

Dialogic Relationship and Creative Techniques:

Are They on the Same Team?

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Introduction

Systems of psychotherapy tend to either focus on the therapeutic relationship with understanding emerging from the relationship, or organize around therapist-controlled techniques that aim to reach preset behavioral goals. Although at times gestalt therapy has been portrayed as if it followed the latter approach, it actually emphasizes the therapeutic relationship and the working collaboratively in a search for understanding. Gestalt therapy brings together a dialogic approach and the use of active techniques, which are called experiments. These gestalt therapy experiments differ from the usual behavioral techniques, which are directed by theory and therapist, aim toward predetermined outcomes, and are measured by research that is designed to confirm the positivist assumptions of the behavioral approach. True experiments are variations in investigation that aim for understanding rather than for a direct change of behavior.

A complete theory of psychotherapy includes a concept of what constitutes a good therapeutic relationship, a theory and methodology of consciousness, and guidelines about what interventions or techniques are consistent with the approach. On the surface, therapy systems that organize around the therapeutic relationship and growth through understanding appear antithetical to approaches that focus on the use of active techniques aimed at changing targeted behavior. In the former, the emphasis is on understanding the patient's experience and behavior, recognizing,

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understanding and accepting the patient's subjectivity, and valuing growth emerging from that relational process.

The relational perspective of gestalt therapy has a systematic theory, a methodology for integrating dialogic relationship and active/creative techniques (Yontef & Jacobs, 2010). These theoretical elements include an experimental phenomenological attitude and careful attention to immediate experience. Dialogical relating and experimental phenomenological methodology are grounded in the principle of contemporaneity.² Active techniques and a relationship-oriented search for understanding can work together effectively in an approach organized around phenomenological experimenting and careful attention to what is experienced here and now. In gestalt therapy experiments, as in dialogue, the quality of contact and emergent clarity of awareness are key. Experiments are not measured by whether they reach preset goals but by how they add to understanding.

In this paper, we will consider the historical/theoretical dichotomy between relational and behavioral approaches and how this split can be transcended through an approach that combines careful attention to the therapeutic relationship and the creative use of active techniques. We will discuss guidelines for the use of experiments in a relationship/insight-oriented therapy. Gestalt therapy's dialogic relationship, relational epistemology, phenomenological method, and experimental attitude will be discussed as the vehicle for this integration.

History

The Schism Between Classical Psychoanalysis and Classical Behavior Therapy

Modern psychotherapy was born out of early psychoanalysis and its definition of the

² The principle of contemporaneity states that what has effect is present in the current field. This is an aspect of field theory derived from the work of Kurt Lewin. (Yontef, 1993, pp. 285-325; Parlett, 2005, p. 47).

therapeutic relationship, theory of consciousness, and specification of technique. In that early, classical approach, the patient had the task of free-associating and the analyst intervened only by interpreting the transference. In this two-language system the language of the patient was one of free association and the language of the analyst was limited to interpretation of the transference. This vehicle for ascribing meaning defined the therapeutic relationship, the view of consciousness, and the allowable technique. The aim was understanding through insight via interpreting the transference neurosis. These interpretations followed a belief in inherited and universal drives and in the conflict between drives and social requirements. Any other activity or technique by the analyst or patient was considered a breach of the therapeutic frame, and was referred to as “acting out” or “acting in.”³

In classical psychoanalysis, if the patient had a viewpoint different from that of the analyst, he or she was usually seen as “resistant.” This meant that the patient opposed the correct point of view, i.e., that of the analyst. To maintain the purity of the transference, no personal information or feelings from the analyst was allowed, and no other activity was legitimated. The only practice allowed for the patient was free-associating and the only practice for the analyst was interpreting. For example, the concept of transference has often been evoked to understand a patient’s anger at the analyst. A classic analytical interpretation of the patient’s anger might be that the anger was displaced from another person and another time unto the current situation, and that the patient, in being angry with his analyst, was actually expressing unresolved anger at absent figures such as his father or boss. As a result, the patient’s original report of being angry with his analyst would be seen as a phenomenon that needed to be filtered through the psychoanalytical lens in order to be understood correctly.

³ “Acting in” referred to behavior in session that did not follow the therapeutic frame of free association and analyst interpreting the transference.

In contrast to this, early behaviorism only considered stimulus and response. Whether operant or classical conditioning was the paradigm for a particular treatment, the patient's thoughts, experience, and feelings were not considered relevant or even regarded as data. Only interventions of classical or operant conditioning were included in the methodology. Early behavior therapy manipulated stimuli to control responses, but growth in patient awareness was not an intended part of this system.

The limitations of the accepted parameters of both the classical psychoanalytic system and classic behavioral system created a sharp dichotomy between psychoanalysis which centered on "mind" and behaviorism which focused on material substance. Both manifested a Cartesian system of the isolated mind, separate from the body and others. The choice was between understanding of the transference neurosis through interpretation and changing behavior directly by controlling stimuli. Rigidly defining methodology and excluding all but orthodoxy not only made an integrated methodology impossible, but also limited growth and expansion in both methods.

Revolution of the 1960s

Alternatives to this dualistic dichotomy appeared in the 1960s and became quite popular. They featured growth through active contact between therapist and patient and active techniques. At the time, the alternative approach was called the Third Force, which included gestalt therapy. The theories and practices of the Third Force varied, but all were alternatives to the psychoanalytic disembodied methodology and behaviorism's emphasis on control and exclusion of relational, affective, and cognitive factors. The theories and the practices of the Third Force therapies were wildly eclectic in their views on the therapeutic relationship and the range of

techniques. Their wide variety of explicit and implicit behavioral and insight goals lacked a clearly stated theoretical integration with their broad range of techniques.

Third Force therapies favored active techniques, often modeled and advocated confrontational modes of relating, and frequently used cathartic and theatrical techniques. These techniques promoted excitement. Emotions were expressed, often exaggerated, at times enshrined, and overly socialized people exploded in confrontation. Patients shouted, pounded pillows, talked to empty chairs, and vigorously encountered each other. The organizing principle here seemed to be to bring the energy into the environment. For example, “Lose your mind and come to your senses” became a well-known gestalt therapy slogan at the time.

The emphasis varied, but usually included a more active, personal, interpersonal and authentic engagement by the therapist, with more focus on contemporaneity, a greater attention to the awareness process rather than interpreting the unconscious, active observation and work with bodies, sensation, affect, and movement. A wide range of active interventions that were neither systematic behavior modifications nor interpretations driven by classical drive theory were not only allowed, but encouraged. These included personal sharing by the therapist of his or her personal reactions and the creation of many active interventions.

However, the exact nature of the therapeutic relationship, the techniques, and the connection between them was only superficially explicated. This necessitated clarification about the exact kind of contact that was effective, what specific understanding to seek and what methods to use in this search for understanding. Just how are the search for understanding/awareness, the therapeutic relationship, and these active techniques related? There were also contradictions. For example, many approaches emphasized individual self-definition and assertion, but used techniques that created group pressure encouraging conformity. Similarly,

some theories of therapeutic relationships encouraged patient self-esteem while using techniques that were shaming (Jacobs, 1989; Yontef, 1993).

1-Person vs. 2-Person Psychology

A key aspect of the growth and maturation of psychotherapy has been the shift from a “one-person psychology” to a “two-person psychology.” A one-person psychology emphasizes the intrapsychic, a term developed in psychoanalytical theory that refers to the internal psychological processes of a person (Wallin, 2007, p. 168). This notion depends on a division of inner and outer experience and implies that a person’s problems come from within him or herself, and are not relational phenomena. The change theory in the one-person model promotes the idea that the therapist’s task is to fix the patient and to help create the new person from inside.

However, in gestalt therapy field theory and phenomenology, people are seen as inextricably interconnected and as part of a process of continual mutual influence (Schulz, 2012, p. 28, Yontef, 1993, p. 305). A shift to a two-person psychology moves the focus of our theoretical and clinical investigations away from the inner processes of a person and towards the relational dynamics that exist between people. Awareness is a relational event and “change does not occur by looking inward, but by what happens between people” (Yontef, 1993, p. 33; Yontef, 2002). This shift has been integral to the renewed and increased emphasis on the relational in gestalt therapy and in relational and intersubjective approaches to psychoanalysis (Wheeler, 2009, p. 20; Stolorow, et al., 2002, p. 85).

Awareness and Contact

With the move from an individualistic to a relational approach, gestalt therapy organized around the central theoretical concepts of awareness and contact, i.e. around what people are experiencing (rather than repression) and their actual contact (rather than an assumed transference

interpretation) (Perls, et al., 1951, p. 8). In this model the ability to contact one's world with awareness becomes the central concern, of which an essential aspect is knowing what one is in touch with. Phenomenological focusing and experimenting in gestalt therapy are primary tools for patients to know what they are in contact with, to become mindful of their awareness process and to learn how they are relating to their life context.

Contact refers to the motor and sensory process that occurs between the person and the rest of the person/environment field. Awareness is a form of contact and is not something that happens inside a person, it is rather what happens between the person and the environment. Awareness always is awareness of something. It reaches to the surround and is impacted by the surround.

Contact is regulated by a combination of habit/implicit awareness and focal awareness (Yontef, 1993, pp. 181-201). Most of a person's self-regulation is by habit; in other words, forces that are operating in the background of awareness. For instance, it is not usually necessary to be aware of how our feet touch the floor or about the fluctuation in our breathing while attending a concert. Most of our contact functions move below the threshold of focal awareness and do not need our continued attention. But we do need explicit awareness when dealing with complex situations, when/while solving problems or when our habitual responses are not adequate.

Awareness in gestalt therapy does not just refer to mental insights, but encompasses a holistic process that includes the entirety of a person's capacities for contacting – the ability to use sensory, emotional and mental experiences to gather and process information and use it in his or her interactions with the world. This includes people knowing their choices and taking responsibility for these choices (Yontef, 1976, 1979 and 1993).

Focal awareness is archetypically articulated as, “I am aware that...” Implicit awareness operates in the background and refers to non-verbal awareness, regulation by the whole organism, and body processes. Optimally, these forces become figural as needed. When awareness does not develop as needed, inhibiting people learning from experience, psychotherapy is indicated.

The Developing Theory of How Therapists and Patients Relate

The Paradoxical Theory of Change

A cornerstone of contemporary relational gestalt therapy is a theory of how people change. This theory is at variance with a common belief that to achieve growth or a cure, people have to both desire change and make efforts to be different from who they are. Therapists and patients alike often hold this attitude, and it is frequently also articulated in the professional and general literature. Gestalt therapy has a different perspective on how people change, one that is more consistent with its radical relational stance, called the Paradoxical Theory of Change.

“...Change occurs when one becomes what he is, not when he tries to become what he is not” (Beisser, 1970, p. 1). In order for fundamental and lasting change to occur, a person must acknowledge who he or she is. When someone identifies with their state of being, i.e., how they feel emotionally, how they experience their bodies, how they think, what they choose and how they behave, then the person is in touch with their existence. That promotes natural growth. Not knowing oneself or rejecting oneself leads to inner conflict and stagnation. In other words, people change and grow when they experience who they are in the world.

Gestalt therapy and gestalt therapy training include learning to identify genuine experience and accept the actuality that is experienced. This involves experiencing personal struggles, working through painful emotions, being torn between options, reacting to the experience of

shame, accepting compliments, and so on. For example, a patient might feel conflicted about the continuation of her relationship with a boyfriend. She tries to think through the “pros and cons,” but realizes that this is not helping her clarify the issue. Following the principles of the Paradoxical Theory of Change, the therapist might encourage her to pay attention to her emotional experience and to her bodily sensations while she discusses her relationship. She might acknowledge her sadness over the potential loss of the relationship or feel the tension in her stomach as she imagines continuing it. Bringing any of those experiences into her awareness might help her to achieve a clearer sense of the situation and enable her to make a decision consonant with her whole self.

People learn about themselves and learn to accept or reject themselves through their relationships with other people. The Paradoxical Theory of Change requires a therapeutic relationship and a clinical methodology that work by helping patients know and accept themselves, and that support growth and exploration of new possibilities through self-awareness and self-acceptance.

The Dialogic Therapeutic Relationship

The traditional one-person psychology viewpoint is of separate individuals who subsequently come together into various relationships. In gestalt therapy, contact is considered primary and is the “simplest and first reality” (Perls, et al., 1951, p. 3). Gestalt therapy builds on post-Cartesian philosophy and the relational model of Martin Buber to understand the person as always being “of the field.” In other words, neither the person contacting the environment nor the environment shaping the individual are primary, instead the simplest reality is the interface of person and environment – human and non-human.

In Buber's conception there is no self without the other. There is the I of the relational mode "I-It" and the I of the relational mode "I-Thou." But there is no "I" existing alone. People always exist within a relational dynamic that influences the very experience of the "I" – our sense of self. There is no I except the I of the I-Thou and the I-It (Buber, 1970, p. 54).

Contact has been a core theoretical concept in gestalt therapy theory since its beginnings, and the contact between therapist and patient has been key to gestalt therapy practice. In the freewheeling 60s, a variety of contact styles were rampant, different from both classical psychoanalytic and behaviorist styles. But since then, the question of what kind of contact is therapeutic has been explicated in the gestalt therapy literature.

Dialogue, as articulated in Martin Buber's philosophy, is a particular type of contact that is best suited to psychotherapy. Most relevant is the premise that the therapist meets the patient, follows the patient's experience, and does not aim for the patient to be different. This is contact consistent with the Paradoxical Theory of Change.

Gestalt therapy's dialogic method and attitude values the patient's experience and offers the benefits of a genuine exchange, one in which there is an inherent egalitarianism and a fundamental reciprocity of influence. Buber believed that patients seek psychotherapy as a way to heal their relational deficits. His notion of the I-Thou refers to an approach of being with another person in which the relationship is an end in itself (Buber, 1970, p. 112). In the I-Thou mode, being in a relationship with one another is the crucial aspect of the relationship. An example might be a close friendship, which usually requires openness towards each other and toward one another's personal concerns. In the I-It mode of relating, in which the interhuman meeting serves a particular function, the other is experienced more as an object (Buber, 1970, pp. 63, 64). An example of the I-It mode might be an exchange with a cashier at the grocery store. In

this situation, the cashier and the customer are usually not invested in their relating, but in getting through the business transaction.

Buber thought that we cannot function in the world without the I-It, but that we cannot be fully human without the I-Thou. It is helpful to see these two relational modes as part of a spectrum on which all human interactions exist, with each interaction containing at least some elements of both the I-It and I-Thou. Healthy relating requires flexibility and the ability to move along the I-It/I-Thou spectrum according to the needs of the situation.

For Buber, psychotherapy could enhance this flexibility, and his conception of the dialogic method has become an important resource for gestalt therapists in their efforts to meet their patients. Meeting the patient, in Buber's conceptualization, was the path that promoted psychological healing.

Buber's dialogic method has three characteristics: inclusion, authentic presence and commitment to dialogue.

About inclusion Buber wrote, "... for in its essential being this gift is not looking at the other, but a bold swinging – demanding the most intensive stirring of one's being – into the life of the other" (Buber, 1999, pp. 81, 82). For a therapist this translates into a recommendation to feel an approximation of what the patient feels – an approximation so close that the therapist feels it in his or her own body – while maintaining a sense of self. Inclusion is a form of contact, not a merger. This concept has some overlap with the general idea of empathic attunement. Inclusion from the relational perspective is mutual, i.e., the patient also experiences an approximation of what the therapist is experiencing (Staemmler, 2012, p. 59).

Inclusion requires authentic presence, which means that the therapist must be present as a person, discriminately revealing him or herself: "...if genuine dialogue is to arise, everyone who

takes part in it must bring himself into it” (Buber, 1999, p. 86). This approach is diametrically opposed to that of a blank screen classic analyst, who was forbidden in principle from showing anything personal because it would contaminate the transference. Therapist disclosure in service of the therapeutic task is one example of an intervention that applies this second principle of dialogue. Therapeutic presence is the disciplined and discriminating use of the therapist’s aware experience in the service of the therapy.

The third characteristic of the dialogic method is a commitment or surrender to dialogue. The therapist practices inclusion and presence, and something emerges out of this relationship that the therapist does not aim for or control. The therapist stays engaged in the therapeutic process and by surrendering to what arises from the therapeutic dialogue, is him or herself changed. The therapist’s perspective is not privileged and it is not only the patient that learns about self, but also the therapist. Thus the old sense of self and the world of both the patient and the therapist change.

In a dialogue-centered psychotherapy, the therapist works from the principle of existential meeting, i.e., meeting the patient and being interested in what and how the patient experiences. The orientation is to the present experience, the principle of contemporaneity, with careful attention to explicating the process of awareness, the behavior, and the relationship as it changes over time. The therapist is present in an authentic manner, showing him or herself as a human being rather than a blank screen, an idealized person or a master manipulator of behavior. Both the therapist and the patient participate in a direct experience and gain a potentially healthier understanding of the self and how the self relates to the world, especially to other people.

Relational Epistemology: Phenomenology

Change in Theory Leads to Changes in Therapeutic Interactions

As our underlying assumptions about human psychology change, so does our perspective on the psychotherapeutic relationship. These assumptions, including our beliefs and our values as therapists, influence how we view our patients and the issues they present in therapy. Therefore, our theoretical outlook guides our interactions with our patients and leads to specific therapeutic interventions. For instance, important guiding principles are at work underneath the simple question, “How do you feel?” They include the belief that the patient’s subjective experience is important and that an understanding of the patient’s emotional life is an essential element of therapy.

Our therapeutic techniques reveal the principles and attitudes that support them. An example might be a theoretical shift towards a phenomenological approach that results in a changing methodology, such as the change from an expert-style interpretation (classical psychoanalysis) to the phenomenological exploration of contemporary and relationally oriented gestalt therapy. With the advance of a non-hierarchical and increasingly collaborative philosophy of modern psychotherapy, the expert stance no longer seems sufficient to address the relational experiences of our patients. Trying to make sense together is a very different approach from assuming that the patient needs fixing and constructing behavioral programs to do so.

Philosophic Background

The classic dichotomy of working with relationship and understanding versus working directly with behavior stems from the classic Cartesian-Baconian philosophic stream that runs through Western culture. The integrative, relational approaches that emerged, including relational gestalt therapy, are built on a post-Cartesian, non-Baconian philosophy.

Relational gestalt therapy is a system in which truth is always contextual, perspectival, probabilistic, and corrigible. This is contrary to the predominant belief throughout the history of Western thought, at least from the time of Plato, that Truth is absolute, i.e., that Truth is universal, necessary, certain, and is true in any time or any culture. Truth is not mere experience; it is what causes experience.

Rene Descartes sought the path to Truth through the mind, i.e., through logic. He believed that only through logic could we attain certainty. For Descartes, the mind was separate and different from the material world. He did not value information from the senses, including empirical studies, since these do not bring certitude. The question of how to relate the isolated mind to the world “out there” is a legacy of this approach.

Cartesian thinking relies on logic to discover Truth. But logical conclusions still depend on underlying premises. Even if our logic is solid, how do we know that our premises are accurate? Therefore, the Cartesian approach does not succeed in finding a Truth that cannot be doubted as Descartes intended.

An alternative to Descartes, conceived at roughly the same time, was the philosophy of Frances Bacon, who also sought objective Truth. But for Bacon, the mind was the problem and the path to Truth was through sensory experience. Thus, he believed that facts inevitably added up to the Truth. Baconian thinking was a precursor to modern positivism and behaviorism. However, facts do not add up without human interpretation, and where there is interpretation, there are always alternative conclusions. Ergo, no absolute Truth.

For a time, Isaac Newton’s view of the world was assumed to reveal Truth. However, in the late 19th century the discovery/creation of non-Euclidian geometries and Einstein’s relativity

theory showed that what had been thought of as absolute Truth was only a temporary understanding, subject to correction (Schulz, 2012, p. 7).

Both the classical psychoanalytic approach to consciousness and the classical behaviorist approach assumed that their theories were based on Truth. In both cases, the practitioners and their theory-derived viewpoints were given privileged status.

The positivists, in the Baconian tradition, have erroneously thought that they could know an unfiltered reality. But this assumption does not hold up to modern scientific knowledge or philosophy. In fact, some radical constructivists have gone to the opposite extreme by saying that there is no reality except that which we construct. Neither the positivist's or radical constructivist's position integrates mind, body, and otherness and so do not support the fullness of an integrated system of relational therapy that uses active experimentation.

Relational gestalt therapy does support that integration. It is built on the epistemology of existential phenomenology. The phenomenological method is the foundation for the integration of dialogue and experiment. Following this approach, perception, memory, and knowledge are seen as joint constructions of the perceiver and the environment. We are not isolated minds, nor are we passive recipients of the external world. The whole person/environment field determines what we "know" and do.

Therefore, we are always already "of the field" and continually interact with our surround, affecting and being affected by it. Our minds are neither isolated from the outside world nor capable of knowing a logical reality that yields absolute truth.

Gestalt therapy is based on existential phenomenology, which attempts to understand human existence and consciousness. It studies the process of awareness in an attempt to distinguish between actual experience, assumptions and expectations. This method and its

foundational theory are contextual, perspectival, probabilistic, and corrigible. Its goal can be likened to cleaning a mirror so that we can perceive ourselves more clearly.⁴

The Experimental Phenomenological Method

The phenomenological method emphasizes description rather than explanation (Spinelli, 2005, pp. 19-35). Epoché (bracketing), one of its elements, asks the practitioner to put aside their assumptions and biases about truth and fact in order to optimize their openness to new impressions. Existential phenomenology does not believe that bias can be eliminated. *What is suspended is the assumption that what one thought was true is indeed objectively true.*

Through this phenomenological method one becomes more open to experiencing the world at a moment of connection before assumptions, reflection and interpretation. Part of the method is the rule of horizontalization (Spinelli, 2005, p. 21). There is no a priori limitation on what is relevant data. A phenomenologist is open to a broad range of phenomena and everything observed or experienced is assumed to be relevant.

An expansion of the phenomenological method is experimental phenomenology (Ihde, 1986). In that phenomenology, one can systematically create variations, try something new, and use phenomenological focusing to see what one becomes aware of. The therapist or the patient can suggest systematic observations or various experiments, so that the patient can become clearer about what resonates as true for him or her. Part of the goal is to distinguish between what is invariant and what is merely a variation. When a patient is observed doing something, such as lowering his voice when talking about his career, we can ask ourselves what this behavior indicates. Is it random, or is it an example of an underlying and ongoing theme? In the experimental phenomenological method one can experiment in a variety of ways, and by looking

⁴ Transcendental phenomenology, a phase in Husserl's thinking, used the science of consciousness to get to an absolute understanding of reality. The epistemology of existential phenomenology, including relational gestalt therapy, does not strive for or believe in the absolute Truth that this approach sought.

at a process over time using repeated inquiries/observation and a variety of angles, one can get clarity on what is random and what is an ongoing pattern.

By using phenomenological inquiry and experimentation, not just interpretation, many patients eventually learn to do awareness work on their own. At advanced levels, patients become less dependent on the expertise of the therapist, more able to do work themselves, and thus more powerful co-investigators with the therapist. For the therapist, this has the advantage that their beliefs, observations and interpretations are tested against the patient's experience.

Combining the Relational and Active Behavioral Approaches

Active behavioral methods are frequently contrary to the principles of the Paradoxical Theory of Change, and often undermine the patient's self-recognition and acceptance. Patients often experience the suggestion of active techniques as an indication that the therapist thinks that they are not good enough as they are, thus reinforcing guilt, shame or a sense of failure. Moreover, this might establish the idea that the therapist knows the solution, the correct outcome and the way to get to that outcome. If the therapist gives the impression of knowing what the patient should do and having set procedures for controlling the therapeutic pathway, it is hard to convey respect for and trust in the patient's ability to discover, direct, and grow.

Contemporary gestalt therapy has bridged the gap between the primacy of meeting patients and engaging with them so that they feel met and understood and methods that use active behavioral techniques to achieve directed patient change. This integration includes a psychoanalytically informed attention to repetitive patterns of behavior, thinking, and motivation.

In the relational therapies, the goal, other than the process goal of working together to make sense of things, may well emerge rather than be clear at the outset. Similarly, goals may change with exploration. For example, the emerging pattern of feeling, thought, experience or

behavior is often very different than initially imagined, and a trait that the patient initially wants to get rid of, when explored, may turn out to be needed and desired.

Experiment as Solution

What is an Experiment?

Experiment (noun): a test, trial, or tentative procedure; an act or operation for the purpose of discovering something unknown or of testing a principle, supposition, etc.: a chemical experiment; a teaching experiment; an experiment in living (“Experiment,” 2012).

Experiment (verb): the conducting of such operations; experimentation: a product that is the result of long experiment (“Experiment,” 2012).

An experiment in psychotherapy is a search for phenomenological data, and a psychotherapeutic intervention is the use of psychotherapeutic techniques that aim to further the goals of treatment. In gestalt therapy specifically, an experiment is an intervention and active technique that furthers the collaborative exploration of a patient’s experience as needed for the therapeutic task. Of course, experimenting is just one use of self by the therapist in service of the patient’s welfare, growth and healing.

With this in mind it becomes evident that experiments as psychotherapeutic actions can range widely, from making a guess about the patient’s experience – “this sounds like a very difficult challenge for you” – to the suggestion during a couples session that a patient move around the office to find the “right distance” from his or her partner. The dialogic interaction between the therapist and patient can facilitate the emergence of a new and more useful understanding. This collaborative process is fundamentally different from a psychotherapeutic path in which the patient is encouraged to accept the therapist’s interpretation as a superior

understanding - the patient's experience, not the therapist's viewpoint, takes center stage.

Experiments in relational gestalt therapy are interventions in which the therapist and the patient work together to seek the understanding and growth that emerges from dialogic contact and phenomenological exploration. We do something different, think something different, move our bodies in a different way, imagine something desired or feared and so forth, to see what we experience. Something useful usually emerges from this activity. It is not assumed that the experiment will reveal a better way of doing things, but instead, it provides a rich ground for exploration of how the patient lives in his or her world.

All Psychotherapeutic Interactions Are Essentially Experimental

We believe that no therapist can reliably know what a patient needs, accurately predict how they will impact that patient, or fully understand how the patient is affected by a particular intervention. The therapist's questions, comments, interpretations, and disclosures express an intention, but how the patient will experience these is unpredictable. On one hand, this leads to a less certain pathway for therapists, but an experimental attitude helps him or her stay open to the unique responses of each patient in each moment, and keeps them concentrated on the main focus of their work - the ongoing exploration of the patient's experience.

Experimental Attitude

An experimental attitude in the psychotherapeutic work supports careful attention to the patient's input and allows what emerges between patient and therapist to guide the direction of the therapy. It favors creativity in the therapeutic work (Yontef, 1993, p. 91). A metaphor for this attitude might be a research scientist who follows up on his hunch with an experiment that is designed to generate more data about his idea and adjusts his prior theories and hypotheses according to new findings. Similarly, psychotherapeutic experiments do not need to be performed

well or to be completed – they are simply tools for further discovery in the therapist-patient system. Since the therapist is not the ultimate authority on what is important or how to understand the patient's situation, the patient and the therapist need to work collaboratively.

Experiments can yield new information and are also vehicles for novel experiences for the patient. As human beings, we learn from experience, which includes new insights, physical sensations, emotions and our relationships to other people. An experience involves the whole person, and therefore trying out something new can be scary, exciting or frustrating, etc., and might even challenge one's sense of identity. For instance, asking a patient to look at the faces of the other members in a therapy group might carry the risk of further exposure and shame for that patient.

A newcomer to the concept of experiments might ask: is it important for the success of the therapy that the patient follows the therapist's suggestion? Not at all! The suggestion of an experiment is itself an experiment. The patient's reactions to a suggested experiment will yield important information and it might even be a triumph for the patient to be able to finally resist an authority figure and to say "No!" to the therapist. Exploring the hesitation of a patient to participate in an experiment is more important than that the experiment will be performed.

How is Dialogue Compatible With the Philosophy of Experimentation?

To offer an experiment means to engage the patient beyond his or her current experience. For instance, we might ask him to repeat a particular word or phrase and highlight it even further by asking him to say it louder than before. The therapist's motivation for such a suggestion varies depending on the situation, but when used with an experimental attitude, it attempts to elicit further engagement and further exploration of the material presented by the patient. If an

intervention aims to help the patient to become more assertive or fix him or her via catharsis, then it is not a gestalt therapy experiment.

As mentioned earlier, discussion of the dialogic method leads us to the question of whether experiments correspond with the tenets of the dialogic philosophy. Dialogic meeting, in a Buberian sense, is at times misunderstood as a directive to not diverge from the patient's agenda or to be empathically attuned at all times.

Actually, dialogue refers to an engagement between people, who each bring their unique experiences to that meeting, and while reflection of the patient's experience is necessary, it is not sufficient. Buber's dialogic method requires not only inclusion, but also presence (Buber, 1965, p.85). The therapist's emotional commitment, knowledge, creativity, kindness, and so forth also play a vital role.

Dialogue itself is an experiment. Every encounter between patient and therapist is a moment of contact, and at the same time a meeting of differences. Both parties bring their unique beings into their interactions, and communicate these differences verbally and nonverbally, whether they are aware of it or not. The dialogic theory implies that we can meet the other, but that in so doing we do not lose our differences.

As therapists, we use inclusion to try to understand the emotional undercurrent of a patient's words and feel our way into his or her experience by carefully attuning to our own responses or imagining the patient's reactions.

Thus, communicating our understanding of the patient's experience is investigational and serves as a means of furthering the joint therapeutic exploration. In other words, our part in the dialogue is always experimental in nature; we continually probe for a better grasp of the patient's experience, knowing that our understanding will always stay provisional.

Let us look at an example of an interaction between a patient and therapist: the patient looks down and seems lost in thought. The therapist inquires, “Talking about your sister seems to have affected you. Are you thinking about her right now?” “No,” replies the patient, “I was just thinking that I have never talked to anyone about this, and how lonely I have been feeling about it.” Clearly, the therapist’s inquiry has several motives and layers. He wants to connect with the patient and communicate his understanding of the patient’s current experience, but he also wants to use an open-ended mode to further the interaction between them. It does not matter that the therapist did not guess the patient’s experience “correctly.” The communication and question themselves served well as probes to allow the patient to bridge a gap in the therapist’s understanding and to further fill out the story of his relationship with his sister and his experience and memory of it. Also, it demonstrates the therapist’s care and his trust in the patient’s experience as an authoritative test of the accuracy of the therapist’s interpretations.

How is the Paradoxical Theory of Change Compatible With the Use of Experiments?

Experiments are complementary with the dialogic theory, but is this also the case with the Paradoxical Theory of Change, another of gestalt therapy’s theoretical cornerstones? How can we maintain the principles of the Paradoxical Theory of Change, based on the idea of learning from current experience, with gestalt therapy experiments? Do we not ask the patient to move away from her experience when asking her to talk to an empty chair or to imagine herself back as the four-year old that missed her mother?

In fact, the Paradoxical Theory of Change is not a way of keeping the conversation and therapeutic investigation solely focused on what is happening in the here and now. As a therapeutic principle, it guides the therapist to interact with a patient without aiming for a particular outcome (Yontef, 2005, p. 83). Imagining the future and remembering the past are

crucial human talents, and many of our patients' concerns involve exactly these imaginings and remembering. Even though a person will project himself into the future, for example to the dreaded public address he will have to perform, or into the past, when thinking about a event in his childhood, the experience of imagining those events is occurring in the present moment, here and now.

A full awareness of current experience also includes the understanding that habitual ways of thinking, feeling and behaving might not adequately address the current situation. Here is an example: a person in a psychotherapy group is talking to another group member in an abstract way, while looking at the floor. The therapist might ask how she is experiencing herself talking, possibly leading to a conversation and an increased awareness about her hopes and fears when communicating with another person. A more active experiment in this situation might be an invitation for her to look at the other group member and to talk to him about her emotional experience as she attempts to connect with him. Although this suggestion might introduce something that she did not pay attention to at that moment, it is also a way of engaging her with her style of interacting with the other person. Provided that the therapist keeps his suggestions in the spirit of experimentation, trying out of new ways of thinking, expressing oneself and behaving will allow her to further explore her ways of connecting with her fellow group members, and ultimately with her social world in general.

This experimenting frequently brings to the foreground things that had been kept in the background and out of awareness. This might include deeper levels of emotion, emotions other than the ones the patient was already in touch with, associations from the past and links to the present. As mentioned in the section on dialogue, the interaction between therapist and patient is not static, and lives off of the flow of verbal and nonverbal communication. The spirit of both the

dialogic theory and the experimental attitude requires that the probing questions by the therapist or his empathic comments are meant to connect with the patient and/or to further explore the patient's experience, and should be not designed to make the patient "see the light" or to behave differently. This psychotherapeutic stance is an essential ingredient of both of those concepts.

The therapist's investment is not in the status quo, as a superficial reading of the Paradoxical Theory of Change might suggest. And however dramatic or cathartic an experiment might be, its goal is greater awareness, not a directed change in the patient's behavior. Most importantly, the exploration aims for self-recognition and self-acceptance and not self-denial, self-rejection, or self-hate (Yontef, 2005, p. 83). When the experiment reveals the rejecting self-reactions, that important process is observed, accepted, and is not judged by the therapist. That is the Paradoxical Theory of Change at its best.

The central aspect of the here-and-now orientation is that at each moment something arises in awareness, emerging from the background and becoming figural. For the psychotherapeutic process, it is important that the therapist and the patient pay attention to these emerging figures and the process of how they are regulated.

Cultivation of Uncertainty and Flexibility

Psychotherapeutic work, like life, entails a certain amount of uncertainty - uncertainty about outcomes and about specific ways to behave, interact, feel, think or be. A therapist's expert stance, as practiced in classical psychoanalysis or behaviorism, allows the patient and the analyst/therapist to trust in a preexistent, charted course. As gestalt therapists, we also trust that important progress can be made in psychotherapy, but not with certainty and not towards a specified behavior or way of thinking and feeling. Our therapeutic path assumes that people have the capacity to find their own way through their particular life situations and to learn, grow,

create, find solutions and improve the world – given the necessary support and awareness. We feel that our task as therapists is to facilitate the emergence of this needed awareness, even though we cannot know the patient’s specific needs at the outset of the therapeutic journey. The ability to focus awareness is a tool that will be useful regardless of where the uncertain road leads. Phenomenological focusing and dialogic contact are not only the tools of psychotherapy, but can become part of ordinary functioning. Donald Ihde refers to this as phenomenological ascent (Ihde, 1986, p. 109).

Frank Staemmler advocates that we “cultivate uncertainty” (Staemmler, 2009, p. 335). Relational gestalt therapy allows patients to better tolerate the uncertainty that life brings, and also supports the uncertainty that comes with creativity and experimentation.

Trying new approaches in life creates uncertainty for both the patient and the therapist. If the therapist does not follow a prescribed, manualized protocol, he or she has both the challenge and the freedom of discovering what is needed at each moment and what will come next. This uncertainty can result in an insecurity that can be terrifying and shameful for a new practitioner. Therefore, gestalt therapists need a firm footing in therapeutic theory and philosophy for their own support. The therapist’s own tolerance for uncertainty will increase as he or she feels more grounded in the benefits of this method, for instance through his or her own therapeutic journey.

The relational gestalt therapy model requires the therapist to be flexible and willing to make course corrections as needed. For example, as an experiment provides new data, e.g. a new way of perceiving or experiencing a situation, this information will need to be processed and integrated by the patient and the therapist. The therapist’s investment should not be in the correctness of his guesses, but in his openness to exploring alongside the patient and to changing his perspective as new material emerges.

Why Suggest an Experiment?

The central focus of a gestalt therapy experiment is the awareness process: what can we learn in regard to our emotional and mental processes, our bodily experiences or the therapeutic relationship? We learn from our actions and experiences in the world, not just from talking about them, and patients learn by discovery, by working actively with the material presented during the session in addition to verbally describing their situations. Experiments give us a chance to be systematic in learning by doing. In effect, we are asking our patients to explore their awareness process and to discover how their thinking, feeling, sensing or behaving works for them or how it does not.

The goal of experiments is ultimately an increased awareness about relevant aspects of the patient's life. Various aspects of awareness work that can be the focus of the experiments include:

- Clarifying and sharpening awareness.

The therapist might suggest, "concentrate on your critical inner voice for a moment and verbalize it." Or, "as you are tuning into yourself, what seems of most interest to you to focus on?"

- Bringing into focal awareness what was peripheral before.

Therapist: "As you are talking to me, pay attention to your breathing." Or, "You started to take a quick look around to the other folks in the group. What do you see in their faces?"

- Bringing awareness to what has been kept out of awareness.

Therapist: "What are you feeling as you are telling me this?" Or, in a therapy group, "Joe just gave you a compliment, but you didn't seem to react to it at all. What did you experience as you listened to him?" Or, "That is a very powerful story that you told me. What are the sensations in your body right now?"

- Bringing awareness to what interrupts awareness.

Through the therapeutic work, a patient becomes aware of an introjected belief that interrupts his awareness process: “A good person doesn’t criticize his mother!” Or an avoidance of a painful memory: “I will be depressed for the rest of my life if I go back to that difficult time.”

- Experimenting with novel ways of thinking, feeling or behaving.

In a therapy group, a member might be asked to look at other people in the room after revealing something emotionally risky. Or the therapist might say, “you have been afraid of your father your whole life. Why don’t you tell me what it is that you always wanted to say to him?”

Support for Experiments

As has been noted in recent writings on gestalt therapy, our ability to interact with the world is made possible through support. Support is defined as whatever makes contact possible (Jacobs, 2006, p. 3). For example, I feel supported by the interest on my students’ faces during a lecture and I rest on the support of my musculature to stand at the podium. Every action, thought or feeling is made possible by some kind of supportive process. An experiment is only useful for a patient if it fits his or her available supports. Psychological growth occurs when a balance between challenge and support is found that suits the patient’s needs. If an experiment is too challenging, the best outcome might be that the patient cannot assimilate the experience. On the other hand, an experiment only facilitates growth if it introduces enough novel challenge to stimulate potential learning.

Support includes both self-support and environmental support. These types of support do not refer to a location within or outside of the patient, but can only serve as a way to describe the variety of supportive and difficult factors in the patient’s life. These concepts are not dichotomous, and are in fact so intertwined that a dividing line cannot truly be determined

between them. Self-support can refer to the ability to understand the suggestions for an experiment or the capacity to integrate the experience, while the accepting attitude of the therapist would be an example of environmental support.

While we need to assess the patient's support in order to determine his or her ability to gain from a particular experiment, we cannot predict with certainty how our suggestions will be received - otherwise it would not be an experiment. In the end, we will only know from the patient's reactions if the experiment was useful at all.

Cautions In Suggesting an Experiment

When the concept of experiment is introduced, especially to new therapists, they often take it as, "finally, we are getting to something that we can apply - something to do!" The broader concepts of the dialogic method and the Paradoxical Theory of Change might at times seem overly vague or lacking in specific enough guidance for the beginner. But even though the gestalt therapy experiment is very useful as an interventional methodology and gives the therapist something to do, there are also risks to consider in employing these techniques.

The pressures on therapists to find solutions, to help or to relieve painful symptomatology are not insignificant, and they can become powerful motivations to move the therapy in a particular direction rather than to work alongside the patient. The patient, too, often wants to change in particular ways. Usually, we therapists enter the mental health profession to help our patients and to improve some of their difficult situations. However, the psychotherapeutic work itself is often intangible and the results of our work can be difficult to pinpoint. Not knowing what to do as a therapist can be a very scary and shame/guilt inducing experience. Thus, our caring as well as our insecurities can become strong motivational factors in aiming for a particular therapeutic outcome.

Therapists at all levels of experience sometimes suggest experiments in order just to “do something” or to show competence and confidence, or to avoid the intense and uncomfortable emotions triggered by the therapeutic work. However, if psychotherapeutic interventions become vehicles for these kind motivations and aims, they serve the personal needs of the therapist rather than the therapeutic task.

Resistance

However creative, clever, informed, or insightful our interventions may be, the patient might not agree with our ideas. He or she may feel too scared, insecure or shamed to follow our suggestions or may think that they are silly or useless. As noted earlier, classical psychoanalysis and behavior therapy regarded resistance as the patient fighting the system, as a “bad” thing and as something to eliminate. But resistance is important to respect and explore. It gives important insight to the patient’s support, values, and process. The patient might even be right!

Clearly therapists must be attuned to the patient’s responses to suggestions for an experiment and to the experiment itself. If the patient does not want to go along with our ideas, we had better listen. A patient’s so-called resistance against following our suggestion for an experiment is a valid response and by overriding it, we risk rupturing the therapeutic relationship or even retraumatizing the patient (Polster & Polster, 1999, p. 121).

If we do not yet know the reasons for the patient’s reluctance to follow our suggestion, it behooves us to explore and learn about it, rather than to “talk the patient into it.” Resistance towards an experiment, or toward any aspect of the therapy for that matter, needs to be appreciated as a communication of importance, as a message that is not yet fully understood by the therapist or the patient. As with any unclear aspect of the content or process of therapy, it is usually very useful to explore what we do not yet understand.

For instance, I (FS) once offered an “empty chair” experiment to a patient of mine. She had been in therapy with me for a few years, and when she seemed reluctant to go ahead with my suggestion, I felt comfortable enough to urge her on a bit. She then did go along with my proposition, which only resulted in a flat exercise during which she spoke in a monotone voice, seemed only marginally interested and was certainly distracted. However, our solid therapeutic relationship enabled us to discuss her reactions to the experiment, including the fact that she complied with my request despite her strong reservations. The resulting exploration of our individual contributions to the event proved quite useful to our future work together and to our understanding to both her method of withdrawing by becoming less present and my pushing in order to connect with her. Using a dialogic attitude, our experiments do not have to be accomplished, but need to be, as with any intervention, subject to disagreement, to revision and most of all, to exploration by all parties.

Types of Experiments

As mentioned previously, experiments are interventions designed to facilitate an expanded exploration of the patient’s experience within the context of the therapeutic task. Experiments can be as simple as asking the patient for their reaction to a particular interaction in therapy or as active as role-playing an inner conflict that the patient is struggling with. The type of experiment is limited only by the creative input of both the therapist and the patient. In most cases, the therapist suggests the experiments, but the initiative could also come from the patient. This is more often the case after the patient has been in therapy for a while and has become comfortable enough to get more actively involved in directing the course of therapy.

Here are examples of some of the more active therapeutic experiments:

A **mental experiment** might be used to differentiate various aspects of the situation to determine what aspect is important, what interpretation is accurate, or what exactly triggers the patient's reaction. For example, it might be a particular visualization or a thought experiment that has to do with a past experience or a dreaded or hoped-for future. Or, it might be used to imagine an encounter with a loving parent, a spiritual guide or a feared situation. The therapist might say, "imagine that you are 5 years old and that your angry father is sitting next to you on your way to kindergarten. What are you feeling or thinking?" Or, "what are you aware of as you imagine your job interview tomorrow?" Or, "imagine your brother says he is feeling sorry and that he apologizes in an sincere and heartfelt way. What is your emotional reaction to that?"

A **meditative experiment** can be a relaxation exercise or a structured observation of thoughts, sensations and emotions that flow through one's body/mind. A formal meditation exercise might serve as an experiment as well, if the outcome of the practice is not seen in terms of success or failure, but instead focuses on actual and spontaneous experience. This creates time and space for new awareness and leads to an exploration of the benefits or negative results of the practice.

"**Checking in**" often happens at the beginning of a group therapy session as an awareness exercise. The group members are asked to check in with their current experience and articulate some of it to the group or a specific person. But "checking in" can also be useful with an individual patient or a couple.

Exploration of polarities refers to the examination of different aspects of the patient's experience; for instance their emotional or mental conflicts. Let us say that the patient is unsure about whether or not to go back to college. The pros and cons that the patient is conscious of only comprise one facet of his ambivalence. He may also have internalized different opinions from

friends or family, making it even harder for him to gain clarity. He might be confused about which aspects represent his own preferences, and which embody his need to accommodate or resist his parent's wishes. These seemingly polarized views can be given voice during the session, and the resulting dialogue may include all of the often-perplexing elements of his decision-making process. Focusing on reactions in the body might be a helpful aspect to such an experiment. This could also work as a homework assignment, e.g., writing a dialogue in a journal. Other polarities that are frequently explored are love/hate, desire/fear, and coming close/needing distance.

Empty chair work is often used to highlight inner conflicts or polarized voices within the patient, or as a vehicle to express what is difficult to say to people in the patient's life, such as a parent, a boss or a girlfriend. In the latter situation, an absent person could be imagined to be in the empty chair, allowing the patient to express him or herself more freely for the purpose of the therapeutic exploration. Similarly, a part of the patient's conflict – for example an inner critical voice – could be talked to as a figure/person in the empty chair.

Exaggerations of the voice or of a body movement can clarify the diffuse emotional energy behind a comment, fantasy or gesture: “You just put your hand in front of your mouth as you remembered your Mother's scolding. I have a suggestion. Hide your face behind your hands and tell me what you are experiencing.” Or, “your voice became very low when you imagined telling your sister about your feelings for her. I suggest you try saying the same thing in a loud and clear tone while noticing how that feels to you.”

Enactments are ways to act out memories, wishes or dreaded events: “Please walk around the room like your father would and talk in his voice about the need to be practical and make one's way in the world.” Or, “you have wanted to tell these things to your friend for many

years. Imagine she is here with us and that she can hear your words. Tell her what is on your mind. How does that it feel to do that?”

Body movements are not separate from the other types of experiments, but at times can help the therapist and patient focus on the physical aspect of experience. As a trainee, I (FS) once was asked to use body language to ask for acceptance from other group members in my training group. When after a while, I assumed a posture of supplication, I became very emotional and felt transported to a feeling state that had been completely out of my awareness at the time. Feelings of need, of the shame to need, of anger and of the desire to surrender became suddenly very present and emerged from these particular gestures. I (GY) remember being asked in movement therapy to move like my mother did, and suddenly became aware of intense anger towards my mother that I had not recognized earlier.

With couples it is often helpful to have them **practice listening skills**. The term practice might suggest the idea that the couple is deficient and now needs to improve these skills. This could be the case, but the experimental attitude places the emphasis on exploration, not on creating a particular behavior. It is less helpful for the couple to feel that they need to learn a desirable set of skills than for the therapist to explore with them what is helpful, objectionable or interesting in that experiment.

Another experiment that can be very useful when working with couples is to play the “**alter ego**” for one partner during a session. For example, the therapist might “double” the husband and articulate how she imagines his emotional voice. She might say to the wife, “Mary, you often criticize me for not helping you more. But your tone of voice and your words are so hurtful and make me so angry that the last thing I feel like doing is accommodating your wishes.” The therapist then checks in with the husband and asks him to correct her role-play or add to it.

This could result in an exploration of the husband's reluctance to voice his feelings to his wife. Of course, it is also important to hear the wife's responses to her husband's feelings and thoughts and/or to the therapist's role-playing.

Conclusion

We have discussed the tension between a relationship-oriented and a behavior-oriented psychotherapeutic approach. At first this tension existed for the classical psychoanalytic and behavioral therapies. The psychotherapeutic orientations that were part of the Third Force, including gestalt therapy, diminished that tension, but their philosophies regarding the integration of the therapeutic relationship and their techniques used in treatment were rarely well articulated. This lack of coherence often led to an unclear direction in clinical practice and at times even did damage to patients.

As for gestalt therapy, the confrontational and active style that was often seen as its hallmark, in particular during the 60s and 70s, changed to a more dialogical and relationship-centered approach that is actually more consistent with its foundational philosophy. A growing awareness about the importance of the relational aspects of human existence diminished the status of the techniques that gestalt therapy had become identified with. What might be called a classical gestalt therapy, a more technique-focused style of working, gave way to a more dialogue-centered methodology. With this change, the gestalt therapy experiment, both as a concept and as a form of intervention, changed in focus, became more clearly articulated and was better integrated into the intersubjective relationship.

Now, gestalt therapy experiments are phenomenological in nature and as such are an important aspect of gestalt therapy theory and practice. A contemporary gestalt therapist does not

need to choose between a relationally oriented approach and the use of active techniques. In fact, all psychotherapeutic interactions are essentially experimental and an experimental attitude is a crucial element of a relationship-oriented psychotherapy.

One of our concerns was to clarify that the Paradoxical Theory of Change and the dialogic methodology of gestalt therapy are not in conflict with, but are enhanced by, the gestalt therapy experiment, and that experiments are part of the therapeutic conversation. Experiments are part of the therapeutic dialogue and should not be used for the therapist's extra therapeutic needs or to override the patient's reluctance towards their own feelings or the therapist's perspective. After all, experiments are ways of exploring the patient's experiential world and are part of the ongoing dialogue between therapist and patient, not a method to fix the patient or to make therapy more "exciting."

The examples of gestalt therapy experiments that we discussed are just a small sample of all the creative ways a therapist can engage with his or her patients, but a repertoire of techniques is not a substitute for the psychotherapeutic dialogue or a way to avoid the uncertainty that necessarily exists in the therapeutic meeting and in life in general.

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