with another person involves entering into dialogue without controlling the other half of the dialogue.

In sum, in Gestalt theory, the ontic importance of contact is stressed by some authors, such as the Polsters. Buber emphasizes even more that the specific form of contact - dialogue - becomes the ground of selfrealization. In Buber's view, contacting stands at the center of development, from psychological to spiritual. And for human beings, the raison d'etre of contact is that it takes one beyond mere survival into the realm of one's humanity.

I-Thou, Awareness, and the Paradox of Change

Buber says that dialogic relation unifies one's soul and makes one whole (Friedman, 1976b, p. 97), whereas in Gestalt therapy, wholeness comes through awareness (Latner, 1973, p. 55). Actually, Perls, Hefferline and Goodman stress contact, with awareness as a subset, but for many Gestalt practitioners awareness has become a major focus, while contact has receded into the background. For me, all three positions are intimately related. Contact, dialogue as a specific form of contacting, and awareness are all compatible aspects of a single whole when Gestalt therapy's phenomenological approach to awareness is taken into account.

Hycner (1985), believes that a dialogical Gestalt therapy would not take awareness as a goal, but rather the restoration of full dialogue. Yet he also admits that one cannot aim at dialogue. I agree one cannot aim. In fact, having the restoration of dialogue as the goal of therapy goes counter to the dialogic position that the patient is the only one who can choose his or her existence. I hope to show that a focus on dialogue does not change the Gestalt therapy emphasis on awareness as the goal of therapy when the ontic implications of awareness are fully understood. For the awareness process which Gestalt therapy posits is a full-bodied "turning-toward" existence which by implication is a precondition of dialogue.

For Perls (1975b):

> The criterion of a successful treatment is: the achievement of that amount of integration which facilitates its further development. (p.53)

Yontef (1976), defines integrative awareness in Gestalt therapy:

> (Awareness) is the process of being in vigilant contact with the most important element in the individual/environment field with full sensorimotor, emotional, cognitive, and energetic support.
>
> Awareness allows one to respond to a given situation in a fashion appropriate to one's needs and to the possibilities of the situation. Awareness is integrative. When one is aware, one does not alienate aspects of one's existence; one is whole. (p.67)

In order to experience this integration or wholeness, one must not stand in judgment of one's experiencing process, must not discount or alienate aspects of oneself. The phenomenological approach in Gestalt therapy provides the discipline for this kind of awareness(Yontef, 1976). In the phenomenological approach therapists and patients bracket off, or put aside, their preconceptions about what experiences are relevant, and allow their sensory processes to discover whatever is

revealed by the self and the situation (Yontef, 1976).

This phenomenological attitude implies acceptance. Patients who can accept themselves will have no need to judge and deny their experience. In the therapy relationship, the therapist's acceptance seems to open for patients the possibility of self-acceptance, and this permits patients to deepen their own awareness.

> Our deepest, most profound stirrings of self-appreciation, self-love and self-knowledge surface in the presence of the person whom we experience as totally accepting. (Zinker, 1975, p. 60)

From the stance of the phenomenological attitude, one moves along the awareness continuum into the integrative moment of awareness, much as I-It experience can spill over into an I-Thou moment.

Polster and Polster (1976) describe well the faith Gestalt therapists have that integration evolves from the process of following the awareness continuum of both patient and therapist:

> When the therapist is absorbed with what is current, and brings the patient's attention to current experience, a resuscitative process is started which brings liveliness to very simple events....
>
> Amplification of experience emerges organically when one pays attention to what is already happening. One of the great recognitions of Gestalt therapy is that attending to one's own personal experience from moment to moment mobilizes the individual into a growth of sensation and an urgency for personal expression. As this momentum gathers greater amplitude from each moment to the next, it impels the person to say or do what he must. This progression leads to closure; to the completion of a unit of experience.
> With closure comes a sense of clarity, as well as an absorption in fresh developments without the preoccupation which unfinished situations call forth. (p. 260)

When a person's awareness evolves from this ground of the phenomenological attitude, then the characteristics of dialogic process are present. The awareness changes and transcends itself (Yontef, 1976), just as the dialogic process does. More important, in the bracketing off process, one allows for directness and mutuality inherent in dialogue by not putting one's categories between oneself and the situation. The situation can affect one however it will. And finally, one's whole person is involved; one is fully present. Thus it could be argued that the full awareness which Gestalt therapy values is an expression of dialogic relation.

The acceptance of the phenomenological attitude is not required of just the patient. In order to foster the patient's awareness, the therapist must also share in the phenomenological attitude. Beisser's (1970) suggestion for the therapist's stance in the "paradox of change" implies the acceptance inherent in the phenomenological attitude. Beisser asserts that the therapist must take the patient where the patient is. He expresses faith that if one invests oneself fully where one is, then one will change just because all living is a process. The Polsters (1976) say that a therapist believes in two axioms: what is, is, and one moment flows into the next. The acceptance that Buber describes in the I-Thou relation - "acknowledgment" - includes this faith in the process.

A true apprehension of the dialogic attitude advocated by Buber provides a grounding for therapists who wish to operate according to Beisser's paradigm. If therapists function from the perspective of I-Thou, then they have no desire to "change" patients, only to understand their existence and to "meet" them. They will not be seduced into becoming a coercive change agent confronted by a helpless patient. They will be free simply to be with the patient as person-in-conflict. Dialogue provides therapists with support for following Beisser's paradigm of the paradoxical theory of change.

In sum, change occurs with supported awareness of what is. The awareness comes by investing oneself in one's present experience, with no demands to change and no judgments that it should not be as it is. The acceptance of the I-Thou relation permits a deepening of awareness, and is itself an embodiment of the prerequisite for change, which is acceptance of what is. In this way, awareness and the I-Thou relation are integrally related.

Dialogue in The Therapy Process

I have suggested that the basic contact and awareness processes are preconditions for dialogue; also, that the dialogue is a specific form of the contacting process concerned with the illumination of interhuman becoming. The dialogic relation serves as an interpersonal model of the phenomenological approach to awareness valued in Gestalt therapy. Now I shall attempt to integrate these implications into the practice of Gestalt therapy by discussing dialogic relation (I-Thou process), and the dialogic attitude (I-Thou attitude) in the practice of Gestalt therapy.

Dialogic Relation

As I mentioned earlier, Buber asserts that for dialogue to occur, certain "elements of the interhuman" must be present (Buber, 1965b). The elements of what Buber calls "genuine dialogue" - the I-Thou process as it occurs between human beings - are (1) presence, (2) genuine and unreserved communication, and (3) inclusion. In therapy, these conditions become the prerequisites for dialogic patient-therapist relationship. Each element will be discussed below in terms of its application to Gestalt therapy.

Presence

The most basic element, and the most difficult, is presence, as opposed to seeming. One is present when one does not try to influence the other to see oneself only according to one's self image. While no one is free of pretense - the desire to be seen in a certain way presence must predominate in genuine dialogue. For instance, a therapist must give up, among other things, the desire to be validated as a "good therapist" by the patient. When a therapist "heals" primarily in order to be appreciated as a healer, then the dialogic process is interrupted. The other has become an object, a means only, not an end also. Therapists' love for healing must be "uninvested," must not occur only to suit their needs for a certain self -image.

Presence cannot be legislated. But the resistance to it can be examined. Buber and Gestalt therapy value authenticity and encourage both patient and therapist to be in touch with each other's personhood.

In a therapy where contact is seen as a major organ of personality,

> the personhood of the therapist is given central importance in the creation of behavioral change . . . What is more crucial than [a listing] of desirable characteristics is the unavoidable fact that, social designations aside, the therapist is, after all, a human being. As one, he or she affects one. (Polster and Polster, 1976, pp. 267-268)

If "seeming" rather than presence predominates, then only poor-quality contact is possible. Where presence is difficult, many Gestalt therapists take the time to explore what their difficulty is, in order to foster greater ability to be present.

For instance, when I become defensive, I assume a self-protective posture of superiority. My therapy has improved as I have learned to recognize early my defensive feelings, and at minimum I can make contact with my patient around that issue.

Presence involves bringing the fullness of oneself to the interaction. Therapists must be willing to allow themselves to be touched and moved by the patient. The Gestalt therapist also tends to use the full range of emotions and behaviors. Eye contact, physical touching, and movement all bespeak of one's presence.

Being present also means being willing to be both powerful and powerless. A therapist can be a powerful healing influence. At crucial times the loving attitude of the therapist seems to provide an experience of grace for the patient. But ultimately the therapist is powerless to change the patient, and sometimes the pain of wanting to make the patient's life better but being powerless to do so is keenly felt. The therapist who is present brings this pain too to the meeting.

Genuine and Unreserved Communication

A corollary of this principle of presence is the requirement that one's participation in the dialogue be genuine and unreserved. By "unreserved," Buber did not mean to say that all that occurs to someone must be said. Words that are impulsively spoken but are not relevant to the task at hand can serve to obscure genuine dialogue. What must be "unreserved" is the person's willingness to be honestly involved, and to say what one believes will serve to create conditions for dialogue, or further the ongoing dialogue, even if one is fearful of how they will be received. Unreserved communication does not preclude silence, but the silence must be a genuine responding and not based on protecting oneself or the other from one's self-expression. One must assume willing responsibility for the unreserved expression of that which occurs to one in the process of the dialogue.

In Gestalt therapy, unreserved communication, stemming from the therapist's authentic presence, conforms to the special circumstances of the therapy relationship. The need for unreserved communication is not a license for impulsive behavior; communications must be relevant to the task at hand. For instance, Laura Perls and Walter Kempler differ greatly in the respective weights they place on the existential encounter in therapy, but both agree that unreserved communication must be related to the task of therapy. L. Perls states:

> I share verbally only as much of my awareness as will enable the patient to take the next step [in awareness] on his own, and lend him support for taking a risk in the context of his actual present malfunction . . . I will describe some problems and experiences from my own life or from other patients if I expect this to give support to

> this particular patient for a fuller realization of his own position and potentialities. In other words, only if it will help him take the next step. (L. Perls, 1970, p. 127)

The self-expression described by L. Perls is a kind of sharing of the contents of lives, a telling about oneself. Kempler uses another, more immediate kind of selfexpression. He often responds to the patient with a direct reaction based on how he feels with the client at the moment. He and others refer to this as an "existential encounter." He values spontaneity and immediacy of interaction, but also within the context of the task:

> Nor does full self-expression mean saying everything that comes into the therapist's mind. Full personal expression is not without judgment. The therapist is urged to say everything on his mind that he expects to be of value or that would diminish his ability to participate if he withheld it. (1973, p. 271) (Italics mine)

The last part of Kempler's statement is crucial: Therapists must say those things which would diminish their participation were they to be withheld. Therapists cannot always know whether their expression will allow the patient to take the next step. But they can know what they need to do in order to remain available for contact. That is a responsibility of anyone who engages in genuine dialogue, of anyone who presumes to take the other as a Thou.

Kempler's statement is also a warning against the abuses of self-disclosure that have been common in the practice of Gestalt therapy. Therapists often tend to say whatever comes to their minds, assuming that their stream of associations must have something to do with what is transpiring, and therefore must be valuable. What occurs to one is related, if only peripherally, to what is transpiring. But the expression of it may or may not further the dialogue or the therapeutic task. The self-disclosure which results from serving the task of therapy by either furthering the dialogue (as Buber might say) or permitting the next step in awareness (as L. Perls might say) opens the way for a deepening of the experience of the participants.

With "presence" and with genuine and unreserved communication, the therapist's role becomes wideranging, limited only by creativity and personal style, and the therapeutic task itself. Gestalt therapists do not confine themselves to a limited range of responses so that a transference can develop, as in the more traditional psychodynamic therapies. They are free to laugh and cry, to dance, yell, or sit quietly. They are free to be fully present with the patient in ways that suit their style, serve the dialogic relation, reflect the temper of the moment, and further the therapeutic task.

Gestalt therapy expects that by being present, and by communicating genuinely, the therapist will influence the patient. The artistry is in balancing one's presence in relation to the needs of the patient. Standing back is as antithetical to "healing through meeting" as is being overbearing (Perls, 1973, p. 105).

At some point in the interaction of patient and therapist, even in traditional therapies, what is demanded of the therapist is to:

> Step forth out of his protected professional superiority into the elementary situation between one who asks and one who is asked. The abyss in the patient calls to the abyss, the real, unprotected self, in the doctor and not to his confidently functioning security of action.

> The analyst returns from this paradox ... as one for whom the necessity has opened of a genuine personal meeting between the one in need of help and the helper. (Friedman, 1976b, p. 190)

This paradox, that healing through meeting exposes what is possibly unhealed in the self, is only one of many paradoxes of therapy, but is a particularly anxiety-ridden one for therapist and patient alike. It is also crucial in a meeting which heals in genuine dialogic manner.

Inclusion and Confirmation

Buber defines "inclusion" in therapy in this way:

> The therapist must feel the other side, the patient's side of the relationship, as a bodily touch to know how the patient feels it. (1967, p. 173)

It is a concrete imagining of the reality of the other, in oneself, while still retaining one's own self -identity.

In dialogue, there is a special insight or illumination in the personally experienced confirmation of oneself by another. Confirmation means that one is apprehended and acknowledged in one's whole being (Buber, 1965b). The act of confirmation requires that one enter into the phenomenological world of the other without judgment, while still knowing one's own being. In the peak I-Thou moment, the underlying process culminates and spills over into the peak moment, which:

> ... is ontologically complete only when the other knows that he is made present by me in his self and when this knowledge induces the process of his inmost selfbecoming. For the inmost growth of the self is not accomplished, as people like to suppose today, in man's relation to himself, but in the relation between the one and the other, between men, that is, preeminently in the mutuality of the making present -- in the making present of another self and in the knowledge that one is made present in his own self by the other -- together with the mutuality of acceptance, of affirmation and confirmation. (Buber, 1965b, p. 71)

Both Buber and Maurice Friedman believed that Carl Rogers exemplified the practice of inclusion in his approach to therapy (Buber, 1965b; Friedman, 1976a). In a public dialogue with Buber, Rogers described what might be called inclusion:

> I think that in those moments I am able to sense with a good deal of clarity the way his experience seems to him, really viewing it from within him, and yet without losing my own personhood or separateness in that. (quoted in Buber, 1965b, p. 170)

Both Buber and Rogers appear to focus on what the patient is experiencing, whereas Gestalt therapy tends to focus on the experiencing process, or how one is experiencing. (This is especially evident to me in the oral tradition.) I think this difference stems from the Gestalt therapy emphasis on the awareness process. What Gestalt therapy has, which neither Rogers nor Buber had, is a

technology for increasing awareness. The assumption is that patients can learn to deal with what they are experiencing, if they can learn how they experience, and how they interfere with their own experience. Erving Polster (1975) describes this emphasis:

> The first step, therefore, is for the therapist himself to meet the patient in a face-to-face encounter where authenticity of expression and communication are primary.
> The basic psychological function involved is for the individual to meet otherness through his senses and his actions, much as this function is reflected in Buber's writings about I-Thou interaction. Secondly, although for the therapist to be authentic is basic, it is hardly enough. The patient is really behaving in self-defeating ways, and the therapist must give specific attention to the characteristic ways barriers to contact are set up. (pp. 156-157)

I think Buber was over-balanced on the side of inclusion. He made occasional statements to the effect that a therapist could not operate without techniques (Buber, 1967, p. 164) or without attention to the patient's defensive structure (Friedman, 1976b, p. 90), but he really did not seem to value that part of the healing process. His major attention was of "healing through meeting" (Friedman, 1976a). The necessary ground for meeting is inclusion.

But the capacity for dialogue and the healing effects of dialogue are inaccessible to the patient whose defensive structures prohibit entering into dialogue (Friedman, 1976a). The practice of inclusion, while an absolutely necessary starting point, may not be enough. Patients can be assisted in their attempts to enter dialogue by increasing awareness of their defensive structures.

On the other hand, I also think that Gestalt therapy is over-balanced on the side of attention to the awareness process. The experience of being "made present," or included, in the eyes of another, has powerful healing potential in and of itself. Over the years I have noticed a shift in the practice of Gestalt therapists in relation to inclusion. There is an increasing appreciation of the value of the interpersonal event of inclusion as the starting point for dialogue in therapy. It is also an event which can contribute powerfully to restoring a derailed selfregulating process.

Buber (1970) says that the therapist:

> Must stand not only at his own pole of the bipolar relationship but also at the other pole, experiencing the effects of his own actions. (p. 179)

This part of inclusion is well respected in Gestalt therapy. In his later years Perls wrote:

> If the therapist withholds himself, in empathy, he deprives the field of its main instrument, his intuition and sensitivity to the patient's ongoing processes.... He must have a relational awareness of the total situation, he must have contact with the total field -- both his own needs and his reactions to the patient's manipulations and the patient's needs and reactions to the therapist. And he must feel free to express them. (1973, p. 105)

Gestalt therapists tend to be highly attuned to the effects of their actions on their patients, and to respond sensitively; this is particularly true of those therapists who stress contact. But even

these therapists have tended to neglect the other part of inclusion: the willingness to enter into the patient's phenomenological world (Erving Polster, personal communication). An example drawn from my experience as a patient:

> One day I was painting a bleak picture of humanity, and especially of myself. I felt that any "decent" impulse or deed was fraudulent, a lie because I had also been "indecent," and this betrayed my true self. My therapist attempted to demonstrate to me how my thinking/valuing process was confused, "double-binding." I finally said, "Hey,I just want to be heard. I want you to practice inclusion." (He was also reading Buber at the time.) I was both frustrated and despairing. My therapist began to listen, but in a half-hearted manner. I complained that he wasn't really listening, and he blurted out, "I don't want to really practice inclusion." His eyes brimmed with tears as he said, "It's a very sad and tormented experience." Seeing his tears, knowing that he had tasted some of my present existence, caused a felt shift of experience in me. I felt momentarily at peace and whole, and was able to leave the bleak picture behind and move on.

The practice of inclusion in this case was almost like a healing touch.

I do not advocate that Gestalt therapy reorient itself altogether by focusing totally on inclusion (like Rogers used to do), but I do think that more attention to and practice of inclusion would be helpful. I think that a lack of spontaneous inclusion is an interruption of the dialogic relation and only attention to inclusion can restore the dialogic relation in this case.

A word must be said about the relation between inclusion and confirmation, and the confrontation and frustration that are so often a part of the Gestalt therapy process. Buber said that confrontation is not antithetical to a dialogic relation, and that, in fact, sometimes a relation requires confrontation (Buber, 1965a).

But some of Buber's ideas about confrontation stem from a view of human nature which is at odds with Gestalt therapy's view of organismic self-regulation. Steeped in the Old Testament, he had a polar view of good and evil which does fit quite nicely with Gestalt therapy (Hycner, personal communication). But his view of the dynamic relation between the two seems also to have been informed by traditional drive theory of psychoanalysis, with which he was quite familiar. Buber talks of the necessity to do battle with the patient's defenses, as if defenses are merely impediments to dialogue, as I have described above. From the vantage point of holism, defenses are better seen as attempts to forge any kind of relationship under difficult field conditions. The defenses are a part of the whole, aspects of the patient's self-regulating system to be contacted and revitalized, not cast aside.

I believe it is this same difference in views of human nature that leads Buber and Friedman to distinguish so firmly between acceptance and confirmation. Friedman insists that the difference between mere acceptance and confirmation is that confirmation emphasizes that the patient is being affirmed for what he or she will become, even if in there present state they engage in myriad defensive, devitalizing behaviors.

> Everything is changed in real meeting. Confirmation can be misunderstood as static. I meet another - I accept and confirm him as

> he now is. But confirming a person as he is is only the first step. Confirmation does not mean that I take his appearance at this moment as being the person I want to confirm. I must take the person in his dynamic existence, in his specific potentiality. In the present lies hidden what can become.(1985, p.135)

Friedman later states that Rogers and Buber disagree about the difference between accepting and confirming. Rogers equates the two, saying when one feels accepted, and through that lowers ones defensive barriers,

> the forward-moving processes of life take over. It is precisely this assumption -- that the processes of life will always be forward-moving -- that Buber questions.

I believe that Gestalt therapy is much closer to Rogers on this point than to Buber. There is no need to appeal to the ineffable "future becoming" of the patient. As you genuinely meet him or her now, you are meeting someone who is living/changing.

At any rate, Gestalt therapists do tend to confront and frustrate those behaviors which turn the patient away from experiencing the present moment. But when the therapist is entering into the patient's world as fully as the act of inclusion requires, I think the style and the attitude of confrontation is affected. For instance, the old notion of "bear-trapping" must be cast aside. That was a pejorative idea, most likely stemming from the therapist's frustration. When the therapist can see the patient's world from the patient's perspective, then there is not so much manipulation as there is a conflict between desire and fear.

Patients use manipulative behaviors when they do not have faith in their own processes of self-regulation. But "manipulation" is a term that arises when therapists focus on the way the patient's behavior is impacting them. Seen from the point of view of the patient, the behavior might be described as a frightened attempt to get a need met. Both points of view are valid. By practicing inclusion - by entering the patient's world - therapists might find themselves commenting on the need/fear dilemma that is being enacted instead of confronting the behavior itself. Or the confrontation will be suffused with the understanding acceptance one has gained through practicing inclusion.

For me, the notion of inclusion has made me less confrontive than before, despite Buber's insistence that the confirmation which emerges from inclusion sometimes requires doing battle with the patient. His belief in the necessity for battle is based on his erroneous - I believe -view of human nature.

At times practicing inclusion while also confronting requires patience and confidence in the elasticity of one's own boundaries. I may not like what a patient is doing. I may even be angry. But I try to keep these feelings against the background of the overall dialogic attitude that I am maintaining. This dialogic attitude is often not communicated in words, really; it develops over time, and is more often sustained by nonverbal behavior or by tone of voice than by any words spoken. In a few instances recently, when I confronted patients,I could really feel my ability to be with the patients in my anger, and still be open and receptive to them. The vibrancy of the meetings was remarkable. This was very different from times when I have set limits out of my own frustration, been psychologically cut off from the patients' experiences, and wanted them to do something to make me feel better.

Dialogic Attitude

Buber holds that the dialogic attitude is the requisite stance for anyone who would be an educator or therapist (1970). The dialogic attitude of the therapist is different from the dialogic relation of friendship: the dialogic attitude is assumed by the one -- teacher or therapist -- who is voluntarily engaged in furthering the learning of the other; and while the friendship is defined by fully mutual confirmation, the dialogic attitude of the therapist can be assumed independent of the inclinations of the patient.

When both persons assume a dialogic attitude,then the fully mutual dialogic relation can accrue; but one can appreciate another in dialogue without mutuality. One person, the therapist can be present and "imagine the reality" of the other. This is the dialogic attitude. The dialogic attitude is an expression of the latency of I-Thou; thus, the I-It phase, within the context of a dialogic attitude, is embedded in the process that permits the possibility of the I-Thou moment between the two people.

Buber is in agreement with most of the writing of psychotherapy that the position of the psychotherapist is a paradoxical one. A therapist must "live in confrontation yet be removed"; the therapist's responsibility is to genuinely meet another person -- nor it is in the meeting that healing occurs --and yet the therapist cannot attempt to coerce or require such meeting without violating the ground of the meeting by demanding that the patient change. For Buber, therapy is a change process, but the therapist always confirms the existence of the individual as is, first. Our position is even more radical, I think.

For if the therapist is only starting where the patient is in an effort to move the patient, then the therapist is not truly confirming the patient, the patient is not a Thou, and the life affirming potentials of the patient cannot be released.

Whenever the apprehension of the patient by the therapist moves from I-It to I-Thou, then the paradox becomes irrelevant and there is only the genuine communication of that moment. In Gestalt therapy, therapists maintain a dialogic attitude which allows them to attempt, as much as conditions will permit, to develop such a relationship. It is a delicate dance. The therapist remains "aggressively in the I-Thou" (Yontef, 1976, p. 183), with someone who has only limited ability to allow for an I-Thou moment, much less a mutual dialogic relationship.

Gestalt therapists do not demand that patients enter into such a relationship. They can only be present and authentic, and through the dialogic attitude refuse to forsake either their own "I" or the potential "I" of the other, while maintaining respect for the actuality of the other. Recall Enright's statement:

> ... the strategy is always to keep a steady gentle pressure toward the direct and responsible I-Thou orientation, keeping the focus of awareness of the difficulties the patients experience in doing this and helping them find their own way through these difficulties. (1975, p. 25)

Task as Thou

Buber points out that the dialogic attitude must be present within all therapists who work to

"heal through meeting" and release the potentialities of the patient. Therapists serve not only the patients whom they meet, but also the task which brings the meeting about. Be it healing, teaching, or developing, the task is crucial; it defines the relationship, and the therapist must have faith in the invaluable importance of the task in order to meet the patient without reservation in the context of the therapy relationship.

In effect, the Gestalt therapist maintains a dialogic attitude toward the task. In the I-Thou moment there is no intention, the attitude is simply part of the moment. But the dialogue flows between the momentary mutual confirmation and the period of I-It. In the period of I-It, the pressure of the paradoxical engagement tempts the therapist to abandon the dialogical attitude for a more coercive relationship.

The pressure comes from the need that arises in the therapist (or anyone) during an encounter: the wish to be confirmed by the other. To engage at the level of I-Thou without the demand that the other confirm one is the essence of the therapist's dialogic attitude.

The goal of Gestalt therapy is awareness. To serve it is to participate in the patient's discovery of his or her own way. Awareness in Gestalt therapy emerges at the boundary of the meeting "between" therapist and patient. It occurs within the context of the I-Thou relation, in the context of the alternating rhythms of I-Thou and I-It. It is the dilemma of the therapist that one encounters the patient with the attitude and involvement of
dialogue, yet does not seek to be confirmed through the direct human encounter. The therapist's confirmation comes through the expression of oneself in the service of the task. Friedman has suggested, and I agree, that while therapists do not seek confirmation from patients, they must be open to the possibility as inherent in the dialogical relation. In fact, the therapist is confirmed when a patient allows him or herself to receive help (1985, p. 19). Yet ultimately, the therapist's own self-acceptance, self-esteem, and faith in the "truth" of the task, in the liberation of both people that the task will allow, enables him or her to hold aside the wish to be confirmed by the other, and instead to be confirmed through knowing that the task is most creatively served in this way.

Taking the task as Thou requires this dialogic attitude: the therapist is confirmed by realizing the task, which includes the confirmation of the patient as Thou and the creativity of serving the task in relation to this unique other of the patient.

To illustrate this point, examine an example which Yontef presents:

> Techniques arise out of the dialogue between I-Thou and the I-Thou sometimes requires a technological intervention. Example: Patient talks without looking at the therapist. The dialogue has been interrupted in that the patient talks, but to no one in particular. A real dialogue now would require a vigorous response by the therapist. Possibilities: 1. "You aren't looking at me," 2. "I feel left out," 3. "I suggest an experiment: Stop talking and just look at me and see what happens." (1976, p. 72)

Any number of responses to the situation are possible, and therapists will respond according to their style, feelings, and intuitive appreciation of the other at that moment. It is important that the response arise out of a dialogic attitude toward the patient, and that it attempt to serve the task of therapy.

For instance, the response,"I feel left out" -- here the therapist directly confronts the client. But the response is stated with an entirely undemanding authenticity, because the therapist offers the response as a creative involvement with the person and the task, and does not need for the patient to respond in any particular way, to take care of the therapist's "left out" feelings. The therapist need not and should not require I-Thou
reciprocity from the client; instead, the therapist is confirmed by having actively engaged with the patient in the service of the task, which is the highest fulfillment of his/her position as "helper," or one-who-is-asked.

The Place of Technique in Genuine Dialogue

Existential therapists typically frown on the use of technique as a reduction or objectification of the patient's being (Dublin, 1976). However, this attitude results in an unfortunate limitation of the therapeutic practice. A dialogic relationship is not limited to the interpersonal encounters in which the figure of interest is the relationship itself. Often, engagement with an external issue is the truest dialogic relation of the moment, for dialogue, like awareness, is grounded in the dominant interest of the person in that moment.

Buber appears not to have favored the use of technique, perhaps because of the infancy of psychotherapy at the time, he did not realize the implications for his own assertion that "without It a man cannot live" (Buber, 1970, p. 85).

The ego functions are impaired in neurosis, just as the peak moment of contact is impaired. The recovery of ego skills through awareness techniques makes the dialogic process a possibility in the patient's life. There are two types of awareness in Gestalt therapy: the integrative moment, and the awareness continuum or "attention to awareness." It is through this attention to awareness that corrections to the contacting process are often initiated.

Thus, when working on contact functions or on defenses, there is often a place for "I-It" in the therapy process. In a sense, when working on defenses the therapist is merely taking the patient exactly where he or she is -- in an I-It state -- and working to enable the patient to use his/her own awareness process to reclaim a more integrated state. Dublin provides an example:

> A young married male patient complains of "a deadened feeling . . . hardly any sensation" upon ejaculation. He does not use "I"; he has no complaint of himself, or of his wife; he complains of his penis as an "it," disclaiming any responsibility for its functioning ... [The therapist] asks the patient to split off his penis, and to dialogue with it. If the patient protests that this is silly, makes no sense, is not what he really wants, etc., the therapist points out that he (the patient) is already splitting it off, separating it from the rest of his personhood, and that he (the therapist) is only asking him to do so more thoroughly in order to experience more fully how he is doing so. As technique, this functional splitting off of the penis takes the form of an experiential dialogue between the person-minus-penis and the splitoff penis, the patient taking both roles experientially, verbally, and perhaps motorically. As is well known to experienced Gestalt therapists, the ultimate effect ... is not a further experiential distancing or alienation . . . but rather an experiential reclaiming or owning.

(1976, p. 132)

When working on contact functions the patient can gain skill in using It-mode functions to support deepening the dialogic process. A patient who can learn to allow his tone of voice to express emotion rather than always speaking in a deadpan manner will be freer in dialogues with others. The expressiveness may require practice and may initially even feel fraudulent; but by experimentation the patient finds his own appropriately expressive style (Polster and Polster, 1973, p. 239).

The important thing is that the awareness techniques emerge organically from the ongoing dialogue. When the timing is right for a patient to explore just how he interrupts himself, then an experiment based on what is transpiring in the therapy process is appropriate. Some techniques intensify and clarify current experience, such as when the patient exaggerates the tightening of the jaw. Other techniques focus on the evolving awareness process - - such as when the patient "brackets off" judgments, or allows body sensations to dictate body posture and movements. Still other techniques - such as role-playing polarities - may experiment with blocks in awareness, or alienated awareness.

A major caution is that in order to be operating from the context of the dialogic attitude, the therapist cannot expect any results from the experimentation. Possibly the most frequent misuse of techniques occurs because therapists are tempted to use them whenever they feel stymied. A technique becomes away to "make something happen," or to push the patient in a certain direction -- say, towards fuller expression -- in order to satisfy the therapist's frustration.

The experiments must be offered without investment in a particular result, but with investment in focusing on awareness, whatever the patient does. When experiments are offered with this attitude, the experimentation process becomes a model of the phenomenological approach to awareness. Goals and judgments are held aside, and attention is directed simply to what is happening.

In the therapy process there are times when the attention to awareness leads to evolving, transcending awareness, moving to the "Aha!" of integration. The art for the therapist is in knowing, by attending to and trusting what emerges, when to abandon directed, willful focus on awareness and simply be present for the patient. The integration that occurs is the existential trust (Buber, 1967): faith in one's self- regulation and in the process of dialogue. Much of the work in therapy is addressed to how patients interrupt contact and awareness to such an extent that they lose this faith.

Therapy as a Special Case of Dialogue

Buber describes the healing relationship of psychotherapy as a particular form of dialogic relation (1965b, 1970). He considers it a necessary tragedy of helping relationships that, unlike friendships, they cannot be fully mutual. (1965b, 1970). Buber contends that while a therapist may at certain moments experience full mutuality with the patient, therapy, by the nature of its task, involves a limited relationship. Returning to and expanding an earlier statement of Buber's:

> The therapist must feel the other side, the patient's side of the relationship, as a bodily touch to know how the patient feels it. If the patient could do this, there would be no need of therapy and no relationship. (1967, p. 173) (Italics mine)

It is possible that in order to make his point clearly, Buber exaggerated the difference between therapy and a more fully mutual dialogue. Certainly, some patients are capable of fully mutual inclusion with the therapist. But even these patients would not be serving their own best interests by engaging in a predominantly mutual therapy relationship. The task of therapy requires that the focus be primarily on the patient, not on the therapist.

Because of the nature of the task, the therapy relationship is limited. Buber describes the therapy relationship as a "one-sided inclusion" rather than mutual inclusion (1970). In one-sided inclusion, the helper strives to imagine the reality of the other, but the reverse does not ordinarily happen and is not intended. If the relationship is mutually inclusive, then it cannot be therapy. The essential difference between mutual inclusion and one-sided inclusion is not based on an assumption that the person of the therapist is different from the person of the patient. The difference comes from the fact that the task sets the two people in different relations to each other and to the task. The therapist has willingly set aside personal investments in order to serve the learning of the patient. Patients are invested in their own learning, not that of the therapist. At moments of the I-Thou relation, such role definitions are irrelevant, but the alternation between the phases of I-It and I-Thou (or the phases of a contact episode) occurs within the context of the onesided dialogic attitude. If a fully mutual dialogic relationship develops, then although the relationship will be therapeutic for both participants, the therapy contract no longer exists.

Buber's second point is that in therapy it is the responsibility of the therapist to meet the patient, and not vice versa (Buber, 1967). In a more fully mutual dialogue, each participant may be expected to assume responsibility for meeting the other. In therapy there is no such expectation. The therapist's willingness and receptivity to the sphere of "between" is the scaffolding against which the existential trust of the patient is formed.

Frederick and Laura Perls make similar assertions about the therapist's responsibility for the therapy itself.

> In these cases of "failures" I either lack the ability to show them convincingly the need for change and reorientation, or else I myself am insufficiently integrated to be aware of the crucial resistance. (F. Perls, 1975b, p. 59)
>
> As far as I am aware, I want my patients to get better. If they don't, then I have to search for what I have failed to become aware of or to make them aware of in the on-going relationship. (L. Perls, 1970,p.126)

Erving Polster (1975) suggests that it is up to the therapist to establish an interactive climate wherein good-quality contact is a possibility for the patient. Therapists do not impose the model of I-Thou on their patients (Yontef, 1975), but they retain the dialogic attitude themselves out of the belief that such an attitude is the means by which patients' potentialities are released. Because therapists are responsible for setting up the interactive climate for this release, sometimes they must at times initiate contact, extending themselves to meet a severely restricted patient where the patient is (Polster and Polster, 1976, p. 157).

This means that the requirements of the dialogue in therapy are different. The inclusion is one-sided, and confirmation is largely one-sided as well. The therapist confirms the patient, but not vice versa, except in rare moments. In essence, it becomes the therapist's responsibility to establish

the conditions for dialogue (Friedman, 1976a). The therapist must do everything possible to come fully to the relationship: be present, engage unreservedly in the dialogue, and perhaps most important, practice inclusion.

To this end, Hycner makes an interesting point about the personhood of the therapist. He asserts that therapist individuality is important only insofar as it serves the task. As Hycner (1985) says:

> In a genuine dialogical approach it seems to me that the therapist is a "steward of the dialogical." By this I mean that in a very profound sense, the individuality of the therapist is subsumed (at least momentarily) in the service of the dialogical, which is the entire therapeutic Gestalt and includes the individuals in it.... It assumes that genuine uniqueness arises out of genuine relations with others and the world. Individuality is but one pole within an overall rhythmic alternation between our individual separateness and our participation in something larger than us, i.e. "Being." (p. 33)

A special requirement of the therapy relationship is that the therapist must not only encourage the patient's self-becoming through the dialogic relation -- inclusion in particular -- but must also put "before the patient the claim of the world" (Friedman, 1976a, p. 201). This means that the therapist does not view the patient's individuation as something that can be achieved in isolation from real relationships in the real world.

The neurotic is one who has withdrawn from dialogue, and healing involves resumption of the dialogue in one's concrete daily existence (Friedman, 1976a). I suggest that through awareness work done within a dialogic context, we restore the possibility of dialogue. The patient's involvement at that point, is based on an aware choice to deepen dialogue or to turn away. I do not think a therapist can restore a mutual dialogue with the patient. A therapist can only work to meet the patient. The mutuality is a choice the patient must make. *

Finally, Buber's most important contribution to psychotherapy is his central tenet that in order to heal "the very roots of the patient's being," therapy must incorporate a genuine meeting, for it is through the dialogic relation that healing occurs (Buber, 1967, p. 169).

> The deciding reality is the therapist, not the methods. Without methods one is a dilettante. I am for methods, but just in order to use them, not to believe in them. Although no doctor can do without a typology, he knows that at a certain moment the incomparable person of the patient stands before the incomparable person of the doctor, he throws away as much of his typology as he can and accepts this unforeseeable thing that goes on between therapist and patient. (Buber, 1967, p. 165)

In Gestalt therapy, the typology used is that of contact and awareness, with attention to the patient's interference with these processes. We bring this typology and our intention toward a dialogic relationship when we begin to meet with the patient. At certain points the demands of the dialogue require that we abandon the typology, and it is at these moments, according to Buber, that the essential healing may occur (1970, p. 179).

*I am indebted here to a personal conversation with Maurice Friedman where he suggested that on a continuum of means, ends, means and ends, in sequential steps, perhaps the end of awareness in Gestalt therapy is a means to dialogue in the larger context of the person's life.

Summary and Implications

This paper reflects a trend toward greater emphasis on the patient-therapist relationship in the Gestalt therapy process. Gestalt therapy is increasingly aware not only that the relationship is an important curative factor, but also that the relationship should be specifically the genuine, loving meeting described by Buber as the dialogic relation. I have attempted to show that use of the I-Thou model is a fitting and logical extension of the Gestalt therapy focus on the contacting process, and that the dialogic relation is itself a vehicle for the restoration of awareness, which is the goal of Gestalt therapy.

The dialogic relation is a model of contacting lived out to its highest potential. The process of organismic self-regulation, as reflected in contacting and awareness, is itself involved in a developmental process: the development of one's uniquely human becoming. It is not enough to say that contact and awareness serve our biological and emotional needs. There appears to be a kind of ontological imperative, an urge toward growth, so that these processes operate at increasingly finer levels of complexity and abstraction from biology. Contact and awareness are not merely the processes that express the dynamic relation between stasis and growth; they are themselves spiraling developmental processes, always emerging and transcending. The epitome of their development is lived through in the dialogic relation.

The dialogic relation is also a model for the kind of therapeutic relationship that is consistent with the Gestalt theory of change. A therapist who operates from a dialogic orientation will establish a present-centered, nonjudgmental dialogue that allows the patient both to deepen awareness and to find contact with another person. The therapy becomes a chance for the patient's selfhood to unfold in the presence of another person.

In Gestalt therapy, awareness is used to restore awareness, and this restoration can be facilitated by establishing a dialogic context. In this context, contact can be used to restore contact. The therapist's meeting the patient in a dialogic relation becomes a model for the restoration of contact and awareness, and hence, the possibility for growth.

Gestalt therapy is considered a "growth discipline" (Latner, 1973; Polster and Poister, 1973). Healing and growth through the restoration of awareness are an expression of the transcendental possibilities of human existence. But the Gestalt therapy language of contact and awareness does not evoke Buber's sensitivity to the possibilities of wholeness. Whereas the concept of contact serves to ground Gestalt therapy in the natural biological rhythms of all organisms, I-Thou transforms contact into the realm of the uniquely human: the interhuman relationship and the development of oneself.

The most important therapeutic implication is that the therapy must take place within a dialogic relation if it is to be true to the ontic possibilities of contacting. Patients must be afforded the chance to meet another person if they are going to know themselves. Therapy composed solely of awareness techniques, without the contactful engagement of the therapist/person with the patient/person, limits the awareness possibilities for the patient and interrupts the becoming of both

people.

This is not to say that techniques should not be used. I agree with Poister (1975) that contact is not enough. Without also increasing patients' awareness of just how they avoid contact, the therapy runs the risk of becoming a "Dance of Orpheus"; patients will be able to respond, to engage, only when the therapist is present to initiate the contact. Awareness techniques teach patients how to correct their interrupted contacting. They are a powerful methodology. But the techniques must evolve organically from the dialogic process. In so doing they will reflect the next step in the patient's becoming.

Buber's paradigm of the dialogic relation offers the Gestalt therapist some concrete guideposts, as well as a kind of vision, for establishing with the patient a relationship that will be both conducive to the patient's growth and gratifying to the therapist. When one enters into dialogic relation, even in the sometimes unreciprocal relationship of therapy, one experiences the release of one's own potential as well as that of the patient. The practice of the art of therapy becomes not only an expression of one's being, but a step in one's becoming.

FOOTNOTES

1. The majority of this paper is taken from my doctoral dissertation, I-Thou Relation in Gestalt Therapy, California School of Professional Psychology, Los Angeles, 1978. See also Enright, 1975; Friedman, 1985; Hycner, 1985; Kempler, 1973; Naranjo, 1975; Yontef, 1975,1976; Zinker, 1975.

2. Both Erving and Miriam Polster are widely regarded as model "dialogical" therapists. But in their writings they refer to "contact" to describe the existential patient-therapist relationship. In fact, some of the surge of interest in dialogue in gestalt therapy can probably be traced most directly to the influence of their book, Gestalt Therapy Integrated (1973), which deals extensively with contact issues. Interestingly, a later article of theirs (1976), refers only to contact; awareness is not mentioned at all.

3. I am indebted here to a personal conversation with Maurice Friedman where he suggested that on a continuum of means, ends, means and ends, in sequential steps, perhaps the end of awareness in gestalt therapy is a means to dialog in the larger context of the person's life.

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