GESTALT THERAPY AND COGNITIVE THERAPY—CONTRASTS OR COMPLEMENTARITIES?

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The article investigates the relationship between crucial concepts and understandings in gestalt therapy and cognitive therapy aiming at discussing if and how they can be mutually enriching when considered as complementary parts in a more encompassing integrative therapeutic approach. It is argued that gestalt therapy, defined as a field-theoretical approach to the study of gestalt formation process, can complement the schema-based understanding and practice in cognitive therapy. The clinical benefits from a complementary view of the two approaches will be a wider scope of awareness toward individual and contextual aspects of therapeutic change processes, toward different levels of memory involved in these processes, and toward the relationship between basic needs, sensation and cognition in therapeutic work. Further, a dialogue between the two approaches will pave the way for addressing the connection between fundamental awareness work in gestalt therapy and the tendency within cognitive therapy toward incorporating mindfulness as a therapeutic tool. In the conclusion of the article, additional complementary points between the two approaches are outlined.

Keywords: integrative therapy, gestalt formation process, field theory, memory, mindfulness

Gestalt therapy and cognitive therapy are both anchored in phenomenology and are undogmatic in their attitude toward integration of elements from other therapeutic and scientific approaches, as long as such elements do not violate the phenomenological principles (Resnick, 1995; Rosenberg & Mørch, 2005). In spite of this commonality, the approaches are different from each other in several respects concerning their view on human nature, mental health, and methodology. While cognitive therapy has become increasingly respected and popular in academia, among professionals, health institutions and insurance companies, gestalt therapy is lacking recognition in these areas. One of the reasons for this might be the better adaptability of cognitive therapy to training models for applied therapeutic approaches compared to experiential models. Another reason might be that gestalt therapy has been more of an oral tradition with a comparatively sparse production of written material and

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an almost nonproduction of traditional research, while cognitive approaches were born with a metaphor of man as a scientist (Kelly, 1955) and since their inception have been inhabited by researchers and writing practitioners. While cognitive therapists can celebrate this state of affairs, we find the situation unfortunate for those clients who would benefit more from gestalt therapy, and for the potential contributions from gestalt theory to the scientific knowledge base in psychotherapy and psychology, which will stay in a state of potentiality unless the gestalt approach is brought into research-based dialogues with other therapeutic and theoretical approaches.

The aim of this article is to contribute to such dialogues by establishing a meeting point between the theoretical structures of gestalt therapy and the cognitive approaches as a baseline for investigating mutual areas of inspiration. The article is part of an ongoing development of a so-called ‘integrative gestalt practice,’ in which we investigate the potential of gestalt theory serving as an integrative framework for the understanding and practice of psychotherapy, supervision, and organizational work (Tønnesvang, Hammink & Sonne, 2007; Sommer & Tønnesvang, 2008). After a review of central theoretical foundations of gestalt therapy and cognitive therapy, the article will investigate the potential complementarity between the approaches and point to some of the clinical implications of a dialogue between them with respect to complementary nodal points. Toward the end of the article a schematic overview of complementarities and comparisons between the two approaches is presented.

Basic Concepts in Gestalt

Gestalt Formation Process as the Basic Unit of Analysis in Gestalt

Gestalt therapy was defined by Perls, Hefferline & Goodman as the “science and technique of figure/background forming in the organism/environment field” (1951/1994, p. 250). It is a field-theoretical approach to understand and investigate how we (as organisms) create meaning through processes of forming and dissolving gestals. It holds the view that such gestalt formation processes are initiated by organismic needs in both a physiological (hunger, thirst, shelter, touch, etc.) and a psychological (interest, curiosity, growth, etc.) sense. In that respect, the gestalt approach parallels the organismic-dialectic position in Deci & Ryan’s (2000) self determination theory in which needs for relatedness, competence, and autonomy are considered basic to human nature. When a need presents itself (that is: when something is needed), our phenomenological field polarizes into figure and ground. Energy arises in relationship to the figure, which sharpens it and brings it into the foreground of our awareness. In this way, the need, in relationship with the context, becomes a determinant factor in the awareness process and the following cognitive, emotional, and behavioral attempts to satisfy the need. If successful, the need is satisfied and the gestalt dissolves.

According to Burley (2004), the central part-processes in the gestalt formation process are: figure formation, figure sharpening, self-environment scan, resolution, assimilation, and the undifferentiated field. These part-processes will usually follow each other in the presented order. If, for example, a therapist is concentrated on working with a client while peripherally registering an unfamiliar sound in the room, we would say that the sound exists as an unclear figure in the gestalt formation process (figure formation). If the sound persists, it becomes sharpened as a figure as more awareness is focused on it (figure sharpening). The therapist becomes distracted from the contact with the client and interested in knowing the source of the sound and if possible stopping it. The therapist mentions the distraction to the client, looks around the room (self-environment scan), and discovers that the new thermos is hissing. At the moment of this discovery the figure shifts to resolution (intending, planning, execution, verification) of the situation as the therapist adjusts the top of the thermos and the sound stops. Assimilation in the form of registering the changes in the self-environment field as the result of the resolution of the gestalt formation process will take place, and for a brief moment the field will be undifferentiated (equilibrium) before a new figure forms and sharpens again, when the therapist returns with full attention to the client.

Figure formation processes including the steps above can vary in length of time stretching from less than a second till days and even years. Under certain circumstances there can be attempts at figure formation that cannot be successfully completed. This might be the case with each of the
part-processes. The usual progression in the gestalt formation process can be blocked or turned off at any point in the sequence. The blockages can either be in the service of the organism (useful prioritizing) or they can result in unhealthy ‘unfinished business’ in the organism’s self-regulation. When, for instance, a client inhibits an appropriate expression of criticism in the therapeutic setting this might result in unhealthy ‘unfinished business’. When avoiding being critical toward a potential violent person on the street the same sort of blockages might be functioning as useful prioritizing.

Field-Theoretical Foundation

As a field-theoretical approach, gestalt therapy is inspired by Smut’s holism (Perls, 1947/1969, p. 28) and Lewin’s field theory (Parlett, 1991). As clarified by Staemmler (2006) there have been discussions as to whether or not the field should be considered only in terms of the psychological field or in terms of the field as a whole including (but not limited to) the psychological aspects. While Yontef and Jacobs (2008) propose that we only consider the psychological field as being a genuine part of the gestalt approach, we find such a proposal as unnecessarily limiting for an integrative gestalt approach. To avoid reductionism and unnecessary dichotomization between psychology and other scientific disciplines (for instance, neurobiology and sociology) we would argue that the gestalt conception of the field should be in accordance with the Lewinian conceptualization of the ‘field as a whole’ including both its psychological and nonpsychological aspects (Lewin, 1951, pp. 172–174).

Working with the whole field as the basic stance doesn’t mean that the therapist must include the entire complex, and, in principle, infinite field when working with a client. In psychotherapy as well as in research it is a methodical necessity to delimit the field focus under investigation (Lewin; in Perls, Hefferline, & Goodman, 1951/1994, p. 277). And the way in which such methodical limitations of the field are realized is continuously up to the therapist’s professional skills, aesthetic judgment and capacity to be aware of the fact that this is what is happening at the moment.

To work with a field conception means that an understanding of the client must include relevant aspects of the field in which he or she is embedded. It must be recognized that the field is influenced and experienced differently in relation to the client’s position therein (Yontef & Jacobs, 2008, p. 12). And it must be recognized that these conditions are the same for the therapist, who, therefore, cannot have a complete understanding of what is going on in an interventive process or in the life-space of the client. But the therapist can continuously gain more understanding through the use of contact.

The Concept of Contact

Given that we always find ourselves within a complex field, which we influence and are influenced by, contact processes become the key to understanding how such influences take place. The gestalt concept of contact can be defined as the exchange of information between I-ness and otherness. Defined this way, contact is not only something that is going on between one person and another, or between a person and something else in the field (a table, for instance). Contact refers also to the exchange of information within the organism that makes it possible for the ‘I’ to experience a sensation in its own foot or to create an experiential relation to an emotion. At the definitional level, the gestalt conception of contact does not differentiate between contact in physical, social and psychological spheres. The benefit from such a definition is that it makes it possible to work with contact in the therapeutic relation (the social sphere) without dichotomizing the exchange of information in that relation from the exchange of information in the client’s psychological sphere. For example, if the client provides the therapist with information about the weather and the therapist nods his head, there is contact in the sense of exchange of information. This might be considered a superficial contact with no further therapeutic implications or it might be

1 Correspondingly, it is the exchange of information with otherness that creates the possibilities for development and creation of meaning for the individual organism. Because the I-ness of the organism in this way is linked to otherness in the field, it is a logical outcome of gestalt theory that the gestalt therapist works with dialogue, contact and contact disruptions in the therapeutic process. Gestalt theory and gestalt practice are based on the same premises and consistently aligned to each other, aiming at investigating gestalt formation processes as they take place in contact-relations in the organism-environment field.
considered a first step in establishing a sense of trust between client and therapist. As in all forms of contact the therapist is being aware of the contact patterns of the client. If the more superficial level of contact regarding the weather reflects the client’s tendency to avoid contact with conflictual themes, and the therapist brings awareness to this avoidance, the client might experience a deepening of contact with the therapist (a feeling of being seen). This deepening can pave the way for the client’s contact with the origins of the avoidance pattern and its gestalt formational character (figure formation, figure sharpening, self-environment scan, resolution, assimilation). A short example will illustrate the point:

Therapist: “I notice that as I am speaking there are tears in your eyes.” (By focusing awareness, the therapist invites the client to recognize sensation, e.g., figure formation)

Client: “I can’t stand it.” (It seems like the client gets more contact with the feeling, e.g., figure sharpening)

T: “Try looking at me and saying, ‘I can’t stand it!’” (The therapist invites to self-environment scan and to expanding/deepening contact with therapist.)

The client looks at the therapist; crying becomes louder and deeper.

C (through the tears): “When you said that you had to cancel our next appointment because you have to go to a funeral, I felt as if you stabbed me in the heart. I know it’s crazy but that’s how it felt. I was just about to run out – I can see that is what I usually do.” (The client’s awareness of old patterns of gestalt formation processes becomes a new figure.)

T: “Even with people you love and trust?” (The therapist invites to sharpening the new figure.)

C: “Yes.” (The client seems to experience contact with the new figure.)

T: “What are you doing now that is different?” (The therapist invites to sharpening the figure of the new gestalt formation process.)

C: “I’m still here.” (The client affirms the figure sharpening.)

T: “Can you look at me and say that?” (The therapist invites to stay with the new figure in contact with the therapist.)

C: The client looks at the therapist and says, “I am here.” (Resolution)

T: “How does this feel?” (The client is invited to self-contact.)

C: “Scary but right.” (Assimilation)

Health and Pathology in Gestalt Theory

During smooth organismic self-regulation the gestalt formation process is brought to an end by the fulfillment of the need(s) that underlie it’s initiation. This of course does not always happen as easily and unproblematic as in the aforementioned thermos example, or as smooth as in the dialogue above, and, in some situations, it does not happen at all. Thus, in some cases the outcome will be unfinished business that continuously will absorb energy with the unfulfilled need functioning as a tense readiness to seek fulfillment in different suitable and unsuitable situations. In other cases, it may be a matter of ending an unfulfilled gestalt by recognizing that the need cannot be met (in its present form, at this point, in this context, or never). In such cases, ending the gestalt formation-in-process will lead to an acceptance of the fact that the need cannot be fulfilled. This might be linked to different degrees of self-soothing or grieving processes extending from the recognition of a lost childhood (where one, e.g., has to say forever goodbye to the hope that one’s mother would be present as a secure base) to the less comprehensive grieving project in everyday life situations; for instance, when one has been looking forward to spending some time with a good friend who cancels because of illness. The nature and scope of such self-soothing and grieving processes are, of course, relative. For those with an unstable personality structure, it is characteristic that - what by others would be considered a small blow and disappointment of everyday life - can be experienced as a shaking of foundations (in the terms of Tillich, 1948).

Just as a gestalt formation process can be dissolved in different ways, the appearance of needs can have different degrees of ‘legitimacy’ (Burley, 2004). Some needs might be the result of a faulty perception of a bodily state or a faulty interpretation of, for instance, body sensations in the stomach region as hunger when in fact they are an expression of thirst or possibly nervousness. As a consequence, the continued figure formation process will rest on a false premise and result in an impaired organismic self-regulation. It will not lead to the health and well-being that usually results from the flow of healthy organismic self-regulation.

In a gestalt framework mental unbalances and disturbances are seen as expressions of organismic self-regulatory processes that have been mistrained or misformed such as the example in the previous paragraph. As a result, the processes through which figures are formed and dissolved are either diffused or blocked or rigid, creating unsuitable and poor functional fits between the individual’s administration of needs and the de-
mands of the surroundings. When organismic self-regulation takes place without too many ‘process lumps’, the result will be that the most vital and central need in the situation becomes figure (cf. the description of the first stages in the process of gestalt formation). This requires the individual organism to know and acknowledge what it senses, feels, thinks, and does here and now. It further requires that it adapts the fulfillment of these needs to the concrete context (interpersonal, material, and cultural) wherein it is situated. In order for such “creative adjustments” to happen, the individual’s ego-boundaries must be properly permeable. They must, on the one hand, make it possible to be in contact with and say yes to that which facilitates creative adjustment and, on the other hand, make it possible to reject that which is psychologically or physically invading and disabling (Perls et al., 1951/1994, p. 230; Yontef & Jacobs, 2008, p. 20).

Ego-boundaries can be off-balance in many ways, and to a greater or lesser extent. For some clients with a personality disorder, we will find excessive permeability amounting almost to dissolution when a potentially nourishing contact with another activates fear of merging into and/or being destroyed by the other. At the same time, an intense anxiety of being left to ones own immature (mistrained or misformed) self-regulation and self-support can be activated when these persons get nearer a potential ego-boundary and recognize their separation. Recognizing the life-situations at the contact boundary for such persons gives us a clue about the painful existential extremities that basic contact disorders are about.

Gestalt Diagnosis

Traditionally, gestalt theoreticians and therapists have had a strained attitude toward diagnosis. Many have completely disassociated themselves from the use of it. However, with the boost of evidence-based therapy during the last decades, gestalt therapists have come to recognize that the nonchalant strategy of rejecting diagnosis is a residual from the past. It is therefore suitable that Burley (2005) developed the contours of a diagnostic strategy, which on the one hand is anchored in basic gestalt principles and on the other hand seems to promise a match of the symptom descriptions in ICD-10 and the DSM system with the gestalt formation processes beneath the symptoms.

The central assumption in gestalt process diagnosis is that the type of disturbed self-regulation is a manifestation of specific dysfunctions in the gestalt formation process (Burley, 2004, 2005). Where there is a problem in the gestalt formation process, and what that problem is in each of these steps (figure formation, figure sharpening, self-environment scan, resolution, assimilation respectively) will determine the differences between specific psychopathologies at a process level. Thus, psychopathologies in which figure formation is inhibited from the start are different from psychopathologies in which figures are formed, but not held clear long enough to secure the realization of the need of which it is an expression. And psychopathologies in which an overtly strong figure is formed are different from pathologies in which figure formation holds a split between two phenomenological worlds that are mutually exclusive. The situation concerning splitting is, for instance, characteristic of borderline disorders where ground as well as figure is split in two mutually excluding phenomenological modes that coexist through the whole gestalt formation process. When one of these phenomenological modes is activated (and dominates) the client’s figure formation process has a positive valence and s/he might idealize the therapist, while when the other mode dominates, the figure formation process has a negative valence and s/he might devalue the therapist. Due to the split between the two modes the client will not recognize the inconsistency in the two processes leading to the oscillating attitudes. The situation in which we find inhibited figure formation, is characteristic of depression where no figure of interest is formed—followed or determined by feelings of helplessness or hopelessness. When no figure is formed there will be no need-based action (resolution) and satisfaction (assimilation). In obsessive–compulsive disorders there will be a clear figure formation, but at the moment (in the gestalt formation process) when self-environment scanning takes place, the clear figure is captured (and replaced) by other figures in the environment; the result being that the primary need (the original figure) remains unsatisfied and therefore, there is no resolution or assimilation of that need. (For further elaboration and examples, see Burley, 2005).
Uncovering Character Structure

Within a gestalt framework, psychological disturbances are considered to be expressions of dysfunctional gestalt formation processes. As mentioned, the different types of disturbance are the result of where in the gestalt formation process the organism has a tendency to interrupt, as well as to the typical style or way in which it interrupts itself. With reference to Burley and Freier (2004) we can say that the implicit tendency to perform particular gestalt formations expresses the character structure of the individual, which will manifest itself in a uniform way regardless of the individual’s participation in differing contexts. It will appear in therapeutic situations with a typical ‘phenomeno-logic’ pattern which will repeat itself in divergent life situations more or less pronounced. Although different life situations call for different experiences, behaviors, and manifestations of identity, the way in which the individual forms and dissolves gestalts orators, and manifestations of identity, the way in which the individual forms and dissolves gestalts and process interruptions will typically be the same across contexts. For example by repeating a pattern of mistrust in otherwise trustworthy relationships or by seeking the same enforced mirroring responses in all sorts of different relationships. Correspondingly, it is the character structure, expressed in the patterns of the individual’s gestalt formation processes that are the basic goal of the transforming therapeutic work (Burley & Freier, 2004; Yontef & Jacobs, 2008). The pivotal point in gestalt therapeutic work is to bring awareness to how gestalt formation processes typically unfold (as the patterns making up the character structure) in relation to different experiential content and contexts.

Awareness as Means and End in the Therapeutic Work

Awareness refers to the attentiveness that we can have toward what is going on and when it happens. It is a sort of knowing as one is doing. More strictly, awareness can be defined as contact with difference and movement at a boundary. Framed this way, the meaning of awareness is close to the meaning of core consciousness as defined by Damasio (1999), as a sense of being an organism in which something happens due to its relation to an object. To be aware (as a process) is related to that which the awareness is about (sensations, feelings, thoughts, acts, etc.). In relation to the transformational work on gestalt formation processes, awareness is the means by which the individual comes to know (the problems in) the steps of the process through which figures are formed and sharpened, followed by self-environment scanning, resolution, and assimilation. At the same time, awareness is an end in the sense that by becoming aware of what happens and when it happens, smooth organismic self-regulation most likely will occur.

It is, tangentially, in close relation to the establishing of process awareness that we find the rationale behind conceiving gestalt therapy as a how-therapy, in which the therapeutic activity primarily focuses on the “how” instead of the “why” or the “what” (Perls et al., 1951/1994, p. 232). It is the very process (how, what is happening, happens) that is the focus of attention. The purpose is to provide the client with the opportunity to capture and experience with awareness the gestalt formation processes as they are taking place here and now in the contact between the client and the therapist. The point is that the contact between therapist and client nurtures the client’s capacity to be in contact with, to sense, know, and accept the changing figures that appear from moment to moment (Yontef & Jacobs, 2008, p. 35). And to the extent that the client increases his or her awareness of these changing figures, the organismic self-regulation will improve, thus loosening the rigidity of the character.

Exploration and Techniques in Gestalt Therapy

The prototypical methods and strategies in gestalt therapy will explore direct experience in contact-relations through phenomenological experimentation (Yontef & Jacobs, 2008, p. 36; Naranjo, 2000, p. 50). Phenomenological experimentation implies focused attention to the gestalt formation process and can unfold in any creative experimental way that the skilled therapist might choose (Zinker, 1978). The two-chair dialogue has been one of the techniques used for that, and since it has been repeatedly used, it has often been mistaken for being equivalent to gestalt therapy, which it is not. Gestalt therapy is not a set of techniques but a basic explorative stance toward working with facilitation of organismic self-regulation through contact-full dialogue, and
Cognitive Understanding of Pathology and Health

The cognitive model explains psychological disturbances and disorders as dysfunctional thinking at different levels. The most superficial level is the situational level of automatic thinking and the most fundamental level is the level of schemas (also termed core beliefs) considered as personality structure (Beck, Freeman & Davis, 2004, p. 27). Schemas are organizing principles or meaning structures, which—when activated—establish a perceptual and experiential filter in the individual’s relation to the environment. According to Young, Klosko & Weishaar (2003, p. 54) schemas originate in the dyadic interaction between caretaker and child and have affinity with Bowlby’s working models. They develop from early (preverbal) childhood through adolescence, and though they become rather stable when they have been established, they will continuously be elaborated and adjusted throughout life. The crucial difference between psychological disturbance and health is the rigidity versus flexibility that characterizes different schemas as well as the relative ease and strength with which they are activated. In personality disorders we generally find that the most central schemas are prepotent (repress other schemas into the background) and hypervalent (low threshold of activation) (Beck et al., 2004, p. 28). Further, there will be rigidity with a tendency to not let information and experiences that diverge from the activated schema make an impression; consequently, there will be no modification or adjustment of the activated schema. In accordance with Piaget we can say that the adjustments will primarily be assimilative and not accommodative.

Maintenance of Schemas

Once schemas have been established, the individual will typically try to confirm and maintain them, also in the face of disconfirming data in the environment. It happens partly through cognitive distortions, and partly through the behavioral patterns that are developed to cope with schemas. Young et al. (2003) presents three such coping strategies: (a) compensation; (b) surrender; (c) avoidance. Each of these strategies can manifest themselves as behavioral patterns or as mental (thought) patterns. Thus, in relation to a schema such as distrust—which is often activated in therapy with neglected youngsters, and which in Young’s model belongs to the domain of disconnection and rejection—the following strategies may be used: (a) an overcompensating coping style in which one acts according to a mental and behavioral logic of using or hurting others before getting hurt oneself. Next: (b) a coping style of surrender in which one, for example, repeatedly attaches oneself to friends who abuse and take advantage, sexually, economically, or in other ways. And finally: (c) the coping style of avoidance by which one’s distrust makes one avoid involvement and intimacy with others, including the therapist whom one also tries to keep at a distance in different ways. The paradox in these strategies is that all three of them are self-perpetuating because others typically respond to them in ways that confirm their beliefs that social contact with others is compromising.

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Maintenance of Schemas

2 Correspondingly, the gestalt experiment serves to bring into the present contextual aspects including the conditions of experiencing, the social milieu and the habitual self-regulations of the client, to support awareness of the gestalt formation process in the here and now (Sonne, 1998). Even if the therapist can see the behavior and convictions of the client as limiting and inappropriate, the client may not be able to see or understand this. A fundamental aspect of such a problem might be the client’s way of thinking about the problem. The experiment is designed to give the client a possibility in a new setting to experience the problem—including the organism/environment field—with the purpose of heightening awareness of the gestalt formation process involved, the result being heightened awareness of self-regulations (involving cognitive, behavioral and somatic aspects) and awareness of new possibilities, which might seem more satisfying and less limiting than the old ones. The purpose of the experiment is, so to speak, to unfold the phenomenology of the client, not with the explicit purpose of changing anything, but, through awareness of what is, to give way to the client’s own choice of change. In principle, the therapist and client together design the experiment. The purpose of the experiment is to explore whether the once-appropriate self-regulations and convictions of the client are still appropriate.

3 We choose to ignore the concept of modus, which is proposed to be at a deeper level than schemas by referring to a state in which more schemas are activated at the same time (Beck, 1996; Rosenberg & Mørch, 2005). The concept of modus is used somewhat differently by, for instance, Beck and Young. We leave out the discussion of how modus should be understood and will use schemas as referring to the most basic level (together with modus).
Young’s model consists of 18 early established maladaptive schemas that can be grouped into five broad categories termed schema domains. These domains are related to the assumption that five basic and universal emotional needs (when not being met sufficiently in childhood) provide the background for the development of maladaptive schemas in varying degrees. The more maladaptive these schemas influencing and guiding the person are, the more severe the disturbance and disorder will be. According to Young et al., we can outline the basic needs and their related domains as the following:

1. Secure attachment related to the schema domain of disconnection and rejection. Examples of specific schemas contained are mistrust, defectiveness, and emotional deprivation.

2. Competence, autonomy and experience of identity related to the schema domain of impaired competence and autonomy with specific schemas as for instance, vulnerability to harm, enmeshment/undeveloped self and failure.

3. Freedom to express needs and feelings related to the schema domain of other-directedness. Examples of schemas contained are self-sacrifice and subjugation.

4. Spontaneity and play related to the schema domain of inhibition and overvigilance, where emotional inhibition and unrelenting standards are examples of specific schemas.

5. Realistic limits and self-control related to the schema domain of impaired limits. Examples of schemas under this domain are entitlement/grandiosity and insufficient self-control.

Besides the described coping and behavioral strategies, cognitive distortions are a crucial part of maintaining already established schemas. Some of the most common distortions are: (a) selective abstractions in which parts of reality are ignored while others are accentuated; (b) overgeneralization when events in a specific situation become general assumptions; (c) dichotomous thinking with changing polarities of, for instance, good-evil, hate-love, self-determination-subjugation; (d) personalization in which events in the environment are ascribed to oneself; (e) arbitrary conclusions in which causal explanations are randomly and inconsistently distributed; and finally (f) catastrophic thinking related to anxiety.

**Therapeutic Goal and Treatment Principles**

In line with the conceptualization of psychopathology as dysfunctional cognitions, the goal of cognitive therapy is the adjustment of the client’s way of thinking and interpreting. In other words, if the dysfunctional beliefs can be modified in a more functional and self-supporting direction, it will result in less suffering and reduction of symptoms (Beck et al., 2004, p. 4). Even though cognitive therapists as Young et al. (2003) and Beck (2005) are also concerned with behavioral oriented coping strategies, they consider these pathology-maintaining strategies to be dictated by schemas, and so the therapeutic aim will still be a modification or healing of the client’s schemas. While modification or healing of schemas is to be expected, it should be noted that this is not the same as a more fundamental restructuring, which is rarely realistic. As a change at a less schema-modifying level, reinterpretation can be a strategy toward establishing more suitable ways of living with the already existing schemas. In the treatment of, for instance, a histrionic person, this could be manifested in supporting the person in finding relevant scenarios and contexts in which it may be possible to realize a desire of being at the center of others’ attention.

Regarding the therapeutic work with modification of schemas, Young et al. (2003) describes four general change strategies. These are:

1. The therapeutic relation with particular focus on the empathic confrontation and the so-called “limited parenting” directed toward those of the client’s needs that have been thwarted.

2. Cognitive strategies using standard cognitive methods. For instance, Socratic questioning and guided discovery to create insight in the content of thinking, and in the attributional processes and biases that reinforce nonadaptive belief systems and behaviors.

3. Experience-oriented Strategies borrowed partly from gestalt therapy.
Behavioral strategies with the aim of interrupting the behavior that maintains and sustains the existing schemas.

Collaborative Empiricism

In cognitive therapy the therapeutic relationship is understood according to the principle of collaborative empiricism forming the basic mindset for using specific cognitive methods and general strategies. Collaborative empiricism refers to a joint investigation of how the client interprets and acts in the world, which consequences this may have for the client, and how the client identifies and obtains transformational goals (Holm, 2001; Padesky, 1993). The mental and behavioral patterns and the symptoms that are the objects of the therapy are considered as data, which like other data can be submitted to a closer exploration and be tested for their validity. Implicit in the attitude of collaborative empiricism is an aim that the client will learn to evaluate thoughts, behaviors, moods, and life circumstances more generally aside from the specific problems that brought the client to therapy (Padesky, 1993). Further, the collaborative attitude also implies that the cognitive therapist seeks to communicate the cognitive framework to the client—in a condensed and simplified form (of course), adjusted to the individual client’s level of understanding.

Case Conceptualization

Related to the collaboration between client and therapist in cognitive therapy, the individual case conceptualization is important in at least two ways. Partly as a joint working tool for the therapist and client, and partly as a support to the therapist’s planning of the treatment: in the preliminary stages as well as in its function as a guideline for the therapeutic sessions and as a horizon for the therapy in its entirety (Beck, 2005). As a common denominator in all the variants of case conceptualizations (see, for instance, Young et al., 2003, p. 66; Beck, 2005, chap. 2; Mørch, 2005, p. 209), case conceptualization provides an individual-specific version of the general cognitive model of psychological difficulties. In the cognitive case formulation, the client’s current difficulties and symptoms are illuminated through childhood and life experience as remembered by the client and through identification of exactly this client’s central schemas and assumptions, as they have been constructed from prior experience together with the strategies that have been developed in order to cope with them. In that respect, a clear individual-specific version of the general model appears that can shed light upon the predisposing as well as the maintaining cognitive systems. The method is commonly regarded as an essential tool in the treatment of personality disorders where it also serves a function in predicting cooperation difficulties in the therapeutic relationship.

Pedagogical Elements

Together with strategies for developing the client’s insights into his or her problems, pedagogical elements also play a significant role in cognitive therapy. The two most central elements in that respect are psycho-education, aimed at giving the client knowledge of his or her mental condition; and social skills training, dealing with the development and training of the communicative skills and problem-solving strategies of the client, so that s/he can learn better and more effective methods for communication and problem solving, including more suitable ways of coping with symptoms.

Points of Convergence and Complementarities Between Gestalt and Cognitive Therapy

In gestalt therapy and cognitive therapy we find different terminologies, different views on what constitutes individual variability and health, and different views on therapeutic methodology. Basically we can say that cognitive therapists, working in modes of collaborative empiricism, are aiming at modifying thoughts and behavior in order to make these more adaptive and self-supporting. Gestalt therapists are aiming at creating, expanding, and focusing awareness on the gestalt formation process as it happens here and now in a therapeutic contact modus between I-ness and otherness. This is due to the fact that awareness of this process must precede any possible basic change. Considered this way, we can differentiate between a modifying cognitive methodology and a facilitating gestalt therapeutic methodology (Kellogg, 2004).

In our view these differences are usually considered more incompatible than necessary given that both positions have a common understanding of the significance of memory in psychological
dysfunction; that the current dysfunction is the result of patterns formed through a child’s adaptation and creative adjustment to conditions in the years of growing up. In the gestalt approach such patterns are understood in terms of typical figure formation tendencies, and in the cognitive approach they are understood as typical tendencies in schema activation. In both positions, memory is considered central to both the establishing of these typical tendencies and to their persistence in the face of changing circumstances. Within the cognitive position, inertia against change is seen as determined by the persistence of schemas, once they have come into existence and been related to the maintaining system, with behavioral strategies, interpersonal contexts, and coping patterns having a strong self-perpetuating effect. In the gestalt position the inertia against change is anchored in frozen organismic self-regulation (rigid character structure patterns) creating contact disturbances in gestalt formation processes. The schematic processing systems in the cognitive approach and the character structure patterns in gestalt are both determined by memory. But the aspect of memory that becomes the most central differs in the two approaches with the cognitive approach paying most attention to semantic memory, and the gestalt approach paying particular attention to procedural memory. Our point, then, is that precisely because they focus on different aspects of the memory system, we are given a key for opening a dialogic doorway between the positions, by which we can gain a better understanding of the relation between process and content in psychological dysfunction and the treatment thereof. We shall, therefore, start our considerations of the complementarities between the two approaches by looking at this.

Procedural Memory and Semantic Memory

As famously elaborated by Tulving, we can assume the existence of three different memory-systems: procedural, semantic, and episodic (Tulving, 1983). All three systems make possible the utilization of acquired and retained knowledge, but they differ in the ways in which different kinds of knowledge are acquired or used. As stated by Tulving:

“Procedural memory [. . .] is concerned with how things are done—with the acquisition, retention, and utilization of perceptual, cognitive, and motor skills. Semantic memory [. . .] has to do with the symbolically representable knowledge that organisms possess about the world. Episodic memory mediates the remembering of personally experienced events.” (Tulving, 1985, pp. 2)

According to Tulving, the three systems are hierarchically ordered with procedural memory as the most fundamental and inclusive category entailing semantic memory as a subcategory, which then again entails episodic memory as a subcategory. Each form of memory is also characterized by a different kind of consciousness. While episodic memory is related to autonoetic consciousness (self-knowing), semantic memory is related to noetic consciousness (knowing), and procedural memory is related to anoetic consciousness (nonknowing), bound to current situations.

Procedural memory then, is nondeclarative, bodily anchored, and implicit in the activities that are unfolded. When we ride a bike, tie our shoes or when a combination for a lock simply “lies in our fingers”, we use procedural memory as an automatically activated pattern of movements. If the combination for the lock is demanded from us, we might not be able to figure it out without doing the movement pattern once again. Unlike episodic and semantic memory, procedural memory is self-contained in the sense that it does not include any reference to nonpresent extraorganismic stimuli and states of the world. It is a memory for doing things without reflected thoughts and use of language. It is learned through attunement between the organism and the situations that it happens to be in and relate to: procedural memory happens at the moment when it happens.

While procedural memory can be understood as a memory for how to handle situational activities (broadly speaking), episodic memory is a figurative memory for the episodes we participate in. Such episodes become part of autobiographical memory and the life-narratives we tell about ourselves as building blocks of our identity (McAdams & Pals, 2006). Episodic memory develops through accretion with a specific self-reference: It was I who was in that specific situation at that given time in my life. This auto-noetic consciousness in episodic memory does not belong to semantic memory. It is with semantic memory that we extract and generalize information and knowledge about the world on the basis of situations with a certain resemblance. Semantic memory develops and changes through restructuring processes, in which we form internal representations (beliefs or schemas) that can be processed and manipulated at a purely mental level and at a distance from direct contact to
specific situational happenings and without behavior response. When a cognitive therapist uses Socratic questioning and guided discovery to explore the background for and the actual functionality of a belief, the exploration will most typically be at a semantic level with glimpses of episodes to validate or invalidate the assumptions and spoken words. If procedural memory is to be activated, it will typically afford some kind of bodily action or concrete sensation, which cannot be manipulated solely at a mental level but has to be lived out more directly.

**Forms of Memory in Gestalt Therapy and Cognitive Therapy**

According to Burley and Freier (2004), it is primarily at the procedural level that we find the tendencies for psychological dysfunctionalities to persistently repeat themselves, and so the procedural level should be of primary concern in the therapeutic process, if we want therapy to promote long-term change. At the same time they argue, that this is precisely what gestalt therapy is aiming at. Though there might have been a tendency for those looking from the outside to consider gestalt therapy as a cathartic approach working with relieving situations out of episodic memory in the here and now, this is not what defines the approach. As mentioned earlier, the defining element of the gestalt approach is to bring awareness to the gestalt formation process in order to provide the organism with the possibility of greater choice (more appropriate self-regulation) and thereby freeing it from typical patterns dictated by procedural memory. This process may include mental processing at the semantic level but it is not always necessary or even desirable. If awareness is not consistently directed toward the procedural level, the individual will keep on doing what s/he is doing, regardless of how unsuitable this might be in a specific life situation; that is, if the behavior is anchored at the procedural level. An individual may often be capable of recognizing (at a semantic level) the unsuitable aspect of a particular behavior pattern. For instance, after some time in therapy one might see that one’s core belief of oneself as being unlovable says more about the family one grew up in than it says about oneself. Nonetheless, one continues to live the procedural pattern as if it was true. This procedural pattern will then be activated every time one finds oneself in situations with affinity to one’s former relationship with one’s parents, with the consequence that one (independent of one’s semantic knowledge) makes efforts to be lovable in the eyes of others and oneself. Procedural patterns win over semantic knowledge.

In Burley and Freier’s (2004) view, cognitive therapy and gestalt therapy differ from each other in their different estimations of memory: cognitive therapy pays primary attention to semantic memory, while gestalt therapy is methodologically focused on procedural memory. While we fully agree with the latter part of the postulate, we do not fully agree with the former part. Even though there is a sense of truth in the claim that cognitive therapy typically is more semantically orientated, it is also true that procedural level aspects are implied in the behavioral experimental orientation included in the cognitive methodology. Cognitive–behavioral experiments are primarily created (a) to test the validity of thoughts as constructions of world, self, and others; (b) to create new/modified living rules and schemas; and (c) to practice new behavior. We do, however, agree with Burley & Freier that the fact that the explanatory models in the cognitive approach are primarily anchored at the semantic level will tend to steer the typical practice of cognitive therapy in a specific direction for considering which micro processes that are stimulated for investigation, and how their influences should be conceived.4 Thus, we would agree that some of the central instructions of traditional cognitive therapy make it less likely that certain micro processes are prioritized and granted the necessary time to create sufficient awareness on them to promote change at the procedural level. When, however, Teasdale et al. (2002) recently differentiated between metacognitive knowledge and metacognitive insight, they seemed to attune the cognitive approach to such processes, and thereby also brought it closer to the awareness work at a procedural level in gestalt therapy. The point is that metacognitive knowledge deals with semantics by referring to “beliefs about cognitive phenomena stored in memory as propositional facts in much the same way as other facts” (p. 286), while metacognitive insight refers to the...

4 With the same sort of attention Williams illustrates (from a cognitive frame of reference) the inertia in procedural memory changes when related to the effect of trauma. He reminds us that in therapy we should be attentive towards “not only what they remember but the way in which they remember it; not only their conscious recollection, but their behavioral memories that have survived long after the initial event that precipitated them; not only their retrospective memory but their prospective memory (Williams, 1996, p. 111).
way mental phenomena are experienced as they arise, which points directly to what gestalt therapists would call awareness of the gestalt formation process. Interestingly, Teasdale et al. (2002), independently use the term metacognitive awareness, when they talk about metacognitive insight as “actually experiencing thoughts as thoughts . . . in the moment they occur” (p. 286).

Experiential Processes Versus Attributional Processes

From a gestalt perspective, the tight structuring advocated in traditional cognitive therapy of the individual sessions and the therapy in general with explicit formulations of goals (preferably agreed upon and operationalized early on) will be seen as a restriction on the possibility of investigating the procedural patterns in gestalt formations as they evolve and are experienced by the client in the present, lived moment. Also, from a gestalt perspective, the cognitive focus on cognition will seem to be restricting the scope of investigation by excluding sensation and awareness of need-based gestalt formation processes in a broader sense. According to Fodor, the cognitive stance means that “highlighting the moment of experience is often lost in the talking about beliefs” (1996, p. 33). It is characteristic of the cognitive-Socratic investigation of thinking (i.e., what goes through your mind right now? what do you tell yourself?) that it invites the client to make attributions and assumptions about the now, which is lived and experienced. In gestalt therapy such assumptions are preferably suspended,5 while in a sensory, present, almost meditative attitude the therapeutic work is oriented toward sharpening and focusing awareness of the gestalt formation process in order to strengthen the organismic self-regulation. In that respect it is interesting that Naranjo (2000, p. 24) compares the (gestalt) therapist’s frequently used support and encouragement of the client to be aware of the stream of consciousness with a verbalized interpersonal meditation.

On the other hand, in relation to the cognitive classic “what are you telling yourself right now?”, there is, in principle, nothing that prevents the therapist from being silent and letting the now-moment unfold in its dynamic experiential structure if that is what is considered most conducive in the present situation. Neither is it forbidden to ask the client what s/he senses (in her/his body). What s/he attends to right now? Or to tell her/him that I (the therapist) notice that her/his shoulders are rising a little bit, and that I would encourage her/him to lift them even more. The aim is to investigate whether by focusing awareness on a present, though unaware (procedural) behavior, and through conscious exaggeration of the behavior, there could be a facilitation of the therapeutic process by creating more awareness at precisely the procedural level.

Though there is, again, in principle, nothing wrong with such interventions and mirroring in a cognitive framework, they are not the most obvious interventions in cognitive therapy. With reference to their therapeutic guidelines cognitive therapists will presumably tend to look at such interventions as less productive errands on their way. They might seem to be too much of a diversion from the cognitive case conceptualization, the negotiated goals for the therapy, and the explicitly formulated agenda items for an individual session.

In this respect gestalt methodology can obviously contribute to creating more room for the experiential and sensational moments in cognitive practice. On the other hand, the conceptual apparatus of cognitive therapy can contribute to being more specific in formulating the cognitive aspects of the gestalt formation process than has traditionally been done in gestalt. As also pointed out by Burley (2004), gestalt formation processes are not just about sensations and experiences but contain meaning ascriptions and interpretations at a fundamental level. In cognitive terminology, such ascriptions and interpretational elements are called thinking, and according to Fodor (1996) it is a mistake to consider them as dichotomous with sensation. To counterparaphrase one of Perls’ famous quotes, there is no point in loosing our heads when we turn to our senses. It will be more profitable to use our heads in sensitive ways and to avoid bringing ourselves in a delimiting position in which work with awareness is restricted to sensation and experience.

5 To be sure this does not mean that gestalt therapists do not work with thinking or interpretations. The concept of introjection in gestalt therapy is, for instance, rather consistent with the cognitive terminology of dysfunctional and irrational beliefs. Likewise, gestalt therapists are usually interested in separating sensations from fantasies and ideas (that is, thinking).
The question then is: Are psycho-functionalities - that in the cognitive approach are explained with the activation of schemas and underlying assumptions - roughly the same as those which, in the gestalt approach, are explained with reference to gestalt formation processes? Kellogg (2004) thinks so, and when we define gestalts as dynamic knowledge structures that organize experience, Fodor would agree (1996, p. 34), and so would we—at least generally as an invitation to continue looking at the approaches as complementarities rather than contradictions.

**Mentality of the Individual Versus Field Orientation**

One of the fruits of a complementary position is an increased attention toward aspects that the approaches in themselves would not be attending to with the same strength. Concerning the relation between schemas and contexts in cognitive therapy, the field orientation of gestalt would, for instance, more consistently than the cognitive descriptions of triggering situations investigate the contextual circumstances under which specific schemas are activated. In cognitive therapy, triggering situations are explicitly investigated in the initial phases of therapy as part of collecting data in order to obtain a systematic analysis of the client’s difficulties in everyday life and to formulate hypotheses about the central rules and schemas that are underlying the different problem situations of the client. But when the clarification of the client’s maintaining system through a cognitive case conceptualization has been made—and due to the fact that cognitive therapists through situational analyses often manage to make the client’s maintaining thought and behavioral patterns appear very vivid and clear—it seems as if no further clarification of the field is necessary to understand the client’s phenomenology and actions. While there might be some advantages to such focused strategies, the potential disadvantage is—of course—the risk of treating the client’s beliefs (and maybe his or her disorder in general) as being uninfluenced by the various contexts in which he or she lives (Fodor, 1996). With a field orientation as a basic stance, the therapist will - all things being equal - be more inclined to dwell on which contextual circumstances support or provoke the activation of a particular thought/schema and will, therefore, get a more thorough understanding of the field-determined how of the individual’s schema-activation.

**The Meaning of the Therapeutic Relationship in Therapy**

In the cognitive literature, discussions of the therapeutic relationship are often concerned with how the collaboration between therapist and client can be maintained or reestablished after interruptions in order to reinstate the use of standard cognitive (restructuring) methods (Burns & Auerbach, 1996; Beck, 2005). The general attitude seems to be that for a therapy to be successful it must be done within an atmosphere of warmth, genuineness, and empathy. Presumably, because this is considered obvious, discussions of the therapeutic relationship and contact are typically lacking or at least not prioritized in the cognitive literature. Instead, discussions of the subject are concerned with the technical directions for maintaining the collaborative relationship and adjusting the standard methods (for the specific symptom disorders) so that they might become suitable for working with personality-disturbed clients (Beck et al., 2004; Beck, 2005). The number of problem identifications and methodological suggestions for solutions, created in that respect, are definitely inspirational material. Still, they concern the technical aspects of therapy and not the therapist/client contact and relationship as such.

From the observer of the field, a question could be that if certain techniques alone are what make the difference in therapy, then why not just replace the psychotherapeutic context with a mixture of self-help books and computer programs—provided that the computer technique becomes sufficiently sophisticated (Naranjo, 2000, p. 3). Aside from our guess that probably not many psychotherapists would think of this as a realistic possibility, two objections arise based on what Hougaard (2004, p. 622) calls the anthropological dilemma of psychotherapy. The first objection will adduce that experiences of contact and the process between people in the therapeutic room with all its ramified implications of lived presence between client and therapist are actually healing in and of itself. Thus, the contact (as an exchange of information between I-ness and otherness) in the therapeutic relationship becomes an end in itself and not only a means. The second objection will adduce that no matter how sophis-
ticated and effective our techniques, it still takes two to tango; that is, an interpersonal space and processes therein are what make the techniques work. Thus, the relational contact becomes a necessary means for the healing potential in the techniques to work. While the prototypical cognitive stance will be in accordance with the latter understanding, the gestalt approach will basically match the view that contact has a definitive function in the therapeutic work with change processes.

Conclusion

By virtue of a common phenomenological stance, a compatible understanding of psychological dysfunctionality as related to memory, and a reasonably common attitude toward the client in the therapeutic room, gestalt therapy and cognitive therapy are so sufficiently alike that it seems reasonable to consider the relationship between the approaches in integrative terms (not just technically or from an eclectic stance, but also theoretically). Precisely because they are also sufficiently different in several respects, they have the potential of being complementary in clinical practice. Although we have argued that the gestalt formation process and the processes concerning development and maintenance of schemas in essence are to be considered as synonyms describing the same phenomena, the two approaches are at the same time focusing the processes differently. While cognitive therapists are mostly concerned about what the machinery does, and how it can be modified, gestalt therapists are mostly concerned about how the machinery works, and how the working processes can be facilitated. Precisely this attention regarding different aspects of the same process phenomena makes a mutual dialogue between the approaches on their complementarities a worthwhile endeavor - a dialogue in which neither of the positions should be reduced to a derivation of the other.

Among the themes that we have been working with in the article, we can sum up the following characteristics of the positions in the hope that they may stimulate a continuing dialogue among advocates of gestalt and cognitive therapy regarding the complementarities between the approaches (Table 1).

To avoid a misreading of the content in the table, it should be kept in mind that it is summing up prototypic (and principal) differences between the two approaches. We expect both gestalt therapists and cognitive therapists to have their personally anchored strategies which in the diversity of the therapeutic meeting will to some extent compensate for those aspects of reality that are not so well described in their preferred theoretical and practical references. By sharpening the lines between the perspectives, the aspects of the human condition that each approach are particularly attentive to, become clearer.

To those who are concerned about the evidence of effectiveness of gestalt therapy in comparison with the effectiveness of cognitive and cognitive–behavioral therapy, there are some outcome studies that compare the effect of the approaches showing that gestalt therapy is at least as promising as the more evidence-investigated cognitive approaches. For instance, Beutler et al. (1991) found that gestalt therapy outperformed cognitive therapy in treating depressed persons. Johnson and Smith (1997) found that in the treatment of a phobia, the gestalt technique of the empty chair and cognitive desensitization seemed to work equally well in contrast to the no treatment group, and that the gestalt group in contrast to the desensitization group indicated a variety of benefits beyond the focus of therapy. Watson (2006) compared 40 clients classified with either good or poor outcome in either cognitive behavior therapy or manualized gestalt therapy, and showed that good responders of either therapeutic approach exhibited superior levels of emotional processing and that clients receiving gestalt therapy ended up being superior to cognitive behavior clients in emotional processing. And, finally, to mention the classic study of emotionally focused couples therapy by Johnson and Greenberg (1985), it was shown that cognitive behavior therapy and gestalt approaches in a general comparison turned out to be equivalent, and that there is a benefit to gestalt therapy that does not appear in cognitive therapies, namely that those who receive gestalt therapy continue to improve after the end of therapy rather than to simply hold the

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6 We appreciate the discussion with Todd Burley and the references provided by him on this subject during our meeting in the Aarhus Research Group in Gestalt (ARGG) on November 3, 2009.
progress that they have made. The last result might be precisely a result of gestalt therapy working at the procedural level. In general, there seems to be no reason for concern regarding the scientific and practical soundness of either of the two approaches we have discussed in this article. Following Beutler’s (2009) warning against oversimplification of psychotherapy through methodological one-sidedness, our ‘article of faith’ (p. 306) will be, that meaningful disagreements between researchers and practitioners with advanced capacities for perspective taking is the main road toward a future integrative psychotherapy that has transcended sectarianism and included the most valuable parts of our existing knowledge of what really matters.

A Closing Remark About Some Remarkabilities

In combination with the earlier mentioned attention toward metacognitive awareness as formulated by Teasdale et al. (2002), it is quite interesting that meditation and mindfulness have appeared in - what has been called - a third wave or a second revolution within cognitive therapy (Wollestad, 2007; Holden, 2008). The aim of the meditative techniques is partly to cultivate an open and accepting attitude toward one’s experiences without meeting them with judgment or steering them in any particular direction and partly to cultivate the ability to reconcile oneself with reality as it is, without wanting to change it (Neff, 2003). This attitude is astonishingly similar to the assumption in gestalt therapy about paradoxical change: change happens when we become what we are, without trying to change who we are (Beisser, 1970). Further, there is a remarkably strong resemblance between the gestalt assumption about the paradox of change and the dialectical view of the relationship between accept and change as it is seen in dialectical behavior therapy, in which we find an explicit adaptation of Zen-philosophy (Swales & Heard, 2007; Käver & Nilsonne, 2004) (which has been part of gestalt since the early years). The client is supposed to both accept who s/he is and undergo change. Through development of self-acceptance—which to a large extent is transmitted through the therapist’s acceptance and validation of the client’s here and now existence—the client becomes capable of self-transformation in the next now moment (Swales & Heard, 2007, p. 187). Gestalt therapists and some cognitive therapists now seem to agree that change is to be understood in this paradoxical sense. That when we have basically become reconciled to ourselves and to reality as it is, then we have often already changed quite a lot.

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