

# Chapter 11

## Reflections on the Clinician’s Role in the Clinical Encounter



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### 11.1 Introduction

Several years ago, I decided to examine the philosophical and cultural roots of my therapeutic activities. I was aware of how different ontological perspectives – and in turn methodological choices related to the epistemological question “how do we know” – could affect the therapeutic encounter. There might be some hundred different approaches to psychotherapy but the crucial division between the psychotherapies is not between the “schools” but mainly between what I will refer to as the positivist and the post-positivist or constructivist paradigms. Those years ago, I lacked a clear orientation and became aware that I was vacillating between different methods. I also thought I was able to work without the intention of healing my clients if I just stayed with what was happening in the process. When I realised that, in reality, I did actually have an intention of healing, I decided to explore to see what philosophical theories I might be working from. During this process I wondered about the nature of my underlying motivations for the ontological and epistemological choices I had made in my search for answers to the fundamental questions that are either implicitly or explicitly contained in the way I practice gestalt psychotherapy. Today, psychological theory has become more of a philosophical worldview to me, or a way of thinking and perceiving—more than a taught theory about psychological interventions. In reviewing the path I have followed, I have over time come to know several different traditions in psychotherapeutic practice and, consequently, my opinions about important therapeutic concepts have changed, becoming both extended and refined.

With my desire to heal, came a tendency to see myself as being able to know what was best for my clients. This attitude, I suppose, is still prominent in many clinical encounters. For instance, Cognitive Behavioural Therapy (CBT) is the

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“preferred” methodology seen from a political/governmental point of view. This preference is due to how it fits into the norms, methods and practices of evidence based medicine and the positivist (Humean empiricist) paradigm. Institutionalised norms, methods and practices certainly influence our attitudes when working clinically, and inherent values affect patients in clinical practice and medical care. Although I here use my own experience as a gestalt psychotherapist, I think much of what I say will apply to any encounter where there is a power imbalance as is the case between patients and clinicians. I start from a client-centred approach building on Rogers’ (1962) “non-directive” therapy. In this perspective a healthcare system should acknowledge the client as an integrative whole, where the medical issues must be understood not only on the physiological level, but also within a biographical, social and cultural context.

It is equally important to acknowledge the clinician as a person, with everything that he or she brings to the clinical encounter in terms of values, expectations, perspectives and interpretations. How does the clinician influence the encounter with the patient, in positive or negative ways? And how important is it to be aware of one’s own role in the clinical encounter?

## 11.2 Reflections on How Values Affect Clinical Encounters

Historically, gestalt psychotherapy has rejected diagnosis as being depersonalising and anti-therapeutic. This can be seen as a reaction to the dualistic biomedical model, which seems to isolate the issue of psychological suffering as pathological. The DSM (Diagnostic and Statistical Manual of Mental Disorders) is a psychiatric diagnosing tool (American Psychiatric Association 2000) where the diagnostic criteria are, for the most part, based on manifest descriptive psychopathology rather than inferences or criteria from presumed causality or aetiology. The organisational framework by which disorders are grouped into similar clusters are based on shared pathophysiology, genetics, disease risk, and other findings from neuroscience and clinical experience. Being descriptive, it is compatible with how gestalt psychotherapists diagnose clients. In a gestalt perspective, however, psychological suffering is not seen as psychopathology but rather as a creative adjustment to threatening life-experiences and thus, it is based on observations of phenomenology. This includes a focus on body and mind processes, the clients’ well-being, character structure and level of emotional development, but also attention to the strength of the therapeutic relationship and stage of treatment. This means that gestalt theory takes into account the total contextual field of the clinical encounter, and thus takes a holistic, non-reductionist and non-dualistic view. As such, the two diagnostic tools differ radically as the DSM does not fully take into consideration the person within his or her context.

When it comes to the diagnostic practices within medicine, I often experience that clients who are referred to me by their general practitioner (GP) are diagnosed with depression. When no physical biomarker is found, the patients’ symptoms

seem to be attributed to psychopathology and the patients' subjective health complaints are often conveniently reduced to a diagnosis of depression, which may of course be one of their symptoms. This is also often the case for persons who suffer from fatigue and pain related symptoms. The biomedical model and evidence based medicine (EBM) are rooted in the positivist paradigm. Within this paradigm, knowledge is achieved exclusively by what is directly observable and objectively measurable, and little space is left for reflections about subjective factors and underlying mechanisms (Kerry et al. 2012). Being diagnosed as depressed often upsets these clients and they often openly disagree with their GP. The result of such disagreement can result in a lack of trust and worsening of the experienced symptoms.

In clinical interactions, the patient can be addressed as an object, or as a person. Consider the often-used metaphor, that the biomedical model construes the human being as a complex machine. In this machine, dysfunctions might be caused by internal or external harmful factors and the machine is unable to re-establish well-functioning on its own. On this view the person has lost his or her agency and becomes the passive victim of the diseased part subjected to external repair-work.

In contrast, gestalt theory sees the human being as an agent who is in constant interaction with his or her environment, aware of phenomena such as the experience of bodily sensations in response to internal and external interacting factors. Patients are to be recognised as subjects in their own right with their own habitual preferences of behaviour. A clinician cannot truly know what is best for the patient – therefore, it is necessary to give up the desire to be appreciated as some kind of a healer. If not, the patient becomes a means to an end in the clinical process. According to Buber (1965), human interactions can be characterised by a meeting of subjects or a “thingification” of the other. The subject “I”, can be seen as part of an I – Thou attitude or the “I” of an I – it attitude. In Buber's terminology “Thou” means “you”. Therefore, addressing the client in an I – Thou attitude is a central perspective in relational gestalt psychotherapy and any other person centred practices. Accordingly, I will address two pertinent questions. The first one is: *how important is the clinicians' role within the clinical encounter?*

Gestalt psychotherapy is rooted in an existential-phenomenological world-view. In this world-view, all events are a function of the relationships between multiple interacting forces where no event occurs in isolation (Yontef 1993). If we apply this view to the clinical encounter, any therapeutic process is a function of the relationship between the interacting therapist, client and their common field as a whole. Thus, the field is co-constructed as an integral part of the therapist/client experience, which will have an impact on the possibilities for different outcomes of the process. This means that we can no longer speak of individual growth as “self-development” – in fact it is “self/other development”. Additionally, growth of the entire individual/contextual field is only possible if the field has the capacity to adequately support its members. Similarly, in medical practice, any medical treatment might be seen as a function of the relationship between the interacting doctor, patient and the field as a whole, which might be the case in person centred medicine.

In person centred care, the focus is mainly on the patient: how the treatment influences the particular individual, and how the patient responds to the treatment.

First of all, I will highlight the word ‘treatment’. How can we understand this term? When you are treating somebody, it is easy to imagine the doctor as providing the patient with something that might be what he or she needs. When the dialogic encounter is understood from a dispositionalist perspective, however, the focus must be on all the participants who are present. As such, the dialogic encounter can be seen as an emergent phenomenon where the client and the therapist are mutual manifestation partners for the outcome of the therapeutic process (see Anjum, Chap. 2, this book). Thus, the dialogic encounter is not simply uncovering the client’s experience of her situation, but can be seen as a genuinely interactive process where both the client and the therapist bring themselves in as human beings and thereby influence the encounter reciprocally.

Gestalt psychotherapy is based on the meeting between the therapist and the client as the central healing mode. This means a healing through meeting in reciprocal humanness. In this view it is important to acknowledge the clinician as a person, with everything that he or she brings to the clinical encounter. The development and growth of any healthy self in the field requires a field that includes other healthy selves. We are all inter-dependent and the quality of my life will influence the quality of my environment. Therefore, a relational approach requires careful and consistent observation of all the data in the field including my own processes, values and beliefs as a therapist. This leads us to the second question: *how might the clinician influence the encounter in positive or negative ways?*

In my experience, it is “easy” to handle therapeutic processes individualistically and react as if my existence is separate from my environment – especially when my own self-process is jeopardised. In such cases, how might the encounter be affected?

Being part of the therapeutic process, I am not only engaged as a supportive ground, but as a co-participant as well. When “acting” as a tool in the therapy process, the therapist might be drawn into phenomena such as transference and countertransference (Rycroft 1979). These two notions can be understood as the process by which feelings, behaviours or attitudes of clients and therapists that belong in the past, are transferred to the therapy participants in real time. Transference is our unconscious activity that is shaped by normal preverbal perceptions of self and other, which organise our subjective universe (London 1985). Client and therapist actively co-create the shared perceptual field of the therapeutic relationship. Therefore, from a dialogic perspective, the client’s processes of transferring cannot be interpreted as emanating from the client in isolation, but must be seen as emerging as part of an inter-subjective relational system (Hycner 1991). Countertransference refers to the therapist’s feeling towards the client, in response to the projected transference.

When the therapist is unconsciously drawn into transference processes, the outcome of the therapeutic relationship might in best case be ruptured and in worst case be quite the opposite of therapeutic. In my experience, relating objectively to phenomenological data constitutes a major challenge, even for well-trained psychotherapists. Therefore, I see supervision as crucial when working dialogically. I have experienced meeting clients who are sensitive to what they experience as personal critique. Their emotional reaction might be due to shame proneness. Some of these

clients seem to have been severely shamed by previous therapists, before seeing me. The presentation of the work I did with one of my clients later in this text shows how easily this can happen, and also reminds us of the importance of being consciously aware of the therapeutic process. The attentive attitude requires humility and explicitly promotes respect and appreciation of differences.

I am aware of how contextual conditions often change the way I work. With clients who are more psychotic, I work more analytically – just being there, holding the boundaries, not intervening, challenging or contacting. With healthier clients, I work more dialogically. These choices mirror the clients' level of emotional development and character structure as well as the strength of the therapeutic alliance. I am also aware that there might be a difference between theory and practice – how my values might change in practice. In one-to-one settings I am gentle and soft; in groups I am often more robust and challenging. The danger of not taking differences between people seriously enough is constant. In my experience, it is exactly the art of relational psychotherapy to bring the differences into awareness. And in the dialogical encounter differences related to values or attitudes are to be appreciated – not diluted or combatted.

In what follows I present a snapshot of the psychotherapy I enact. By presenting the work I did with Marie over several months, I will illustrate how my work embodies the theory. This illustration shows how the phenomenology I enact fits into the dispositionalist paradigm. I start with a presentation of how I experienced the initial meetings with Marie and my reflections on what she might need. Then I describe parts of the work we did together.

## 11.3 The Work I Did with Marie

### 11.3.1 *Presentation of the Client*

Marie<sup>1</sup> was a 45 year old married woman with two grown up children. Her husband was a chief executive officer in a large multinational company and travelled a lot. Due to this she spent most of her time on her own. Until recently Marie was a manager in a small company, but lost her job last winter. This made her feel lonely and lost. She told me about her happy childhood; her mum and dad and her sister who was 3 years younger, whom she adored. The family spent a lot of time together, either alone or with friends. Both her parents were dead, her father died when she was 20, her mother 2 years ago. After the death of her mother, she did not have much contact with her sister, although they lived in the same part of the town. Before she began seeing me, she had been ill for a month. Her referral to me was via her GP, who had diagnosed her as depressed. Her reason for wanting therapy

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<sup>1</sup> 'Marie' is a fictive name. Some details have been altered for the purpose of de-identification according to ethical and legal standards and written consent to use her story has been obtained.

was that she needed some help to fix her life. She presented with issues of anxiety and panic attacks, feeling isolated from others, especially her husband. Her GP wanted to give her antidepressants, but she refused because she did not see herself as depressed. We agreed to work for a 6 week assessment period to determine whether we were able to work together or not and to review our work after that on an open ended contract.

The first time I saw Marie, I was struck by her attractiveness; she was tall, slender, and well dressed, with a determined stride. Her long dark hair framed her deep blue eyes. Her voice was rich, and sensual. With the pitch of her head forward, her eyes were often cast downward and seldom met mine. Sometimes, when she did look in my direction, she glared. This look of camouflaged contempt made me feel tense. Marie's facial expressions were endless. She commented on everything with a wince, as if every feeling that passed through her body was expressed only by the muscles of her face. When she became anxious in the session, this tendency was especially evident.

My initial reaction to Marie was curiosity and I felt warm and concerned towards her. I experienced her as being extremely bright, demonstrated by the way she presented herself and her use of vocabulary. Marie's connection to her mother changed at the age of three, when her sister was born, and she was sent to her mother's sister for some weeks. Afterwards she became dad's girl. When telling me about her father's death, she teared up, but seemed to be unable to relate to the emotional situation that she obviously experienced. She turned away from me, silently sitting there for a while – then she laughed. I often experience such reactions, which I see as a normal human ability that allows us to put off dealing with emotions until we feel able to address it. When she laughed, I was aware of feeling irritated and when reflecting on why, I became aware of one of my personal assumptions that I might have acquired without full awareness of its purpose: "It's silly to laugh". She described her relationship with her mother as ambivalent, never knowing where she was in relation to her. Marie told me that her mother must have been depressed – she could be silent and withdrawn for days, not addressing anybody. I was struck by how some aspects of her history paralleled my own. I also felt adored by my father and abandoned by my mother, which alerted me to the possibility of transference/countertransference processes. And, I was aware that I could easily be drawn into over-identifying with her. I knew at this early stage that I would need to discuss our relationship with my supervisor to be able to bracket off my own emotional baggage.

### ***11.3.2 Presenting Problems***

Marie came to therapy with difficulties especially in her relationship with her husband. The slightest misunderstanding between herself and others left her with feelings of abandonment and deep loss. Whenever she spoke about an emotion such as her fear of being abandoned, she would immediately discount it with statements such as, "But I know that's crazy, because I should not feel that way!" In this regard

she was extremely critical of the vulnerable aspects of herself. She was also highly critical of others, an aspect of herself which she joked about by stating that it was due to her superiority complex.

### ***11.3.3 Diagnosis***

From a gestalt perspective I think it is fruitful to understand Marie's process historically as a "creative" adaptation to her life situation. This adaptation can be seen as the relationship between Marie and her environment, in which she takes responsibility for creating conditions to take care of her own well-being. Thus, I see diagnosis as a descriptive statement that articulates what I notice in the present, which informs me of how I might be able to help my client.

Gestalt psychotherapy embraces Merleau-Ponty's holistic view of the human being, conceptualised as existing in continuing interplay in the "organism-environment field" (1945/1962). The organism-environment field can be understood as a systematic web of relationships, which consists of a totality of mutually influencing forces that together form a unified interactive whole. Out of this intersubjective field, "figures" emerge. The configuration of a figure against a ground displays the meaning, and meaning is achieved only through relations in the field. Thus, the relationship between the ground of the field and the figures that emerge is what gives meaning to the whole. To perceive and be aware of an emerging figure is the act of contact.

The idea of "unfinished business" is a core notion in the gestalt approach to explain how the act of contact might be interrupted. This notion refers to a tendency of the organism to complete any situation that is experienced as unfinished (Perls et al. 1951). For example, when Marie was not able to get her needs met, some specific contact episodes emerged between us at the contact boundary (Clarkson 1989). I became aware of some aspects of her behaviour, which stood out from the context like figures against a ground. These figures became interesting as a source of further exploration when I observed them as a pattern over time and across situations. Contact boundary disturbances do not refer to psychopathology, but to a disruption in the clear awareness and organismic flow between self and other, which can be either healthy or pathological. Very early on in the encounter with Marie, I became aware of the transference that was taking place between us. I reflected on whom I might represent to Marie – when I felt warm towards her, I would be her father, and when I felt irritated and critical, I would be her mother. So, when I was feeling irritated and critical towards her, she might have been unaware of conveying her feelings by giving me as the therapist an experience of how she feels, rather than by articulating. Thus, there was a possibility that I could end up behaving towards Marie like her mother did.

After this brief presentation of my initial contact with Marie, I now turn to the therapeutic process and present some of these interruptions to contact, and how I work dialogically.



### 11.3.4 *The I-Thou Process*

To illustrate how I worked with my client, I will list four discernible phases in the “I-Thou” perspective (Buber 1965). These phases are (1) “Exploring self; an it – it attitude”, (2) “Becoming aware of the therapist’s presence; an I – it attitude”, (3) “Struggling with abandonment depression; an I – Thou attitude”, and (4) “Moments of mutual satisfaction; a Thou – Thou attitude”. These four phases show how Marie’s and also my own ability to integrate personality aspects that previously were not fully “owned” resulted in an emergent phenomenon, that is, the therapeutic outcome.

**Phase 1: Exploring Self; an It – It Attitude.** When Marie entered therapy she talked about herself and objectified both herself and me as a therapist and asked, “how can you fix me?”. Marie rapidly established an “idealising” transference towards me, which can be understood as Marie’s unconscious recognition of some of her mother’s traits in me, and then started acting out how she previously idealised her mother. When I became aware of the idealising transference she projected onto me, and the immediate impact it had, I realised how flattered I felt. I was able to see that I was not fully present to her as another person. However, the loving attitude I felt towards her, and the mirroring I did during this phase, was an authentic desire to nurture and “mother” her.

My main goal for this phase (6 weeks of therapy) was to build a therapeutic alliance. I focused primarily on building a trusting relationship, and therefore I was initially and primarily concerned with “confirming” her (Buber 1965). By confirming in this context, I mean accepting not only what Marie is aware of, but also aspects of her existence that are denied, e.g. confirmation of the person in her fullest potential. I started to practise “inclusion” (Buber 1965) with her. By this I mean closely listening to both verbal and nonverbal communication, carefully giving her phenomenological feedback to raise her awareness of herself. In this situation I address her as a “person” – not as an “object”. Intuitively I felt she was very sensitive to anything I did that she could interpret as being a rejection. However, instead of telling me directly when she felt ignored or insulted by me, she would get a certain withdrawn and contemptuous look on her face that I came to recognise. When I addressed this phenomenologically, she would comment back to me with a wince, obviously feeling misunderstood and attacked. She was not interested at this point in insight about herself, because she was convinced that all insight would simply lead to criticism. I was imagining that her self-esteem was very fragile and instead of exposing her insecure self, she presented a “false”, defensive self to me. This imagining must be distinguished from empathy, which leaves out one’s own side as a therapist. To be able to practice inclusion the therapist needs to be able, as much as is humanly possible, to attempt to experience what the client is experiencing, feeling, thinking or knowing from her side of the dialogue, as well as meeting her authentically and honestly as part of practicing inclusion with her.

**Phase 2: Becoming Aware of Therapist’s Presence; an I – It Attitude.** Previous sessions had taught me that experiments had triggered resistance and would be seen as criticism of Marie’s behaviour. For example, Marie suddenly stopped talking in



terms of herself and switched from saying “I” to saying “we” without any apparent awareness. Instead of saying: “why don’t you try an experiment and say ‘I’ instead?” I would rather say: “I was wondering if what you were talking about suddenly felt too painful to continue talking of in terms of yourself?” This response made it easier for Marie to explore her painful feelings and helped her to stay in contact with me, and increased her self-awareness without triggering unbearable anxiety.

Marie had introjected her mother’s self-image and idealised her mother in order to maintain any sense of having an ordered, loving family. An “introject” may be seen as accepted personal habits acquired without full awareness of their meaning and purpose (Perls et al. 1951/1998). When she described what she was aware of when she attempted to make contact with her husband, she became more aware of her “impasse”. Here, the impasse can be understood as how Marie acted out the experience of seeing herself as a dis-empowered object (Newirth 1995). She imagined that her husband was much too busy to want contact with her, and the conversation just stopped. This experience left her frustrated, lonely and longing for connection. I asked her to describe her experience of longing, which she experienced as a vulnerable and lonely feeling in her stomach. She added that she feared rejection and quickly stated that her mother had never accepted her husband – and he was not worth connecting to anyway. I encouraged her to stay with this feeling of criticism, and we explored further the frustration that emerged in her. When she was able to disclose more of her feelings of insecurity and low self-esteem, she was able to ask for more support. At this point, she was able to take in the support I offered her when raising her awareness of how her attempts to deal with her vulnerability by being critical towards herself only left her feeling more frustrated and distressed. Gradually she became able to honour herself.

During this phase I experienced that she started to sense her feelings of anger, being aware of her need to express herself, to mobilise her energy, and finally to vent her feelings towards her mum.

**Phase 3: Struggling with Abandonment Depression; an I – Thou Attitude.** Once this trusting and accepting relationship was established, the next phase began, where some of Marie’s problems related to interactions with others were further explored. There were more moments in which I – Thou encounters occurred, than there were moments in which I – it encounters occurred. As Marie started to see me as a person I became more important to her. This was when the therapeutic relationship was challenged.

### *11.3.5 Key Episode 1*

Marie started to project the anger outwards, which she had previously controlled, and became very critical towards me. When I heard her stating: “no one can be relied upon”, I was aware that this was similar to one of my own introjects and I recognised the wounds from feeling rejected by my mother. It was therefore important for me to “bracket off” my own emotional reactions in order to be available to

explore and to fully understand how Marie made meaning out of this statement. In this context “bracket off” means that I held some of my own concerns in abeyance in favour of attending to what was going on when interacting with Marie. I tried to meet her honestly and authentically. I did, however, feel wiped out by her and knew that this was something I would have to explore in supervision. Initially, I was able to stay in contact with her, but I was aware of feeling induced to behaving towards her like my mother did towards me. And because of the sensed similarity between Marie’s mother and my own, I was particularly vulnerable to this induction.

When she started to reveal her dependent, needy side I was aware of feeling irritated and angry with her. I had, in a sense, fulfilled what she expected – being rejected was what she really feared. She exhibited the anger she previously had controlled and talked to me with sarcasm and contempt, when the narcissistic and maternal “supplies” she was seeking from me were withheld. I thought in that moment and subsequently that Marie had benefited from my firm, withholding posture and that I had managed to resist her seductiveness. I was however left feeling uncomfortable about how harsh I had been and continued to be over the next two sessions. I sensed that Marie was withdrawing. We both had reached an impasse. I struggled a lot and felt dreadful until I had discussed what had happened and worked through the process with my supervisor.

**Phase 4: Moments of Mutual Satisfaction; a Thou – Thou Attitude.** In this last phase Marie was able to practice inclusion with me, which means that she was able to stay in the present moment, meeting me honestly and authentically. This happened after I decided to disclose the pain I had felt and explained to Marie what I thought had happened in the process.

### ***11.3.6 Key Episode 2***

I was able to disclose my humanness to her and say I was sorry for the mistake I had made after being able to non-defensively own parts of my own history and been able to heal old wounds. When doing so, the contact between us was paradoxically re-established. I felt I was risking a lot, but in this moment of Thou – Thou mutuality, being authentically present, I felt grace and deep satisfaction. By authentically disclosing myself as who I am, something changed.

Over the course of this work, Marie started to see herself differently. There has been a shift in her attitude towards herself. Instead of seeing herself as the bad part of the mother-daughter relationship, she has started to see that it was not all her fault. In this process, she has started to grieve for the mother who was not there for her. Marie reported that the panic attacks had not occurred since Key Episode 2. She is now able to feel more satisfaction in her life, and her relationship with her husband has deepened.

## 11.4 Reflections

I see philosophy as the way I hypothesise about everything in my life and the essence of how I work as a psychotherapist and researcher. Philosophy also helps deconstruct being social; “how do I connect with what is?”. This fundamental question is an inquiry into what collective experience is possible. On the contrary, to treat knowledge as intellectual, prescribed and something we are taught, is to forget its social and interpretative nature. Thus, this question is of concern to all of us, and not so much in terms of “I”, more so in relation to “we”.

In this short text I have reflected on the clinicians' role and how we as clinicians might influence the outcome of the encounter. I am intrigued by the relationship between the therapist and the client, as well as the relationship between the client/therapist and “significant others” in the clients' lives. This relational aspect is the concrete basis for how I work clinically. The ontological stance we take, either consciously or unconsciously, will influence our norms and methods and, in turn, the way we practice. I hope that this text will stimulate further reflection and discussion on the clinicians' role in the clinical encounter.

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