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The Relational Attitude in Gestalt Therapy Theory and Practice

Abstract: Gestalt therapy theory is relational in its core, although some talk and practice of gestalt therapy is not consistent with the principles. This paper reviews core relational philosophical principles of gestalt therapy: existential phenomenology, field theory, and dialogic existentialism. The implications for practice are explored. Practices and attitudes about gestalt therapy that are inconsistent with these principles are discussed. The article studies the triggering and treatment of shame in gestalt therapy and gestalt training. The article clarifies what relational gestalt therapy is and what it is not.

Keywords: Bracketing, dialogue, field theory, individualism and interdependence, metatheory, phenomenology, relational gestalt therapy, shame, subtext, therapeutic relationship.

1. Introduction

Gestalt therapy is systematically relational in its underlying theory and methodology. A relational perspective is so central to the theory of gestalt therapy that without it there is no coherent core of gestalt therapy theory or practice. Recently much has been written about a relational approach to psychotherapy both in the gestalt therapy and the general psychotherapy literature. In the general professional literature there has been a discovery of a relational perspective (Aron, 1996; Mitchell, 1988; Mitchell & Aron, 1999; Stolorow et al., 1987). In gestalt therapy, "relational gestalt therapy" has been revisiting the relational perspective built-in to gestalt therapy theory (Hycner, 1988; Hycner & Jacobs, 1995; Jacobs, 1989, 1992, 1998; Staemmler, 1993; Yontef, 1993, 1998, 1999).

The function of the current discourse on relational gestalt therapy is to differentiate among significant variations in how gestalt

therapy theory is talked about and even more significant variations in how gestalt therapy is practiced. Some common ways of talking about and practicing gestalt therapy are not fully consistent with the basic relational theory of gestalt therapy. Moreover, there are relational implications implied in the foundational theory that are not consistently, or sufficiently explicated.

In this article I will review each of three fundamental and indispensable philosophic principles of gestalt therapy, that is existential phenomenology, field theory, and dialogic existentialism, and then discuss the variations of talk and practice that warrant taking a fresh look at the relational implications of each of them. I will then discuss shame as it relates to a relational perspective, and a concluding section on what relational gestalt therapy is and what it is not.

2. Existential phenomenology[1]

Gestalt therapy is based on the philosophy and method of phenomenology (Yontef, 1993). In gestalt psychology the phenomenological method refers to "as naïve and full a description of direct experience as possible" (Koffka, 1935, p. 73). The phenomenological method is a discipline to identify and enhance direct, immediate experience and to reduce the distortion of bias and prior learning. An important aspect of phenomenological discipline is methodically refining awareness, reducing bias as much as possible, especially bias about what is valid data, bias of what is real. Edmund Husserl (1931) refers to this as putting it into "brackets". There is a kindred attitude in contemporary psychoanalysis: "holding one's interpretations lightly".

One special feature of gestalt therapy phenomenology, as in gestalt psychology, is that phenomenological study includes phenomenological experimentation.

Phenomenological theories are relational theories. In phenomenological thought, reality and perception are interactional co-constructions; they are a relationship between the perceiver

[1] For the discussion in this paper I use the terms existential phenomenology and psychological phenomenology as synonymous and the terms transcendental phenomenology and philosophic phenomenology as synonymous.

and the perceived. Thus all perception and statements of reality are interpreted (Spinelli, 1989). This basic phenomenological attitude rejects the Cartesian subject-object split. There is no subjective experience that is not related to some object (intentionality); there is no experienced object except through some particular interpretive vantage point. This phenomenological position is different than a radical constructivist position.

The phenomenological method is central to all phenomenological systems, including both existential/psychological and transcendental/philosophic phenomenology and also the phenomenology of gestalt psychology.

In psychological phenomenology, including gestalt therapy phenomenology, the study is of the experience of the subjects and is never finished, objective, or absolute. In the transcendental or philosophic phenomenology of later Husserl, the study is of the objects of perception. In this phase, Husserl claimed a bracketing complete enough to discover universals. Gestalt therapy is not based on transcendental phenomenology (Yontef, 1999). In gestalt therapy it is not believed that one reaches objective truth by bracketing.

2. 1. Discussion

In phenomenological theory there are multiple valid "realities". Insofar as it is phenomenologically derived, no perception can be validly dismissed as not real. Therefore:

The therapist's reality is not more valid or objective or true than the patient's. This is especially true since psychotherapy is centered on the patient, it is the patient's existence that is the reason for the therapy, and it is the patient that has the primary data. The patient's sense of self is as phenomenologically real and valid as the therapist's sense of the patient. Conversely, the patient's sense of the therapist in the therapist-patient interaction is as valid a phenomenological reality as the therapist's self-concept. This attitude is crucial for a truly relational therapy.

Some gestalt therapists talk and/or act as if the trainer/-therapist's reality is privileged in that it is more real or accurate

than the patient's or trainee's.[2] When the term "obvious" (ostensibly referring to what phenomenologists call "the given") is used, it seems to indicate that all bias could be bracketed and an objective truth established. This often out of awareness attitude and its consequences is a key reason for this discussion of the relational attitude in gestalt therapy.

The philosophy of gestalt therapy explicitly promotes respect and appreciation of differences. Practicing this philosophy requires humility. Bracketing and personal therapy for the therapist and trainer support this practice. Unfortunately, even gestalt therapists and trainers who know the philosophy sometimes treat viewpoints different from their own as subjective and interpretive but act as if their own points of view are true and objective.

This is especially important when the difference of perspective is between therapist and patient and when the difference is the patient's perception of something the therapist does that is out of the therapist's awareness. A fully phenomenological stance would be for the therapist to assume that there are two realities, both with some validity. The hubris of the attitude by the therapist that his or her view of self, the patient, and any interaction between them is correct and the patient's different perception is wrong is not consistent with the phenomenological attitude. Such an attitude indicates insufficient bracketing and personal therapy (Yontef, 1999).

Here is an illustrative example. I overheard a trainer at lunch at a training workshop talk with derision of an event that happened in the session of that morning. A trainee had said that he experienced a remark of the trainer as hostile. The trainer continued his derisive storytelling by elaborating that a large part of the group agreed with the trainee. However, the trainer insisted that it was ridiculous that anyone could say he was hostile when he did not experience himself as hostile. This attitude is not only incompatible with the values of gestalt therapy phenomenology, but also incompatible with other main principles of gestalt therapy, dialogical existentialism and field theory. This attitude can be a potent shame trigger (see discussion below).

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[2] When therapy is referred to in this article, it is meant to apply to both psychotherapy and psychotherapy training.

3. Field theory

Field theory looks at all events as a function of the relationship of multiple interacting forces. Interacting forces form a field in which every part of the field effects the whole and the whole effects all parts of the field. No event occurs in isolation. The whole field determines all events in the field, with some forces being in figural awareness and some operating in the background. In the example above, both the trainer and the trainees are responsible for the co-creation of the event of the experienced hostility and how it was processed.

It is inherent in field viewpoint that people are interdependent and not self-sufficient. The person and the field are not separate entities that are brought together. People are not "in a field", but "of a field". There is no field without the forces and no forces without the field.

There are different kinds of fields. In gestalt therapy the field is a phenomenological field (Lewin, 1951; Yontef, 1993). Human events are perceived to be a function of an organismic environmental field. The individual and the environment are all "of the field". There is no "I" without a field – which includes an environmental context. There is also no environment except as a part of a field. We only know "environment" in relation to some observer, only when some observer defines it. The determination of the relevant environment is co-determined by what is out there and the observer.

Problems are problems of a field and the solutions are solutions of that field. Any process, problem, creative advancement, solution to a problem is a function of the relationship between the people "of the field" and the field as a whole. There is a fascinating discussion of this in Max Wertheimer's *Productive Thinking* (1945).

There are no human events that are not of an organismic-environment field. People are always of a field and are interdependent. The people of this field are all part of the force that determines what occurs, hence responsible. All events in the human field are a function of all of the participants and the interactions between them. The rugged individualism ideal, the ideal of self-sufficiency, is not consistent with a field way of thinking.

Living systems grow by contact with that which is outside the system and assimilating needed novelty. This is true both of individuals and of larger systems. A field, person or larger system, can only be defined in relation to its parts and the larger field of which it is part.

3. 1. Discussion

There is an attitude in some gestalt therapy circles, stemming from the confrontive tenor of gestalt therapy in the 1960's, that need is a weakness, a flaw[3]: The patient/trainee is needy; the therapist/trainer is self-sufficient, and the therapist's job is to frustrate the manipulation of the needy patient. Sometimes the concept of "self-sufficiency" hides under the term "self-support". Properly used, the concept of self-support refers to self-regulation as part of the field, referring to defining the needs of self and others, and does not refer to self-sufficiency. We are all "dependent", or, more accurately "interdependent".

The view of need and dependency as a weakness, and the creating of an icon of the self-sufficient hero, so prevalent in American rugged individualism, is fertile grounds for creating shame (Wheeler, 1996; see discussion in Shame section below). If a therapist does not know or admit his or her dependency and other vulnerabilities, it helps trigger or create shame in vulnerable patients.

The discussion of the relational essence of gestalt therapy is needed to correct the shame-creating attitude that was present in cliché level talks in the 1960's and that can still be seen in a more subtle form in some current practice and training. When the patient is expressing or showing a need or desire that could be confronted as needy or manipulative, it is usually more effective and consistent with gestalt therapy principles to meet and understand patients' experience rather than confront or frustrate them. Support, healthy confluence, compassion, kind-

[3] In this paper I use the term confront and confrontation in the sense of being negative, judgmental, non-respectful, and not consistent with the paradoxical theory of change. The terms can also be used to refer to anything that presents a point of view different than that which is already in the patient's awareness. In this latter sense psychotherapy properly confronts patients.

ness, and accepting the validity of the patient's wishes are all part of a good therapeutic attitude, an attitude that is consistent with field theory (see discussion in section on Dialogic existentialism, below).

Implications of a field perspective are also relevant to the issue of responsibility. The therapist and the patient are "of the field" and responsible for what happens. When there is a break in the therapeutic relationship, minute or huge, the therapist is part of that disruption; it is not accurate from a field perspective to say that the problem is the patient's interruption and hold the therapist, such a significant part of the field, free of responsibility (McNamee & Gergen, 1999).

Interdependence and the need to take in from others is as true at a system level as it is at an individual level. One of the issues generating this discussion is that some talk as if gestalt therapy is a self-sufficient system and that knowledge of other systems is unnecessary. Perls would sometimes claim that gestalt therapy is unique in that it is self-sufficient, unlike other existential therapies. The view of gestalt therapy self-sufficiency is often expressed together with a regret or disappointment that some gestalt therapists deem it necessary to take from other systems rather than creating anything necessary from within the gestalt therapy theory. Those gestalt therapists who take in from other systems are then sometimes characterized as inadequately prepared, weak and flawed, not knowledgeable enough about the basic theory of gestalt therapy, not seeing the full potential of gestalt therapy theory to be self-sufficient, or just having fallen into unfortunate error.

Relational gestalt therapy has advocated exchanging perspective and experience with practitioners from other systems, for example modern systems of psychoanalysis. Many gestalt therapists have expressed strong appreciation for relational gestalt therapy for legitimizing the assimilation they have done in their own practice and also have appreciated the enrichment of gestalt therapy by the integration accomplished by relational gestalt therapists. Yet, when I have lectured or written about personality patterns in a manner that includes insight from sources other than gestalt therapy (Yontef, 1993, 2001), which trainees and trained gestalt therapists have found very useful, I

have sometimes received that reaction of disapproval discussed in the previous paragraph from some gestalt therapists who think that gestalt therapy should be self-sufficient.

Often critics of exchanges with other systems forget the difference between introjecting information or ideas from other systems and deconstructing, assimilating, and integrating that which is useful in gestalt therapy. A more field theoretical view would include acknowledging the need to learn from other systems – to assimilate that which is useful. If the information is just added on, as in "gestalt and …", then the inherently integrative nature of a field is replaced by an introjective process of just adding new information or techniques on top of the existing system without the transformation of assimilation.

Another implication of field theory is the need to pay attention to the conditions of the field. I believe that we often pay *insufficient attention to the conditions in the field.* One of the main concerns of relational gestalt therapy is what happens between therapist and patient, that is the field of therapist and patient and between patients in therapy groups. Increasingly relationally oriented gestalt therapists have focused on the exact conditions in the field of patient and therapist as it develops moment to moment.

This field perspective is needed in understanding the processes in all groups and systems. It is important to understand the regulation processes that occur in the communities in which we live, for example the power relations in organizations, agencies, and in the larger community. This includes processes such as competition for power, ostracizing, sub-grouping, marginalizing. These processes happen in individual, group, couple, or family therapy. These are often ignored in both therapy and task groups in the gestalt therapy community. One exception is Miller's discussion of these processes in couples (Miller, 1995).

4. Dialogic existentialism

The phenomenological focus on the awareness of the patient is sometimes practiced as a one-person process, that is looking primarily at the awareness continuum of the patient without consideration of the relational matrix, including what is hap-

pening between patient and therapist. In gestalt therapy, especially in "relational gestalt therapy", clinical phenomenology is a two-person practice. Not only is the awareness continuum of the patient figural, and the phenomenological method expanded by the creation of phenomenological experiments by the cooperative efforts of both therapist and the patient, but the phenomenological method is also expanded into a two-person approach by the emphasis on dialogue. Dialogue can be seen as shared phenomenology.

Every intervention, every moment of therapy, is not only a technical event but also a moment of interpersonal contact. "We speak of the organism contacting the environment, but it is the contact that is the simplest and first reality" (Perls et al., 1951, p. 227). In the therapeutic methodology, the awareness work is done by the relational interaction of patient and therapist. But, what kind of contact is needed for effective psychotherapy?

Gestalt therapy made important modification of the classical psychoanalytic stance of neutrality and abstinence, the stance of the analyst showing nothing personal so that the patient can be induced into a pure transference neurosis. Gestalt therapy made a tremendous advance in its orientation around active personal involvement of the therapist, working primarily with what the patient is aware of rather than restricting practice to interpreting the unconsciousness, and adding phenomenological experimentation to the methodology.

Relational gestalt therapy has been carefully examining what kind of contact is therapeutic. This started in earnest with discussion of "dialogue" in the early 1980's. This has been expanded into relational gestalt therapy because of a growing realization of how dialogue was a part of more fundamental and pervasive relational perspective and because of realization of the conditions of dialogue being violated by many talking the language of contact and dialogue. In short, relational gestalt therapy has been concerned not only with "talking the talk" but also "walking the walk".

The kind of contact most consistent with gestalt therapy principles is marked by the principles of dialogue.

4. 1. Principles of dialogue

4. 1. 1. Inclusion and confirmation

Inclusion is putting oneself into the experience of the patient as much as possible, feeling it as if in one's own body – without losing a separate sense of self. This confirms the patient's existence and potential. By imagining the experience of the patient, in a sense the therapist makes the experience real. Crucial to this approach is the paradoxical theory of change (Beisser, 1970). By contacting the patient in this way and not aiming to move the patient, by meeting the patient and not aiming to make the patient different, the patient is supported in growing by identification with his or her own experience.

The patient is the final authority on the accuracy of these reflections. In relational gestalt therapy we tend to believe that if the patient says, "you don't understand", you don't understand. I must also note that while it has a great deal of heuristic value to emphasize that the patient must be respected when he or she says that the therapist does not understand, and the patient has personal and direct access to his or her own self that is different than the therapist's access to that patient's reality, from a theoretical position it cannot be validly claimed that one party to the dialogue has the exclusive power of definition of what is true.

4. 1. 2. Presence

Dialogue, both in and out of therapy, requires not only practicing inclusion, but also a certain kind of presence. The required presence is not just lively, powerful or charismatic as was the highly visible gestalt therapy styles of the 1960's. It requires a presence with authenticity, transparency, and humility.

Dialogue means being present as a person meeting the person of the other. Dialogue in therapy means that the therapist works on the therapeutic task by contacting the patient as the patient is, the whole person that the patient is, with the whole person of the therapist him or herself. A whole person includes being flawed and allowing that flaw to be a recognized part of one's existence, even in the therapeutic setting with patients.

Relational gestalt therapy emphasizes the importance in therapy of compassion, kindness, wisdom, equanimity, and humility. It is my opinion that these qualities are not given as much emphasis in talk about gestalt therapy as is warranted by their impact.

4. 1. 3. Commitment and surrender to the between

An indispensable core aspect of the relational approach in general and the dialogic approach in particular is the commitment to dialogue, the surrender to what emerges between the participants in the dialogue when the therapist and the patient contact each other – without the therapist aiming. The paradoxical theory of change predicts that identification with ones actual state, experience, and existence is ground that supports personal growth (Beisser, 1970). When the therapist practices inclusion with authentic presence and commits to what emerges in the contact, conditions maximum for growth and healing are created. This requires that the therapist is not committed to any predetermined outcome and can support "cultivation of uncertainty" (Staemmler, 1997). This also requires faith in the awareness and contact process.

In this approach, the therapist also changes. The therapist is touched, feels pain, gets satisfaction from the contact with the patient, and learns from the contact in which the patient's perception is respected. The advantage to the therapist of accepting that the patient's perception of him or her might be accurate and point to a blind spot in therapist self-awareness is that the therapist also grows. This is especially true when the patient criticizes the therapist. For the patient this is can be an experience in which his or her experience, opinion, and feelings are respected and also having the experience that the therapist in which he or she has invested time, money, and respect is also an ordinary human being.

4. 2. Discussion

Some gestalt therapists do not practice inclusion in their work with patients. They share observations, make interpretations, set up experiments. When symptoms arise, they try to move the

patients, to save or rescue the patient, rather than elucidate the patient's experience. Insight into cognition, body process, interruptions to awareness and contact can go hand-in-hand with inclusion and phenomenological focusing – or can be a form of behavior modification, that is the therapist being a change agent trying to cure the patient. I do not consider the latter good gestalt therapy or consistent with basic gestalt therapy principles.

Another practice that is inconsistent with the relational principles discussed here is the presence of the therapist in a manner that encourages charismatic or narcissistic elevation at the expense of the patient. The therapist or trainer in this pattern solicits or encourages his or her idealization, and the patient or trainee projects competence, wisdom, and goodness on the therapist with a concomitant diminishment of self.[4] The patient or trainee then can bask in the light of the therapist's magnificence. The form or style of the therapist or trainer doing this varies. It can be confrontive, seductive, rescuing, empathic, creative, and so forth. The problem is the nature of the relationship, the nature of the role the therapist plays in relation to the patient.

Probably the problematic pattern that is hardest to be aware of is the therapist or trainer that appears to practice inclusion, seems to be present in a dialogic way, but when the phenomenological experience of the patient/trainee and the phenomenological experience of the therapist/trainer meet, the therapist does not really take in and let him or herself be effected by the experience. In this pattern the therapist does not change, the self-concept of the therapist does not change, the therapist does not surrender to the between, does not surrender to what emerges between the patient and themselves if it involves error, pain or change on the therapist's part. This sometimes appears to give the message: "You are you, and I am I, and I am not going to budge an inch" – there is the "you" and the "I", but the between, the flow back and forth and emergence into dialectical synthesis, is stymied.

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[4] I do not advocate that patient idealization be immediately and actively confronted. I am advocating the therapist be aware of his or her role in actively eliciting it. Some patients do idealize the therapist and need to do so in one phase of therapy. Ironically, aggressive confrontation of idealization can itself elicit idealization of the therapist.

5. Shame

Relational gestalt therapy partially arose out of an increasing sensitivity to and sophistication about shame (Lee & Wheeler, 1996; Yontef, 1993, 1997a, 1997b). Sensitivity to shame has shaped the sensitivity to the relational aspects of psychotherapy.

Noticing the field conditions in the practice of therapy has led to awareness of the interruptions in the contact and much of that interruption occurs when shame is triggered in the relationship. Some approaches to gestalt therapy have triggered shame in the patient and defended the therapist from experiencing his or her own shame that might be felt with realization of limitations, errors, biases, countertransference, and so forth.

In relational gestalt therapy we believe it is essential to good psychotherapy to be sensitive to the conditions leading to shame and to minimize iatrogenic shame in psychotherapy practice and training. Patients are vulnerable to feeling shame just by coming to therapy. This is more intense in some patients than in others. Patients come to therapy because of some sense of being inadequate in finding satisfaction and solving the problems of their existence. They mostly start therapy with a sense of not being OK. This is not avoidable. But unnecessarily triggering shame in therapy and training can be avoided.

Insufficient awareness of and inept or defensive response to shame is an important relational issue. Shame can be triggered or increased by being ignored or treated inadequately.

There are many therapist activities that can trigger shame in the patient. Some of the triggers are obvious: Sarcastic humor, attack, condescension, and abandonment. Some triggers are less obvious. For example, one-person interpretations are frequent shame triggers. When the interpretation indicates that the source of difficulty is a process only of the patient, no matter how benignly intended, this increases the shame. An interpretation from a field perspective would take into account the contributions of all the participants in the field, including those of the therapist. A negative example: A trainee tells a trainer that he/she feels shamed by the trainer. The trainer responds: "I will show you how you shame yourself". The trainer is blameless, all difficulty is attributed only to the trainee.

Another shame trigger is an attitude that the therapist knows best. If the therapist is endowed by the patient with the aura of infinite wisdom, the patient assumes the status of "less than". If the therapist fosters this, does not maintain an awareness of his or her limitations and deficits, the patient is reinforced in his or her sense of self as not being competent, worth, or lovable.

A relational approach requires careful and consistent observation of all the data in the field. Particularly relevant for our present discussion are subtext and metatheory. Shame can be triggered by therapist attitudes that are manifest in subtext or unacknowledged metatheory. For example, the attitude that self-sufficiency is better than dependence is a fertile ground for shame (Wheeler, 1996). This is not just a bias, but it is a theoretical stance that is not explicit in the official theory. Another example is a bias about the right level of emotionality. Unless the patient's level of emotionality is consistent with the particular level of emotionality that is valued, the patient is likely to have shame triggered. Relational gestalt therapy brings sensitivity to issues of subtext and metatheory.

5. 1. Subtext

Text refers to what is said; subtext refers to how things are said, for example tone of voice, body language, gestures, and so forth. A message that sounds innocent in its text can have a very critical, shaming, condescending, contemptuous edge to it. And, of course, what may appear harsh in the text may give a different message altogether when the whole subtext is taken into account. When the shame triggering communication is delivered through the subtext, it is more difficult for the other person to cope with and it can be easily denied by the person – "I did not say that".

5. 2. Metatheory

"A metatheory has for its subject-matter the inquiry into, or theory of, a certain subject-matter; it is a second-order inquiry or theory" (Mautner, 2000, p. 353). "Meta" is a prefix from a Greek word-element meaning beyond or above. It refers to the implications of a theory that is a level above the theory itself. It

is parallel to a metanarrative in which there is a narrative that justifies or gives context to a belief.

What we do and what we say as gestalt therapists has implications broader, beyond, the specific words or techniques. There are broad implications in terms of values and philosophy of living of what we say and do. I think we should pay more attention to these implications of what we do and say and not restrict ourselves only to the immediate words and objects we are addressing at the moment. I refer to this as metatheory. Metatheory refers to broad theoretical implications of a theory or act that are not explicitly dealt with in the text of the theory or talked about in the focus on action.

For example, we might be working with a mother that wants to go back to work[5]. For the sake of illustration, assume that the family has very young children and the family finances do not require her to go back to work. There are important values and implications to be considered. The mother's sense of well being and development may be enhanced by going back to work. It may even be necessary for her mental health. The children's' sense of well being and development may be enhanced by the mother staying home with them. There may be societal implications for our children and for providing facilities to care for the children of working mothers. Such issues are never simple. At the level of metatheory, there are real value questions with real consequences for the whole organism/environment/-societal field.

My concern here is not the solution to the issue of the individual needs versus the needs of the children or society. I am focused here on the issue of being aware and attentive to the fact that we are dealing with important value issues, issues that go beyond the immediate affect of the patient. It is easy to focus on one value or another without awareness that other important values are involved. I am advocating some reflection on the issue of the broader implications, for example values such as individualism versus the needs of the community. I do not think that there is one right answer to those questions. But it is important to pay attention to the fact that we are dealing with

[5] Of course, the at home parent wanting to go back to work could be the father.

values and that therapists can be guiding awareness and action along a path without awareness of the larger implications. They may influence a course of action without the awareness, bracketing and other methodological principles of an extensive phenomenological exploration.

Metatheoretical issues include, but are not limited to:

- Attitudes about the person (patient or significant others).
- Philosophy of living, values.
- How growth happens and psychotherapy works.

6. Discussion: Relational gestalt therapy

In its present state of development, relational gestalt therapy has focused on metatheoretical messages that are about the nature of the person, especially the patient, and how these influence the safety and self-esteem of the patients. This has especially been discussed around the issues of shame and the values concerned in confrontive approaches to gestalt therapy, issues of the value (e.g., of dependence, self-sufficiency, and interdependence). The patient, or significant others, can be characterized in ways that relegate them to the status of unlovable or not worthy.

Relational gestalt therapy has also been concerned with metatheoretical messages about how therapy is done. An example of this area is the set of messages that has been promulgated in the name of gestalt therapy that leads patients to think that therapy is just expressing emotions. Larger issues of value have not yet been fully addressed.

An example of the messages about how therapy is done, can be illustrated with my experience with a patient who had a long history in psychoanalysis before seeing me in gestalt therapy. He had learned that the only acceptable data for him to present in therapy were his associations. This provided the material for the analytic interpretation by the analyst. Bringing in any other data was interpreted as resistance. When I suggested bringing in some material that illustrated a problem he was having, for example his emails at work, he objected that this was not legitimate data for therapy.

In the example (above) of the trainer who was told that his remark was hostile when he did not experience himself being hostile, a dialogic and phenomenologically open response might have been something like: "I wonder what it was in how I said what I did that gave you the impression that I was hostile. What did you observe and what did you think I was saying about you?" Then one might inquire: "What was triggered in you when I said what I did in the way that I said it? Did it trigger something about your sense of yourself?" I might also include something about how it affects me that my remarks were taken as hostile and had the effect that it did. For example, I might say, if I meant it, "I am really sorry that I was not more sensitive and that my remark hurt you". In the dialogue other feelings might emerge, for example, my feelings about the patient or what was triggered in my sense of self in this situation. For example, if I was embarrassed or felt shame by triggering what I did in the patient, than I might say so.

7. What relational gestalt therapy is and is not

Relational therapy is an approach within gestalt therapy that is strongly centered on existential phenomenology, dialogic existentialism, and cognitive grounding in field theory. It is not a whole, new system or approach. Rather it is steeped in what is central to gestalt therapy and has sometimes gotten lost or neglected. It continues the gestalt therapy tradition of assimilating new information into the system, for example from modern forms of psychoanalysis, cognitive behavior studies, mindfulness meditation, and so forth.

It is a form of gestalt therapy that emphasizes respect, compassion, the fullest experience and respect by the therapist of patients' experience in accordance with the paradoxical theory of change and manifesting maximum trust in the process of contact with awareness and without aiming. This emphasis in gestalt therapy has sometimes been mischaracterized as being restricted to empathic listening, being nice, and eliminating experimentation. This is not true. The relational emphasis is on honesty, which is more than being nice, but in a process that is attentive to shame-triggering. We are not interested in being empathic and/or sympathetic at the cost of honesty. Relational

gestalt therapy does not eliminate experimentation (active technology), but uses it in a relational manner.

Relational gestalt therapy is centered around dialogue, contact that takes into account the person of the patient and the task of therapy. It is not a dialogue in which the therapist authentically expresses self without regard to the task of the therapy or the needs, strengths, and weaknesses of the patient. Relational gestalt therapy takes into account probable impact on the patient, patient vulnerability, and the impact of the therapy on others that will be affected.

In gestalt therapy with this relational emphasis, careful attention is paid to contact moments and also to overall character organization and development. The quality of the connection of therapist and patient is a subject of central concern. Interruptions are carefully observed both for what it says about what is happening between therapist and patient and also for the here-and-now contact moments as manifestations of ongoing characterological patterns that are a necessary focus in intensive psychotherapy. Each moment is seen as a hologram for the larger whole of the patient's life. This perspective gives guidance to diagnostic questions, and in turn is guided by diagnostic understanding or understanding of the particular characterological pattern of the patient.

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