Gestalt Therapy: An Introduction

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Commentary

This paper, coauthored with James S. Simkin in 1981, is probably the best general introduction to Gestalt therapy that I have written. It was the Gestalt Therapy chapter in the 1989 edition of Corsini and Wedding's Current Psychotherapies *(4th Edition). It appears here with the kind permission of the publisher, F.E. Peacock, Publishers, Inc. of Itasca, Illinois. It is a slightly edited version of the 1984 chapter written jointly by Jim Simkin and myself for the third edition of* Current Psychotherapies. *The 1984 version was a complete rewriting of a version Jim did by himself for the second edition of* Current Psychotherapies. *The revisions I made in the 1989 version were minor and were made after Jim's death.*

Overview

Gestalt therapy is a phenomenological-existential therapy founded by Frederick (Fritz) and Laura Perls in the 1940s. It teaches therapists and patients the phenomenological method of awareness, in which perceiving, feeling, and acting are distinguished from interpreting and reshuffling preexisting attitudes. Explanations and interpretations are considered less reliable than what is directly perceived and felt. Patients and therapists in Gestalt therapy *dialogue*, that is, communicate their phenomenological perspectives. Differences in perspectives become the focus of experimentation and continued dialogue. The goal is for clients to become aware of what they are doing, how they are doing it, and how they can change themselves, and at the same time, to learn to accept and value themselves.

Gestalt therapy focuses more on process (what is happening) than content (what is being discussed). The emphasis is on what is being done, thought and felt at the moment rather than on what was, might be, could be, or should be.

Basic Concepts

The Phenomenological Perspective

Phenomenology is a discipline that helps people stand aside from their usual way of thinking so that they can tell the difference between what is actually being perceived and felt in the current situation and what is residue from the past (Idhe, 1977). A Gestalt exploration respects, uses and clarifies immediate, "naive" perception "undebauched by learning" (Wertheimer, 1945, p. 331). Gestalt therapy treats what is "subjectively" felt in the present, as well as what is "objectively" observed, as real and important data. This contrasts with approaches that treat what the patient experiences as "mere appearances" and uses interpretation to find "real meaning."

The goal of Gestalt phenomenological exploration is awareness, or insight. "Insight is a patterning of the perceptual field in such a way that the significant realities are apparent; it is the formation of a gestalt in which the relevant factors fall into place with respect to the whole" (Heidbreder, 1933, p. 355). In Gestalt therapy insight is clear understanding of the structure of the situation being studied.

Awareness without systematic exploration is not ordinarily sufficient to develop insight. Therefore, Gestalt therapy uses focused awareness and experimentation to achieve insight. How one becomes aware is crucial to any phenomenological investigation. The phenomenologist studies not only personal awareness but also the awareness process itself. The patient is to learn how to become aware of awareness. How the therapist and the patient experience their relationship is of special concern in Gestalt therapy (Yontef, 1976, 1982, 1983).

The Field Theory Perspective

The scientific world view that underlies the Gestalt phenomenological perspective is field theory. Field theory is a method of exploring that describes the whole field of which the event is currently a part rather than analyzing the event in terms of a class to which it belongs by its "nature" (e.g., Aristotelian classification) or a unilinear, historical, cause-effect sequence (e.g., Newtonian mechanics).

The field is a whole in which the parts are in immediate relationship and responsive to each other and no part is uninfluenced by what goes on elsewhere in the field. The field replaces the notion of discrete, isolated particles. The person in his or her life space constitutes a field.

In field theory no action is at a distance; that is, what has effect must touch that which is affected in time and space. Gestalt therapists work in the here and now and are sensitive to how the here and now includes residues of the past, such as body posture, habits, and beliefs.

The phenomenological field is defined by the observer and is meaningful only when one knows the frame of reference of the observer. The observer is necessary because what one sees is somewhat a function of how and when one looks.

Field approaches are descriptive rather than speculative, interpretive, or classificatory. The emphasis is on observing, describing, and explicating the exact structure of whatever is being studied. In Gestalt therapy, data unavailable to direct observation by the therapist are studied by phenomenological focusing, experimenting, reporting of participants, and dialogue (Yontef, 1982, 1983).

The Existential Perspective

Existentialism is based on the phenomenological method. Existential phenomenologists focus on people's existence, relations with each other, joys and suffering, etc., as directly experienced.

Most people operate in an unstated context of conventional thought that obscures or avoids acknowledging how the world is. This is especially true of one's relations in the world and one's choices. Self-deception is the basis of inauthenticity: living that is not based on the truth of oneself in the world leads to feelings of dread, guilt and anxiety. Gestalt therapy provides a way of being authentic and meaningfully responsible for oneself. By becoming aware, one becomes able to choose and/or organize one's own existence in a meaningful manner (Jacobs, 1978; Yontef, 1982, 1983).

The existential view holds that people are endlessly remaking or discovering themselves. There is no essence of human nature to be discovered "once and for all." There are always new horizons, new problems and new opportunities.

Dialogue

The relationship between the therapist and the client is the most important aspect of psychotherapy. Existential dialogue is an essential part of Gestalt therapy's methodology and is a manifestation of the existential perspective on relationship.

Relationship grows out of contact. Through contact people grow and form identities. Contact is the experience of boundary between "me" and "not-me." It is the experience of interacting with the not-me while maintaining a self-identity separate from the not-me. Martin Buber states that the person ("I") has meaning only in relation to others, in the I-Thou dialogue or in I-It

manipulative contact. Gestalt therapists prefer experiencing the patient in dialogue to using therapeutic manipulation (I-It).

Gestalt therapy helps clients develop their own support for desired contact or withdrawal (L. Perls, 1976, 1978). Support refers to anything that makes contact or withdrawal possible: energy, body support, breathing, information, concern for others, language, and so forth. Support mobilizes resources for contact or withdrawal. For example, to support the excitement accompanying contact, a person must take in enough oxygen.

The Gestalt therapist works by engaging in dialogue rather than by manipulating the patient toward some therapeutic goal. Such contact is marked by straightforward caring, warmth, acceptance and self-responsibility. When therapists move patients toward some goal, the patients cannot be in charge of their own growth and self-support. Dialogue is based on experiencing the other person as he or she really is and showing the true self, sharing phenomenological awareness. The Gestalt therapist says what he or she means and encourages the patient to do the same. Gestalt dialogue embodies authenticity and responsibility.

The therapeutic relationship in Gestalt therapy emphasizes four characteristics of dialogue:

1. *Inclusion*. This is putting oneself as fully as possible into the experience of the other without judging, analyzing or interpreting while simultaneously retaining a sense of one's separate, autonomous presence. This is an existential and interpersonal application of the phenomenological trust in immediate experience. Inclusion provides an environment of safety for the patient's phenomenological work and, by communicating an understanding of the patient's experience, helps sharpen the patient's self-awareness.

2. *Presence*. The Gestalt therapist expresses herself to the patient. Regularly, judiciously, and with discrimination she expresses observations, preferences, feelings, personal experience and thoughts. Thus, the therapist shares her perspective by modeling phenomenological reporting, which aids the patient's learning about trust and use of immediate experience to raise awareness. If the therapist relies on theory-derived interpretation, rather than personal presence, she leads the patient into relying on phenomena not in his own immediate experience as the tool for raising awareness. In Gestalt therapy the therapist does not use presence to manipulate the patient to conform to preestablished goals, but rather encourages patients to regulate themselves autonomously.

3. *Commitment to dialogue*. Contact is more than something two people do to each other. Contact is something that happens between people, something that arises from the interaction between them. The Gestalt therapist surrenders herself to this interpersonal process. This is *allowing* contact to happen rather than manipulating, *making* contact, and controlling the outcome.

4. *Dialogue is lived*. Dialogue is something done rather than talked about. "Lived" emphasizes the excitement and immediacy of doing. The mode of dialogue can be dancing, song, words, or any modality that expresses and moves the energy between or among the participants. An important contribution of Gestalt therapy to phenomenological experimentation is enlarging the

parameters to include explication of experience by nonverbal expressions. However, the interaction is limited by ethics, appropriateness, therapeutic task, and so on.

Other Systems

Yontef notes that:

The theoretical distinction between Gestalt therapy, behavior modification and psychoanalysis is clear. In behavior modification, the patient's behavior is directly changed by the therapist's manipulation of environmental stimuli. In psychoanalytic theory, behavior is caused by unconscious motivation which becomes manifest in the transference relationship. By analyzing the transference the repression is lifted, the unconscious becomes conscious. In Gestalt therapy the patient learns to fully use his internal and external senses so he can be self-responsible and self-supportive. Gestalt therapy helps the patient regain the key to this state, the awareness of the process of awareness. Behavior modification conditions [by] using stimulus control, psychoanalysis cures by talking about and discovering the cause of mental illness [the problem], and Gestalt therapy brings self-realization through here-and-now experiments in directed awareness. (1969, pp. 33-34)

Behavior modification and other therapies that primarily try to direct control over symptoms (for example, chemotherapy, ECT, hypnosis, etc.) contrast with both Gestalt therapy and psychodynamic therapies in that the latter systems foster change primarily by the patient's learning to understand himself or herself in the world through insight.

The methodology of Gestalt and psychodynamic therapy uses an accepting relationship and a technology to help the patient change via emotional and cognitive self-understanding. In psychoanalysis the basic patient behavior is free association; the chief tool of the analyst is interpretation. To encourage transference, the analyst withholds any direct expression of personhood (no "I" statements) and practices the "Rule of Abstinence"; that is, the therapist does not gratify any of the patient's wishes. This approach is true of all psychodynamic schools: classical, object relations, ego psychological, Kohutian, Jungian. The psychodynamic therapist isolates his or her person in order to encourage a relationship based explicitly on transference (rather than contact).

Gestalt therapy works for understanding by using the active, healing presence of the therapist *and the patient* in a relationship based on true contact. Transference, explored and worked through as it arises, is not encouraged by the Gestalt therapist (Polster, 1968). Characterological issues are *explicitly dealt with in Gestalt therapy* via the dialogic and phenomenological method.

In Gestalt therapy the immediate experience of the patient is actively used. Rather than free associate while passively awaiting the therapist's interpretation and subsequent change, the patient is seen as a collaborator who is to learn how to self-heal. The patient "works" rather than free associates. "What can I do to work on this?" is a frequent question in Gestalt therapy and frequently there is an answer. For example, a couple with sexual difficulties might be asked to practice sensate focusing.

More than any other therapy, Gestalt therapy emphasizes that whatever exists is here and now and that experience is more reliable than interpretation. The patient is taught the difference between *talking about* what occurred five minutes ago (or last night or 20 years ago) and *experiencing* what is now.

Applebaum, a psychoanalyst, observes that

In Gestalt therapy the patient quickly learns to make the discrimination between ideas and ideation, between well-worn obsessional pathways and new thoughts, between a statement of experience and a statement of a statement. The Gestalt goal of pursuing experience and insight which emerges as the Gestalt emerges is more potent than insight given by the therapist, does help the patient and the therapist draw and maintain these important distinctions. (1976, p. 757)

Therapies such as behavior modification, reality therapy and rational emotive therapy do not work with the *patient's* experience enough to do this. In Rogerian therapy the passivity imposed on the therapist severely narrows the range or power of the therapy to teach these distinctions.

The practice of most therapy systems encourages intellectualizing: talking about the irrationality of patient beliefs, talking about the behavior changes the therapist believes that the patient should make, and so forth. The Gestalt therapy methodology utilizes active techniques that clarify experience. Gestalt therapists will often experiment by trying something new in the therapy hour. Unlike most other therapies, in Gestalt therapy the *process* of discovery through experimentation *is* the end point rather than the feeling or idea or content.

The psychoanalyst can only use interpretation. The Rogerian can only reflect and clarify. Gestalt therapists may use any techniques or methods as long as (a) they are aimed toward increasing awareness, (b) they emerge out of dialogue and phenomenologic work, and (c) they are within the parameters of ethical practice.

The power and responsibility for the present are in the hands of the patient. In the past the patient was psychologically in mutual interaction with the environment and not a passive recipient of trauma. Thus the patient may have received shaming messages from his parents, but swallowing the message and coping by self-blame were his own, as was the continuation of the shaming internally from then until now. This point of view is at variance with psychodynamic attitudes, but consonant with Adler's and Ellis's views.

This viewpoint enables patients to be more responsible for their own existence, including their therapy. When the therapist believes that the past causes the present and that patients are controlled by unconscious motivation not readily available to them, they are encouraged to rely on the therapist's interpretations rather than their own autonomy.

In therapies in which the therapist undertakes to directly modify the patient's behavior, the immediate experience of the patient and therapist are not honored. This separates Gestalt therapy from most other therapies. A resentful patient may increase awareness by expressing resentment. If the therapist suggests this as a means of catharsis, it is not the phenomenological focusing of Gestalt therapy.

In Gestalt therapy there are no "shoulds." Instead of emphasizing what should be, Gestalt therapy stresses awareness of what is. *What is, is*. This contrasts with any therapist who "knows" what the patient "should" do. For example, cognitive behavior modification, rational-emotive therapy and reality therapy all try to modify patient attitudes the therapist judges to be irrational, irresponsible or unreal.

Even though Gestalt therapy discourages interrupting the organismic assimilating process by focusing on cognitive explanatory intellectualizations, Gestalt therapists do work with belief systems. Clarifying thinking, explicating beliefs, and mutually deciding what fits for the patient are all part of Gestalt therapy. Gestalt therapy deemphasizes thinking that avoids experience (obsessing) and encourages thinking that supports experience. Gestalt therapy excludes the therapist's narcissistically teaching the patient rather than being contactful and expediting the patient's self-discovery.

Many persons claim they practice "TA [transactional analysis] and Gestalt." Usually these people use the TA *theory* and some Gestalt therapy *techniques*. Techniques are not the important aspect of Gestalt therapy. When used in an analytic, cognitive style, these techniques are not Gestalt therapy! Such a combination often aborts, prevents or neutralizes the organismic awareness work of the phenomenological-existential method. A better combination would be integrating concepts of TA into a Gestalt framework. Thus the parent, adult, and child ego states, crossed transactions, and life scripts can be translated into Gestalt process language and worked with experimentally and dialogically.

Another difference from other therapies is Gestalt therapy's genuine regard for holism and multidimensionality. People manifest their distress in how they behave, think and feel. "Gestalt therapy views the entire biopsychosocial field, including organism/environment, as important. Gestalt therapy actively uses physiological, sociological, cognitive, motivational variables. No relevant dimension is excluded in the basic theory" (Yontef, 1969, pp. 33-34).

History

Precursors

The history of Gestalt therapy starts with the professional development of Fritz Perls and the zeitgeist in which he lived. After acquiring the M.D. degree, Perls went to Frankfurt-am-Main in 1926 as an assistant to Kurt Goldstein at the Institute for Brain Damaged Soldiers. Here he was exposed to Professors Goldstein and Adhemar Gelb and he met his future wife, Laura. At that time Frankfurt-am-Main was a center of intellectual ferment and Perls was directly and indirectly exposed to leading Gestalt psychologists, existential philosophers and psychoanalysts.

Fritz Perls became a psychoanalyst. He was influenced directly by Karen Horney and Wilhelm Reich, and indirectly by Otto Rank and others. Perls was especially influenced by Wilhelm Reich, who was Perls' analyst in the early 1930s, and "who first directed my attention to a most important aspect of psychosomatic medicine -- to the function of the motoric system as an armor" (F. Perls, 1947, p. 3).

Three influences on Perls' intellectual development should be noted. One was the philosopher, Sigmund Friedlander, from whose philosophy Perls incorporated the concepts of differential thinking and creative indifference, spelled out in Perls' first book, *Ego, Hunger and Aggression* (1947). Perls was also influenced by Jan Smuts, the prime minister of South Africa when Perls moved there with his family (having first escaped from Nazi Germany and then Nazi-occupied Holland). Before becoming prime minister, Smuts had written a major book on holism and evolution that, in effect, examined the broader ecological world from a Gestalt perspective. Smuts coined the word *holism*. Third, Alfred Korzybski, the semanticist, was an influence on Perls' intellectual development.

Laura Posner Perls was a cofounder of Gestalt therapy. Her influence on Perls was generally known, and she wrote a chapter in *Ego, Hunger and Aggression*. She was a psychology student at the time she met Perls, receiving the D.Sc. degree from the University of Frankfurt in 1932. She had contact with and was influenced by the existential theologians Martin Buber and Paul Tillich. Much of the Gestalt, phenomenological and existential influences in Gestalt therapy are through her, although credit and influence were limited by how little she wrote under her name (Rosenfeld, 1978).

Although Perls was a training psychoanalyst, he was among those who chafed under the dogmatism of classical Freudian psychoanalysis. The 1920s, 1930s, and 1940s were periods of great ferment and rebellion against Newtonian positivism. This was true in science (for example, Einstein's field theory), theater and dance, philosophy, art, architecture and existentialism. Both Laura and Fritz lived in a zeitgeist permeated by a phenomenological-existential influence that later become interacted into Gestalt therapy (Kogan, 1976). Among these were acknowledgment of responsibility and choice in creating one's personal existence, the primacy of existence over essence, and the existential dialogue.

Gestalt psychology provided Perls with the organizing principle for Gestalt therapy as an integrating framework. Gestalt refers to the configuration or pattern of a set of elements. Gestalt psychologists believe that organisms instinctively perceive whole patterns and not bits and pieces. Whole patterns have characteristics that cannot be gleaned by analyzing parts. Perception is an active process and not a result of passively received stimulation of sense organs. All situations are believed to possess inherent organization. Organisms have the capacity for accurate perception when they use their native ability of immediate experience in the here and now. The task of phenomenological research and therapy is to utilize this capacity to gain insight into the structure of that which is being studied. Because people naturally perceive whole patterns as they occur, actual awareness can be trusted more than interpretation and dogma.

Beginnings

Perls' *Ego, Hunger and Aggression* was written in 1941-1942. In its first publication in South Africa in 1946 it was subtitled *A Revision of Freud's Theory and Method*. The subtitle of the book when it appeared in 1966 was changed to *The Beginning of Gestalt Therapy*. The term "Gestalt therapy" was first used as the title of a book written by Frederick Perls, Ralph Hefferline and Paul Goodman (1951). Shortly after, the New York Institute for Gestalt therapy was organized, headquartered in the apartment of Fritz and Laura Perls in New York City. This

apartment was used for seminars, workshops and groups. Among those who studied with Perls at that time were Paul Weisz, Lotte Weidenfeld, Buck Eastman, Paul Goodman, Isadore From, Elliot Shapiro, Leo Chalfen, Iris Sanguilano, James Simkin and Kenneth A. Fisher.

During the 1950s, intensive workshops and study groups were established throughout the country. Before the American Psychological Association Convention held in New York City in 1954, a special intensive workshop limited to 15 qualified psychologists was given over a three-day period. Similar workshops were held in Cleveland, Miami and Los Angeles. In 1955 the Cleveland study group formed the Gestalt Institute of Cleveland.

Fritz Perls moved to the West Coast in 1960, at which time Simkin arranged a Gestalt therapy workshop for him. Perls, Walter Kempler and James Simkin offered the first Gestalt therapy training workshops at the Esalen Institute during the summer of 1964. These training workshops continued under the leadership of Perls and Simkin through 1968. After Perls moved to Canada, Simkin, along with Irma Shepherd, Robert W. Resnick, Robert L. Martin, Jack Downing and John Enright, continued to offer Gestalt therapy training at Esalen through 1970.

During this beginning period Gestalt therapy pioneered many ideas subsequently accepted into eclectic psychotherapy practice. The excitement of direct contact between therapist and patient, the emphasis on direct experience, the use of active experimentation, the emphasis on the here and now, the responsibility of the patient for himself or herself, the awareness principle, the trust in organismic self-regulation, the ecological interdependence of person and environment, the principle of assimilation, and other such concepts were new, exciting and shocking to a conservative establishment. In this period the practice of psychotherapy was dichotomized between the older, traditional approach of psychoanalytic drive theory and the ideas pioneered largely by Gestalt therapy. This was a period of expansion, with integration of the principles with each other and the elucidation and enucleation of the principles left for the future. Thus, for example, Gestalt therapy pioneered the use of the active presence of the therapist in a contactful relationship but did not consider in detail what constituted a healing dialogic presence.

Current Status

There are at least 62 Gestalt therapy institutes throughout the world, and the list continues to grow. Virtually every major city in the United States has at least one Gestalt institute.

No national organization has been established. As a result, there are no established standards for institutes, trainers and trainees. Each institute has its own criteria for training, membership selection, and so on. Attempts in the recent past to organize a nationwide conference for establishing standards for trainers have not been successful. There are no agreed-upon standards for what constitutes good Gestalt therapy or a good Gestalt therapist. Therefore, it is incumbent on Gestalt therapy consumers to carefully evaluate the educational, clinical, and training background of people who call themselves Gestalt therapists or give training in Gestalt therapy (see Yontef, 1981a, 1981b).

The Gestalt Journal is devoted primarily to articles on Gestalt therapy. *Gestalt Theory* publishes articles on Gestalt psychology, including some on Gestalt therapy. Bibliographic information can be obtained from Kogan (1980), Rosenfeld (1981), and Wysong (1986).

As experience in doing Gestalt therapy has grown, earlier therapeutic practices have been altered. For example, earlier Gestalt therapy practice often stressed the clinical use of frustration, a confusion of self-sufficiency with self-support, and an abrasive attitude if the patient was interpreted by the therapist as manipulative. This approach tended to enhance the shame of shame-oriented patients. There has been a movement toward more softness in Gestalt therapy practice, more direct self-expression by the therapist, more of a dialogic emphasis, decreased use of stereotypic techniques, increased emphasis on description of character structure (with utilization of psychoanalytic formulations), and increased use of group process.

Thus a patient is more likely to encounter, among Gestalt therapists who are involved in the newer mode, an emphasis on self-acceptance, a softer demeanor by the therapist, more trust of the patient's phenomenology, and more explicit work with psychodynamic themes. There has also been an increase in emphasis on group process, including relation between group members, and a decrease in formal, one-to-one work in groups. There is also an increased attention to theoretical instruction, theoretical exposition, and work with cognition in general.

Personality
Theory of Personality

Ecological Interdependence: The Organism/Environment Field

A person exists by differentiating self from other and by connecting self and other. These are the two functions of a boundary. To make good contact with one's world, it is necessary to risk reaching out and discovering one's own boundaries. Effective self-regulation includes contact in which one is aware of novelty in the environment that is potentially nourishing or toxic. That which is nourishing is assimilated and all else is rejected. This kind of differentiated contact inevitably leads to growth (Polster and Polster, 1973, p. 101).

Mental Metabolism

In Gestalt therapy, metabolism is used as a metaphor for psychological functioning. People grow through biting off an appropriate-sized piece (be this food or ideas or relationships), chewing it (considering), and discovering whether it is nourishing or toxic. If nourishing, the organism assimilates it and makes it part of itself. If toxic, the organism spits it out (rejects it). This requires people to be willing to trust their taste and judgment. Discrimination requires *actively* sensing outside stimuli and processing these exteroceptive stimuli along with interoceptive data.

Regulation of the Boundary

The boundary between self and environment must be kept permeable to allow exchanges, yet firm enough for autonomy. The environment includes toxins to be screened out. Even what is nourishing needs to be discriminated according to the dominant needs. Metabolic processes are

governed by the laws of homeostasis. Ideally, the most urgent need energizes the organism until it is met or is superseded by a more vital need. Living is a progression of needs, met and unmet, achieving homeostatic balance and going on to the next moment and new need.

Disturbances of the Contact Boundary

When the boundary between self and other becomes unclear, lost or impermeable, this results in a disturbance of the distinction between self and other, a disturbance of both contact and awareness (see Perls, 1973; Polster and Polster, 1973). In good boundary functioning, people alternate between connecting and separating, between being in contact with the current environment and withdrawal of attention from the environment. The contact boundary is lost in polar opposite ways in confluence and isolation. In *confluence* (fusion), the separation and distinction between self and other becomes so unclear that the boundary is lost. In *isolation*, the boundary becomes so impermeable that connectedness is lost, i.e., the importance of others for the self is lost from awareness.

Retroflection is a split within the self, a resisting of aspects of the self by the self. This substitutes self for environment, as in doing to self what one wants to do to someone else or doing for self what one wants someone else to do for self. This mechanism leads to isolation. The illusion of self-sufficiency is one example of retroflection as it substitutes self for environment. Although one can do one's own breathing and chewing, the air and food must come from the environment. Introspection is a form of retroflection that can be pathological or healthy. For example, resisting the impulse to express anger may serve to cope with a dangerous environment. In such a situation, biting one's lip may be more functional than saying something biting.

Through *introjection*, foreign material is absorbed without discriminating or assimilating. Swallowing whole creates an "as if" personality and rigid character. Introjected values and behavior are imposed on self. As in all contact boundary disturbances, swallowing whole can be healthy or pathological, depending on the circumstances and degree of awareness. For example, students taking a lecture course may, with full awareness that they are doing so, copy, memorize and regurgitate material without full "digestion."

Projection is a confusion of self and other that results from attributing to the outside something that is truly self. An example of healthy projection is art. Pathological projection results from not being aware of and accepting responsibility for that which is projected.

Deflection is the avoidance of contact or of awareness by turning aside, as when one is polite instead of direct. Deflection can be accomplished by not expressing directly or by not receiving. In the latter case, the person usually feels "untouched"; in the former case, the person is often ineffective and baffled about not getting what is wanted. Deflection can be useful where, with awareness, it meets the needs of the situation (e.g., where the situation needs cooling down). Other examples of deflection include not looking at a person, verbosity, vagueness, understating and talking *about* rather than *to* (Polster and Polster, 1973, pp. 89-92).

Organismic Self-Regulation

Human regulation is to varying degrees either (a) organismic, that is, based on a relatively full and accurate acknowledgment of *what is*, or (b) "shouldistic," based on the arbitrary imposition of what some controller thinks should or should not be. This applies to intrapsychic regulation, to the regulation of interpersonal relations and to the regulation of social groups.

"There is only one thing that should control: the *situation*. if you understand the situation you are in and let the situation you are in control our actions, then you learn to cope with life" (F. Perls, 1976, p. 33). Perls explicated the above with an example of driving a car. Instead of a preplanned program, "I want to drive 65 miles per hour," a person cognizant of the situation will drive at different speed at night or differently when in traffic, or still differently when tired, and so on. Here Perls makes it clear that "let the situation control" means regulating through awareness of the contemporary context, including one's wants, rather than through what was thought "should" happen.

In organismic self-regulation, choosing and learning happen holistically, with a natural integration of mind and body, thought and feeling, spontaneity and deliberateness. In shouldistic regulation, cognition reigns and there is no felt, holistic sense.

Obviously, everything relevant to boundary regulation cannot be in full awareness. Most transactions are handled by automatic, habitual modes, with minimal awareness. Organismic self-regulation requires that the habitual become fully aware as needed. When awareness does not emerge as needed and/or does not organize the necessary motor activity, psychotherapy is a method of increasing awareness and gaining meaningful choice and responsibility.

Awareness

Awareness and dialogue are the two primary therapeutic tools in Gestalt therapy. Awareness is a form of experience that may be loosely defined as being in touch with one's own existence, with *what is*.

Laura Perls states:

The aim of Gestalt therapy is the *awareness continuum*, the freely ongoing Gestalt formation where what is of greatest concern and interest to the organism, the relationship, the group or society becomes Gestalt, comes into the foreground where it can be fully experienced and coped with (acknowledged, worked through, sorted out, changed, disposed of, etc.) so that then it can melt into the background (be forgotten or assimilated and integrated) and leave the foreground free for the next relevant Gestalt. (1973, p. 2)

Full awareness is the process of being in vigilant contact with the most important events in the individual/environment field with full sensorimotor, emotional, cognitive and energetic support. Insight, a form of awareness, is an immediate grasp of the obvious unity of disparate elements in the field. Aware contact creates new, meaningful wholes and thus is in itself an integration of a problem.

Effective awareness is grounded in and energized by the dominant present need of the organism. It involves not only self-knowledge, but a direct knowing of the current situation and how the self is in that situation. Any denial of the situation and its demands or of one's wants and chosen response is a disturbance of awareness. Meaningful awareness is of a self in the world, in dialogue with the world, and with awareness of Other -- it is not an inwardly focused introspection. Awareness is accompanied by *owning*, that is, the process of knowing one's control over, choice of, and responsibility for one's own behavior and feelings. Without this, the person may be vigilant to experience and life space, but not to what power he or she has and does not have. Awareness is cognitive, sensory and affective. The person who verbally acknowledges his situation but does not really see it, *know* it, *react* to it and *feel* in response to it is not fully aware and is not in full contact. The person who is aware knows *what* he does, *how* he does it, that he has alternatives and that he *chooses* to be as he is.

The act of awareness is always here and now, although the content of awareness may be distant. The act of remembering is now; what is remembered is not now. When the situation calls for an awareness of the past or anticipation of the future, effective awareness takes this into account. For example:

P: [*Looking more tense than usual*] I don't know what to work on.

T: What are you aware of right now?

P: I am glad to see you, but I'm tense about a meeting tonight with my boss. I have rehearsed and prepared and I've tried to support myself as I wait.

T: What do you need right now?

P: I thought of putting her in the empty chair and talking to her. But I am so tense I need to do something more physical. I need to move, breathe, make noise.

T: [*Looking but remaining silent*]

P: It's up to me, huh? [*Pause. Patient gets up, starts stretching, yawning. The movements and sounds become more vigorous. After a few minutes he sits down, looking more soft and alive.*] Now I'm ready.

T: You look more alive.

P: Now I am ready to explore what had me so uptight about tonight.

Self-rejection and full awareness are mutually exclusive. Rejection of self is a distortion of awareness because it is a denial of who one is. Self-rejection is simultaneously a confusion of who "I am" and a self-deception, or "bad faith" attitude of being above that which is ostensibly being acknowledged (Sartre, 1966). Saying "I am" as if it were an observation of another person, or as if the "I" were not chosen, or without knowing how one creates and perpetuates that "I am" is bad faith rather than insightful awareness.

Responsibility

People, according to Gestalt therapy, are responsible (response-able); that is, they are the primary agents in determining their own behavior. When people confuse responsibility with blaming and shoulds, they pressure and manipulate themselves; they "try" and are not integrated and spontaneous. In such instances their true wants, needs and responses to the environment and choices in the situation are ignored and they overcomply or rebel against shoulds.

Gestalt therapists believe in the importance of a clear distinction between what one chooses and what is given. People are responsible for what they choose to do. For example, people are responsible for their actions on behalf of the environment. Blaming outside forces (e.g., genetics or parents) for what one chooses is self-deception. Taking responsibility for what one did not choose, a typical shame reaction, is also a deception.

People are responsible for moral choices. Gestalt therapy helps patients discover what is moral according to their own choice and values. Far from advocating "anything goes," Gestalt therapy places a most serious obligation on each person: choosing and valuing.

Variety of Concepts

Gestalt therapy personality theory has evolved primarily out of clinical experience. The focus has been a theory of personality that supports our task as psychotherapists rather than an overall theory of personality. The constructs of Gestalt therapy theory are field theoretical rather than genetic and phenomenological rather than conceptual.

Although Gestalt therapy is phenomenological, it also deals with the unconscious, that is, with what does not enter into awareness when needed. In Gestalt therapy, awareness is conceived of as being in touch and unawareness as being out of touch. Unawareness can be explained by a variety of phenomena, including learning what to attend to, repression, cognitive set, character and style. Simkin (1976) compared personality to a floating ball -- at any given moment only a portion is exposed while the rest is submerged. Unawareness is the result of the organism's not being in touch with its external environment due to its being mostly submerged in its own internal environment or fantasies, or not being in touch with its inner life due to fixation on the external.

Gestalt Therapy Theory of Change

Children swallow whole (introject) ideas and behavior. This results in an enforced morality rather than an organismically compatible morality. As a result, people frequently feel guilt when they behave in accordance with their wants as opposed to their shoulds. Some people invest an enormous amount of energy in maintaining the split between shoulds and wants -- the resolution of which requires a recognition of their own morality as opposed to an introjected one. Shoulds sabotage such people, and the more they push to be what they are not, the more resistance is set up, and no change occurs.

Beisser advanced the theory that change does not happen through a "coercive attempt by the individual or by another person to change him," but does happen if the person puts in the time and effort to be "what he is," "to be fully in his current position" (1970, p. 70). When the therapist rejects the change agent role, change that is orderly and also meaningful is possible.

The Gestalt therapy notion is that awareness (including owning, choice, and responsibility) and contact bring natural and spontaneous change. Forced change is an attempt to actualize an image rather than to actualize the self. With awareness self-acceptance, and the right to exist *as is*, the organism can grow. Forced intervention retards this process.

The Gestalt psychology principle of *Prägnanz* states that the field will form itself into the best Gestalt that global conditions will allow. So, too, Gestalt therapists believe that people have an innate drive to health. This propensity is found in nature, and people are part of nature. Awareness of the obvious, the awareness continuum, is a tool that a person can deliberately use to channel this spontaneous drive for health.

Differentiation of the Field: Polarities versus Dichotomies

A dichotomy is a split whereby the field is considered not as a whole differentiated into different and interlocking parts, but rather as an assortment of competing (either/or) and unrelated forces. Dichotomous thinking interferes with organismic self-regulation. Dichotomous thinking tends to be intolerant of diversity among persons and of paradoxical truths about a single person.

Organismic self-regulation leads to integrating parts with each other and into a whole that encompasses the parts. The field is often differentiated into *polarities*: parts that are opposites that complement or explicate each other. The positive and negative poles of an electrical field are the prototypical mode for this differentiation in a field theoretical way. The concept of polarities treats opposites as part of one whole, as *yin* and *yang*.

With this polar view of the field, differences are accepted and integrated. Lack of genuine integration creates splits, such as body-mind, self-external, infantile-mature, biological-cultural, and unconscious-conscious. Through dialogue there can be an integration of parts, into a new whole in which there is a differentiated unity. Dichotomies such as the self-ideal and the needy self, thought and impulse, and social requirements and personal needs can be healed by integrating into a whole differentiated into natural polarities (Perls, 1947).

Definition of Health I: The Good Gestalt as Polarity

The good Gestalt describes a perceptual field organized with clarity and good form. A well-formed figure clearly stands out against a broader and less distinct background. The relation between that which stands out (figure) and the context (ground) is meaning. In the good Gestalt the meaning is clear. The good Gestalt gives a content-free definition of health.

In health, the figure changes as needed, that is, it shifts to another focus when the need is met or superseded by a more urgent need. It does not change so rapidly as to prevent satisfaction (as in hysteria) or so slowly that new figures have no room to assume organismic dominance (as in

compulsivity). When figure and ground are dichotomized, one is left with a figure out of context or a context without focus (F. Perls et al., 1951). In health, awareness accurately represents the dominant need of the whole field. Need is a function of external factors (physical structure of the field, political activity, acts of nature, and so on) and internal factors (hunger, fatigue, interest, past experience, and so forth).

Definition of Health II: The Polarity of Creative Adjustment

The Gestalt therapy concept of healthy functioning includes *creative adjustment*. A psychotherapy that only helps patients adjust creates conformity and stereotypy. A psychotherapy that only led people to impose themselves on the world without considering others would engender pathological narcissism and a world-denying realization of self isolated from the world.

A person who shows creative interaction takes responsibility for the ecological balance between self and surroundings.

This is the theoretical context (F. Perls et al., 1951) within which some seemingly individualistic and even anarchistic statements of Gestalt therapy are most accurately considered. The individual and environment form a polarity. The choice is not between the individual and society, but between organismic and arbitrary regulation.

Resistance is a part of a polarity consisting of an impulse and resistance to that impulse. Seen as a dichotomy, resistance is often treated as "bad" and, in such a context, often turns out to be nothing more than the patient's following personal dictates rather than the therapist's. Seen as a polarity, resistance is as integral to health as the trait's being resisted.

Gestalt therapists attend to both the working process of consciousness and the resistance process of consciousness. Many Gestalt therapists avoid the word *resistance* because of its pejorative dichotomized connotation, which frames the process as a power battle between therapist and patient rather than as the self-conflict of the patient that needs to be integrated into a harmoniously differentiated self.

Impasse

An *impasse* is a situation in which external support is not forthcoming and the person believes he cannot support himself. The latter is due in large part to the person's strength being divided between impulse and resistance. The most frequent method of coping with this is to manipulate others.

An organismically self-regulating person takes responsibility for what is done for self, what is done by others for self, and what is done for others by self. The person exchanges with the environment, but the basic support for regulation of one's existence is by self. When the individual does not know this, external support becomes a replacement for self-support rather than a source of nourishment for the self.

In most psychotherapy the impasse is circumvented by external support by the therapist, and the patient does not find that self-support is sufficient. In Gestalt therapy, patients can get through the impasse because of the emphasis on loving contact without doing the patient's work, that is, without rescuing or infantilizing.

Psychotherapy

Theory of Psychotherapy

Goal of Therapy

In Gestalt, the only *goal* is *awareness*. This includes greater awareness in a particular area and also greater ability for the patient to bring automatic habits into awareness as needed. In the former sense awareness is a content, in the latter sense it is a process. Both awareness as content and awareness as process progress to deeper levels as the therapy proceeds. Awareness includes knowing the environment, responsibility for choices, self-knowledge, and self-acceptance, and the ability to contact.

Beginning patients are chiefly concerned with the solution of problems. The issue for the Gestalt therapist is how patients support themselves in solving problems. Gestalt therapy facilitates problem solving through increased self-regulation and self-support by the patient. As therapy goes on, the patient and the therapist turn more attention to general personality issues. By the end of successful therapy the patient directs much of the work and is able to integrate problem solving, characterological themes, relationship issues with the therapist, and means of regulating his or her own awareness.

Gestalt therapy is most useful for patients open to working on self-awareness and for those who want natural mastery of their awareness process. Although some people claim they are interested in changing their behavior, most people seeking psychotherapy mainly want relief from discomfort. Their complaint may be generalized malaise, specific discomforts, or dissatisfaction in relationships. Patients often expect that relief will result from their therapist's doing the work rather than from their own efforts.

Psychotherapy is most appropriate for persons who create anxiety, depression, and so forth by rejecting themselves, alienating aspects of themselves, and deceiving themselves. In short, people who do not know how they further their own unhappiness are prime candidates, providing they are open to awareness work, especially awareness of self-regulation. Gestalt therapy is especially appropriate for those who know intellectually about themselves and yet don't grow.

Those who want symptom relief without doing awareness work may be better candidates for behavior modification, medication, biofeedback, and so on. The direct methods of Gestalt therapy facilitate patients' making this choice early in the therapy. However, patients' difficulty in doing the contact or awareness work should not automatically be interpreted as meaning that they do not want to work. Respect for the total person enables a Gestalt therapist to help the patients become clear about the differences between "can't" and "won't" and to know how

internal barriers or resistance, such as prior learning, anxiety, shame and sensitivity to narcissistic injury, inhibit awareness work.

No "Shoulds"

There are no "shoulds" in Gestalt therapy. In Gestalt therapy a higher value is placed on the autonomy and the self-determination for the patient than on other values. This is not a should, but a preference. The no-should ethic takes precedence over the therapist's goals for the patient and leaves the responsibility and sanctioning of the patient's behavior to the patient (of course, the injunctions and requirements of society are not suspended just because the patient is in Gestalt therapy).

How Is the Therapy Done?

Gestalt therapy is an exploration rather than a direct modification of behavior. The goal is growth and autonomy through an increase in consciousness. Rather than maintaining distance and interpreting, the Gestalt therapist meets patients and guides active awareness work. The therapist's active presence is alive and excited (hence warm), honest and direct. Patients can see, hear and be told how they are experienced, what is seen, how the therapist feels, what the therapist is like as a person. Growth occurs from real contact between real people. Patients learn how they are seen and how their awareness process is limited, not primarily by talking about their problems, but by how they and the therapist engage each other.

Focusing runs the range from simple inclusions or empathy to exercises arising mostly from the therapist's phenomenology while with the patient. Everything is secondary to the direct experience of both participants.

The general approach of Gestalt therapy is to facilitate exploring in ways that maximize what continues to develop after the session and without the therapist. The patient is often left unfinished but thoughtful or "opened up," or with an assignment. This is like a roast that continues to cook after being removed from the oven. This is in part how Gestalt therapy can be so intensive on fewer sessions per week. We cooperate with growth occurring without us; we initiate where needed. We give the degree of facilitation necessary to foster patient self-improvement. We facilitate growth rather than complete a cure process.

Perls believed that the ultimate goal of psychotherapy was the achievement of "that amount of integration which facilitates its own development" (1948). An example of this kind of facilitation is the analogy of a small hole cut into an accumulation of snow. Once the draining process begins, the base that began as a small hole enlarges by itself.

Successful psychotherapy achieves *integration*. Integration requires identification with *all* vital functions -- not with only *some* of the patient's ideas, emotions and actions. Any rejection of one's own ideas, emotions or actions results in alienation. Reowning allows the person to be whole. The task, then, in therapy is to have the person become aware of previously alienated parts and taste them, consider them and assimilate them if they are ego-syntonic or reject them if they prove to be ego-alien. Simkin (1968) has used the simile of a cake in encouraging patients

to reown the parts of themselves that they have considered noxious or otherwise unacceptable: although the oil, or flour, or baking powder by themselves can be distasteful, they are indispensable to the success of the whole cake.

The I-Thou Relation

Gestalt therapy focuses on the patient, as any therapy does. However, the relationship is horizontal, thus differing from the traditional therapy relationship. In Gestalt therapy the therapist and patient speak the same language, the language of present centeredness, emphasizing direct experience of both participants. Therapists as well as patients in Gestalt therapy show their full presence.

Since its beginning, Gestalt therapy has emphasized the patient's experience as well as the therapist's *observation* of what is not in the patient's awareness. This allows the patient to act as an equal who has full access to the data of his own experience so he can directly experience from inside what is *observed* by the therapist from outside. In an interpretive system the patient is an amateur and does not have the theoretical foundation for the interpretation. It is assumed that the important internal data are unconscious and not experienced.

An important aspect of the Gestalt therapy relationship is the question of responsibility. Gestalt therapy emphasizes that both the therapist and the patient are self-responsible. When therapists regard themselves as responsible for patients, they collude with patients' not feeling self-responsible and thereby reinforce the necessity for manipulation due to the belief that patients are unable to support and regulate themselves. However, it is *not enough for the therapist to be responsible for self and for the patient to be responsible for self* -- there is also an alliance of patient and therapist that must be carefully constantly, and competently attended to.

Therapists are responsible for the quality and quantity of their presence, for knowledge about themselves and the patient, for maintaining a nondefensive posture, and for keeping their awareness and contact processes clear and matched to the patient. They are responsible for the consequences of their own behavior and for establishing and maintaining the therapeutic atmosphere.

The Awareness of What and How

In Gestalt therapy there is a constant and careful emphasis on *what* the patient does and *how* it is done. What does the patient face? How does the patient make choices? Does the patient self-support or resist? Direct experience is the tool, and it is expanded beyond what is at first experienced by continuing to focus deeper and broader. *The techniques of Gestalt therapy are experimental tasks. They are the means of expanding direct experience. These are not designed to get the patient somewhere, to change the patient's feelings, to recondition, or to foster catharsis.*

Here and Now

In a phenomenological therapy "now" starts with the present awareness of the patient. What happens first is not childhood, but what is experienced *now*. Awareness takes place *now*. Prior events may be the object of present awareness, but the awareness process (e.g., remembering) *is now*.

Now I can contact the world around me, or *now* I can contact memories or expectations. Not knowing the present, not remembering, or not anticipating are all disturbances. The present is an ever-moving transition between the past and future. Frequently patients do not know their current behavior In some cases patients live in the present as if they had no past. Most patients live in the future as if it were now. All these are disturbances of time awareness.

"Now" refers to *this moment*. In the therapy hour, when the patients refer to their lives out of the hour, or earlier in the hour, that is *not now*. In Gestalt therapy we orient more to the now than in any other form of psychotherapy. Experiences of the past few minutes, days, years or decades that are of present importance are dealt with. We attempt to move from talking about to directly experiencing. For example, talking *to* a person who is not physically present rather than talking *about* that person mobilizes more direct experience of feelings.

In Gestalt therapy this I and Thou, what and how, here and now methodology is frequently used to work on characterological and developmental psychodynamics.

For example, a 30-year-old female patient is in group therapy. She is in the middle phase of therapy. She says she is very angry at a man in the group. One legitimate and frequent Gestalt approach is "Say it to him." Instead, the therapist takes a different tack:

T: You sound not only angry but something more.

P: [*looks interested*]

T: You sound and look like you are enraged.

P: I am, I would like to kill him.

T: You seem to feel impotent.

P: I am.

T: Impotence usually accompanies rage. What are you impotent about?

P: I can't get him to acknowledge me.

T: [*the therapist's observations of her previous encounters with the man agree with that statement*] and you don't accept that.

P: No.

T: And there is an intensity to your rage that seems to be greater than the situation calls for.

P: [*nods and pauses*]

T: What are you experiencing?

P: A lot of men in my life who have been like that.

T: Like your father? [*this comes from prior work with patient and isn't a shot in the dark. The work proceeds into a reexperiencing the narcissistic injury from her father, who was never responsive to her*]

Process of Psychotherapy

Gestalt therapy probably has a greater range of styles and modalities than any other system. It is practiced in individual therapy, groups, workshops, couples, families, and with children. It is practiced in clinics, family service agencies, hospitals, private practices, growth centers, and so on. The styles in each modality vary drastically on many dimensions: degree and type of structure; quantity and quality of techniques used; frequency of sessions; abrasiveness-ease of relating; focus on body, cognition, feelings, interpersonal contact; knowledge of and work with psychodynamic themes; degree of personal encountering, and so forth.

All styles and modalities of Gestalt therapy have in common the general principles we have been discussing: emphasis on direct experience and experimenting (phenomenology), use of direct contact and personal presence (dialogic existentialism), and emphasis on the field concepts of what and how and here and now. Within these parameters, interventions are patterned according to the context and the personalities of the therapist and the patient.

At the heart of the methodology is the emphasis on the difference between "work" and other activities, especially "talking about." Work has two meanings. First, it refers to a deliberate, voluntary and disciplined commitment to use phenomenologically focused awareness to increase the scope and clarity of one's life. When one moves from talking about a problem or being with someone in a general way to studying what one is doing, especially being aware of how one is aware, one is working. Second, in a group, work means being the primary focus of the therapist's and/or the group's attention.

Differences in techniques are not important, although the quality and type of therapeutic contact and a fit between the attitude and emphasis of the therapist and the patient's needs are important. Techniques are just techniques: the overall method, relationship, and attitude are the vital aspects.

Nevertheless a discussion of some techniques or tactics might elucidate the overall methodology. These are only illustrative of what is possible.

Techniques of Patient Focusing

All techniques of patient focusing are elaborations of the question, "What are you aware of (experiencing) now?" and the instruction, "Try this experiment and see what you become aware of (experience) or learn." Many interventions are as simple as asking what the patient is aware of, or more narrowly, "What are you feeling?" or "What are you thinking?"

"*Stay with it.*" A frequent technique is to follow an awareness report with the instruction: "Stay with it" or "Feel it out."

"Stay with it" encourages the patient to continue with the feeling that is being reported, which builds the patient's capacity to deepen and work a feeling through to completion. For example:

P: [*looks sad*]

T: What are you aware of?

P: I am sad.

T: Stay with it.

P: [*tears well up. Then the patient tightens and looks away and starts to look thoughtful*]

T: I see you are tightening. What are you aware of?

P: I don't want to stay with the sadness.

T: Stay with the not wanting to. Put words to the not wanting to. [*this intervention is likely to bring awareness of the patient's resistance to melting. The patient might respond: "I won't cry here -- I don't trust you," or "I am ashamed," or "I am angry and don't want to admit I miss him*"]

Enactment. Here the patient is asked to put feelings or thoughts into action. For example, the therapist may encourage the patient to "say it to the person" (if present) or use some kind of role playing (such as speaking to an empty chair if the person is not present). "Put words to it" is another example. The patient with tears in his eyes might be asked to "put words to it." Enactment is intended as a way of increasing awareness, *not* as a form of catharsis. It is not a universal remedy.

Exaggeration is a special form of enactment. A person is asked to exaggerate some feeling, thought, movement, etc., in order to feel the more intense (albeit artificial) enacted or fantasied vision. Enactment into movement, sound, art, poetry, etc., can both stimulate creativity and be therapeutic. For instance, a man who had been talking about his mother without showing any special emotion was asked to describe her. Out of his description came the suggestion to move like her. As the patient adopted her posture and movement, intense feelings came back into his awareness.

Guided fantasy. Sometimes a patient can bring an experience into the here and now more efficiently by visualizing than by enacting:

P: I was with my girlfriend last night. I don't know how it happened but I was impotent. [*patient gives more detail and some history*]

T: Close your eyes. Imagine it is last night and you are with your girlfriend. Say out lout what you experience at each moment.

P: I am sitting on the couch. My friend sits next to me and I get excited. Then I go soft.

T: Let's go through that again in slow motion, in more detail. Be sensitive to every thought or sense impression.

P: I am sitting on the couch. She comes over and sits next to me. She touches my neck. It feels so warm and soft, I get excited -- you know, hard. She strokes my arm, and I love it. [*pause, looks startled*] Then I thought, I had such a tense day, maybe I won't be able to get it up.

This patient became aware of how he created his own anxiety and impotence. This fantasy was recreating an event that happened in order to get in better touch with it. The fantasy could be of an expected event, a metaphorical event, and so forth.

In another case, a patient working on shame and self-rejection is asked to imagine a mother who says and means "I love you just the way you are." As the fantasy is given detail, the patient attends to her experience. This fantasy helps the patient become aware for the possibility of good self-mothering and can serve as a transition to integrate good self-parenting. The image can be used to work between sessions or as a meditation. It also raises feelings about experiences with abandonment, loss and bad parenting.

Loosening and integrating techniques. Often the patient is so fettered by the bonds of the usual ways of thinking that alternative possibilities are not allowed into awareness. This includes traditional mechanisms, such as denial or repression, but also cultural and learning factors affecting the patient's way of thinking. One technique is just to ask the patient to imagine the opposite of whatever is believed to be true.

Integrating techniques bring together processes the patient doesn't bring together or actively keeps apart (splitting). The patient might be asked to put words to a negative process, such as tensing, crying or twitching. Or when the patient verbally reports a feeling, that is, an emotion, she might be asked to locate it in her body. Another example is asking a patient to express positive *and* negative feelings about the same person.

Body techniques. These include any technique that brings patients' awareness to their body functioning or helps them to be aware of how they can use their bodies to support excitement, awareness and contact. For example:

P: [*is tearful and clamping jaw tight*]

T: Would you be willing to try an experiment?

P: [*patient nods*]

T: Take some deep, deep breaths and each time you exhale, let your jaw loosely move down.

P: [*breathes deeply, lets jaw drop on the exhale*]

T: Stay with it.

P: [*starts melting, crying, then sobbing*]

Therapist Disclosures

The Gestalt therapist is encouraged to make "I" statements. Such statements facilitate both the therapeutic contact and the patient's focusing and are to be made discriminatingly and judiciously. Using the "I" to facilitate therapeutic work requires technical skill, personal wisdom and self-awareness on the therapist's part. Therapists may share what they see, hear or smell. They can share how they are affected. Facts of which the therapist is aware and the patient is not are shared, especially if the information is unlikely to be spontaneously discovered in the phenomenological work during the hour, yet is believed to be important to the patient.

Mechanisms of Psychotherapy

Old Deficits, New Strengths

The child needs a parental relationship with a nurturant, organismic/environmental, ecological balance. For example, a mother must see that a child's needs are met and that the development of its potentialities are facilitated. A child needs this warm, nurturing kind of mirroring. And a child also needs room to struggle, to be frustrated, and to fail. A child also needs limits to experience the consequences of behavior. When parents cannot meet these needs because they need a dependent child or lack sufficient inner resources, the child develops distorted contact boundaries, awareness and lowered self-esteem.

Unfortunately, children are often shaped to meet the approval of parents on their own needs. As a result, the spontaneous personality is superseded by an artificial one. Other children come to believe they can have their own needs met by others without consideration for the autonomy of others. This results in the formation of impulsivity rather than spontaneity.

Patients need a therapist who will relate in a healthy, contactful manner, neither losing self by indulgent the patient at the expense of exploration and working through nor creating excessive anxiety, shame and frustration by not being respectful, warm, receptive, direct and honest.

Patients who enter psychotherapy with decreased awareness of their needs and strengths, resisting rather than supporting their organismic self, are in pain. They try to get the therapist to do for them what they believe they cannot do for themselves. When therapists go along with this,

patients do not reown and integrate their lost or never-developed potential. Therefore they still cannot operate with organismic self-regulation, being responsible for themselves. They do not find out if they have the strength to exist autonomously because the therapist meets their needs without strengthening their awareness and ego boundaries (see Resnick, 1970).

As Gestalt therapy proceeds and patients learn to be aware and responsible and contactful, their ego functioning improves. As a result, they gain tools for deeper exploration. The childhood experiences of the formative years can then be explored without the regression and overdependency necessary in regressive treatment and without the temporary loss of competence that a transference neurosis entails. Childhood experiences are brought into present awareness without the assumption that patients are determined by past events. Patients actively project transference material on the Gestalt therapist, thereby giving opportunities for deeper exploration.

The following two examples show patients with different defenses, needing different treatment, but with similar underlying issues.

Tom was a 45-year-old man proud of his intelligence, self-sufficiency and independence. He was not aware that he had unmet dependency needs and resentment. This affected his marriage in that his wife felt unneeded and inferior because she was in touch with needing and showed it. This man's self-sufficiency required respect -- it met a need, was in part constructive and was the basis of his self-esteem.

P: [*with pride*] When I was a little kid my mom was so busy I just had to learn to rely on myself.

T: I appreciate your strength, and when I think of you as such a self-reliant kid I want to stroke you and give you some parenting.

P: [*tearing a little*] No one has been able to do that for me.

T: You seem sad.

P: I am remembering when I was a kid.... [*exploration led to awareness of a shame reaction to unavailable parents and a compensatory self-reliance*]

Bob was a 45-year-old man who felt shame and isolated himself in reaction to any interaction that was not totally positive. He was consistently reluctant to experiment with self-nourishment.

P: [*whiny voice*] I don't know what to do today.

T: [*looks and does not talk*]

P: I could talk about my week. [*looks questioningly at therapist*]

T: I feel pulled on by you right now. I imagine you want me to direct you.

P: Yes. What's wrong with that?

T: Nothing. I prefer not to direct you right now.

P: Why not?

T: You *can* direct yourself. I believe you are directing us away from your inner self right now. I don't want to cooperate with that. [*silence*]

P: I feel lost.

T: [*looks and does not talk*]

P: You are not going to direct me, are you?

T: No.

P: Well, let's work on my believing I can't take care of myself. [*patient directs a fruitful piece of work that leads to awareness of abandonment anxiety and feelings of shame in response to unavailable parents*]

Frustration and Support

Gestalt therapy balances frustration and support. The therapist explores rather than gratifies the patient's wishes -- and this is frustrating for the patient. Providing contact is supportive, although honest contact frustrates manipulation. The Gestalt therapist expresses self and emphasizes exploring, including exploring desire, frustration and indulgence. The therapist responds to manipulations by the patient *without reinforcing them,*without judging and without being purposely frustrating. A balance of warmth and firmness is important.

The Paradoxical Theory of Change

The paradox is that the more one tries to be who one is not, the more one stays the same (Beisser, 1970). Many patients focus on what they "should be" and at the same time resist these shoulds.

The Gestalt therapist attempts to work toward integration by asking the client to identify with each conflicting role. The client is asked what he or she experiences at each moment. When the client can be aware of both roles, integrating techniques are used to transcend the dichotomy.

There are two axioms in Gestalt therapy: "What is, is," and "One thing leads to another" (Polster and Polster, 1973). The medium of change is a relationship with a therapist who makes contact based on showing who he or she truly is and who understands and accepts the patient.

Awareness of "what is" leads to spontaneous change. When the person manipulating for support finds a therapist who is contactful and accepting and who does not collude with the manipulation, he may become aware of what he is doing. This *Aha!* is a new gestalt, a new

outlook, a taste of new possibility: "I can be with someone and not manipulate or be manipulated." When such a person meets "therapeutic" collusion, derision, mind games, game busting and so on, this increase in awareness is unlikely to happen.

At each and every point along the way this new *Aha!* can occur. As long as the therapist or the patient can see new possibilities and the patient wants to learn, new *Aha!'s* are possible and with them, growth. Awareness work can start anywhere the patient is willing, if the therapist is aware and connects it to the whole. The ensuing process in Gestalt therapy leads to changes everywhere in the field. The more thorough the investigation, the more intense the reorganization. Some changes can only be appreciated years later.

Patients in Gestalt therapy are in charge of their lives. The therapist facilitates attention to opening restricted awareness and areas of constricted contact boundaries; the therapist brings firmness and limits to areas with poor boundaries. As sensing increases in accuracy and vividness, as breathing becomes fuller and more relaxed and as patients make better contact, they bring the skills of therapy into their lives. Sometimes intimacy and job improvements follow Gestalt work like an act of grace, without the patient's connecting the increase to the work done in therapy. But the organism does grow with awareness and contact. One thing does lead to another.

Applications

Problems

Gestalt therapy can be used effectively with any patient population that the therapist understands and feels comfortable with. If the therapist can relate to the patient, the Gestalt therapy principles of dialogue and direct experiencing can be applied. With each patient, *general principles must be adapted to the particular clinical situation.* If the patient's treatment is made to conform to "Gestalt therapy," it can be ineffective or harmful. A schizophrenic, a sociopath, a borderline and an obsessive-compulsive neurotic may all need different approaches. *Thus, the competent practice of Gestalt therapy requires a background in more than Gestalt therapy*. A knowledge of diagnosis, personality theory and psychodynamic theory is also needed.

The individual clinician has a great deal of discretion in Gestalt therapy. Modifications are made by the individual therapist according to the therapeutic style, personality, diagnostic considerations, and so on. This encourages and requires individual responsibility by the therapist. Gestalt therapists are encouraged to have a firm grounding in personality theory, psychopathology and theories and applications of psychotherapy, as well as adequate clinical experience. Participants in the therapeutic encounter are encouraged to experiment with new behavior and then share cognitively and emotionally what the experience was like.

Gestalt therapy has traditionally been considered most effective with "overly socialized, restrained, constricted individuals" (anxious, perfectionistic, phobic and depressed clients), whose inconsistent or restricted functioning is primarily a result of "internal restrictions" (Shepherd, 1970, pp. 234-35). Such individuals usually show only a minimal enjoyment of living.

Although Shepherd's statement accurately delineates a population Gestalt therapy is effective with, current clinical practice of Gestalt therapy includes treatment of a much wider range of problems.

Gestalt therapy in the "Perlsian" workshop style is of more limited application than Gestalt therapy in general (Dolliver, 1981; Dublin, 1976). In Shepherd's discussion of limitations and cautions, she notes restrictions that apply to any therapist but should especially be noted in a workshop setting, as well as by therapists not well trained or experienced with disturbed patient populations.

Work with psychotic, disorganized, or otherwise severely disturbed people is more difficult and calls for "caution, sensitivity and patience." Shepherd advises against doing such work where it is not feasible to make a "long-term commitment" to the patient. Disturbed patients need support from the therapist and at least a minimal amount of faith in their own natural healing capacity before they can explore deeply and experience intensely the "overwhelming pain, hurt, rage and despair" that underlie the psychological processes of disturbed patients (Shepherd, 1970, pp. 234-35).

Working with more disturbed populations requires clinical knowledge of how to balance support and frustration, knowledge of character dynamics, need for auxiliary support (such as day treatment and medication) and so forth. Some statements which seem to make sense in a workshop encounter are obvious nonsense when applied in a broader context. Consider for example, "do your own thing" in the context of treatment with acting out patients!

A perusal of the Gestalt therapy literature such as *Gestalt Therapy Now* (Fagan and Shepherd, 1970), *The Growing Edge of Gestalt Therapy* (Smith, 1976) and *The Gestalt Journal*, will show that Gestalt therapy is used for crisis intervention, ghetto adults in a poverty program (Barnwell, 1968), interaction groups, psychotics and almost any group imaginable. Unfortunately the literature provides examples (and a small number at that) without sufficient explication of necessary alterations in focus and without discussing negative results.

Gestalt therapy has been successfully employed in the treatment of a wide range of "psychosomatic" disorders including migraine, ulcerative colitis and spastic neck and back. Gestalt therapists have successfully worked with couples, with individuals having difficulties coping with authority figures and with a wide range of intrapsychic conflicts. Gestalt therapy has been effectively employed with psychotics and severe character disorders.

Because of the impact of Gestalt therapy and the ease with which strong, frequently buried affective reactions can be reached, it is necessary to establish safety islands to which both the therapist and patient can comfortably return. It is also imperative for the therapist to stay with the patient until he or she is ready to return to these safety islands. For example, after an especially emotion laden experience, the patient may be encouraged to make visual, tactile or other contact with the therapist or with one or more group members and report the experience. Another safety technique is to have the patient shuttle back and forth between making contact in the *now* with the therapist or group members and with the emotionally laden unfinished situation that the

patient was experiencing *then* until all of the affect has been discharged and the unfinished situation worked through.

The Gestalt therapy emphasis on personal responsibility, interpersonal contact and increased clarity of awareness of what is, could be of great value in meeting the problems of the present. One example is application of Gestalt therapy in schools (Brown, 1970; Lederman, 1970).

Evaluation

Gestalt therapists are singularly unimpressed with formal psychodiagnostic evaluation and nomothetic research methodology. No statistical approach can tell the individual patient or therapist what works for him or her. What is shown to work for most does not always work for a particular individual. This does not mean that Gestalt therapists are not in favor of research; in fact, the Gestalt Therapy Institute of Los Angeles has offered grants to subsidize research. Perls offered no quantified, statistical evidence that Gestalt therapy works. He did say, "we present nothing that you cannot verify for yourself in terms of your own behavior" (F. Perls et al., 1951, p. 7). In the publication *Gestalt Therapy*, a series of experiments are provided that can be used to test for oneself the validity of Gestalt therapy.

Each session is seen as an experiment, an existential encounter in which both the therapist and the patient engage in calculated risk taking (experiments) involving exploration of heretofore unknown or forbidden territories. The patient is aided in using phenomenological focusing skills and dialogic contact to evaluate what is and is not working. Thus, constant idiographic research takes place. Gestalt therapy has "sacrificed exact verification for the value in ideographic experimental psychotherapy" (Yontef, 1969, p. 27).

Harman (1984) reviewed Gestalt research literature and found quality research on Gestalt therapy sparse. He did find studies that showed increased self-actualization and positive self-concept following Gestalt therapy groups (Foulds and Hannigan, 1976; Giunan and Foulds, 1970).

A series of studies conducted by Leslie Greenberg and associates (Greenberg, 1986) addressed the lack of attention to context in psychotherapy research and the unfortunate separation of process and outcome studies. The Greenberg studies related specific acts and change processes in therapy with particular outcomes. Their research distinguished three types of outcome (immediate, intermediate and final) and three levels of process (speech act, episode and relationship). They studied speech in the context of the type of episodes in which it appears, and they studied the episodes in the context of the relationships in which they occur.

In one study Greenberg examined the use of the two-chair technique to resolve splits. He defined a split as "a verbal performance pattern in which a client reports a division of the self process into two partial aspects of the self or tendencies." He concludes that "two-chair operations conducted according to the principles [of his study] have been found to facilitate an increase in the Depth of Experiencing and index of productive psychotherapy...and to lead to resolutions of splits with populations seeking counseling" (1979, p. 323).

A study called the "Effects of Two-Chair Dialogues and Focusing on Conflict Resolution" by L. S. Greenberg and H. M. Higgins found that "Two-chair dialogue appeared to produce a more direct experience of conflict [split] and encouraged the client in a form of self-confrontation that helped create a resolution to the conflict" (1980, p. 224).

Harman (1984) found a number of studies that compared the behavior of Gestalt therapists with that of other therapists. Brunnink and Schroeder compared expert psychoanalysts, behavior therapists and Gestalt therapists and found the Gestalt therapists "provided more direct guidance, less verbal facilitation, less focus on the client, more self-disclosure, greater initiative and less emotional support." They also found that the "interview" content of Gestalt therapists tended to reflect a more experiential or subjective approach to therapy" (1979, p. 572).

No claim is made in the Gestalt therapy literature that Gestalt therapy is demonstrated to be the "best." There is theoretically no reason why Gestalt therapy should be more generally effective than therapies under other names that follow the principles of good psychotherapy. General outcome research may yield less useful results than process research looking at behavior, attitudes and consequences. An example of this is Simkin's assessment of the effectiveness of Gestalt therapy in workshops ("massed learning") as contrasted with "spaced" weekly therapy sessions. He found evidence for the superiority of massed learning (Simkin, 1976).

Some Gestalt therapy viewpoints on what constitutes good therapy are supported by general research. The research on experiencing within the Rogerian tradition demonstrated the effectiveness of an emphasis on direct experience by any therapist. In Gestalt therapy there is also an emphasis on personal relating, presence and experience. Unfortunately, some therapists regularly and blatantly violate the principles of good psychotherapy according to the Gestalt therapy model, but still call themselves Gestalt therapists (Lieberman, Yalom and Miles, 1973).

Treatment

Ongoing Individual Gestalt Therapy

Although Gestalt therapy has acquired a reputation for being primarily applicable to groups, its mainstay is actually individual treatment. Several examples can be found in *Gestalt Therapy Now* (Fagan and Shepherd, 1970). An annotated bibliography of case readings can be found in Simkin (1979, p. 299).

Gestalt therapy begins with the first contact. Ordinarily, assessment and screening are done as a part of the ongoing relationship rather than in a separate period of diagnostic testing and social history taking. The data for the assessment are obtained by beginning the work, for example, by therapeutic encounter. This assessment includes the patient's willingness and support for work within the Gestalt therapy framework, the match of patient and therapist, the usual professional diagnostic and characterological discriminations, decisions on frequency of sessions, the need for adjunctive treatment and the need for medical consultation.

An average frequency for sessions is once per week. Using the Gestalt methodology, an intensity equivalent to psychoanalysis can often be achieved at this frequency. Often individual therapy is

combined with group therapy, workshops, conjoint or family therapy, movement therapy, meditation, or biofeedback training. Sometimes patients can utilize more frequent sessions, but often they need the interval to digest material and more frequent sessions may result in overreliance on the therapist. Frequency of sessions depends on how long the patient can go between sessions without loss of continuity, decompensation, or lesser forms of relapse. Frequency of sessions varies from five times per week to every other week. Meeting less frequently than every week obviously diminishes intensity unless the patient attends a weekly group with the same therapist. More than twice a week is ordinarily not indicated, except with psychotics, and is definitely contraindicated with borderline personality disorders.

All through the therapy patients are encouraged and aided in doing the decision making for themselves. When to start and stop, whether to do an exercise, what adjunctive therapies to use, and the like are all discussed with the therapist, but the competence and ultimate necessity for the patient to make these choices is supported.

Group Models

Gestalt therapy groups vary from one and one-half to three hours in length, with an average length of two hours. A typical two-hour group has up to 10 participants. Gestalt therapists usually experience maximal involvement with heterogeneous groups, with a balance of men and women. Participants need to be screened. Any age is appropriate for Gestalt therapy, but an ongoing private practice group would typically range from ages 20 to 65 with the average between 30 and 50.

Some Gestalt therapists follow Perls' lead in doing one-on-one therapy in the group setting and use the "hot seat" structure. "According to this method, an individual expresses to the therapist his interest in dealing with a particular problem. The focus is then on the extended interaction between patient and group leader (I and Thou)" (Levitsky and Simkin, 1972, p. 240). One-on-one episodes average 20 minutes, but range from a couple of minutes to 45 minutes. During the one-on-one work, the other members remain silent. After the work, they give feedback on how they were affected, what they observed, and how their own experiences are similar to those the patient worked on. In recent years the one-on-one work has been expanded to include awareness work that is not focused around a particular problem.

In the early 1960s Perls wrote a paper in which he said:

Lately, however, I have eliminated individual sessions altogether except for emergency cases. As a matter of fact, I have come to consider that all individual therapy is obsolete and should be replaced by workshops in Gestalt therapy. In my workshops I now integrate individual and group work. (1967, p. 306)

This opinion was not then shared by most Gestalt therapists, and is not currently recognized Gestalt theory or practice.

Some observers have described the Gestalt therapist's style of group work as doing individual therapy in a group setting. This statement is valid for those Gestalt therapists who use the model

just discussed and do not emphasize or deal with group dynamics or strive for group cohesiveness. However, this is only one style of Gestalt therapy -- many Gestalt therapists do emphasize group dynamics.

Greater use of the group is certainly within the Gestalt methodology and is increasingly used in Gestalt therapy (Enright, 1975; Feder and Ronall, 1980; Zinker, 1977). This includes greater involvement of group members when an individual is doing one-on-one work, working on individual themes by everyone in the group, emphasis on interrelationships (contact) in the group, and working with group processes per se. The varied degree and type of structure provided by the leader include structured group exercises or no structured group exercises, observing the group's evolving to its own structure, encouraging one-on-one work, and so on. Often Gestalt groups begin with some exercise to help participants make the transition into working by sharing here-and-now experience.

A frequently used model is one that encourages both increased awareness through focus on contact between group members and one-on-one work in the group (with other members encouraged to participate during the work). This encourages greater fluidity and flexibility.

Workshop Style

Some Gestalt therapy and a good deal of training in Gestalt therapy is conducted in workshops, which are scheduled for a finite period, some for as short as one day. Weekend workshops may ranged from 10 to 20 or more hours. Longer workshops range from a week through several months in duration. A typical weekend workshop membership consists of one Gestalt therapist and 12 to 16 people. Given longer periods (ranging from one week up to a month or longer), as many as 20 people can be seen by one therapist. Usually if the group is larger than 16 participants, co-therapists are used.

Because workshops have a finite life and because just so many hours are available to the participants, there is usually high motivation to "work." Sometimes, rules are established so that no one can work a second time until every other participant has had an opportunity to work once. At other times, no such rules are set. Thus, depending on their willingness, audacity and drive, some people may get intense therapeutic attention several times during a workshop.

Although some workshops are arranged with established groups, most assemble people for the first time. As in ongoing groups, the ideal practice is to screen patients before the workshop. An unscreened workshop requires a clinician experienced with the range of severe pathology and careful protection for possibly vulnerable group members. Confrontive or charismatic Gestalt styles are particularly likely to exacerbate existing mental illness in some participants (Lieberman et al., 1973).

Other Treatment Modalities

The application of Gestalt therapy to working with families has been most extensively elaborated by Walter Kempler (1973, pp. 251-86). The most complete description of Kempler's work appears in his *Principles of Gestalt Family Therapy* (1974).

Gestalt therapy has also been used in short-term crisis intervention (O'Connell, 1970), as an adjunct treatment for visual problems (Rosanes-Berret, 1970), for awareness training of mental health professionals (Enright, 1970), for children with behavior problems (Lederman, 1970), to train staff for a day-care center (Ennis and Mitchell, 1970), to teach creativity to teachers and others (Brown, 1970), with a dying person (Zinker and Fink, 1966), and in organization development (Herman, 1972).

Management

Case management by a Gestalt therapist tends to be quite practical and guided by the goal of supporting the person-to-person relationship. Appointments are usually arranged over the telephone by the therapist. Office decor reflects the personality and style of the therapist and is not purposely neutral. The offices are designed and furnished to be comfortable and to avoid a desk or table between therapist and patient. Typically the physical arrangement leaves room for movement and experimentation. The therapist's dress and manner are usually quite informal.

Arrangement of fees varies with the individual, and there is no particular Gestalt style, except straightforwardness. Fees are discussed directly with the patient and usually collected by the therapist.

Clarity of boundaries is stressed, with both the patient and the therapist responsible for attending to the task at hand. The "work," or therapy, starts from the first moment. No notes are taken during the session because it interferes with contact. The therapist takes personal responsibility for note taking after the session, if needed, and for safeguarding notes, video or tape recordings and other clinical material. The therapist sets down conditions of payment, cancellation policy, and so forth. Violations or objections are directly discussed. Decisions are made together and agreements are expected to be kept by both. The therapist arranges the office to protect it from invasion, and where possible, soundproofs the office.

The evaluation process occurs as part of the therapy and is mutual. Some of the considerations involved in the evaluation process include deciding on individual and/or group therapy, estimating the therapist's capacity to establish a trusting, caring relationship, and letting the patient decide after an adequate sample if the therapist and the therapy are suitable.

Problems arising in the relationship are discussed directly, both in terms of dealing with the concrete problem and in terms of exploring any related characterological life-styles or relationship processes that would be fruitful for the patient to explore. Always the needs, wishes and direct experience of both participants guide the exploration and problem solving.

Case Example

Peg was originally seen in a Gestalt training workshop, where she worked on the grief and anger she felt toward her husband, who had committed suicide. His death left her with the full responsibility for raising their children and beginning a career outside the home to support herself and her family. She was in her late 30s at the time.

With considerable courage and initiative, Peg had organized a crisis clinic sponsored by a prominent service organization in the large Southern California city in which she resided. She was one of 11 people who participated in making a Gestalt therapy training film with Simkin (1969). The following is excerpted from the film, *In the Now*:

Peg: I have a ...recurring dream. I'm standing on the ground, up by Camp Pendleton. There's an open, rolling countryside. Wide dirt roads crisscrossing all over it. A series of hills and valleys and hills and valleys....And off to my right I see a tank, like in the army -- marine tanks with the big tracks...and there's a series of them and they're all closed tight and they're rumbling over these hills and valleys in a line, all closed up. And I'm standing beside this road and I'm holding a platter of Tollhouse cookies. And they're hot cookies. And they are just on the platter -- I'm just standing there, and I see these tanks coming by one at a time. And as the tanks come past, I stand there and I watch the tanks. And as I look to my right I see one -- and there's a pair of shiny black shoes, running along between the treads of the tank as it comes over the hill. And just as it gets in front of me...the man bends down and the tank goes on, and he comes over toward me and it's my best friend's husband. And I always wake up. I always stop my dream...and I laughed. It doesn't seem so funny anymore.

Jim: True. What are you doing?

Peg: Trying to stop my teeth from chattering.

Jim: What's your objection?

Peg: I don't like the feeling of anxiety and fear I have now.

Jim: What do you imagine?

Peg: Ridicule.

Jim: Okay. Start ridiculing.

Peg: Peg, you're ridiculous. You're fat...you're lazy. You're just comic. You're pretending to be grown up and you're not. Everybody looking knows that you're a kid inside, masquerading as a 39-year-old woman and...it's a ridiculous disguise. You haven't any business being 39. A ridiculous age. You're comic. You have a job you don't have the remotest idea how to do. You're making all kinds of grandiose plans that you haven't brains enough to carry through and people are going to be laughing at you.

Jim: Okay, now please look around and note how people are laughing at you.

Peg: I'm scared to. [*Looks around, slowly*] They appear to be taking me quite seriously.

Jim: So who is laughing at you?

Peg: I guess...only my fantasy...my...

Jim: Who creates your fantasy?

Peg: I do.

Jim: So who's laughing at you?

Peg: Yeah. That's so. I...I'm really laughing at what's not funny. I'm not so damned incompetent. [*pause*]

Jim: What are you really good at?

Peg: I'm good with people. I'm not judgmental. I'm good at keeping house. I'm a good seamstress, good baker, I...

Jim: Maybe you'll make somebody a good wife.

Peg: I did.

Jim: Maybe you'll make somebody a good wife again.

Peg: I don't know.

Jim: So say that sentence. "I don't know if I'll ever make somebody a good wife again."

Peg: I don't know if I'll ever make someone a good wife again.

Jim: Say that to every man here.

Peg: I don't know if I'll make someone a good wife again.... [*repeats the sentence five more times*]

Jim: What do you experience?

Peg: Surprise. Boy...I assumed I would never make anybody a good wife again.

Jim: Right.

Jim: What do you experience right now?

Peg: Satisfaction. Pleasure. I feel good. I feel done.

Although Peg's "ticket of admission" was a dream, what became foreground was her anxiety and fantasies of being ridiculed. The dream served as a vehicle for starting and, as is frequently the case, the work led to a most unpredictable outcome.

At the weekend workshop during which the training film was made, Peg met a man to whom she was attracted and who, in turn, was attracted to her. They began to date and within a few months they married.

A second sample of Gestalt therapy follows, selectively excerpted from a book to illustrate some techniques (Simkin, 1976, pp. 103-18). It is a condensed transcript of a workshop with six volunteers. The morning session included a lecture-demonstration and film.

Jim: I'd like to start with saying where I am and what I'm experiencing at this moment. This seems very artificial to me, all of these lights and the cameras and the people around. I feel breathless and burdened by the technical material, the equipment, etc., and I'm much more interested in getting away from the lights and the cameras and getting more in touch with you. [*inquires as to the names of participants of the group and introduces himself*]

I am assuming that all of you saw the film and the demonstration, and my preference would be to work with you as you feel ready to work. I'll reiterate our contract, or agreement. In Gestalt therapy the essence of the contract is to say where you are, what you are experiencing at any given moment, and, if you can, to stay in the continuum of awareness, to report where you are focusing, what you are aware of.

* * * * *

I'd like to start first with having you say who you are and if you have any programs or expectations.

Tom: Right now I'm a little tense, not particularly because of the technical equipment because I'm kind of used to that. I feel a little strange about being in a situation with you. This morning I was pretty upset because I didn't agree with a lot of the things you were talking about, and I felt pretty hostile to you. Now I more or less accept you as another person.

Jim: I'm paying attention to your foot now. I'm wondering if you could give your foot a voice.

Tom: My foot a voice? You mean how is my foot feeling? What's it going to say?

Jim: Just keep doing that, and see if you have something to say, as your foot.

Tom: I don't understand.

Jim: As you were telling me about feeling hostile this morning, you began to kick and I'm imagining that you still have some kick coming.

Tom: Uh, yeah. I guess maybe I do have some kick left, but I really don't get the feeling that that's appropriate.

* * * * * *

Lavonne: Right now I'm feeling tense.

Jim: Who are you talking to, Lavonne?

Lavonne: I was just thinking about this morning, I was feeling very hostile. I still think I am somewhat hostile.

Jim: I am aware that you are avoiding looking at me.

Lavonne: Yes, because I feel that you are very arrogant.

Jim: That's true.

Lavonne: And as if I might get into a struggle with you.

Jim: You might.

Lavonne: So the avoidance of eye contact is sort of a put-off of the struggle. I don't know whether they can be resolved.

Jim: Would you be willing to tell me what your objections are to my arrogance?

Lavonne: Well, it's not very comforting. If I have a problem and I talk to you about it and you're arrogant, then that only makes me arrogant.

Jim: You respond in kind is what you are saying. Your experience is you respond that way.

Lavonne: Yes. Right on. Then at this university I feel that I must be arrogant and I must be defensive at all times. Because I'm black, people react to me in different ways ... different people ... and I feel that I have to be on my toes most of the time...

* * * * * *

Mary: I want to work on my feelings for my older son and the struggle that I have with him -- only, I suspect it is really a struggle I'm having with myself.

Jim: Can you say this to him? Give him a name and say this to him.

Mary: All right. His name is Paul.

Jim: Put Paul here [*empty chair*] and say this to Paul.

Mary: Paul, we have a lot of friction. Every time you go out of the drive on your own, independent, I hate you for it. But...

Jim: Just a moment. Say the same sentence to Mary. Mary, each time you go out the drive, independent, I hate you for it.

Mary: That fits. Mary, each time you go out the drive, independent, I hate you for it, because you are not being a good mother.

Jim: I don't know about your "because."

Mary: No. That's my rationale. That's the same I do to myself doing yoga.

Jim: You sound identified with Paul.

Mary: I am. I know this. I envy his freedom, even from the time he was a little kid and went to the woods. I envied his ability to go to the woods.

Jim: Tell Paul.

Mary: Paul, even when you were a little boy and you would go for all day Saturday, and not tell me where you were going but just go, I envied you for it I envied you very much, and I felt hurt because I couldn't do it too.

Jim: You couldn't, or you wouldn't?

Mary: I would not do it. I wanted to, but I would not do it.

Jim: Yeah. For me to have somebody around that keeps reminding me of what I can do and don't really pisses me off.

Mary: This is what I do to myself. I keep reminding myself of what I can do and won't do. And then I don't do anything. I'm at a standstill. Firmly planted.

Jim: I'd like you to get in touch with your spitefulness. Put your spitefulness out here and talk to Mary's saboteur.

Mary: You idiot. You've got the time to do your work. You also have the energy to do your work...which you dissipate. You get involved in umpteen dozen things so you will have an excuse not to do your work, or to do anything else... [*pause*] You just spend time making yourself miserable and complicating your life.

Jim: What's going on here? [*points to Mary's hand*]

Mary: Yes. Tight-fisted...won't do.

Jim: Are you tight-fisted?

Mary: Yes, I think I am.

Jim: OK. Can you get in touch with the other part of you -- your generous self?

Mary: I don't really know my generous self very well.

Jim: Be your tight-fisted self just saying, "Generous self, I have no contact with you, I don't know you, etc."

Mary: Generous self, I don't know very much of you. I think you try every now and then when you give presents to people instead of giving yourself. You withhold an awful lot that you could give.

Jim: What just happened?

Mary: I rehearsed. I just wasn't talking to my generous self. I was talking to...you primarily. I was withholding part.

Jim: I have difficulty imagining you as a withholding person. You came on in the beginning as very vibrant and alive...to me, very giving.

Mary: I don't know whether I really am giving or not. Sometimes I feel like I do give and what I give is not accepted as a gift. And sometimes I want to give and I can't. And I feel sometimes I have given too much and I shouldn't have.

Jim: Yeah. This is what I'm beginning to sense. Some hurt. You look like you've been hurt -- in the past. That you've been vulnerable and somehow hurt in the process.

Mary: To some degree I'm hurting.

Jim: To me you look like you're hurting now, especially around your eyes.

Mary: I know that, and I don't want to do that..I don't want to show that.

Jim: OK. Would you be willing to block?

Mary: [*covering her eyes*] When I do that, I can't see you.

Jim: That's true.

Mary: When I do that, I can't see anyone.

Jim: Very true. When I block my hurt, no one exists for me. This is my choice.

Mary: I made it my choice too.

Jim: I am enjoying looking at you. To me, you are very generous at this moment.

Mary: You are very generous to me. I feel that you are. I hear you respond to me and I feel that I'm responding to you...

Jim: I'm curious if you can come back to Paul for a moment now. Encounter him and explore what happens.

Mary: Paul, I want to be warm to you, and I want to be generous to you, and I think I might hurt you by being so. You're six feet tall now and sometimes I very much want to come up to you and just give you a kiss goodnight or just put my arms around you and I can't do it anymore.

Jim: You can't?

Mary: I won't. I won't, because, uh...I've been shoved away.

Jim: You've been hurt.

Mary: Yeah, I've been hurt. Paul, I think it's your own business if you want to shove me away, but that doesn't stop me from being hurt.

Jim: I like what, I believe, Nietzsche once said to the sun, "It's none of your business that you shine at me."

Mary: I keep hoping that, Paul, when you're 25 or if you go to the Army or whatever...that I can kiss you good-bye. [*pause*] I'll try to remember what Nietzsche said to the sun.

Jim: OK. I enjoyed working with you.

Mary: Thank you.

Summary

Fritz Perls prophesied three decades ago that Gestalt therapy would come into its own during the 1970s and become a significant force in psychotherapy during the 1970s. His prophecy has been more than fulfilled.

In 1952, there were perhaps a dozen people seriously involved in the movement. In 1987 there were scores of training institutes, hundreds of psychotherapists who had been trained in Gestalt therapy, and many hundreds of nontrained or poorly trained persons who called themselves "Gestaltists." Thousands of people have experienced Gestalt therapy -- many with quite favorable results -- others with questionable or poor outcomes.

Because of the unwillingness of Gestalt therapists to set rigid standards, there is a wide range of criteria for the selection and training of Gestalt therapists. Some people, having experienced a weekend workshop, consider themselves amply equipped to do Gestalt therapy. Other psychotherapists spend months and years in training as Gestalt therapists and have an enormous

respect for the simplicity and infinite innovativeness and creativity that Gestalt therapy requires and engenders.

Despite the fact that Gestalt therapy attracts some people who are looking for shortcuts, it also has attracted a substantial number of solid, experienced clinicians who have found in Gestalt therapy not only a powerful psychotherapy but also a viable life philosophy.

Those looking for quick solutions and shortcuts will go on to greener pastures. Gestalt therapy will take its place along with other substantive psychotherapies in the next several decades. It should continue to attract creative, experimentally oriented psychotherapists for many years to come.

Gestalt therapy has pioneered many useful and creative innovations in psychotherapy theory and practice. These have been incorporated into general practice, usually without credit. Now Gestalt therapy is moving into further elaboration and refinement of these principles. Regardless of label, the principles of existential dialogue, the use of the direct phenomenological experience of patient and therapist, the trust of organismic self-regulation, the emphasis on experimentation and awareness, the "no shoulds" attitude by the therapist, and the responsibility of the patient and therapist for their own choices all form a model of good psychotherapy that will continue to be used by Gestalt therapists and others.

To summarize, a quote from Levitsky and Simkin (1972, pp. 251-252) seems appropriate:

If we were to choose one key idea to stand as a symbol for the Gestalt approach, it might well be the concept of authenticity, the quest for authenticity...If we regard therapy and the therapist in the pitiless light of authenticity, it becomes apparent that the therapist cannot teach what he does not know...A therapist with some experience really knows within himself that he is communicating to his patient his [*the therapist's*] own fears as well as his courage, his defensiveness as well as his openness, his confusion as well as his clarity. The therapist's awareness, acceptance, and sharing of these truths can be a highly persuasive demonstration of his own authenticity. Obviously such a position is not acquired overnight. It is to be learned and relearned ever more deeply not only throughout one's career but throughout one's entire life.

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