Psychopathology in terms of Gestalt Therapy

Abstract

This article attempts to define psychopathologies in Gestalt terms. The question is asked, "What is the benefit of using Gestalt language in describing our clients' pathologies instead of employing "common clinical jargon" in analyzing their difficulties?" The author maintains that by trying to understand his client's behavior and mental problems in Gestalt terms he immediately renders Gestalt diagnostic terms into creative therapeutic techniques. The author proposes a "bargain": Upon describing a client's problem in Gestalt terms, this problem can be immediately converted into Gestalt therapeutic practices. The emphasis given in this article is not only on the therapeutic efficiency of choosing the appropriate approach or technique for the client, but more so on the ability to place the client's problem on a sequence of potential humanistic therapeutic experiences. The author claims that by explaining the client's difficulties in Gestalt terms, the client's problems are transformed into optimistic practical creative experiences, which form a unique therapeutic approach. The author compares the DSM definition of personality disorder with Gestalt clinical terms and thereafter analyzes post-psychotic clients' behaviors in Gestalt terms to demonstrate the clinical therapeutic approach that derives from those defects.

Highlights:
Gestalt psychopathology, Gestalt clinical diagnosis, psychopathology in Gestalt terms

Keywords:

Gestalt, Psychopathology, Diagnosis, Clinical Gestalt

Based on my masters dissertation (1989) I present in this article a clinical interpretation of the six Gestalt therapeutic principles: (1) Holism, (2) Awareness, (3) Here & Now, (4) Prangnanz, (5) Figure & Ground and (6) Polarities. There is quite a challenge in attributing the term "Gestalt" to a pattern, mold, mode, issue or a psychic component of a person's behavior. An entire syndrome of problems and symptoms are reduced to one concise term. "He has a problem with retroflection, she is suffering from contact issues", etc. This simplicity helps in the beginning of a therapeutic process to approach the client with an optimistic attitude. Concision requires generalization, perspective, distancing and diminishing of large data into a concluding statement. Yet this simplification wills eventually push us therapists, later in the therapeutic process, to diagnose the client repertoire with a differentiated approach (which inevitably will require a whole range of detailed data gathered about the client). I claim that as we use Gestalt terms in the beginning of therapy, we are challenged nonetheless to continue diagnosing the client throughout the therapy with further Gestalt concepts that are at our theoretical disposal.

Back in 1991, I worked in a closed unit of a mental health hospital. This period would now be considered the "middle ages" pharmacologically speaking. When I did Gestalt work with post-psychotics at that time, the use of Gestalt required a "crusade" in order to justify the notion that even a post-psychotic patient has a right to and is able to benefit from Gestalt therapy. It would not only not jeopardize him/her (as the pessimistic claimed then), but would open up new horizons of sanity in a place where "playing with the patient" was considered a risk for breakdown.
Both literature evidences and my experience demonstrate prerequisites needs of strong Ego forces for the client to posses in order to benefit from Gestalt therapy. A certain caution is obviously required from the Gestalt therapist. While working with a client with a wounded or fragile Self, extra caution is required. This means that along the gamut of patients with personality disorders, especially clients with severe narcissistic disorders, working with Gestalt therapy may be quite challenging. Activating the client, shifting him/her from a complaining passive position to the Gestaltian active approach of the "here and now" and "taking responsibility", may be perceived by him/her as humiliation, negligence, or even abuse. However, steps of caution, gradual work and explanations, as well as elaboration of the experience afterwards, bestows Gestalt therapy with an effective optimistic therapeutic power.

There is no doubt about the efficiency of Gestalt therapy with the severely ill. Brailer and Stratford reported on their clinical work in the 1970s. Serok (2000) reported on improvement in reality testing, information processing and the state of awareness among schizophrenic patients after treatment with Gestalt therapy. However I should emphasize that in all those reports, as well as in previous ones, we read about a basic report describing the client using "clinical" concepts, thereafter Gestalt techniques are proposed, results are reported but seldom do we read about pathological phenomena in Gestalt terms.

Clinical versus Gestalt diagnosis of the Client

I shall now try to define "Personality Disorder" as defined in the DSM and translate it into Gestalt terms. Thereafter I shall bring live clinical case studies with post psychotic clients, analyzing their clinical symptoms in Gestalt terms versus the DSM. According to the DSM, the general criteria for Personality Disorder are judged according to several categories (A & B etc.):

Category A: An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two (or more) of the following areas:

(1) Cognition (ways of perceiving and interpreting self, other people and events).

(2) Affectivity (the range, intensity, ability and appropriateness of emotional response)

(3) Interpersonal functioning

(4) Impulse control

How can we translate this paragraph to Gestaltinan terms? Gestalt therapy sees pathology as disruptions in the process of natural development. Disruptions which lead to repetitive behavior, very often with high intensity, in order to bring a **problem** or a **need** to its **solution or satisfaction.** Pathology is related to a **"stuck" state.** We shall use the term "dysfunction"; hence pathology will be defined in Gestalt terms as a disruption in a process, or "a state of being stuck". The result of being stuck will bring only a partial solution of the behavioral mode. Therefore, each symptom, each sickness, each conflict, even if malignant, or causing pain, is perceived in Gestalt therapy as **a human attempt to turn life into a more bearable state**. People in the patient's environment may pay a high price for such "solutions" (Zinker, p. 94). "Personality Disorder", in Gestalt terms will be defined as "**a disruption in the holistic potential of a human being to express him/herself in an appropriate way on the three levels of mind, feeling and body**. On the "mind level" (cognition) it will be expressed in idiosyncratic explanations, on the "feeling level" (affect) a damage in the homeostatic mechanism and on the "body level" (control of drives) it will be expressed in Retroflection. In relating to inter-relationships (DSM) we shall refer to disruptions in "contact" skills. "Contact" will be defined as "awareness of the field, or movemental responses in the field. We might also refer to a disruption in the ability to identify boundaries and the ability to function within boundaries. Control of drives (DSM) will be translated in Gestalt terms to "the ability to shift along a bi-polar sequence between drive and control, or disability to move about the "experience cycle" which includes: relaxation, sensation, stimulation, excitement, approximation, contact, dissemination, rest etc.

Category B: The enduring pattern is inflexible and pervasive across a broad range of personal and social situations

In Gestalt terms, we will speak about a difficulty in boundary formation which causes incapability to "contact". We might talk about the inability to properly activate the mechanism of "figure and ground", bringing a Gestalt in the "figure" into satisfaction but then shift it back to the "ground", enabling a flexible figure-ground flow in facing life's challenges. We speak about "unfinished business", a state that causes certain issues to shadow, disrupt or block the ongoing flow of new options deriving from new and challenging situations.

This article will relate to psychoses only, rather than personality disorders, whose clinical definitions can be translated into Gestalt terms and correlated to therapeutic techniques. Psychoses are the most difficult pathologies on the "normal-pathological"

spectrum. I shall convert the schizophrenic-psychotic state into Gestalt terms and demonstrate therapeutic techniques that combine Gestalt therapy with clinical expressive arts psychotherapy.

Psychosis in Gestalt terms

The psychotic patient is labeled "falling apart", yet the Gestalt therapist will not see him/her as "a broken human being" but **as a** human being organized differently and temporarily. The following example will illustrate the therapeutic approach:

On the group level: post-psychotic patients arrive to a day therapy group in a state of "disruptive behavior" characterized by repetitive behaviors locked into rigid defensive conduct. In the first session of this day therapy group, I noticed that the patients talked to themselves, hardly relating to one another. My impression of this primary pathology related to the Gestalt principle of "the whole and its parts". According to the first aspect of the Holism Principle (1a), the psychotic patient has a problem with inter –relationships and dependency between the whole and its parts. Healing will therefore take place where paradoxically "the sum of the parts will be considered more than the whole itself".
Serok (1983) states that "the way one brings the parts into a whole is very significant for mental health". In that very first session I gave the members of the group blank sheets of paper and asked them to draw something with a pencil. The need to draw and create art breaks down the echolalia group behavior. Suddenly there is shame, pride, anxiety, initiatives, and a new energy in the circle. We spread a large white sheet in the middle of the room, members of the group are asked to choose and cut out a part of their personal drawing. The hand trembles. One needs to choose between alternatives. Each patient is required to become the part he/she had chosen to cut out (Pic. # 1)
"I am a huge tree, I have blue flowers in the form of a heart."
"I am a smiling sun, I burn anyone who passes by me."
"I am a beautiful butterfly who flies towards freedom."
"I am the flag - blue and white."
"I am a woman without legs flying in the wind."
I ask the group members slowly and in turn to put their parts together on the big white sheet to create a common group drawing. The drawings give the patients the possibility for a concrete touch with the symbols that emerged in the process. Now it is exactly the right time for reality testing. Some say:" What – a tree in the sky?", "Why doesn't she have legs?" some members volunteer to draw blue sky and a brown ground line. Reality becomes a common base for everyone. Here we apply one aspect of the Gestalt principle that "The whole is more than the sum of its parts", as each member of the group contributes his/her part to create a group whole with a different quality based on reality testing.
An example of the personal level: David is a young man, two years after obligatory military service, he uses light drugs and was hospitalized after a schizophrenic attack. Ever since he arrived to the unit he speaks about obtaining a job, David does not get any job. I ask David to explain to the group how he does not succeed in getting a job. David is a clever man, he comprehends the humor and paradox of my question, yet he answers sincerely: "Believe me I don’t know, but each time I get a refusal, I am content." He would not attend occupational therapy that has the dynamics of work. The group members are told to close their eyes. I lead a guided fantasy. They are

asked to visualize a pleasant place where they can feel tenderness, preferably a place with water. I encourage the members of the group to see the place with details in their imagination, colors, smell and how it feels there. Thereafter they will also be asked to draw the place they visited in the guided fantasy. I ask who wants to present the drawing. David shows his drawing (pic # 2) : a blue circle with blue stripes inside it – a lake. Around the lake in a symmetrical form are blue and green trees stuck to the ground, each tree similar to the other, in the lake at the far shore bushes are drawn as a green fence. "Become the lake," I tell David. "I am a deep lake, it's impossible to get out from me, the trees guard it so that it would be impossible to get out of me". Members of the group are required to stand around David like trees. His drawing serves as a script for this psychodrama. I ask David to try and come out of the circle (lake) and the friends around him (trees) are not to let him escape. A physical struggle takes place. David is exhausted, sits on the floor in the middle of the circle, looking at me helpless. I tell him: "Yes, it's like life, you wish to go to work and it is impossible." Members of the group are astonished, up until this moment they did not see the connection between the movement of the game and David's problem, which had been presented to the group in the beginning of the session. Now the picture is clear. I put David's drawing near him in the center of the circle. I say,"There is one more part in the drawing which we haven't experienced yet – the bushes. Become the bushes!

David: "I am the bushes, we are on the lake's side, hold us firmly and with our help you will somehow climb out of the lake". I ask some of the group members in the far end to offer hands to David, become the bushes, let him hold on to them and thus escape the circle-lake. I ask David, "Who, in your life, are these bushes?" David says, "All sorts of temporary jobs". Someone in the group says laughingly:" Maybe occupational therapy".

The way in which David organizes the problem by dividing it into different elements in the drawing (lake, trees, bushes) and the way he copes with the disseminated frame and finally rebuilt it anew, enabled him to reach a new insight.

The psychotic patient who arrives to the daycare group is handicapped on all three levels of the second aspect of the "Holism Principle"(1b): Mentally he still dwells in the remains of hallucinating thoughts, often his thinking exhibits organic signs. Speech is associative, schematic, revolving around his medication and the urge to go home. Physically, the patient is characterized by side effects of the medication, such as trembling, dry mouth and lips, rigidity in the eyes, catatonic postures, eye contact is minimal, as if the body is "shy", in Gestalt language: severe retroflection. Members of the group smoke continuously. Emotionally, the affect is shallow, speech does not correspond with facial expressions, the patient has just emerged from emotional psychotic peaks and now "rests" without intimate contact with himself or others. Therapeutically we here face immense challenges on the levels of context, empathy and boundaries. A further example: Robert is a chronic patient, with many hospitalizations in his history; he looks much older than his actual age. In the group, he expresses his desperation from his state; he wishes to stop his medication as he claims he sleeps all day. I notice the mental statement is clear and logical; there is definitely a reason for this desperation. His tone is monotonous, no eye contact with the group members, no feelings and no body, as he says:" the body is asleep". I present hula-hoops to the group. Each one is asked to stand near a hoop on the floor and go around and around the circle. The circles are small, we turn around monotonously. I say and they repeat, "Routine is boring, wake up, go to hospital, take remedies, get back home watch TV, sleep, wake up, go to hospital, take remedies, go

back home…" Members of the group are asked while stumbling around, to repeat those sentences and to add associations from their own routine, I stumble as well. The dramatic effect is enormous: the tight circulation accurately reflects the narrowness of their lives .Their frustration was reflected by "Robert's problem". Suddenly Robert falls on the floor and crawls into the hoop. I stop the movement, the room is silent, Robert's withdrawal is significant and dramatic I ask," Robert what happened?" Robert, "I can't anymore." I say, "Pay attention to what you do when you have no strength to continue. The circle is the routine, and outside the circle is life, be aware of where you fall." The insight is clear. Body and feeling are fully part now of the experience. One of the patients says," We fall into madness".

The third dimension of the Holism Principle (1.3) relates to three more layers. Between the layer of "thought - action" there is a hidden layer which we hardly notice, "the middle layer" of playfulness, fantasy, dream. Simulation, body language, images and metaphors take on a significant role in Gestalt applications. This is the meeting point between different arts and Gestalt therapy. Perls (1973) saw intercorrelation between imagination and reality, while the common ground between these polarities are the symbols that create the language of fiction but are taken from reality. Fantasy is efficient for normal functioning, as human beings think about problems in fantasy in order to arrive to solutions in reality. Feeling and affect play dominant roles in these processes. There is a causal connection between the cognitive and emotional systems. Cognitive change presumes the initiation of change in affect and vise versa.

In my opinion, the psychotic patient is sucked into the "middle layer." He is enslaved to symbols, his/her language is bizarre, and he/she is totally in fantasy. Patients arrive to the group greatly confused. Their confusion is characterized by guilt feelings and suspicion. As a Gestalt therapist I enable the patient to experience the "middle layer" (known to him/her very well from the psychotic period, but with one very significant difference – now he/she experiences this layer out of choice and control.

Rose is 25 years old, working in the group on a problem with her glasses. She tells the members of the group, "They hurt me all over my head, they create electrical pressure and I hate them". Each attempt of the group members to convince her logically that glasses cannot possibly create electricity in her head is useless. Everybody feels that the content is not adequate. Rose should not be led to the feeling layer, or the physical layer. She does adequately express her suffering and rejection of her glasses. We should help her experience the meaning of her complaints on the logical layer that is stuck. However, she might very likely reject any explanation. She apparently still needs the psychotic perception. I ask Rose to put her glasses on the mattress in front of her and to convey to her glasses what she feels and thinks about them. Rose's response expresses her anger towards her glasses, "You hurt me all over my body!" Her accusations are outrageous. Now she is asked to enter the glasses' side and answer. She is asked kindly to change roles and sit on the mattress where the glasses are located. "You need us, without us you will be blind. Without us you will not know what is happening to you," they say. Rose is confused. The glasses all of a sudden became an independent entity. A dialogue gradually develops between Rose and her glasses. Self-esteem and femininity issues emerge. Precisely when she acts the part of her glasses, she permits her rational part to be exposed. When she moves back to present herself, she conveys an irrational, unrealistic, capricious, childish and

overwhelmed position. In the playfulness layer, we find humor and paradox. Members of the group, who found themselves arguing previously with Rose, are now enjoying with laughter the irrational Rose who fights the "clever glasses". This struggle is their struggle**.** Post-psychotic patients, unlike neurotics, do not defend themselves against the Gestalt techniques. Awareness (Principle #2) which is derived through experience, grants them new intellectual insights.

In the psychotic group there is immense difficulty as far as Awareness (2) is concerned. The following picture can be observed: People are dressed in extravagant and inadequate garments, speech is too loud and mostly simultaneous with others' speech, hyperactivity, introverted body gestures, physical negligence, trembling, smoking, some of the patients stand up occasionally for no reason. There are patients who continuously report about themselves aloud, "My hand is trembling, I have no strength to sit any more, I am bored…the statements are monotonous. It seems their appearance gives away their mental state. I encourage the people to become the trembling organ, the item of clothing, a certain garment, or the overt behavior that is perceived as exaggerated. "I am Sara's trembling jaw. I tremble because the doctor refuses to reduce her medication." I frequently use the expression in therapy, "See how, be aware how… how do you say this, how does it tremble, how does it make you happy, how does it take you away from us…" The patients easily learn the constructing-healing side of being aware, we constantly use the Gestalt principle of the "Here and Now" in the group (3). Awareness can bring great shame on the one hand, but at the same time, also grants control, slowing the rhythm, freedom, use of humor, focusing and respect.

I assume that the "perceptional field" of the psychotic patient is distorted regarding the Figure-Ground (principle #5) relationships and content. According to Boring (1950) theory, we can assume (a paradoxical assumption) that the psychotic is imprisoned in the "unclosed frame". The psychotic believes in the "absolute and non-replacability" of the content or perception he holds, expands and inflates the psychotic content and does not relate to the "ground" images, does not agree to differentiate, break down or analyze the holistic psychotic experience, in order to re-arrange it into a meaningful insight.

In addition, there is an impression that in the psychotic state the charactiszations of the "ground" (Rubin 1954) became the "figure" into which the patient had been encapsulated: the fantasized images, the heard voices and images usually blurred, like a dream, denote formless and undifferentiated contents. Distancing is expressed through the indifference of the patient from his/her environment, like in the cases of megalomania or analgesia. The psychotic patient has lost the healthy ability to pull out a "frame", or "issue" from the "background" and present it in the "figure", close the figure by bringing it into appropriate satisfaction and pull out the next desired frame (Perls, 1973). Instead, he/she "prefers" or is obliged to remain imprisoned in one hermetic frame, sick frame, yet defending it! He/she blocks his/her ability to transfer frames from the ground to the figure and so forth, to maintain a "healthy shifting mechanism," and does it by uniting the two opposing poles, the figure and ground, into one existential entity. We face such manifestations also in grief neurosis, when the grieved person is encapsulated in the "grieving frame" and will not emerge from it. In the psychotic state, not only the figure and ground are united on the content

level, here the unison is on the perception level, therefore in psychosis the unity of figure and ground is hermetic and total.

In the group, the psychotic patients suffer from a conscious conflict. On the one hand, the medication helps them realize again the figure-ground relationships. Apparently, the medications activate the figure-ground mechanism. Yet the psyche refuses to give up the relative relaxation, the shelter, the uniqueness and possibility of defense that the "hermetic unity of figure-ground" state grants. We face this dramatic struggle in the group therapy. The patient is required inevitably to give up the "benefits" of the disease, repress the illness and relegate it to the "background" and from there unsheathe the traumatic story that drove him/her into psychosis. From my experience, even in the cases where an organic factor is dominant and initiated the disease, there are always psychological and social factors involved in the illness's etiology. The Gestalt of the traumatic story is kept well-hidden deep in the far "ground" of the patient's consciousness and at times is inaccessible. However, the "rehabilitating Gestalten" and the everyday routine are not easy either and are short of optimism and attraction.

Gestalt therapy is a therapy of the here and now (3). We bring every experience to presence, thus taking responsibility for thoughts and feelings. Looking at facts from the "how" point of view leads to the structure of the event, and once the event is comprehended, the inner motivation (why) is clarified. The present experience creates symbols and insights beyond its interpretations. Emphasis on the symbolism of the experience will grant the person new meanings. Eventually the process will enable him/her to generalize insights beyond concrete experience. Past and future are fantasy; therefore being in touch with reality depends upon permanent touch with the expressions of present time (Greenwald, 1975). Perls (1947) emphasized that speech in present time develops an ego idiom that enables the experience in present time to become realistic so that we can take responsibility for the processes of change undergone.

Psychotic patients are characterized by a "false presence". They return home from hospitalization and are invited to join a routine life. A short review of what actually happens to the patients during the period starting with their release from the hospital up to the day they start therapy at the day center shows that they do not have significant enough presence to attend. Falling into a severe psychotic state detaches them from time and place. Upon admission to the hospital, we witness a withdrawal from routine life. While staying in a closed ward where the psychotic state diminishes, the patient is exposed to very narrow and minimal routine content. Upon arrival to group therapy sessions in the day center, they appear like robots that were sent to attend the circle. The days, appointments and places are merely data written for them on a card, which they hardly remember. The presence of the closed ward rules their responses and is exhibited in the group milieu. The Gestalt principle of the here and now (3) permits a new atmosphere and ecology. I insist that the patients talk to each other directly and not through me. I help them keep eye contact and when necessary I say, "Could you tell him/her this without words"? Then, we witness nonverbal emotional encounters between human beings who burst out from the "plastic wrap" that increases with the illness and the side effects of their remedies. The patients learn that although most of them have a pathological common behavior, they differentiate significantly and full legitimacy is given to their individuality. The

word "Me" – "I" is repeated constantly: "I am the paralyzed hand of David"; "I do not want to go on with this exercise." A member in the group addresses me:" Why didn't you come last week, I am angry at you." Susan says," I do not wish to participate." "I think, I feel, I sense…"

One session challenges the group with the departure of two members. The session is difficult. Naturally, the group is divided into two camps: those who leave and those who remain. I ask the members to express their feelings towards the departure of Karen and Jacob. Robert doesn't participate, he prefers to lie on the mattress. David feels frustration, Karen feels happiness, Suzan feels optimism, Judith is sad, Rose cannot express what she feels but asks to draw. I accept Rose's request and encourage the members of the group to draw or sculpt their feelings with clay or plasticine. Finally, everyone gathers their works on a large white sheet on the floor. In the drawing (pic # 3), we can see a flag of Israel but instead of the Star of David there's a small red flower with a green stem in the middle. There is a complicated maze with an arrow at its end, another spiral maze, Rose's maze, that parts of it lead to its beginning, green tears, a human image lifting its arms, its face angry and fists closed and finally a half smiling body. Each member is asked to become the artwork he/she created.
"I am the departing tears" says Judith and wipes her eyes. "I am the flower in the middle of the Israeli flag because the Star of David is a sign of sickness," says Effi (a new patient). "I am a blue maze which continues a long convoluted way but in the end there is a way out…" says Jacob. "I am Karen's happiness who leaves the hospital as she wanted very much to move to the clinic near her home." "I am a spiral maze, some times I imprison Rose and sometimes I release her." The patients experience in present time the intensity of the experience of departure, those who leave sense the anxiety of independence, those who stay receive legitimacy to feel anger, a dull ache and hope.

Discussion

What is the benefit of trying to speak the language of Gestalt in describing our client's pathologies? Why not make use of the "common clinical jargon" in analyzing their difficulties? I learned that by trying to understand my client's behavior and mental problems in Gestalt terms I immediately translate the analysis into creative therapeutic techniques and interventions. The transaction is depicted as follows: Describe your client's problem in Gestalt terms and it can immediately be converted into a Gestalt therapy experience. The emphasis here is not only on the therapeutic efficiency of being able to choose the appropriate approach or technique for the client, but also on the ability to pinpoint the client's problem on a spectrum of potential humanistic experiences. Explaining your client's difficulties in Gestalt terms is transforming your client's problems into optimistic practical creative experiences which form a unique therapeutic approach.