GESTALT BRIEF THERAPY:

an Address by Gaie Houston to the Association of Cognitive Analytic Therapists National Conference,
London March 5th 2000

Recently I was asked to write a summating article on this topic for the British Gestalt Journal, and was confronted with several well-articulated views, some of which flatly contradicted each other. Here I shall set out what I hope would be agreed as the underlying assumptions held by Gestalt therapists, to which I shall add some of the method and intention I have seen to be of use to patients, either directly or from the viewpoint of supervisor.

Rather like the Monty Python teams who competed to tell the whole of Proust in the fastest time, I'll first try to give you the bones of Gestalt Therapy itself.

It is a process theory, specially concerned with **how**. The word Gestalt means something like pattern or organisation, and Gestalt emphasis is on noticing patterns of behaviour and interaction.

After **awareness-raising**, which is a central aim in this method, the Gestalt therapist's job is in part to create the conditions in which the patient can **de-construct** dysfunctional fixed or habitual sequences of interaction, of **contact** in Gestalt language, thus making space for the formation of new gestalts, and more spontaneity, more aliveness, than before. He can if he chooses increase his **response-ability**.

Theory of Mind

The theory of mind is holistic, emphasising the indivisibility of organism and environment. It is optimistic, assuming a tendency or capacity for growth and excitement, in the words of the subtitle of the major theory book, **growth and excitement in the human personality** [Perls et al 1951]. Daniel Stern's [1986] theory of development expresses the Gestalt interest in both intersubjectivity, and the laying down of benign and other fixed gestalts or RIGs in early and indeed later life.

Gestalt emphasises the tendency in the human mind towards integration, organisation, co-operation. 2nd Law of Thermodynamics doesn't get too much of a look in here. However, **indivisibility of organism and environment** is a central concept in Gestalt, with all that implies about mutual influence, and about limitation. Perception is seen as occurring within a field. **Need** is the organiser of that field.

Theory of Change Change is often assumed to happen paradoxically, as a result of full acceptance of what is, rather than a striving to be different. [Beisser 1970].

Other routes to change are implicit in Gestalt. One could be called Aristotelian or mimetic learning, through exposure to the unjudgmental dialogic presence of the therapist. Another is through the creativity of experimenting with behaviours or contexts that are novel.

Which Clients are Suitable for Gestalt Brief Therapy?

Who is suitable for Gestalt Brief Therapy? After many years I have come to the cautious view that the right partnership is that of a willing therapist with a willing client. Now, in some ways many patients are likely to be in part unwilling, conflicted about a talking treatment, particularly in these islands. I shall come back to a Gestalt attempt at working with this, in the Method section.

There are also patients who are very willing, but about whom the therapist may feel reluctant. This is a two-sided decision.

On her side, the therapist needs to know herself and her capacities pretty well; she needs insightful and intelligent supervision. She needs too to be able to judge rather quickly whether she has the sense that she can be or at least wants to be of use to the patient within the limits of the time available. In practice this may often mean that she follows some of Malan's [1982:104] rejection criteria:
history of serious suicide

attempts; drug addiction; long-term hospitalisation; more than one episode of ECT; chronic alcoholism; incapacitating chronic obsessional symptoms; gross destructive or self-destructive acting-out.
But she remains open to the person as well as the description, and so may take on some people for whom there might be, on paper, a poor prediction of successful outcome. In other words, Gestalt Brief Therapy is not a beginner's task.

I imagine that most of us sitting here can recall patients for whom there were many contra-indications for Brief Therapy in the literature, but who have nevertheless made good or very good use of the opportunity [Burton 1998] . Likewise there are others who read on paper like suitable candidates, but who do not thrive, from some cause not spotted straightaway by the therapist, but possibly relating to her.

A robust referral system is intrinsic to the work, and in Primary Care or Workplace Counselling Gestalt therapists are likely to offer seminars where referral criteria, and methodology, including clarity about the extent and limits of confidentiality, can be agreed, with all the people involved. This is an aspect of the holistic view encouraged in this approach. If a Gestalt Therapy Group is available, some people maybe routed there at this early stage. Not only the therapist needs to keep awareness of Paul's [1967] dictum about **what treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances.**

Method Given that the therapist may have no more than half a dozen meetings with the patient, all that can be done to prepare and inform both people beforehand is seen to be of use. I advocate the use of a friendly questionnaire for the prospective patient to fill in before the first meeting. The help of a Practice Nurse or receptionist can sometimes be used, if a patient has difficulty in writing from one cause or another. The questionnaire also contains some information for the patient, for instance about duration, confidentiality, the therapist's role and expectations.

The opening paragraph of one of these forms runs:

The aim of brief therapy is to give you the chance to talk through what is distressing you, with someone who will not tell you what to do, but who wants to help you find your own way of coping, understanding or changing. The Gestalt therapist is concerned to establish a working alliance based on co-operation and a recognition of the authority of both parties and an acknowledgement that every symptom the patient shows has its own inner rationality.

How the patient organises what we call the **contact boundary**, the moment to moment meeting or avoidance of the therapist, is a major diagnostic tool in Gestalt. Indeed some therapists dispense with any history taking for brief therapy, and rely completely on what emerges at this immediate level. **Now** and **How** are two important foci in both diagnosis and treatment.

Now encompasses whatever is occupying or preoccupying the patient's mind. The past or the future may fill a person's attention, to the exclusion of the immediate. So Now is seen as a route to getting a sense of the patient's way of handling the world.

In a first meeting, the patient may or may not have a sense of his **need**, of what he wants from the therapy. Not infrequently he will say that the doctor thought it might help, or that his manager sent him. Raising awareness of the nature of a talking therapy is thus an important early step. A willing patient may assume that he is to be a docile passive recipient of a Treatment, albeit one that requires from him a confessional input, as indeed would a visit to the doctor.

Patient in Charge Learning something of the interactive and co-operative task the therapist has in mind, will encourage some people, and dismay others. So, even in such a short episode of treatment, I recommend the

therapist at the end of the first session to ask the client or patient to think over whether he wants to continue, and to get in touch about this in some specified way at or within an agreed time, but certainly not before having time to sleep on the decision. The Questionnaire says:

Some of what you write here may in itself help you think about your difficulties in a new way. It will also help us both decide if and how we can best work together when we meet. After our first meeting you will have until X to decide if you would like to continue seeing X for the remaining X sessions.

Many people have told me that this small device has helped them to feel committed and in charge of their own therapy. It also gives reflection time to the therapist, and an opportunity for her to refer on at this stage.

This is the exit of the first session. Before it comes, the hope is that the patient has had time to describe what is troubling him, and to say what he wants from the therapy, if he can at this stage, and to form an impression of the therapist and her way of working.

On her side, the therapist does what she can to take on board the patient's way of looking at the world. The Gestalt belief in holism means that attention is paid to what the patient **is**, in terms of position, social history and the measurables of life; what he has in the way of symptoms and difficulties; what he **does** in present and reported behaviour and relating, and what he **tells**, the poem he makes of his own life. [McHugh and Slavney 1985]. The therapist sees if she concurs with him about the task of the therapy, and consults him about **her** first impressions of what the task is for them and how they might go about it. As I have implied earlier, the **contact** or emotional process has particular salience in this method.

Experimentation. The Middle Phase.

Gestalt emphasises idiosyncrasy and is wary of programmatic treatments. So the middle phases of brief therapy vary markedly with each person. Certainly in the second session the hope is that the partners will confirm or alter the terms of the working alliance they began to make in the first session. Thus the tasks of therapy can at best be named clearly by both people.

The therapist will probably need to say more about her assumptions and methods, so the patient grasps the rationale of Gestalt Therapy. An assumption she may spell out is that all data is good data, that the more the client notices and reports his emotional, sensate and cognitive experience, the more likely they are to make headway.

Gestalt sees living as creative experimentation. So whatever is undertaken in therapy is described as an experiment. **Phenomenological dialogue** is the recommended underpinning experiment. In shorthand this means that the therapist pays attention to the effects on her of the presence as well as the words of the other. This means that she may report minutiae of her own experience and observation, and track how these lead to guesses in her mind, for example about what might be happening for the patient, or how what she is experiencing may parallel interactions the patient reports from other parts of his life [Houston 1993:108]. Interpretation, in other words, is presented more transparently than in some therapeutic styles. The therapist herself is fairly translucent too.

What Does *This* Client need?

In a simple case, perhaps a recent bereavement, the patient might seek reassurance that he is not mad or ill. The therapist's task then may be to great extent to **be with** the anguished person for a few weeks, accepting his despair or catharsis, and probably giving some reassurance. An interventionist style might not be of use.

Many patients will arrive with a scatter of difficulties ranging from physical symptoms through relational problems and substance abuse to problems with the social security [Tansella and

Thornicroft 1999]. One path with such a person is to bring into focus the **foreground** problem, the one that is apparently the most distressing or preoccupying. Then there can be conversation about what change is hoped for in perception or behaviour, and range scales can even be used to give an indication of how progress can be monitored. An agreement is then sought, to focus awareness in that area. The therapist may even spell out her guess that what is being focused on will prove to be a fractal, a representation of other difficulties the patient is experiencing. So any learning about the particular may generalise to other areas of life.

Another Gestalt path might be to take the immediate process, for instance a grasshoppering round and round from difficulty to difficulty as itself the focus for work. **Contact**, intersubjectivity, is the focus in this process, also described as **analysing the structure of the contact**.

Creative Experiments

The **creative experiments** arising from the dialogue, suggested first by the therapist and later perhaps by either person, will range through the physical, sensate, emotional and cognitive.

Two-chair conversations, one of the best-known Gestalt methods, often encompass all these aspects. The patient may be asked to imagine himself facing the other party to the dialogue. This other party might be an acknowledged part of himself, or might be named as another person. Rather than talk, he might be encouraged to register his sense of their relative sizes, to notice his feelings, to sense how power is distributed between them, to note what is happening to his own breathing and patterns of muscular tension in this encounter. Through such a dialogue the patient can often gain new perspectives on both sides of some intrapsychic or interpersonal conflict. Where appropriate, such an experiment might be tried with the therapist as other, rather than an empty chair. Or the client might take the therapist's chair and role for a spell.

Many kinds of experiential learning are offered, through attention to breathing, stance, gesture or much else as well as speech, as these phenomena become figural. Drawing, writing, homework tasks, diary keeping, are a few of the wide repertoire of experiments likely to be devised and tried out in Gestalt Brief Therapy, if any of them are deemed likely by both parties to support the agreed task. Anything is grist for the mill.

Differences from Longer-Term Work With all of these approaches, one of the differences from an open-ended therapy is the amount of expository effort the therapist puts in, with the aim of bringing into focus the patient's power and authority in the work. Another difference is that there is a mechanistic shaping of the episode of therapy: both people know they have however many weeks and no more. The Gestalt is shaped by this imposition of closure. The therapist is likely to keep this as an open topic and a comment on how the patient deals with time boundaries or imposed constraints. So the end shows in the beginning yet more clearly in Gestalt Brief Therapy than in the more organic process of open-ended work. The Gestalt Cycle of Awareness may even be shown to interested clients, as a notional marker of the way the episode of therapy is evolving.

Gestalt Group Work with Somatising Patients.

One of my supervisees, a doctor in Primary Care, set up a Gestalt group for what he called his somatising patients. They met weekly for ten week terms, with two leaders, himself and a Health Visitor with relevant experience. A researcher from Sussex University used an adaptation of Kelly's Repertory Grid to follow the group through part of its life, and its members during the following year. The outcomes in terms of subjective testimony, and reduced numbers of subsequent visits to the surgery, were a great vindication of the work, in

which no interest has so far been shown by medical journals.

I have a strong belief in the value of brief therapy in small groups, and in many cases see it as preferable to one to one work. The therapist is no longer half of the world, but an eighth or tenth of it. The troubles of one patient are put in the context of those of other people, so vicarious as well as direct work is always going on. Idiosyncrasies in getting on with people will more likely show in the group. Solidarity, group feeling, will probably evolve and contribute to people's progress. What is more, it is much cheaper to see ten or twelve people for ten two-hour group sessions than for six sessions each.

The ground-rules in such a Gestalt group usually include an encouragement to listen rather than interrupt, to express oneself through I-statements rather than judgements of others, to report emotionality before opinion, and to take responsibility for oneself in terms of level of participation. Personal goal-setting and self and peer monitoring are maintained through a round at the beginning of each session, from which the focus of the rest of the session is likely to emerge. Experiments may involve the whole group or one or two people. Physical contact, with its indisputable therapeutic benefits for some people, is a less fraught experiment in a group than one to one. All these statements are meant to encourage the audience to set up brief group therapy if they have not already done so!

Ending and Beyond

The final phase of the work has to mark closure, and raise awareness of the patient's way of dealing with closure. Is it an end or a stop? It will also contain a summation of what has happened as viewed by both people. From this comes a picture of what might, can or needs to happen next. The therapist aims to leave the patient with heightened awareness, with the benefit of having been recognised and attended to by an interested and unjudgmental other, with a sense of increased skill or an understanding of a limitation. All this and more is summed up in the Gestalt concept of **response-ability**, ability to respond to the environment appropriately.

Care is taken to let the patient work out changes he wants to consolidate or bring about, in the light of the Brief Therapy. This may range from planning social support for maintaining new behaviours or avoiding other behaviours, to making some environmental shift. At the other end of a wide spectrum, the episode may have developed into what serves as an assessment for longer-term therapy, in the light of what has become clear in this episode. Such an outcome has the ethical requirement that such help can be offered, if the revolving door phenomenon [Burton 1998: 95] is to be avoided. The Gestalt Brief Therapist is recommended to create and maintain a wide network of referral. In some areas this is far more easily said than done.

I have ended with comment about the economy and politics in which the topic of this conference is embedded. It is perhaps part of our task today to raise Governmental awareness that Mental Health is Health, and that mental distress cannot always be dealt with adequately by ultra-brief therapy or none at all.

Gaie Houston, 2000

REFERENCES

- Beisser A.R. *The Paradoxical Theory of Change.* Ch. 6 in Fagan J.and Shepherd I.L. [1970] Eds. *Gestalt Therapy Now.* New York: Science and Behaviour Books.
- British Gestalt Journal [1999] Vol. 8, 1: 4-34
- Burton M. [1998] Psychotherapy, *Counselling and Primary Mental Health Care.* Chichester: John Wiley and Sons.

- Houston G. [1993] *Being and Belonging.* Chichester: John Wiley.
- Malan D. [1982] in *Techniques of Brief Psychotherapy,* Flegenheimer W [Ed.] New York: Jason Aronson Inc.
- McHugh P. and Slavney P. [1986] *The Perspectives of Psychiatry.* Baltimore: Johns Hopkins University Press.
- Perls F, Hefferline R. and Goodman P. [1951] *Gestalt Therapy: Excitement and Growth in the Human Personality.* New York: Julian Press.
- Paul G. L. [1967] *Strategy of outcome research in psychotherapy,* Journal of Consulting Psychology, 31: 109-118.
- Stern D, [1986] *The Interpersonal World of the Infant.* New York: Basic Books.
- Tansella M. And Thornicroft G. Eds [1999]*Common Mental Disorders In Primary Care* London: Routledge
- Vevers J. and Hemming A. [1985] Unpub. Research paper: *Gestalt Groups for Patients in General Practice Using Repertory Grid.*