

**Transcript of a lecture-discussion
with Lynne Jacobs, Ph.D.,
captured at the Portland Gestalt Therapy Training Institute,
March 7, 1998.**

Lynne: I'll start by explaining some core notions about the I-Thou relationship in Gestalt therapy, and then I want to show how it's not just that relating with a dialogic attitude toward our patients is a moral good-you know, a sweet altruistic value-it also matches other basic concepts in Gestalt therapy: contact in process, field theory, paradoxical theory of change, and our phenomenological approach, (that is) awareness and phenomenology. They're all of a piece, and the dialogical approach, dialogical therapeutic relationship, embodies all those things, so it is also a really good theoretical match with other concepts in Gestalt therapy.

That's just one of the amazing things about Gestalt therapy as a theory - how the original thinkers in it created a new gestalt by pulling from what was in the zeitgeist of the day. They made this new gestalt called Gestalt therapy, and they were just elegant at feeling their way through what in current thinking (at the time) could be taken and modified to form the coherent whole that Gestalt therapy is.

The meaningfulness to me, and to other Gestalt therapists, of Buber's philosophy of dialogue is that Buber places a specific form of contact at the center of human being. We're a humanistic therapy. For Buber, he was asking the question all the time, "What is it that makes a human being?" Which is sort of the question, the way we psychologists would dry it out and ask, "What is self? How does one's self develop?" But I like Buber's question better, "What is a human being?" What is it that is uniquely human in human beings? His answer is, human being-ness is found in relation. Now, this is no longer hot news! All good therapies are moving in the direction of acknowledging that the human psyche, if you will, is born and developed in relation. There is no "human" without relation.

Buber didn't have the advantage of being part of that zeitgeist; he was drawing on Jewish tradition which had been fundamentally relational all along.

I rode up on the plane last night and sitting next to me was a woman who started to have a conversation with the woman who was sitting next to her about the graduate class she was teaching. She was struggling in this class, because of the men (there were seven men and ten women in the class); she found herself engaging constantly with the men in the class because they were the ones who were actively engaging with her in what she was teaching. And the women were more passive, and the professor was trying to figure out how to change that class dynamic. So I couldn't resist asking what this was all about, and it turned out that this was a class on "Feminism and Theology." She teaches something called "process theology." One of the issues in process theology is a commentary, an approach to Christian theology which, among other things, tries to make God a non-represented god. If you represent God, you end up with a white male, and so one of the things that process theology tries to do, because of the subtle, but profound psychological consequences of having a white male god on women and minorities, is to make God a process rather than a representation. That's where this idea of Jewish tradition vs Christian tradition came up. So she's my authority on the subject, and she agrees with what I'm about to say...(laughter)

Maya: (laughing) That's a long way to pack yourself up, Lynne!!

Lynne: So this thing is that Jewish thinking, Jewish religious thinking, has always involved engagement in dialogue. The Torah involves statements from God and commentary from (I think they're called) prophets (but

I'm not sure). So when you study the Torah, you study multiple interpretations of what God might have meant. So that there is always dialogue...am I getting this wrong?

Student: I think it's the Talmud.

Lynne: I'm sorry, the Talmud. Right. You can tell how much I know about religions. (Laughter) And these commentaries occur at different points in history, so the commentaries are always historically based as well, which means that they are always a part of an evolving process, and they're always in dialogue.

Maya: And they always reflect the zeitgeist of the time.

Lynne: Right. Or an attempt to critique the zeitgeist, and you cannot do that without representing the zeitgeist, because you are in what you're critiquing. And that is the tradition that Buber comes from, the tradition of having a dialogue. Also in Jewish tradition, whenever you engage in dialogue with another human being, you are engaging in dialogue with God. Now, I'm saying this in a very simplistic way, but that's part of what Buber's ideas on dialogue are built on, and Buber was an Hasidic scholar. So, his Jewish roots are part of the context of understanding him. I think his ideas can be applied way beyond Judaism, which you can tell, because I'm not Jewish and love his ideas.

So, he comes from this tradition where knowledge through discourse is, essentially, godly, is exalted, but it is also the pathway to realizing your human being-ness. So he puts dialogue at the ontological center of life, meaning that you cannot come into being except through dialogue. I'm really underscoring this, because I'm about to tell you about his two ways of conceiving dialogue, or his two ways of conceiving self in relation, and they're not nearly as important as this fundamental thing, which is that there is no self without other. Self comes into being with other. The mind is formed and developed in relation.

This may be instinctive to you. My context is I also talk about this with psychoanalysts, and to psychoanalysts this is a harder concept to grasp. They're used to thinking of the mind has having formed and developed in response to biology alone and all of the interactions that an infant and a toddler and a young adult may have don't do much really to shape the mind. We've always had a much more interactional understanding of these things.

(Comments regarding the writing of a book she collaborated on with Richard Hycner, *The Healing Relationship in Gestalt Therapy: A Dialogic, Self-Psychological Approach*.. Lynn regards this one of the finest applications of dialogical thinking for Gestalt therapists that exists today.)

So anyway, Buber has two notions about kinds of relatedness, and they're both about the process of relating, and that's one of the reasons it's so compatible with Gestalt therapy. One kind of relating he calls "I-It;" another kind of relating he calls "I-Thou." Is there anyone who's never heard those words before?

In the process of I-It relating there is a subject/object split. Some of us remember Descartes from high school & college philosophy classes-a split between subject and object. We are also centered in time; we have an awareness of time. We use judgment. We use orientation. We think. We reflect upon. We can say what we're feeling. In other words, it's the means of relating, the means of interacting with the world that we live in 99 per cent of the time. And, without "It" one cannot live; that's a famous Buber saying. It's the mode that you're in right now, and it's the mode that I'm in right now. Then, there's this other mode called "I-Thou," where Buber would say, "but without Thou, without being able to say, 'Thou' to another, one is not fully human." So, this is

where he gets into what it is that makes a human being. And it's not our skills at I-it-realm relating, the process of relating with thought, and awareness of a separate subject and a separate object. It is the process of relating I-Thou, which is, among other things, one of the qualities that adheres in the I-Thou moment of relatedness and is something he calls confirmation. In confirmation, the heavenly bread of self being (as Buber might say) is passed from one to another. He talks about all of us longing for a "Yes!" coming from somebody else. The "Yes, you are recognizable and you exist." In the moment of I-Thou the confirmation of your existence as a unique subject occurs. It's a moment that is not necessarily a sweet moment; for that kind of confirmation can come in a heated argument. It's the recognition that is the confirmation - recognition, and it's a moment where you recognize the other, and in a mutual I-Thou moment are recognized by the other. Where your singular being is grasped, is recognized, accepted for what it is without for that moment any wish to change the other. So, it's quite a powerful moment, or can be quite powerful.

What are the qualities that could give rise to this moment, this possibility of what we call an I-Thou moment? And by the way, these moments are self limited; you cannot live in I-Thou. Our self-reflective consciousness won't allow it. Which is also one of the things that is said about human beings, that they have the capacity for self-reflective consciousness, which is a capacity we use in the I-It mode. Buber sort of neglected that part, but in a moment of I-Thou, in the experience, these things (immediacy, directness, presence, and mutuality) come into view.

This is so much the focus of our work in Gestalt therapy; in the immediacy it is so much in the here-and-now, and it's also the unmediated-ness; there is in this moment no mediation by thought, by agenda - no aim. In the moment of an I-Thou meeting there is no aim. The meeting is complete in and of itself.

Maya: One of the ways I think about that is of a surrender to the moment.

Lynne: Yes.

Maya: It's not confluence; it's surrendering to the moment, momentarily.

Lynne: Yeah. It's surrender to the moment, because you have confidence in an ongoing process, an ongoing mutual and self-regulatory process, so that you don't have to think about where you're headed in the next moment. And that's part of what allows the surrender again.

Student: Then, in a popular way of talking, a dialogical moment, or a dialogical relationship, wouldn't be an "intervention."

Lynne: Absolutely not! I don't think you can aim at I-Thou moments. I'm going to differentiate in a few minutes between a momentary I-Thou, which is what Buber wrote about, and a process of being in a dialogical relationship where that issue will be clarified.

Student: Would you say, then, why Buber says that moment can't last? You made mention of that; in reality that's obviously true, but why is it that it can't last?

Lynne: It is because of self-reflective consciousness that it can't last.

Student: You mean because that would just kick in?

Lynne: Right. Right. That's what he would say (he wouldn't know what those words were, but yes)...

Student: Does that suggest that one possibility is to try to suspend for longer so that you can try to remain in that moment?

Lynne: No. Because once you're trying anything, you're already out of the moment. It's an existential occurrence, and it's cool when it happens, and it's over when it's over!

Student: So the confidence exists in the moment so you don't have to worry about where you're going, per our discussion last night about support, so the support would be fostering the confidence in the moment.

Lynne: Right, right. People who have poor self support for contacting, or for identifying with their own ongoing, moment by moment experience, will be estranged from the possibility of I-Thou. And that's one way to think about why people come for therapy - because their capacity for dialogue has been impaired. We all seek intimate relatedness, and that has been impaired, and we feel estranged from, or cut off from what Buber would call the latent I-Thou.

If you all take a moment and just reflect on certain experiences you've had - with a tree, with a piece of art, with an animal, with another human being - where in that particular moment, when you reflect back on the moment you realize that it was a moment that was eternal, in the sense that it was timeless. There was no sense of time, and although paradoxically there was no sense of a separate self and a separate other, you also look back on that moment as a moment when you felt more fully YOU than the moment in which you're now reflecting back on it. And you, on reflecting back, realize that you weren't aiming at anything in this very brief moment that you're reflecting back on because it was so cool you wish you could go back and get it. You weren't aiming at anything. You weren't pretending anything. You weren't defending anything. You were lost to the moment, but more like surrendered to the moment, and your attention, paradoxically, although you felt yourself on reflection most fully you, was not on you. You were fully absorbed with that with which you were engaged.

Maya: I'm thinking of a moment when my granddaughter came to visit, and walking into the house and running toward me, and my dropping to my knees, and our meeting. And my experience of that meeting, upon reflection, is that in that moment I knew God. It was just the joy of meeting.

Lynne: One of the keys in this that I want to underline is that where you are absorbed is over there. You are, in a sense, at one with the object of your attention. It's sort of a tricky way of talking about it, but it just has to do with the fact that that's entirely where your attention is, without you being thoughtful about where your attention is. The moment may last a split second; it may last a little longer, but it's not going to last much longer than a split second.

And if you aim at it, you can't get there. It happens by what Buber calls "grace," and what I prefer to think of as surrender to existential trust. Since one of the ways that the ground for an I-Thou moment is prepared is that you're willing to accept what you find in that which engages you, without judgment, without a need to change what you find, if you're aiming at I-Thou, you're trying to change what you're reaching for, so you can't aim and lay the ground for I-Thou at the same time. You can't do it, but you can do therapy with someone, never have an I-Thou moment, and consider it a dialogical therapy. It isn't the moment that matters, and I want to underscore this; don't go back to your training groups and ask, "Was this an I-Thou moment, was that an I-Thou moment?" Irrelevant! The question to ask is, "What in how I'm working would prevent the emergence of an I-Thou moment if it should be a potential?" What in how I'm doing gets in the way of genuine dialogue?

Now, here's the thing: genuine dialogue is a rubric, and there are two subsets to the rubric, the I-Thou relating and the I-It relating. Genuine dialogue accomplishes both of those modes. What brings people into therapy is not that they don't have those small I-Thou moments, but that even their I-It relating doesn't have in it the possibility for I-Thou to ever emerge. Neurosis can be understood, from a dialogical perspective, as an estrangement between the realms of I-It and I-Thou. See, one of the ways to think about I-Thou is that it is a latent, or background possibility; it's really, I think, a latent process that occasionally emerges in this moment, but it's a latent possibility unless your I-It way of being has so much defensiveness, or self-protectiveness around it that the chance of non-judgmental acceptance of yourself and others, and the chance of surrender to a moment where you can't predict the outcome, is so far removed that you feel increasingly deadened and inhuman (because you're cut off, then, from I-Thou as a possibility).

Student: So, according to Buber, in what you just said, if you're cut off from the possibility of the I-Thou moment, then you are cut off from your humanity.

Lynne: That's correct.

Maya: There's another quality here that I would like to interject, which is that a dialogic psychotherapy includes meeting the client where they are, not asking them to move into "the moment." Rather, a dialogic psychotherapy can be about meeting in an I-It modality.

Lynne: Right. In fact, a lot of your meeting will be (I-It), but here's the thing about the dialogical attitude: Buber was describing this thing as a two-person process; it's a mutuality. For him, he was most interested in this moment of full mutuality, meaning both parties to this are absorbed in each other, as I was describing before, but then he said teachers, therapists, other people who want to help in the development of the humanity of another do something he would call, "one sided." I'm going to describe some qualities of this in a minute that will help make sense to you, but in the one-sidedness of it one person in this relationship assumes the dialogic attitude, and for it to be dialogical in his (Buber's) sense, you have to not require it of the other person. And that's sort of a paradoxical therapy here - one of the paradoxes in therapy: I meet my patient with a dialogical attitude, which by its nature lays the ground for the possibility of I-Thou without ever aiming at I-Thou. I'm aiming at meeting the patient when I'm in I-It mode of this dialogical relationship. There may be times when my aim is surrender, and it's at those times when the possibility of I-Thou can happen, but whether or not it happens is not so nearly as important as my relating in ways that honors the patient. That's my way of saying, "Thou," to the patient, whether or not there is ever an I-Thou moment.

Student: I want to clarify. Are you saying that this is an I-Thou process or attitude that fosters a potential for an I-Thou moment?

Lynne: I would say it a little differently, but you're very close.

Student: Okay, I want to clarify also, how is this different from I-It? I hear you saying that we operate in an I-It mode, but if I am approaching my interaction with my client, it seems that there is also the possibility in which I can, in what I used to think of as I-It, that I can really operate in the sense of roles. I'm a therapist; you're a client; this is the thing that we do here today from this hour to that hour; I dispense so many interventions and it's supposed to result in these conclusions, you know. That seems to be very sterile...

Lynne: And to me that's estranged I-It. You know this may get more clear when I talk about the qualities of a dialogic attitude, but it's true that most of our relating to each other is going to be in I-It mode, but there's a difference between I-It that stands on the ground of the dialogic attitude and I-It which is more technical. Like

assessing somebody, deciding what interventions they need, then doing those interventions and watching the results is a very technical mode, and I would say that's a mode that's divorced from the dialogical attitude. I'm going to describe the dialogical attitude, and you're going to begin to see, I think, how you can have an I-It way of relating for the moment but that it's standing on the ground of the dialogic, or the I-Thou attitude, and it's that ground which does lay the possibility for I-Thou moments, if such a thing is going to happen (but that's not what's vitally important about it). What is vitally important is that the patient is being apprehended in their humanity, and that coming to their humanity will infuse their daily living with more of the dialogic attitude. If they take to this; if they like it, that's where they'll go with it and then that lack of estrangement in the dialogic attitude will enrich their life, whether or not they ever have one of those moments. But they're likely to have one of those moments, if not in therapy, then outside of therapy.

Student: So, would a dialogical relationship, as you hear the term, would that be essentially one in which people are approaching each other with a dialogic attitude?

Lynne: Yes.

Maya: It would not be approaching each other. In other words again, and especially in psychotherapy, the therapist's position and attitude is dialogic; the client we don't know.

Lynne: Well in the one-sided relationships that's right, but I think you were asking more generally - in general, when you...or were you asking about therapy, because if you were asking about therapy, Maya's point is very well taken?

Student: I was trying to clarify what I have commonly heard to be the dialogical relationship, as one of the tenets of Gestalt therapy. What is that?

Lynne: Okay. That's what I'm going to describe now, and then I think these pieces will come together. There are certain disciplines that I, as a therapist, bring to the dialogical relationship in psychotherapy. I bring a dialogical attitude, and I do that through these disciplines, (points to written down visual aids), these things, and I'm going to describe them. See this is the moment, and these are process qualities that you bring from moment to moment. This is the discipline that you bring, and it's what I call, then, the dialogical attitude (and, by the way, I made that up. You'll see that in our book as if it's a real thing, but we made it up).

Student: How does anything get to be a real thing? (laughter)

Another Student: And what does "real thing" mean? (more laughter)

Lynne: I don't think Buber wrote about it as dialogic attitude; he wrote about it as one-sided inclusion, but I changed it to dialogical attitude. You start with what Buber would start with, and so I'm going to start with it - inclusion. What Buber calls inclusion most of us would call empathy. But it is as full-bodied an apprehension of what it's like to live life from the patient's perspective as I can get. Buber called it imagining the real. In the therapeutic relationship he says we need to stand at both poles of the relationship. Now he's describing an epistemological impossibility, but it's phenomenologically not so strange to us. To hold both poles simultaneously - the patient's pole, or what it's like to be in this relationship from the patient's perspective; our pole - what it's like to be in this relationship from our perspective, and that's the requirement on the therapist, not on the patient, and that's why he called it one-sided inclusion. So my job is to imagine the reality of the patient, to see if I could take the patient's eyes, glue them to my forehead, and look at life, and especially look at our relationship through these new eyeballs.

Student: I have a question. In one of the articles I read, Buber talks about coming in and out of the boundary of the patient in relationship to this. Sometimes I find that is really scary.

Lynne: Right, right. I think you can't do inclusion or empathy without being changed. And this is the point that Maya is making, and again is one of these points that you can't underline enough. If I stay the same, I am not in contact. So, in the littlest way, if I don't swallow the bread, if I don't allow myself to interact with the bread I was just eating, I'm not being changed, I'm not in contact with the food. Okay? And that happens psychologically too. When patients' experiences are vastly different from yours, for me that's when it's spookiest. And I finally get a sense of...I mean I remember struggling and struggling to grasp what the patient was saying about a particular way they see the world. I couldn't get it, and I couldn't get it, and couldn't get it, and then I GOT it, and I felt like my body changed shape, and I was kind of dizzy. And I felt changed forever, and if you had asked me that day what it was that changed I would have been able to articulate a way of seeing the world that I had never seen before, and now it's become so much a part of me, I can't even find which way it was. I will never find it that new again with the next patient, because it's now in my body shape, but I remember that day having to go through the shape shifting.

Student: So, would it be fair to say that if you're working it over time, you're not noticing that your body is changing shape, or you may not be making headway?

Lynne: Either it means you've seen all there is to see about the human condition, had a taste of every experience that's possible, or something is sort of deadened. And see, here's what I mean about how the I-Thou relationship is a logical fit with Gestalt therapy. We say the same thing about contact that I'm saying about inclusion. You are changed through inclusion; you are changed through contact. The I-Thou is a subset, or one kind of contact. It is perhaps the dialogical way of interpersonal contacting we do think of as having the most potential for self development, or human development, but it's the same process as, in very abstract way, as my eating that bagel was.

Student: So, in order to stay in relationship where you are experiencing inclusion, then you'd have to be able to, and willing to, tolerate the anxiety that that produces between us.

Lynne: Among other things, yes, because for inclusion you have to be able to tolerate whatever you're meeting. It could be anxiety; it could be any number of things...

Student: You mean whatever you're meeting in yourself or what you're meeting in the client?

Lynne: Both, both. Whatever's around and in you, because really what you meet in the patient will arouse something in you, so in that sense it always comes back to what's being aroused in you.

This is the key too: when I'm having trouble with a patient, I come back to (the fact that) there's been a breakdown in my capacity to practice inclusion. Where is the breakdown; what am I resisting confronting here? What kind of experience am I trying to avoid? I have found over and over again that if I can start with that assumption, when there's some trouble with me and the patient, I will find something I don't want to be touching, and then I can try to work with that.

Okay, we've got this inclusion, which is empathy, which is imagining the reality of the patient, especially the patient's experience of being in a relationship with you, and that's another reason you get pretty anxious, because their experience of being in a relationship with you may be very different from what you intend, and very different from the way you think you ought to be being experienced. You're not practicing inclusion if you decide that their way of experiencing the relationship is wrong.

Student: Well, you know like working with a paranoid client? That's tough!

Lynne: And vitally necessary! Because they, above all others, need to have someone who's willing to struggle to make sense of some reality they have a grip of that nobody wants to see.

Student: But, the first session is tough, and it's hard to keep them, because it's like a mine field.

Lynne: Yeah. I've actually been working for some time now with an extremely paranoid patient, and it's very difficult and frustrating work; you have to sit on your hands a lot.

Student: Yeah, given this talk on support last night, how do you know when there's any support there for the client?

Lynne: See, if you're practicing inclusion, you have some kind of idea as to what kinds of support are there; you see, it's not a question of is there any support; there's always support for something. You look for where the contact possibilities are, and often with a paranoid the support is for honoring the legitimacy of a truth inside the story, and appreciating their capacity to see, and not giving up seeing something that nobody else wants to see.

Student: Is that, i.e., their paranoia?

Lynne: There is something that is disrupted in their dialogical relations with others that they're framing in ways we call paranoia. But there is a subjective truth about that that if they give it up, they're giving up their existence. I want to honor that and see if I can find a way, a shared language in which we can talk about that.

Student: It seems that this is not just for paranoids.

Lynne: Right. it's anybody, but you see it extremely with a paranoid.

Maya: The way I think about this, and it doesn't matter about the diagnosis, is about creating a holding environment where the possibilities of the other are supported and held as I support and meet those possibilities.

Lynne: And this environment is always negotiated, but the more rigid the patient's defensive structures the more you're the one who's going to have to do the accommodating. As the therapy relationship gets more and more robust, the negotiation will have more of a two-person flavor to it. But that's over time, and with more disturbed patients it's going to be over a long period of time.

The moment of contact is touch touching something, where what belongs to whom is irrelevant in that moment, but in the contacting process you have not only the appreciation of differences, which is also talked about, but you also have to have some empathy for the other's position. Without that there is no means to bring the touch. There's not just differences, but there is empathy; it's empathy and the appreciation of differences.

So, one side of inclusion is that I bring the attitude of endeavoring to try to understand what it's like for the patient in their life, and especially in their relationship with me, and I don't have to get it right. I want to underscore this; you don't have to get it right. You have to have that as your attitude, your discipline, your approach. What you bring is the intent to do that. Then, there are two other things that you bring.

One is that you bring something called presence, the quality of presence. You are willing to be seen rather than aiming to be seen as you would like to be seen. You are willing to be seen as you appear, and you don't

try to manipulate or manage how you're being seen. Now, we always manage how we're being seen to some extent, but a willingness to let go or be seen beyond that is what's important - a willingness to have presence predominate. That gives the patient the chance to meet an other, because remember there is no self without other. Part of what patients come into therapy with is experiences throughout their lives with people who are not willing to be an other for the patient - not willing to be a subject to the patient. Parents who were walled off, who were depressed, who were narcissistically self-involved, couldn't allow their children to find them. They needed to be seen in a certain way and couldn't allow their children to find them. So you become, perhaps, the first person in their lives who they can reach to, and find, and thereby find themselves through relating to an other - to a true subject, over there, who's willing to be a subject. That's the presence part. Well, the presence is willing to be used in that way, and then genuine and unreserved communication is that process happening. The inclusion happening, you being available as a present subject for the patient, and sort of a summary statement I make about genuine and unreserved dialogue is, this is where your authenticity comes in, which becomes, then, a sort of calibration between inclusion and presence: you can't always know what needs to be said to further the dialogue with a patient, but you can at least make a pretty good guess as to what, if you don't say it, will lead to you shutting down. Like, if you're feeling defensive with a patient, you may try to look inside, this is where I go to when I'm feeling threatened with humiliation, and I discover that if I say, "Well, now what am I missing in the patient that makes me come up against this feeling?" And what I find is that I have stopped the time line in looking at my patient. They're attacking me. I'm feeling humiliated and defensive, and I want to retaliate. What I hadn't realized, where my inclusion broke down, is that I had said something two moments earlier that was hurtful to them, and they reacted with their shame by attacking me. If I backtrack and try to understand what it's like to be in their shoes, then I get, "Oh, well that hurt them, and so of course they felt ashamed, and of course they want to attack when they don't expect me to listen to them, and then if I do attack back, they're right, I won't listen to them." So, that active inclusion helped me calm down my feeling threatened, feeling humiliated, some of the time. Sometimes it still doesn't work and I have to say, "I'm sorry about this; it's not your responsibility, it's my business, but we're stuck with me as who I am; I'm defensive again. I'm digging in my heels again. I'm in dread of being humiliated again; can we stop the process now and look at what's unfolding between us?" I have a patient where this is a chronic problem, and that really helps in our work. So, that's what I have to say, because if I don't say it, I'm either going to retaliate or I'm going to withdraw defensively. So I have to say it, even though it's not a pretty picture of me, because to me it means that I'm not living up to an ideal I have of myself as a therapist. Of course, it does serve another ideal I have, which is to say what I need to say to stay present.

These three things, the inclusion, the presence, and the commitment to conversations, even when the conversations are difficult, are the qualities of a dialogic attitude that make the relationship...Oh, and there's another thing...My effort is to meet the patient where they are, without any attempt to change them. That's the confirmation part, to meet and engage with a patient with as full a grasp as I can of who I'm meeting with, without any attempt to change them, and inclusion, and the presence, and the commitment to dialogue - those are the qualities of a one-sided, dialogic relationship that make all the I-It realm work and still part of the dialogue. All the I-It work you're doing with the patient is standing on that ground. It's different to focus with a patient on a symptom, if you will, standing on the ground of that kind of dialogic attitude than it is focusing on the symptom standing on the ground of a technical attitude.

Now, let me spend just a few minutes tying this into contact, awareness, phenomenology, paradoxical theory of change; it may be obvious by now. You see, what happens is that when we start talking about this, I get psyched about it, and partly for me it's a moral crusade. You can tell in the way I've been talking about it, and what I want to do now is to remove it from the morality and just look at it in the pragmatics of it. We have a theory that says that contact leads to growth, because contact, which is the process of living, is also the process of growing. There is no life without contact, and without contact there is no growth, and every moment

of contact is growth or change. That's the is-ness of it. So, that being true, I hope you can see how this is just one form of contact. It's a special form of contact, but the same thing can be said here; if I am in contact with my patient, through being present and practicing inclusion (that's how the contact happens), I will be changed, and the patient is changed too, because they are engaged in contact with me also. It may not be a change that you're aiming for, but that's your business, not theirs. If you take that contact always leads to change, because contact IS change, then you can rest very comfortably on the paradoxical theory of change. The paradoxical theory of change being: If you immerse yourself in, or identify with your present existence, change happens automatically, because fighting against your present existence is what inhibits contact. Identifying with your present existence makes contact a possibility; contact equals change. You see how these things are tying together now? If I meet the patient, that, in and of itself, is the contact, and is the ground, then, of change, and it may not be the change that I thought beforehand was what I wanted, and that is irrelevant. The patient, now, will find his or her life through their contacting. In that moment with you they may titrate the contact very carefully; that's their option. From the dialogical attitude I would have to say, "That's their option."

Now, what does awareness have to do with any of this? In order to have this attitude of inclusion being that I want to meet what is there, I want to find what is there to define in the other without any attempt to change the other... That's not easy to do, right, because I'm a therapist, and I care and I want the best for my patients, so I have ideas about how, if they were changed, their lives would be better? We all bring that into the room; we try to suspend it, be aware of it, work with it, whatever, but there are two supports for keeping your eye on that and not letting it get in the way too much, and one is the paradoxical theory of change. If I really do have faith in the paradoxical theory of change, it is easier to do what Buber called inclusion. The other thing is that the phenomenological method is part of what enables me, or is a support, for practicing inclusion and presence. Phenomenology says that you take what is given, you respond to what is given without prejudgement, without interpretation. Now, again, these are epistemological impossibilities, but they are ideals, if you will. The idea about the phenomenological method is that you be aware of, and try to bracket off judgments, or you be aware and hold very lightly judgments and interpretations. Don't believe in them too much, just recognize them. Sort of like a Zen thing, seeing a thought and letting it go by, seeing a thought and letting it go by. And that discipline you learn, through this program, I hope, of not believing so much in your judgments and not believing so much in your interpretations, but just allowing them to go right by, is a discipline that will help you with inclusion and presence, because you'll be less judgmental of yourself, so you'll be more free to know what's being aroused in you, which is crucial for presence, and you won't be judgmental of what you find in the patient. You'll be more accepting of what you find in the patient, which means that the patient is more likely to bring more of themselves into the meeting with you. If you are judgmental, and you think they need to change what you find, they're going to hide stuff that's important to them - as they should; it would be unwise to let you have access to it. So, that's how all these things are, to me, all of a piece; they come together. The I-Thou, the dialogical relation that Buber describes, is the embodiment of bringing together, contact, awareness, and the paradoxical theory of change; it's the embodiment in our lived-out relationship with the patient.

Student: What about field theory?

Lynne: Oh! Sorry about that. Two really important things about field theory that get played out in this is that (1) nothing can be defined separate from its context, so again it's a self-in-relation theory. Field theory and self-in-relation theory are compatible. Because there is no self without other, everything in field theory is relation. The next (2) is that in field theory there are multiple perspectives on any common event. A common event is going to be experienced differently based on the different points of observation (if the common event is between us) of that event and the nature of our relation to different aspects of the field as we look at that event. Reality is perspectival. Reality depends upon where you are standing in the field and what you are related to in the field at that moment in the field, and, therefore, my reality has no greater claim to truth than your reality, which helps you have the phenomenological method in your approach to patients. You're interested in their experience of

their reality, and you don't have to make an assessment as to whether their reality is right or wrong based on your reality, because your reality is merely one perspective, and that puts us back into inclusion.

I want to make one distinction here in that mutuality, when people say equality and parity, I want to say that parity is only a momentary experience. It's the moment when the boundedness of the relationship is irrelevant, when you reflect on it later, and you realize that the distinction between therapist and patient in that I-Thou moment was irrelevant. The overall dialogical relationship in therapy is mutual in that there is constant mutual, reciprocal influence going on, but it's asymmetrical. The parity is only in the moment. It's asymmetrical in the sense that the patient and I are both agreed that we are both there to serve the purpose of the patient's development.

Student: We looked at the example of a paranoid person for a bit, and I'd like to switch to another kind of person, which would be a sociopathic, character disordered type of person, because to me it seems like there are some difficulties there. I sort of get an idea that if I'm genuine and trusting in the paradoxical theory of change, practicing dialogical attitude, and things like that that somehow, my faith in the Gestalt therapy tells me that the real need, the real crux of the matter will eventually shine through, but what I'm also struggling with is the tension that that person isn't being honest. That person is probably conning me, trying to run a game on me, and if I'm approaching them with this almost naive, wanting to be genuine and present and all that kind of thing, then...

Lynne: Okay...

Student: Do you sense the tension?

Lynne: Yes, and I can address it in a couple of ways, and I'm going to address it in two very simple-minded ways that, I know, in the trenches feels very different, but I have to do it the simple-minded ways.

One is the issue of presence. When I experience myself as being manipulated, I don't like how it feels to me. I feel degraded. I want to find a way to use that experience in a genuine dialogue with the patient from the discipline of my therapeutic perspective, which is inclusion, genuine dialogue, and presence. But I'm not going to ignore the effect on me; that's part of the presence. So that's one thing - and where presence comes in handy to think about how you are being effected by the patient, of course, and how you want to address that in a genuine dialogue with the patient.

The other, the overarching question is, if you're really doing inclusion...you're presenting the sociopath as if the sociopath ought to change, and that's not dialogical. This is really a hard one to get your mind around. You may not like how the sociopath is, society may not like how the sociopath is, but if I really have a dialogical attitude toward the patient, then, at least in our conversations, I'm not out to change them.

Student: Yes, but in that conversation what you're getting is accepting that they're not being genuine, accepting...

Lynne: ...yes, and I'm going to try to find out what propels that.

Student: Yeah, but I'm thrust into the dilemma of suspecting that I'm not being told the truth, and that's a projection.

Lynne: What's a projection?

Student: It's my organization of what they're giving me.

Lynne: If that has meaning to you, you can bring it into the conversation if you want, if you want. But if you're trying to figure out how to cure the sociopath...See, what I hear is you want the sociopath cured. I don't; I want to meet the sociopath. If I organize my experience of this relationship with this sociopath as, "I'm being lied to," then that's in the way of my being able to meet that sociopath. That I may want to address.

Student: Well, I'm not trying to cure the person; I'm thinking of a particular person, and so it's not just a purely hypothetical situation, and in our relationship I have been trying to practice a dialogical kind of relationship, and yet I come up with this dilemma that I'm not equal, that it's not a mutuality thing. The person is so disabled that they're not able to meet me...

Lynne: It's not their job. I think you think you're not trying to change that patient, but you are. You are trying to get them to meet you instead of you meeting them. You may not be able to meet them. I mean, what can happen in an effort to have a genuine dialogue is that there is no dialogue. But that's also not their problem. That's your problem.

Maya: One way to think about this is to think about this as extreme resistance, and if you can support the resistance, you have the possibility of meeting, as opposed to trying to transform the resistance.

Lynne: M-hm. Yes.

Student: This question is going to go from loftiness, to elegance, to whatever's at the other end. I'm inspired by something you were saying, in the last thing that you were saying, to ask, "Is it necessary to like your patient?" Because something makes me want to say, "Yes, if I've understood you."

Lynne: I do think love cures, interestingly. Buber had a really good point; he said, "You can't legislate love, but you can legislate treating someone lovingly, or with great care." I have patients whom I do not love, and I have one patient whom I do not like, nor do I respect him, but we are talking about that because we both know that if that doesn't turn around, our therapy is sunk. I've got to at least find something I can respect with this guy, so we're at least having to address it. But I really do think that the patients that have transforming relationships with me are the ones that I love. Now, luckily I think that if you meet patients with this attitude, ... except, I mean sociopaths - it's a different ballgame; it's hard to love a sociopath. You can be charmed, but it's hard to love them, because it's hard to love someone who has no capacity for empathy. But if you work from this model, it's hard not to fall in love with your patients, so I'm not worried about it mostly. And even this guy whom I don't like and respect, I have that kind of devoted love that makes me want to struggle through this mess instead of refer him on, which would really be a rejection of him.

Student: I have one question, no two. You said something about the I-Thou moment between the client and the therapist was irrelevant, and I don't know...

Lynne: Oh, the designation of roles - in the moment, who's patient and who's therapist is not very relevant. It is immediately afterwards, and it is immediately before.

Student: But it's not existent is the way I understood...

Lynne: In the experience of the patient and therapist, it's not existent. Right.

Student: The other thing is that at the beginning of this lecture you said that being in conversation with another human being, Buber says is like engaging with God. So, if you approach that with that kind of conversation with a patient, how can you help but find something that you like about them?

Lynne: Well, because I may be serving God by adopting a dialogical attitude, but I find God in the genuine conversation, and that's two ways; it has to be two ways. I was working with a religious patient recently where this kind of came up. She knew I was an atheist, and she is quite religious, and we had quite a special moment between us, and she described it as, "I'm talking to the God in you, and you're talking to the God in me." And I REALLY knew what she meant; it was very moving, very moving. I knew what she meant. It was a moment of mutuality.

Student: Oh, mine was just a tiny comment based on a previous statement that a colleague of mine was reading some new research to me over the phone some weeks ago. It was outcome research done across several different theories - between analysts, Gestalt therapists, and behaviorists, etc., - and the outcome measure among patients who described their therapy as successful was that they said their therapist loved them - not cured them of a behavior, not pointed them in the right direction - people who thought they had a great therapist said that their therapist loved them.

Lynne: Wow. In analytic research one of the things they found is that what patients remember about their positive experiences in therapy, is that they don't remember the interpretations, which is what analysts think cures. They remember moments when the therapist broke the analytic frame (laughter), which is the way in classical analysis that you would know that your therapist actually has personal feelings for you, or a loving connection with you - when they can't do the discipline of interpretation one more minute. They have to have a spontaneous response.