Chapter Nine

Relationality and Relational Process in Gestalt Therapy

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> The point is to travel the way which lies between us. The obstacles from here and from there are the same, the distance is the same from me to him, as from him to me.
> —Letter from Hans Trub to Martin Buber, 1926 (Agassi, 1999: 163)

It all began for me in 1970. Or was it 1971? I was in college, a paraprofessional volunteer at a local free clinic. I was co-leading group therapy alongside a volunteer psychiatrist. I picked up a copy of the book, *Gestalt Therapy Verbatim*, and my long love affair with Gestalt therapy began. What attracted me viscerally was the focus on immediate experience, contact and the therapist's presence. Those three elements, especially the therapist's presence and willingness to meet and be met, person-to-person, shown guiding lights into the darkness that was my isolation.

Gestalt Therapy is a Relational Process

I am one among many therapists who have focused on elaborating on the foundational relationality of our theory and on its implications for the practice of gestalt therapy. Considerations of the relational perspective on gestalt therapy have three major dimensions. The first is the foundational relationality of gestalt therapy (among many other contemporary psychotherapy theories). The second dimension is that of the ethical implications of a relational perspective. The third dimension is an elaboration of relational processes and their significance as they occur in Gestalt therapy.

I shall write about all three dimensions, starting with the most abstract: the foundational relationality of gestalt therapy. I shall then move on to the other two dimensions, both of which are "closer to the ground." They address more directly the therapeutic process. Readers who prefer more direct experience before contextualizing the experience in the more abstract theory might want to skim the first section lightly, and then return to it after reading the later section of the chapter.

Foundational Relationality

Frank-M. Staemmler (2016) traced the arc of the movement from our original individualistic ethos to the relational ethos of today, and then the movement from a "weak relationality," (self-in-relation), to more radical, or "strong relationality" (relationship as constitutive) (ibid pp. 8-9). Despite some remarkable–for their time–post-Cartesian ideas in our founding text, *Gestalt Therapy* (Perls, Hefferline, & Goodman, 1994), Fritz Perls' individualistic style of clinical demonstration, which popularized gestalt therapy, dominated the scene in the early years, eclipsing the more subtle relational style that Laura Perls, her students, and the Polsters and some of their colleagues from a Cleveland study group preferred. Fritz Perls' style was not an inevitable outgrowth of the theory that he, Laura, Paul Goodman and others were developing, but it fit the *zeitgeist* of the time (Ibid p. 4; Bowman, 2005).

In fact, the evidence of radical relationality in the founding text, *Gestalt Therapy*, is shown in the following quotes:

> It is the contact that is the simplest and first reality. (Perls et al., p. 227) …the definition of an animal involves its environment: it is meaningless to define a breather without air, a walker with-out gravity and ground, and so on, for every animal function. The definition of an organism is the definition of an organism/environment field. (*ibid*., pp. 258f.) …Social relations, like dependency, communication, imitation, object-love, are original in any human field, long prior to one's recognizing oneself as an idiosyncratic person. (Ibid p. 320).

In the '80's and '90's, publications by Rich Hycner and myself (1995), and Gary Yontef (1998), among others, initiated a more concerted focus on the therapy relationship and its essential role in gestalt therapy. Since that

relational turn–which began for Hycner, Yontef and myself with an integration of Martin Buber's philosophy of dialogue into gestalt therapy–other explorations of the relationality of gestalt therapy (and the implications of the inherent relationality of human existence) have held a central place in gestalt therapy theory development. Some of the theorists who have tackled the subject are Bloom (2016), Brownell (2010), Fairfield and O'Shea (2008), Francessetti *et al (2014)*, Phillipson (2001), Robine (2016), Spagnuolo-Lobb (2013), Staemmler (2016), and Wheeler (2000). Some of the explorations have drawn centrally on our field theory roots, others on contacting and our roots in phenomenology. Of course, many other therapy modalities have made a relational turn as well, and insights from many other sources have informed some of the thinking of many gestalt therapists, for instance, Jacobs, (1992) Zahm and Breshgold (1992), and Taylor (2014) among many others.

No matter what influences extend our understanding of the radical relationality put forward by the theories of self and of contact, the embeddedness of gestalt theory in concepts of phenomenology and holism and field theory put forward by PHG, be they; the philosophy of Buber and others of 'dialogicality,' attachment theory, neurobiology, non-linear dynamic systems theory, psychoanalytic intersubjective system theory, etc., all the approaches to relationality share some common precepts (some of what follows is taken from Jacobs, 2009):

1. First and foremost, our relationality is irreducible. Our relatedness in our environment and with each other does not begin with us as separate selves, with relatedness being an "add-on." This is the "strong relationality." Our very existence is utterly, thoroughly context-dependent, and our worlds of experience are emergent from our contexts. We have no experience that is prior to relatedness. As Merleau-Ponty has demonstrated is his writings on corporeality, we are born into a world "always already there" (Taylor, C., 1989). I am reminded of Peter Philippson's invocation of the Escher drawing in which who is drawing whom cannot be discerned (2001). Every experience we have is co-emergent from what I bring and what you bring, along with our setting, our task, and other aspects that go into comprising our situation. Your world of experience and action and mine are utterly interdependent. We constitute each other.
2. We are all more alike than not. We come into being in the shared context of being human: of using meaningful language, of physicality, of a neuronal readiness and capacity to resonate and respond to each other and to new emotional experiences.
3. While our commonalities make connection possible, our individuality (or individual expressiveness in a given situation) makes connecting interesting, novel and provides us a chance to learn something new, to develop, to expand our experiential horizons. This is the essence of contacting. Contacting and growth are inescapably intertwined. There is not one without the other. All contacting is growth. We might better say, contacting is constitutive. We are called into contact, and we call others into contact. We are called into being, and call others into being.
4. And paradoxically, *our uniqueness is also an emergent configuration that points to our shared humanity*. On the one hand our mutually shared human situation puts us in a more common position than otherwise, despite whatever differences of language, culture and personal narratives we have. On the other hand, each person carries a way of being that emphasizes a different aspect of our humanity, and thus anyone with whom we come into contact gives us the gift of enriching our ground. They broaden our own human possibilities as well.
5. Our sense of self, including such dimensions as: sense of agency, emotional capacities, even individuation and differentiation, our capacity for intimacy, is contingent, dependent on our developmental and our immediate emotional contexts. This means not just that we are all interrelated, but that the quality of our self-functioning, and most importantly, our developmental possibilities, depends on our relational/contextual supports.
6. We are always reacting and responding to each other. This is inescapable, unavoidable. Every act we initiate is always also a response or reaction to our situation.
7. Mutual co-regulation is an on-going and unavoidable phenomenon. In all contacting there is a reconfiguration of the person/environment field, and that reconfiguration is mutual. That is, we who are "environment" for each other are reconfiguring/being reconfigured with each other. This is happening in the smallest of moments, as when two people shift slightly, perhaps without awareness, to accommodate each other on a sidewalk. Gestalt therapists pay close attention to their body sensations, in part based on the recognition that our bodies are coordinating with each other all the time. When my patient tightens his breathing, I notice I do as well. When I consciously attend to deepening my breathing, my patient's breathing undergoes a change.
8. When we are in relationships, in the repeated contacting patterns, we constitute *identities* with each other:

   > we… *become* somebody. That is, we come to play a certain part or adopt a certain identity. With my mother, I come into being as a child; with my children I come into being as a parent, and so on. Each relationship will bring me into being as a certain sort of person, and the actions that I acquire will enter the repository of potentials for future use (Gergen, 2009, p. 136).

9. Finally, the co-regulation and co-emergence, and even co-constitution come together (the simultaneity of the strong and weak relationality) *intentionally* in dialogue, for example, when Hans Georg Gadamer asserts,

> To reach an understanding in a dialogue is not merely a matter of putting oneself forward and successfully asserting one's own point of view, but being transformed into a communion in which we do not remain what we were (1989, p. 379)

Ethical Implications of a Relational Perspective

The premises of co-regulation and co-emergence, that we are all emergent within our world of both human and nonhuman contacting and relatedness, (the premises of strong relationality) begs the question of our ethical responsibility to each other. Clinically, the premise of strong relationality places the therapeutic relationship into an inescapably ethical context. We are intimately involved in the experiential world of other vulnerable people who entrust themselves to us.

I draw inspiration–as did Laura Perls (see Amendt-Lyon, 2016)–from Martin Buber's philosophy of dialogue, in which he emphasizes that:

> Man wishes to be confirmed in his being by man, and wishes to have a presence in the being of the other. The human person needs confirmation because man as Man needs it...secretly and bashfully [man] watches for a Yes which allows him to be and which can come to him only from one human person to another. It is from one man to another that the heavenly bread of self-being is passed. (Buber 1965b, p.71)

> Buber describes such things as a "surrender" to what emerges between us, to a "full-bodied turning towards the other," and to "courting surprise." (Agassi, 1999, pp 3-21)

My ethical responsibility as a therapist is to adopt a dialogic attitude. In this attitude, I recognize that my patient and I can further develop our creativity and spontaneity and expand our range of contacting and new relational possibilities, if we do so together. Whatever problems inhere in our relationship are *our* problems, not the patient's problem nor my problem, but ours together.

Hans Georg Gadamer (1989) noted that in genuine dialogue, even the most absurd utterance that a person may make requires us to strive to understand how that utterance makes perfect sense from the perspective of the speaker. He refers to "under-going the situation" together. He recommends that we take the most absurd utterances and try to understand them as the speech of a reasonable person. From a relational perspective I suggest that the utterance emerges from our shared world. That is, in the clinical situation every utterance, every thought, feeling, sensation, every movement that happens in our consulting rooms is variably mutually influenced (and influencing).

Engaging another in dialogue accords the other a respect and dignity that confirms him. Buber asserted that psychological suffering was a direct result of being alienated from dialogic relations. In writing about psychological problems, he said, "sicknesses of the soul are sicknesses of relationship" (1969, p. 150).

These assertions linking dialogue with human dignity match nicely with the therapeutic orientation that Arnie Beisser introduced us to after some years of friendship and colleagueship with Fritz Perls, "the paradoxical theory of change" (2004). Beisser's simple assertion is that change occurs not by trying to become different, but rather by contact with your present existence. Your existence is always moving and changing, and the principle of pragnanz suggests that you are always solving your problems, resolving your Gestalten with the best form possible given the resources that are available. Thus, identifying with your existence as it is–moving and changing–allows the growth and development that is possible.

As therapists, we are one of the resources for the patient. Our presence and our willingness to meet the patient without aiming at changing them, are crucial supports, however challenging it may also be for both of us. Zinker (1987), an early gestalt therapist, wrote of presence in a way that clearly intertwines presence as ethic and practice. He described deep, full breathing, a sense of being grounded, diffuse attentiveness and readiness to respond, lack of judgment and evaluation. This is an aspect of a dialogic attitude and the paradoxical theory of change. It supports the therapist to meet the patient without trying to move the patient.

In the paradoxical theory of change, ethical implications and clinical implications of our foundational relationality come together. By surrendering to emergence and dialogue–by letting go of trying to aim at an outcome and by letting ourselves be affected by the dialogue–I believe we are confirming the patient's dignity while at the same time supporting therapeutic conditions that facilitate contacting in the service of the now-for-next that is the moment-by-moment developmental process (Spagnuolo Lobb, 2013).

With Relationality in Mind: What Does It Mean to Practice with a Relational Perspective on Gestalt Therapy?

This section will involve a consideration of the basic orientation, the adoption of a dialogic attitude, the use of embodied dialogue, and the provision of support.

Basic Orientation

My starting place for practicing with relationality in mind is to pay attention to my participation in the relationship that exists between me and my patient. The following questions hover; is my presence in this moment facilitating the dialogue with the patient (facilitating the development of presence, of contacting and awareness)? Is my engagement facilitating the patient gaining access to their experience? Or is my engagement inhibiting the patient's flow of their emotional life and access to their experience? Am I inhibiting dialogue with the patient? Much of time my questions are self-reflections. Occasionally they become conversational fodder, most especially when I think that my way of being with the patient is inhibiting our dialogue, and I want to explore together how I am contributing to our difficulty.

There are two corollaries to my attention to my participation in the relationship. The first is that practicing from a relational perspective does *not* mean that the patient has to pay attention to our relationship. I keep our relationship in mind so that I can make my best guess as to how my patient can make good use of me. But often, patients make good use of my presence as a background to their stories and explorations. They may develop a confident expectation that they will be well heard and generally well understood, without ever paying explicit attention to how I am being with them. Obviously, there are times in the therapy process when paying attention to our relationship can be quite useful to the patient. My point here however, is that working relationally does not mean that therapist and patient together must always be focused on the relationship between them.

Dialogic Attitude

The second corollary that goes along with a relational perspective, is a dialogical orientation. As I mentioned earlier in this chapter, some of us draw, as Laura did, on Martin Buber for our inspiration. Buber's phenomenological approach emphasized that humans are inevitably interrelated. They come into being in relationship. He described two modes of relating, commonly known as It-IT and I-Thou. We live primarily in the I-IT mode of managing and moving about in our world. But moments of I-Thou are necessary in order to feel human.

> Whilst the I-It stance is concerned with doing and achieving in the relationship, the I-Thou is a state of *being* in relationship. The I-Thou relation trusts the between and is therefore willing to surrender to that between and in that surrender the other's humanness is affirmed. An I-Thou meeting can only take place when both parties are willing to surrender to the between, it cannot be forced or coaxed, as Buber states it comes through grace. Many clients that walk through our doors have been starved of such relating, they are not in a position to surrender to the between of a relationship, to gain the nourishment they yearn. It is through the therapist's willingness to hold an I-Thou attitude during I-It relating, to reach out and be available to the client without the expectation of being met that creates the ground for profound relational healing (Mann, 2010, p. 218).

Buber described three "elements of dialogue" that inhere in dialogue that supports one's coming-into-being. The three elements are presence, inclusion, and commitment to dialogue. The three elements come together in what I call, a dialogic attitude (Jacobs, 1989). In simplest terms the dialogic attitude is a specific attitude of welcome.

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. 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). 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 (Yontef and Schulz, 2016, p. 20, footnote 3).

With presence, the therapist brings a willingness to be seen by the patient without hiding behind a wall of therapeutic authority. It means a willingness to be seen even in ways that do not flatter us. We also bring a willingness to be touched, moved, changed by the patient. We try to understand, bodily as well as with words, our patient's experiential world, from within the patient's perspective. We feel our way into how what they are bringing makes sense, given their world view. With inclusion, our task is to feel our way into its rightness. This practice of inclusion is especially important when the patient is speaking of their experience of being in the relationship with us. It is not easy to hear our effect described as deleterious or hurtful, or grossly mistaken, for instance. It is in such times that an attitude of welcome is difficult to sustain, and yet vitally important. The third element, the commitment to dialogue means we are willing to say what begs to be said, even if difficult, perhaps even anxiety-evoking. Or perhaps something that might make us feel some shame.

Taken together, all these elements comprise the dialogic attitude, which calls us to include the otherness of the other as fully as possible while being present to the other–a kind of porous, vulnerable nakedness. It calls on us to recognize that, while we practice inclusion, and stand revealed in our presence, we are humbled in the poignant yet expansive awareness that my understanding, my recognition, of this other before me, is inescapably incomplete. This person before me is always more than I can know of him, her or they. And my knowing of myself has become slippery, fluid, a soft-assembly. This is a form of contacting that risks our very sense of who we are, risks our very sense of self. And yet, as we move along, it is also felt as our fullest sense of ourselves!

Embodied Dialogue

This basic orientation, with its first questions and dialogic attitude, also calls on us to pay attention to our "sense of things," what our sensations, our viscera, our movements and our breathing are telling us about being with this other person. We also try to sense what our patients' sensations, their viscera, their movements and breathing, are saying about being in this situation with us.

Margherita Spagnuolo-Lobb calls this, "aesthetic relational knowing." "*Aesthetic relational knowledge* allows the Gestalt therapist to grasp the *now-for-next*, the client's intentionality for contact implied in their habitual and desensitized way of experiencing the contact boundary" (2013).

Dawn Gwilt, writing in the first edition of New Gestalt Voices, described a process of meeting guided by aesthetic relational knowing (or, perhaps better stated, "aesthetic relational sensing-my-way-along"). The process was a moment in time in her work with a patient who tentatively began to describe his interest in sexual bondage.

> I felt an opening up to curiosity, a heart opening. I felt honoured and respectful, like I was engaging a different gear of sensitivity - more sensitised, alive, alert. Much background support kicked in automatically. Some of this background support was in the form of intentions. My intention was to bring safety to this space, to protect the tender shoots emerging, to go slow enough, to engage fully. This intention of protection made the space safer. In this moment, I am remembering the feeling of safety growing and surrounding us, with judgments cleared away to create an open invitation. I wasn't speaking aloud, but my intention was saying, "Give him space. This is important. This is a voice that needs to be heard." I felt quite vigilant about pushing to one side anything extraneous for now, to allow this new voice to be heard. At the same time, I was aware of protecting him from the glare of the spotlight; protecting against anything in me that might push too hard or be too inquisitive. My intention was to follow and support his pace – to meet him where he was in terms of pace and energy, as well as content. This was a minute- by-minute gauging of how much curiosity was the right amount–like constantly adjusting the tension on a guide rope – slightly tighter, slightly looser–and all the while looking at, feeling into, and sensing his responses to this–mostly in the energetic flow between us, not verbally. I checked for any response in me of fear, disgust, or needing to put on the brakes. I also checked into my sense of his experience. What I felt was a sense of heightened engagement from both of us. It's not so much what I did externally, as the intentional and implicit boundaries that I engaged with that provided a safe enough space to continue. (2017, p.7, British spelling retained)

In her process with the patient, Dawn could sense her way into a mode of being-with that facilitated sensitive, meaningful dialogue. It was built on what had come between them, and Dawn grasped and supported the now-for-next of the patient's wish to be known in a particular way and be welcomed.

One of my patients has been depressed for several years. He laments that he feels locked away and unable to participate with others in social situations and in learning situations. He feels too afraid of embarrassing himself by sounding stupid. We would have long stretches of silence in our sessions. He told me he would like me to reach for him yet when I did so he rebuffed me and retreated into further silence. My own feelings in response to him didn't seem to match his description of himself as afraid of sounding stupid. I found myself tempted to be provocative and a bit confrontive with him. I told him I thought of him as stubbornly, perhaps defiantly, withholding himself from engaging with me. He agreed and told stories about life in his family that seemed to corroborate the idea that to preserve himself he had to withhold himself from being taken over by others.

Our discussions did not shift the dynamic. In fact, both of us seemed to be hardening in our positions. He would continue to tempt me to engage him to help him explore, and then rebuff me and retreat into a resentful silence. I would perhaps ask a question or make an observation, and then in the face of his rebuff I would retreat into a righteous, resentful silence as well. I was so frustrated I was unable to consider the possibility that my way of approaching him might not be well attuned to his anxieties. After some weeks of the increasing intensity of our mutual implosive power struggle, I said, "I feel at a loss as to how to be of use to you. What I know is that I don't like how I am treating you. I am being defensively reactive. And I don't like how I feel about myself when I sit in silence having angry thoughts about you."

In the following session, my patient said that was the first glimmer he got that I was fumbling along just as he was, that I was not a master puppeteer who knew exactly what I was doing and wanted to control him. That was the beginning of a long process of making our way out of what could have become an impasse. Subsequently, he has become much more able and willing to identify with his desires for engagement with others, our conversations are more free-wheeling, and his depression has lifted. We enjoy enjoying each other.

One implication of our inescapable relationality is that all experience in the therapy situation is co-emergent. The words one chooses, body movements, even the smallest shifts in attention or emotion emerge from the situation. While it is true that we enter new situations with pre-formed habits and styles of engagement, the manner and timing with which the habits and styles are present reflects the unique system created by the particular therapist-patient pair. Therapist and patient are involved in reciprocal mutual influence, as illustrated in the vignettes above.

Our patients' suffering originated in relationships. It has been maintained in relationships. The creative-adjusting they have learned occurred in difficult environments. In social situations, we tend to fall in line with the messages we get from others about how to engage with them, and they do the same for us. In therapy, if we pay attention to our bodies, we can discern–based on our bodily reactions–how the patient generally wants to be treated, at least superficially.

Yet, if we only relate to the patient in response to their habitual modes of engagement, no expansion of contacting occurs. The therapeutic relationship balances between a sense of safety and a sense of risk. Any new moment, calling for a creative now-for-next engagement, poses a risk. This is therapeutic art. The unusual relationship of psychotherapy affords the possibility of new creative adjusting and new, more nourishing relational experiences. This requires attending to the relationship as it forms over time (whether it be 6 weeks or 6 years), rather than attending merely to what is happening in the current moment. What is happening in the current moment takes place against the backdrop of what has come before and the implied directionality of our intentions as we move into the next moment. So, although we have many opportunities to disconfirm a patient's fearful expectations, useable disconfirmation takes place within a complex relationship that also repeats, to some degree, what is familiar to the patient and the therapist. In the vignette above, one of the disconfirmations that was quite powerful was that I was able to reflect on my own participation in what was a repetitive relational pattern. I was not able to avoid the pattern, but I could address it with humility. My commitment to dialogue supported me, despite some shame and some anxiety, to speak of my angry thoughts, and call attention to my resentful withdrawal. Not a very flattering self-portrait, but it proved useful for interrupting our slide into impasse.

My reflection supported the patient to dare to risk greater spontaneity with me. Malcolm Parlett, discussing "support" in gestalt therapy noted:

> The closer people come to their wounds or scars, the more they tend to veer off into habitual modes of protection. In my view, creating a field which contradicts 'expectations of danger' is often the key function for the therapist: the fixed gestalt wobbles and finally collapses if the environment proves to be different from what's expected. *Support is often seen as the opposite of challenge: but supporting someone can often challenge them greatly* (BGJ 2016, p. 47) (italics mine)

Supporting contacting, especially the dialogical contacting so vital to a sense of being human, does not come easily. Over time, the gravitational pull of our embodied habits and the patient's embodied habits militate against fresh creative adjustments. The adjustments become an admixture of newness and habit. With the patient above, our first few sessions had more newness for both of us, and then the pull of the dynamic that had brought him to therapy in the first place, and the pull of my habit of reacting defensively in the face of withholding resentment, gained more and more prominence in our process. My defensive retreats or provocations confirmed, rather than disconfirmed, his worst fears. My exposure of my humility *dis*confirmed his worst fears and opened a new path for us.

Support

I don't think it is a bad idea that there is a tension between the old and the new. Patients come to therapy with both hope and dread. The hope is for an experience in therapy that can open a wider range of possibilities for living. The dread is that therapy will merely reconfirm that they are doomed to the painfully narrow and rigid way of life

that they currently suffer. But they also dread they will be ridiculed for the adaptations they have made and cling to, or that they will be pushed too fast to change. The old modes of engagement, however painfully narrow and rigid, are also their safety. One of the problems in early gestalt therapy is that there was often not sufficient attention paid to developing a relationship with the patient that could become safe enough to allow the patient to experiment with new modes of being-together.

Gestalt therapy prizes leaning into one's coming solutions with as much spontaneity and flexibility as your resources (including those of the situation/relationship) allow. But it may take some time together to acquire the competencies for new contacting. We need to keep our eye on the patient's intentionality–what new contacting they seek–but we also need to be sensitive to the presence or lack of supports in the relationship.

Laura Perls considered support a bedrock gestalt therapy concept. In her workshops and teaching, she frequently stated that in therapy she wanted to "provide as much support as possible, and as little as is needed". Support is bedrock because without it, contacting is not possible. More precisely, the contacting that is possible in any given moment is that for which there are supports.

Supports come in many sizes and shapes. For instance, breathing into one's diaphragm is a support for remaining open and present. It is also a support for speech that can reach to another person. All of our senses can be used as supports. Aspects of our history are called upon as supports as they are relevant to the current situation. Knowledge and various skills are supports. Receptivity and the capacity to use the supports available in our environment are perhaps the most fundamental supports. For instance, without air I cannot breathe. But if I tighten my throat and chest, I am not receptive to all that the air can offer.

Aspects of the therapeutic relationship can be experienced as a support for contacting in different ways at different times. In the example above of Dawn's attention to her patient, calibrating her intensity and her curiosity to be in tune with the patient's delicate revelations, was a support for him to reveal himself more fully. With my patient, my emotionally tinged self-disclosure was a support for expanding our range of contacting possibilities. In another instance, the offer of an experiment that offers a chance to play with new experience is the support (Yontef and Schulz, 2016). Sometimes laughing together is a support for taking the next step of plunging into vulnerable explorations.

Sometimes a fight supports new contacting. For example, a patient and I used to get caught up in a fight over whether or not her anxieties should be met with tender loving kindness or with a heartier, "you can handle it," response from me. Our disagreement was a thread in our relationship for several months. Ultimately, she used her experience of fighting with me as a spur to standing up for herself in other arenas of her life. This enabled her to enter into a romantic relationship for the first time in over 30 years (her first relationship had been disastrous for her in part because she never spoke up for herself). Interestingly, even after our disagreements had been resolved, the experience had proved useful to her in another way; our relationship had shown her not only that she had the strength to stand up for herself, but that a relationship could actually become stronger by allowing disagreements and working them through, as ours had. Our successful and useful resolution occurred, in part, because I was willing to see myself as a problem for her, while at the same time, I believed I had something useful to offer to her.

My commitment to dialogue was crucially important in this process. We see many patients, who in one way or another, are seen, and experience themselves, as "a problem," first, a person second. To work with them, requires that I recognize that I, too, am a problem. Recognizing that my patient had every reason to experience *me* as a problem, meant my self-identity was not always as important as I might wish it to be, and this can feel like a form of dispossession or annihilation, which is sometimes a necessary suffering.

The possibilities of what might support contacting are endless. The thing to remember is that something is a support only if it can be used for contacting. That is, something I say or do, that I intend as a support, is not necessarily support. It stands to reason that something can only be judged as a support based on whether or not it is of use to the patient.

A final note on support: I find that paying attention to how my presence is or is not a support for expanding contacting, functions on two levels that are mutually reinforcing. The first level as in the example above of our fights, is how expanded contacting possibilities occur as a consequence of various kinds of supports that the therapist's participation brings. The second level is that the therapist's willing participation in experimenting until the most usable supports are found, builds the patient's confidence that the therapeutic relationship can be counted on to welcome the patient's most vulnerable and shameful experiences. This happens in part because the therapist is willing to be fallible and to be corrected by the patient, while still trusting in their own expertise, as the patient and therapist together find the useable supports as they muddle along together.

Presence

By way of ending this chapter, I want to circle back to one of the aspects of gestalt therapy that is unique. I think no other therapy I know of places as much value of the therapist's presence as does gestalt therapy.

I know that for many people their first acquaintance with gestalt therapy was a form of grand activity and show. But my first acquaintance was with subtle musical, dance-like interplay between therapist and patient. The experience of “truth-telling” is a sensory experience that one feels in the muscles of one’s face, in one’s breathing, in the expansion in one’s diaphragm, in one’s growing freedom of movement in the moment. Therapeutic communication, even when profound suffering enshrouds us, has a beauty that transcends pain without obliterating the pain. So, what first drew me to gestalt therapy was the beauty of meaningful dialogue, the “being-with.” It remains one of the strongest supports for putting my heart at risk in our encounter with suffering.

A life-blood of meaningful dialogue is presence. As I mentioned earlier, Joseph Zinker wrote a lovely essay in the first year of the publication of the *Gestalt Review* entitled, "Presence As Evocative Power in Therapy" (1987). Zinker says of presence that it "stimulates unknown parts of oneself, parts not yet fully sensed, described or named as awarenesses. Another's presence makes me feel my own being-here, my own validity. Presence is generally empowering (p.3)." He describes qualities of presence in sensate terms: deep full and even breathing, a sense of being grounded, diffuse attentiveness, readiness to respond. Sitting with someone’s presence, as Zinker writes: “I feel free to express myself, to be myself, to reveal any tender, vulnerable parts, to trust that I will be received without judgment or evaluation(Ibid)."

Being in the presence of presence is, dare I say, healing in itself.

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