# Sydney Gestalt Institute, 2nd Year 2009: Relationship Essay

The relationship between the therapist and client is, according to Gestalt therapy, at the very heart of what is healing in the therapeutic encounter. The most efficacious type of relating, in this modality is called a dialogical relationship or therapeutic approach. A dialogical relationship is one in which the attitude and the intention is to meet “the other person as a person” with awareness and acceptance (Yontef, 1995). The experience of being seen and accepted in a fulsome way is, as we are increasingly finding out from both neuroscience and the social sciences, deeply healing (Yalom, 2005). As Zinker so beautifully puts it, “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 in Joyce & Sills, 2001)

Learning how to enhance the dialogical within a relationship is a delicate task for a budding new therapist. What is to be learnt can be listed and described, but putting this into practice is an ever-evolving process of human becoming. In a very gestalt irony, this means that my own journey of personal development is shared with my clients, making the client and I very much equal partners in the process of human growth, in practice as well as in essence. The following pages are a description of those qualities and attitudes which contribute to a dialogical approach as well as those that detract from it. Where possible I use examples from my own experience as client, student therapist and group member, to illustrate.

There are four key principles which Joyce and Sills identify as enhancing a dialogical therapeutic approach. These are “presence, inclusion, confirmation, and willingness for open communication” (Joyce and Sills, 2001). Other writers use slightly different categorizations or phrases - such as Yontef’s reference to a “commitment to dialogue” - but the majority seem to be referring to the same core concepts. The first of these, ‘presence’, points to something which is almost a numinous experience of human being-ness. In the book Grace Unfolding, this is captured for me in the opening description of the sage or master: “She is a welcoming presence who can allow for and embrace all being and nonbeing” (Johanson and Kurtz, 1991). Presence can perhaps be described then as what we are before we become distracted by our thoughts or enrolled in an identity; embodied awareness receptive to what *is* in each transitory moment. As Joyce and Sills explain, for most of us, most of the time, we achieve this experience by actively bracketing or letting go of our “concerns and strivings and allow (our self) to ‘be there’” (Joyce and Sills, 2001).

When I practice as a therapist, I notice that more energy is required for this bracketing in the initial minutes of a dialogue. I was very much aware of this the other day as I sat opposite C in a dyad. At first I was quite distracted by my internal monologue. My inner voice prattled on: ‘Is this acting like a therapist? Oh no, now I’m just being friendly, I should be more neutral…Oops I forgot to concentrate, what did she just say?’ and so on. My performance anxiety was acting as a kind of exit point from presence with C. Because of my anxiety I had gone into my head and my attention was at least partly tangled up there. One part of me, my underdog, was polarized wanting to be friendly because that was familiar and easy, and the other, my top dog, was

firmly issuing instructions about getting into the role of the therapist because this seems more professional. Since the space in between these polar ways of interacting is quite unfamiliar to me, I found it hard to bracket these competing expectations and voices and just be present with C.

In tracking my process I am able to see how I can use presence as a practical re-entry point into relationship. As I continued listening to C, I recall focusing my attention on how my body was feeling and from here was able to cycle into my emotional world, to notice C as she was, and then to sit with a more open sense of awareness. Now I was aware of the part of my self who was both affected by C and was available to be revealed to her, if that became appropriate. I noticed a sense of frustration, almost panic, which manifested as tightness in my chest, and a thought that went with this; 'I must find a solution to this'. I had a sense that this might be how C was feeling. I was also aware of how protective I felt towards her, empathy due in part due to the familiarity of her story. I also noticed how few feeling words she was using to describe her experience versus the growing intensity of my own feelings. I didn't have a chance to reveal these noticings because of the timing of the exercise, but had we explored any of these it is likely we would have moved into more dialogic relating. The learning for me is that focusing on my body sensations is one helpful way for me to become more present to another. Presence is also critical because it is a pre-condition for that most valuable tool, awareness. As this vignette shows, with presence I had a chance of being in contact with a whole world of information. As Yontef explains, awareness is "a form of experiencing…the process of being in contact…with full sensorimotor, emotional, cognitive and energetic support" (Yontef, 1995). This meant that instead of needing to avoid being impacted by C I could relax into it and it was helpful. Lee notes that this is one of the markers of the dialogical attitude; where "both patient and therapist are emotionally affected by and learn from the therapeutic interaction." (Lee and Wheeler, 2008)

Confirmation is the second principle which enhances the therapeutic relationship. It means providing the client with a lived experience "of being unconditionally accepted" - both the parts of themselves that are in awareness and "also what is alienated, deflected or out of awareness." (Joyce and Sills 2001) The contribution of the therapist is to assist another, through their way of relating, to become aware of themselves and to experience any and all parts of themselves as acceptable. I have had this experience with my therapist R very powerfully in the last few months. As I have brought more and more parts of myself into the relationship my experience has been that he has seen and acknowledged each of these, and continued to relate to me with warmth, care and interest. In one important session I spoke of how I had recently become lost in profound self-rejection, sharing my horror and what I have previously experienced as a deeply shameful part of my intrapsychic experience. In another series of interactions I brought a different part of me – that which is forthright, powerful and erudite and which in the past and in other relationships has overwhelmed others. In this instance I voiced concern about his approach to me as a therapist, and had the scary but exciting experience of him being able to remain in contact with me, managing whatever shame responses he may have been having, and in turn helping me to handle mine.

In this way confirmation is providing me with more and more ground for self awareness through new template experiences of self-revelation linked to acceptance. As Lynne Jacobs explains in The Voice of Shame, confirmation detoxifies or at least lessens our shame response and allows for the possibility of bringing “the most noxious aspects of our personality” as we see them into relationship with others (Lee and Wheeler, 2008). The attitude of confirmation by the therapist is particularly important because they are in a position of power. The therapeutic environment is in some ways a place of “last resort” for revealing our innermost self and to be rejected is in some sense to be given the message that we are “beyond the pale” and “unfit for human company” (Lee and Wheeler, 2008). By providing confirmation instead of rejection “the (client) establishes friendliness with all the polarized forces within himself and begins to experience his wholeness” (Zinker, 1978). As my therapist R responded to my dissatisfaction with curiosity, horizontalism and stayed stable and accepting of himself as a ‘good enough therapist’ I reflected that perhaps I too am good enough, even if I do not always satisfy others in the way that they hope or expect. I was able to explore my dissatisfaction and imbibe a new perspective or introject. In this way the interpersonal experiences with R have started to engender intrapsychic mirroring responses in me in which I am able to begin to metabolise acceptance into my own self concept. This kind of experience illustrates the gestalt principle that “healthy contacting begets healthy contacting” (Lee and Wheeler, 2008) and in my own experience is profoundly healing.

R’s confirming attitude towards me has a quality of authenticity because I have experienced him practicing the third element of the dialogic relationship, inclusion. Zinker captures the essence of this concept from the therapist’s perspective when he says “I try to understand and feel – to psychologically gargle – the other person’s mode of being in the world” (Zinker, 1978). More prosaically, Hyncer describes what the therapist does as “the back and forth movement of being centred in one’s own existence, and yet being able to go over to the “other side”” (Hycner, 1991). Zan in our group sessions often talks of ‘leaning in’ to the other’s experience and then back into one’s own. Inclusion enables the therapist to enrich their phenomenological understanding of the client, themselves and the ‘in between’ by noticing and feeling into, the “thinking or imagery, feeling and body process” (Joyce and Sills, 2001) of the client.

If done well, inclusion gives the client an experience of the therapist attuning to them. Attunement takes place via non-verbal messages such as posture, facial expression and energy and verbal cues such as language, tone etc. Communicating inclusion requires much sensitivity. I recall some years ago my therapist at the time ruptured my sense of contact with her when, in response to the abandonment stories of my childhood, she responded with the affect of someone deeply moved, hurt and saddened. Her response repelled and confused me because I did not have enough support to drop into these feelings myself. Although her intention was to communicate “advanced empathy” she went further in her affect than I could accept (Joyce and Sills, 2001). As Yontef explains facial expressions and other non-verbal signs are particularly important when seeking to communicate inclusion to clients with issues of ground or internalized shame because this is “developmentally earlier than guilt and at heart less

verbal" (Lee and Wheeler, 2008). I notice in myself that I have a much lower tolerance of non-verbal empathic responses than words of empathy and I am beginning to understand how this connects to early internalised feelings of shame around feelings of 'neediness'. In this way R often gets it right for me simply because he tends to have a fairly neutral face. As a result it is easy for his responses to be below mine, and so I experience myself as more able to move into my feelings. In this way it is clear how inclusion involves a process of monitoring and adjusting support and challenge through body posture, words and tone based on attentive monitoring of your effect on the client, where possible trying not to overtake them, and watching for when you might miss them.

When a therapist inevitably gets it 'wrong' for the client, as my earlier therapist did, this usually diminishes the capacity of one or both people to remain in contact. Reconnecting to the client requires commitment by the therapist to honest and authentic relating. In the case of my previous therapist, she did this by attending to my discomfort and fear, acknowledging that she had got it wrong for me, and supporting me to notice my response with gentle curiosity. Her respectful and honouring handling of this affect misattunement was so powerful for me that I carried this vignette around with me for years, conscious that it had meaning and importance, but also aware that I was unable yet to metabolise the message which was in her affect response. In this way willingness for open and honest communication builds trust and enables dialogic relating. As Joyce and Sills so insightfully point out "it is often the willingness of the therapist to be there for the client, openly struggling with her mistakes, that convinces the client you are wholeheartedly committed to the working alliance." (Joyce and Sills, 2001)

Not being able or willing to engage in honest and open communication manifests in myriad ways, both subtle and obvious, and can both contribute to, and detract from, therapeutic value. As a Lifeline counsellor, I know that I often find myself wanting to interpret or explain a caller's behaviour or attitude to them. Sometimes this is helpful and sometimes it breaks contact. Interpreting and labeling a client's experience is what is called I-It relating, and is in a sense the opposite to the dialogical I-Thou relationship. As Hycner explains "all categorizing and labeling interferes with the genuine unfolding of what is most vulnerable, real, and essential in the human being" (Hycner, 1991). In this way interpretation can be a sign that we have in that moment lost faith in the other's natural process of "organismic self regulation". (Yontef, 1995) For me I notice that I tend to lose faith in this way when I can hear strong and destructive introjects within the client. In these moment's I can come out 'guns blazing', operating under the temporary but misguided illusion that I can dethrone their parental introjects and empower them with their own brand of wisdom (which is usually present, but struggling to emerge). This kind of relating also runs the risk of the therapist aligning with one part of the person, in opposition to another, for example the top dog versus the underdog. As Beisser notes, "the Gestalt therapist believes that the top dog/under-dog dichotomy already exists within the patient, with one part trying to change the other, and the therapist must avoid becoming locked into one of these roles" (Beisser, 1970).

There are, in summary a variety of ways that a therapist can inhibit or contribute to a dialogic relationship. If we become unwittingly stuck in the role of the therapist, relating in a way which makes us unavailable for authentic connection then we get in the way of presence and hamper our capacity for awareness. Alternatively if we can access our own phenomenology such as body sensations, thoughts, feelings and so forth, and we hold a basic willingness to engage in open and honest communication, then the scene is set for more richness and here-and-now connection. As we move through each moment, we have an obligation to bracket our own personal issues and allow the fullness of the client to emerge, confirming them as they are and including them, and the whole therapeutic relationship, in our experience. By staying with this experience, rather than interpretations, theories or labels we provide each other with a very real opportunity for going on a beautiful journey of human connection and growth.

## References


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