

# Awareness, Dialogue and Process

## Preface to the German edition, by Gary Yontef

In the five years since the publication of *Awareness, Process and Dialogue: Essays on Gestalt Therapy* there has been a growing movement to a relational Gestalt therapy. This trend is represented in some of the essays in the book, especially the chapter on shame. Relational Gestalt Therapy considers the therapeutic relationship crucial and focuses on the causes of disruptions in the relationship and on the effects of these disruptions.

There has been an increasing recognition of the power of the relational aspects of therapeutic work in promoting growth, healing severe disturbances, but also for inhibiting growth and even harming patients. While contact is the basic unit of relationship, i.e., contacting establishes relationship, the relationship also shapes contact. The impact on the patient of the therapist's attitude, behavior, and meta-messages is just now beginning to get the attention it needs. There is now an established Gestalt therapy shame literature that calls attention to iatrogenic triggering and enhancement of shame in psychotherapy and in training.

Relational Gestalt therapy has moved to an attitude that includes more support, more emphasis on kindness and compassion in therapy, and that combines sustained empathic inquiry with crisp, clear, and relevant awareness focusing. It has moved beyond the confrontation, catharsis, and drama emphasis of the 1960's and 1970's. It has moved beyond the more camouflaged shaming by therapists who are insensitive to their shame-triggering attitudes and behaviors.

In Gestalt therapy theory the essential nature of self is relational. The self is defined as the interaction of person and environment; self is the "system of contacts necessary for adjustment in the difficult field...Self ...is not itself isolated from the environment; ...it belongs to both, environment and organism (Perls, Hefferline, and Goodman, p. 151)".

Although Gestalt therapy has always been a relational approach, the relational principles and their implications have often been ignored, treated in a cavalier manner, insufficiently developed, or inadvertently violated both in theory and practice. Although Gestalt therapy theory defines the self as totally relational, theoretical statements abound in which the self is treated as separate from the organism/environment field and patients are often treated as if their behavior in therapy is separable from the relational field of therapist and patient.

Of late this problem is being addressed and the principles and implications of the Gestalt therapy relational theory are being discussed more thoroughly and cogently. There is also a budding trend toward discussing how these relational principles are enacted or violated in what therapists actually do. Relational Gestalt therapists have found that disruptions in the therapist-patient relationship are the source of most therapeutic blockages.

With systems, as with individuals, growth is relational. Therefore, relational Gestalt Therapists tend to welcome exchange with relational forms of psychoanalysis, especially the intersubjective self and relational approaches. Relational Gestalt therapists tend to treat dialogue between Gestalt therapy and other therapy systems as an opportunity for mutual learning and growth and eschew approaching Gestalt therapy as self-sufficient. The current trend in relational Gestalt therapy has been influenced by this interchange.

The relational perspective is at the core of each of the three philosophic pillars that are the bedrock of Gestalt therapy, i.e., field theory, existential (psychological) phenomenology, and dialogic existentialism. Even our biological inheritance is influenced by and shaped in a relational context. For example, the basic human genetic inheritance can be altered by toxins ingested by mother or father even before conception. Individual taste preferences can be influenced by what the mother eats during pregnancy. The biological inheritance "reality", indeed all perception and memory, is co-constructed. Husserl's transcendental phenomenology contradicts his earlier work and certainly is not consistent with the phenomenology of either Gestalt psychology or Gestalt therapy.

Transcendental phenomenology has never been a part of my understanding of the theory of Gestalt therapy or its inheritance. Gestalt therapy is based on the non-Husserlian phenomenology of Gestalt psychology and existential (psychological) phenomenology, which is not based on transcendental phenomenology. Bracketing in Gestalt therapy is not meant to provide complete absence of suppositions or objective. Rather it is a method for therapists to systematically be as aware as possible of their biases, to stay cognizant of the truth of multiple realities, and the lack of purely objective or purely subjective perception.

I object strongly to claims of objective or absolute truth by anyone, especially by therapists. I agree with Sapriel's criticism of transcendental phenomenology on this score. But I believe she erroneously reads transcendental phenomenology into Gestalt therapy theory -- and then wants to eliminate what was not in the theory to begin with. It is transcendental phenomenology that is inconsistent with field theory and not psychological phenomenology. Both field theory and psychological phenomenology make knowledge of the perspective or frame of reference of the observer essential.

The methodology of relational Gestalt therapy emphasizes the personal presence of the therapist as a person. But, the subjectivity of the therapist is not likely to support patient growth in the patient unless it is a presence honed by training, personal therapy of the therapist, and receptivity to the different reality of the patient -- without any assumption that the patient's reality is inferior to the therapist's. This is the essence of bracketing. Bracketing supports the therapist in doing this. Bracketing does not give the therapist an "objective" or superior view of the situation. It only gives the therapist a clearer and cleaner sense of his or her own process.

It is vital that therapists bracket their preconceptions as much as possible so that they can be impacted by and respond to the unique person present at a particular time and place. This facilitates growth by both patient and therapist. Much of what we do in therapy is guiding patients to look at fixed gestalten, preconceptions, so they can be influenced by and influential in the current organism/environment field. In effect the patient also learns to bracket.

Eliminating bracketing would be an unfortunate solution to the problem that some therapists, including some well known Gestalt therapists, act as if their awareness of both the patient and themselves is in a superior position, is correct and above criticism -- and the treatment of patient's criticism of the therapist as distorted because it is not consistent with the self-concept of the therapist.

I think this is a very serious problem, and an illustration of how disruptions in the relationship and in the progress of therapy often results from the therapist's defensiveness, subjectivity, and countertransference. This is a failure to bracket and practice inclusion. I do not believe that this hubris comes from transcendental phenomenological principles in the theory of Gestalt therapy. Most of the therapists that I know who show this defect in their practice know theoretically that no awareness is objective and uninterpreted.

The naive belief that one's own experience is not biased is an example of an initially given subjectivity that has not sufficiently gone through phenomenological discipline and self-examination. Discarding the concept of bracketing would discard the solution and solve the wrong problem. The problem is not transcendental phenomenology in Gestalt therapy, it is the failure by such therapists to truly face the existence and impact of their unbracketed subjectivity, defensive shame-triggering, and so forth.

The "solution" of eliminating bracketing would be very unfortunate. Bracketing by whatever name, is central to a phenomenological method, whether Gestalt psychological, intersubjective, or existential phenomenological. Bracketing is crucial to dialogue and to field theory.

Some therapists protect their sense of self, their self-esteem, by acting as if their awareness is in a favored position, as if the patient's subjective sense of something in the therapeutic relationship that is out of the therapist's awareness could not be valid. For example, if the patient feels shamed by the therapist and the therapist does not regard him or herself as shaming, in superior therapy practice the patient's subjectivity is respected and taken seriously. By "taken seriously" I mean explicitly that the therapist be open to having his or her own sense of the situation, his or her sense of self, and his or her sense of who is responsible for therapeutic impasses changed by taking in the patient's sense of the situation.

When there is conflict between therapist and patient, whether minor or acrimonious, and therapists give the message that the problem is with the patient, not in the relationship of which the therapist is a part, shame is usually triggered in patients. This defends therapists from being aware of their part in the interaction, and often from their own shame.

An actual example: Patient feels shamed by the therapist and says so. The therapist responds by saying that he or she will show the patient how she, the patient, shames herself. In this actual situation the therapist did not take the patient's experience seriously, was not open to examining his or her own role in the exacerbation of the patient's shame. The patient experienced an intensification of her shame. I have heard many similar examples from patients and trainees.

An important relational clinical cue is when the patient says that the therapist does not understand. I have often said that if the patient says the therapist does not understand, that the patient is right. Sometimes this can be the therapist having a more positive view of the patient or the patient's future than does the patient. My own experience is that when I feel positively about a patient but am willing to sit with the patient in their sense of self-loathing and despair, that therapeutic blocks usually dissolve and therapy progresses. When I am convinced of the truth of my positive regard for the patient, when it is too painful for me to walk the path of the patient's despair, i.e., the patient's reality, patients are likely to feel not understood.

In relational Gestalt therapy the therapy is co-constructed by the therapist and patient. The patient is not led somewhere by the therapist. We practice the paradoxical theory of change. This does not mean that the therapist automatically accommodates to every aspect of the patient's subjectivity. The work is in bringing together the therapist's actual experience and expertise and the patient's so that a true dialectical transformation can occur out of what happens between them.

**Gary Yontef**

*Los Angeles, January 1999*