



Diagnosing in the Here and Now

A GESTALT THERAPY APPROACH

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*E*xperience is messy. It is continuous, disorganized, shapeless, chaotic, and overlapping. Gestalt therapy rests on the fundamental assumption that we, as humans, are predisposed to organize this experience in order to make meaning.

Gestalt therapy borrows this assumption from Gestalt psychology's theory of perception, which postulates that we create a figure (organization) out of the ground (experience). We do this by scanning, evaluating, and assessing our internal and external environments. Formal diagnosis is the attachment of a specific form of meaning (labeling) to a recurrent pattern of figure/ground formation of an individual.

This chapter explores formal diagnosis (DSM-IV; American Psychiatric Association, 1994) from the theoretical perspective of Gestalt therapy. The Gestalt therapy "experience cycle" (Polster & Polster, 1973; Zinker, 1977) will be presented as the basis of a diagnostic system (see Figure 19.1). Specific diagnostic formulations from DSM-IV (borderline, specific phobia, histrionic, and posttraumatic stress syndrome) will be analyzed, and intervention strategies will be articulated.

WHAT IS DIAGNOSIS?

Diagnosis is first and foremost a descriptive statement that articulates what is being noticed in the present. Yet it also means going beyond the present, im-

plying a pattern as well as a prediction, no matter how minimal. In addition, diagnosis may or may not include a concept of causality. Thus, to diagnose is to attempt to enlarge the picture, to move from what is observable now to what is habitual. It includes a schema not only of what is to be observed but of the patterns and configurations into which our observations are organized.

Gestalt theory does not imply a system of cause. Gestalt therapists believe in causation, but they perceive it as inherently unknowable. Aligned with both systems (Kraus, 1989; Huckabay, 1992) and field theory (Parlett, 1991, 1993) perspectives, they are aware that the number of influences that impinge on any given system is so vast that a full and meaningful description of cause is improbable, if not impossible.

As indicated previously, Gestalt therapists believe that one constantly derives meaning after first organizing unorganized experience. Gestaltists believe that how one organizes what one observes is the fundamental process of meaning making, and that it is unique to each individual (including each patient and diagnostician) and to each situation. Therefore, there can be no absolutely correct diagnosis.

Despite this strongly held belief, there are several compelling reasons for diagnosing in a more formal, narrow, and systematic manner:

First, diagnosis gives one a map and describes possibilities of how a person can evolve. Therefore, the therapist benefits from a structure, that is, a compass to help organize the information and provide clues to a direction to navigate through the vast field of data.

Second, the process of diagnosing allows the therapist to control anxiety. By removing her-/himself from the data, the therapist may remain calm while waiting for a figure to emerge. Thus, the process of diagnosing is grounding and keeps the therapist from jumping precipitously into the infinite while waiting. Simply stated, it gives one something to do.

A third reason to diagnose in a more formal way is that by linking Gestalt theory to other systems of diagnosis, a vast array of research and theory opens to the clinician. Furthermore, it is efficient in that the therapist can make predictions without having to wait each time for the data to emerge from immediate experience.

Fourth, Gestalt therapists in particular need to be grounded in a wider perspective that includes the future and particularly the past. However, although Gestalt therapists explore the patient's past, this exploration is of a different nature: "We explore phenomenologically in order to understand, not believing that the past caused the present" (Yontef, 1988, p. 22).

Finally, fifth, diagnosing prevents the Gestalt therapist from becoming isolated from others with different theoretical orientations. Consequently, Gestalt theorists, even while debating issues concerning process versus structure, still use traditional diagnostic labels such as schizophrenia, narcissism, and borderline personality disorder (From, 1984; Tobin, 1985). Thus, although the use of diagnostic categories may not be totally congruent with our theory, we still employ them in communicating with others.

HOW DOES GESTALT THERAPY DIFFER FROM OTHER SYSTEMS?

Gestalt diagnosis is gleaned essentially from the moment, and this provides the key to intervention, interpersonal process, and change. Because of this viewpoint, it is important to reiterate at the outset that Gestalt theory, informed by field theory, includes the therapist in the assessment process and thus makes the therapist part of the diagnosis.

This implies not only that the therapist influences what is seen but also that what is seen evokes reactions in the therapist that help create a unique systemic experience. When making a formal diagnostic statement the Gestalt therapist is making a choice to deal with only one part of the organism–environment equation, as if the clinician and environmental components could be frozen and the patient isolated from the interaction. Although this perspective is admittedly limited and incomplete, it is fairly consistent with the way people experience and interpret the world.

In diagnosing, the Gestalt therapist focuses on process and pattern making in the here and now and does not label individuals in terms of long-term, ongoing, and fixed characteristics. Gestalt therapists pay attention to blocks in one's process (i.e., avoidance or distortion of awareness or contact) and describe them as disturbances or neurotic self-regulation—projection, confluence, retroflexion, retrojection, and deflection (Polster & Polster, 1973). By locating these psychological processes in the here and now, Gestalt therapy takes a therapeutically optimistic stance that is more likely to support change in people who might otherwise be restricted by the more traditional, historical, and permanent diagnostic categories. By locating diagnostic categories in the here and now, one remains open to seeing possibilities and noticing clues to new meanings and changes in the patient. The negative implication of this philosophical approach is that the therapist may fail to recognize or acknowledge, as the more traditional diagnostician might, the degree to which people's patterns of behavior are acontextual—more a function of habits and intrapsychic traits.

Consistent with the here-and-now focus on change is the Gestalt tendency to diagnose with verbs and not nouns. Seeing the world in an active and therefore potentially changing way, the clinician chooses words that emphasize behavior. Thus, the description is of "obsessing" rather than "obsessive." Once a noun is used, the person and not just the behavior is characterized, and a bit of hope is lost, for the diagnosis is not only a description of the moment but also a subtle prediction of the future. Therefore, Gestalt therapy's approach to identifying behavior patterns as opposed to character deficiencies has served as an appropriate and optimistic counterpoint to Freudian determinism.

Because of Gestalt therapy's process orientation, the individual is seen as continually moving through an overlapping series of experiences that are organized into beginnings, middles, and ends. Because of the complexity of these phenomena, one can become stuck at many different points along the

experience continuum. Therefore, the value of a diagnostic tool is to help the clinician discover the point of difficulty for the patient and intervene at the correct place to maximize awareness, understanding, and change.

Gestalt therapists, because of their process perspective, risk overlooking the possibility that their in-the-moment assessments are in fact diagnoses. To avoid this oversight, what is needed is a recognition of the nature of diagnosis within the Gestalt framework and a healthy inclusion of aspects of more traditional diagnostic approaches. This latter recommendation addresses the pitfall mentioned earlier of the therapy being too fixed in the here and now without an acknowledgment of the patient's habitual behavior patterns. Therefore, it is useful to broaden the Gestalt diagnostic perspective by borrowing from other therapeutic disciplines (see Delisle, 1991; Yontef, 1988). Ultimately, however, regardless of how one defines diagnosis, it is crucial to remember that is merely a tool for change. Its purpose is not to burden the patient or therapist with constricting and irremediable labels but to facilitate the patient's awareness, growth, and health.

HOW DO GESTALT THERAPISTS DIAGNOSE?

Traditionally, Gestalt therapists have diagnosed by paying attention to the phenomenon in the moment. At some point an aspect of behavior becomes interesting, something stands out, and a pattern emerges. This pattern might lead to a diagnostic statement such as, "The patient appears to be retro-reflecting" (constricting his or her emotions). The remaining therapeutic work in the session might be focused on that retroreflection. This form of diagnosis is valuable for a number of reasons: first, the behavior is readily observable; second, the techniques outlining how to work with retroreflections are clearly articulated and straightforward; and, third, the diagnosis defines a piece of therapeutic work that can often be satisfactorily completed in one therapy session. It should be pointed out that Gestalt therapists do not have a single way to deal with the phenomenon of someone who characteristically—that is, more often than is usual—retroreflects energy when faced with stressful situations. Furthermore, we do not have a theory for predicting if the constant work on retroreflections will result in some enduring change by affecting the ground of the individual.¹ The ground consists of the traces of experience, history, and physiology contained in larger, deeper grooves out of which lively figures spring forth. This ground must ultimately be affected if a person is to experience a more permanent change.

THE EXPERIENCE CYCLE AND CHARACTER

Healthy, organized functioning can be defined by breaking down figure formation and destruction into an "experience cycle" (Zinker, 1977), which is illustrated in Figure 19.1. The crosshatched portion represents emotional

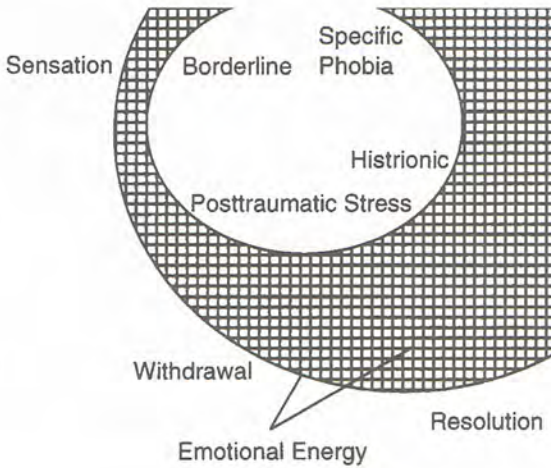


FIGURE 19.1. Experience cycle.

energy, which is a physiological response to stimulation. Emotional energy builds in intensity from sensation to contact and then recedes through the withdrawal stage. Individual phases are placed around the outside of the outer circle, and various disorders are placed along the inside of the inner circle. Their placement corresponds to the hypothesized original areas of blockage and distortion. It should be noted that this schema is a beginning attempt at integrating the cycle and DSM-IV diagnostic categories and rests on the following assumptions:

1. The stages of the experience cycle are in fact artificial demarcations of a continuous, flowing unit of experience; thus, the phases are overlapping.
2. Competence is directly related to the skills and abilities needed to articulate and complete each stage satisfactorily (Zinker & Nevis, 1981). Ultimately, being able to complete a cycle, to create and destroy a figure with clarity, defines healthy functioning (Wallen, 1957).
3. Although the cycle was originally intended to describe momentary experience, it can be extended to encompass larger periods of time.
4. The stages of the cycle reflect a developmental progression. The earlier in the cycle the disturbance occurs, the more the experience tends to (a) consist of very old ingrained patterns, (b) be primarily physiologically as opposed to behaviorally influenced, and (c) be less observable to others and thus less amenable to therapeutic change.

5. A disturbance at one stage of the cycle will affect all remaining stages.
6. Although one might intervene at later stages of the cycle with some success, chronic, habitual behavior can be changed ultimately only by intervening at the phase where the disturbance originally occurred.
7. The intervention(s) must occur many times before any long-lasting changes can occur.
8. When working as therapists, we are able to utilize direct observation to "see" the patient move through the middle stages of the cycle where emotion is highest, that is, mobilization, action, and contact. Therefore, our understanding of the patient's experience during the other stages is usually inferred from self-reports. Thus, most patient difficulties are originally noticed as an inability to mobilize emotion, move toward action, or make contact. Much of therapeutic work involves pinpointing other phases that present difficulty and helping the patient develop skills and resources to move through and successfully complete these phases.
9. Although we recognize the difference between personality and neurotic disturbances, for purposes of illustration we are not distinguishing between them. This is in keeping with the DSM-IV: "The coding of Personality Disorders should not be taken to imply that their pathogenesis or range of appropriate treatment is fundamentally different from that for the disorders coded on Axis 1" (American Psychiatric Association, 1994, p. 26).
10. For the purpose of this chapter, we are ignoring relationship patterns as a primary vehicle for assessing blockage and distortion (see Evans, 1994). In fact, Gestalt therapy places much emphasis on here-and-now dialogue as well as the developing relationship between therapist and patient (see Melnick, 1997).

INDIVIDUAL PHASES OF THE CYCLE

Sensation/Awareness. The first phase of the cycle, sensation/awareness, involves all experiences taken in by the senses. The individual must be able to sort out an awareness from the vast array of internal and external stimuli impinging on the senses. Sensations consist of everything one sees, touches, hears, smells, and tastes and include all of the physiological, proprioceptive, and kinesthetic sensations. Completion of this phase results in the ability to articulate a clean awareness, that is, one upon which to accurately build as well as one that reflects with accuracy the sensory experience of the individual.

Mobilization. The second phase is mobilization. As an awareness is defined, an individual's interest and emotional energy begin to grow, ultimately organizing a want, a desire. Thus, competing figures recede into the background as emotional energy is invested in a dominant content (Zinker & Nevis, 1981; Zinker, 1994). The task of this phase is to form a sharply delineated figure out of a rich and varied ground.

Movement or Action. The third phase, the movement or action stage, is built on sensation/awareness and mobilization. Since this is the first stage that is clearly obvious to others, blockage in the previous two stages will most likely be evident here. This stage involves the ability to move toward an attractive object or away from an unattractive one.

Contact. The fourth phase of the cycle is contact. According to Zinker and Nevis (1981), contact “is the fruit of the movement/ action phase. Wants or concerns have been melded into a newly created whole—a whole which is different from its parts” (p. 10). Strong contact is based on a clear awareness supported by ample emotional energy. Contact also produces and enhances emotional arousal. This stage continues the sharpening of a compelling figure. The contact phase, too, is largely observable to others.

Resolution/Closure. The fifth phase, resolution/closure, involves review, that is, a summarizing, reflecting, and savoring of one’s experience and meaning making. It involves both an appreciation of what has been and a regretting of what could not be. This is a slow stage because most of the emotional energy has been drained from the figure and the person is psychologically positioning him-/herself to let go, to withdraw, and ultimately to turn to a new sensation.

Withdrawal. The final stage, marking the end of the cycle before a new one begins, is withdrawal. It is a period during which one’s boundaries are drawn closer and emotional energy used in contacting the environment is minimal. Many in our action-oriented society might perceive this phase as boring and thus miss the significance of this integrating stage. Both resolution/closure and withdrawal are primarily internal in nature and not easily observed by others.

The experience cycle is more than an abstract theoretical framework—it has practical utility. It is able to describe behavioral phenomena discussed by other theories in a way that not only makes sense but also leads to effective intervention. In the following four subsections we hope to demonstrate this. First, four popular diagnostic categories from DSM-IV (American Psychiatric Association, 1994) will be outlined. After each description, they will be discussed using the framework of the experience cycle. Last, interventions that arise naturally from the theoretical description will be articulated.

The Sensation/Awareness Stage: Borderline Personality Disorder

Borderline personality disorder, as described in DSM-IV, is an example of blockage at the sensation/awareness level. Diagnostic criteria are outlined in Table 19.1.

TABLE 19.1. DSM-IV Diagnostic Criteria for Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning in early childhood and present in a variety of contexts, as indicated by five (or more) of the following:

- (1) Frantic efforts to avoid real or imagined abandonment. **Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5).
- (2) A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
- (3) Identity disturbance: markedly and persistently unstable self-image or sense of self.
- (4) Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). **Note:** Do not include suicidal or self-mutilating behavior covered in Criterion 5).
- (5) Recurrent suicidal behavior, gestures, threats, or self-mutilating behavior.
- (6) Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).
- (7) Chronic feelings of emptiness.
- (8) Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
- (9) Transient, stress-related paranoid ideation or severe dissociative symptoms.

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As one can surmise from these diagnostic criteria, the borderline patient cannot maintain a stable emotional response to input, whether internal or external. Whether this is caused by the distorted intake of sensations, the inability of an individual to code sensory stimuli into a manageable form, or the overloading of stimuli that interferes with figure formation is of much theoretical debate. What is certain is that some individuals cannot easily tolerate, manage, or translate these sensory stimuli into acceptable and manageable forms and figures.

One result is high emotional lability and acontextual responses to stimulation. To use Gestalt terminology, the ground available to the borderline patient is nonsupportive, resulting in an inability to tolerate more than minimal stimulation.

It should be pointed out that sensations are difficult for all of us. Most of our sensory appetites are too large for what is organismically acceptable, and thus we have to learn management techniques. However, most people do not have to deal with the variability, range, and enormous distortion of sensation with which people who are characteristically bound in this phase must contend.

The therapeutic work with a borderline patient is to help with the management of sensations by lowering and limiting them at both an internal and

external level. Once sensation is manageable, awareness can emerge and movement through the cycle can continue.

In psychotherapy, the task is to teach these patients to manage sensations by lowering input—or, when this is impossible and stimulus overload occurs, by draining the mobilized energy through supportive and nondestructive forms of expression. The first task involves learning to slow down the input in order for the individual to run less of a risk of being flooded. Sensations need to be made smaller in order to form a figure that can be satisfactorily completed. This is accomplished by helping patients focus on their experience and label it accurately.

Techniques that increase sensations, such as the use of the empty chair, are potentially dangerous (From, 1984), as are confrontational, behavioral, and paradoxical interventions that tend to produce added or ambiguous sensory input. Another major therapeutic mistake would be to teach borderline patients management or repertoire expansion techniques that assume that their sensory mechanisms are working properly. The basic problem is not one of inadequate behavioral repertoires.

When flooding occurs, the therapeutic work involves teaching the patient to drain energy in a nondestructive way. Stimulus overload can be minimized in this instance by a therapeutic stance of “soft, clean contact.” It is here that the concept of soothing is important. If the therapist becomes upset—for example, becomes mobilized or increases his/her sensations—it will add to the patient’s already excessive stimulation. The therapist must learn to keep internal stimulation low by self-soothing and ultimately by teaching the patient soothing techniques. (It is interesting that this approach to the treatment of borderline patients is consistent with that articulated by the self-theorists and outlined by Tobin, 1982, and Yontef, 1983.) However, unlike self-theorists, and as stated earlier, Gestalt theorists do not believe it is necessary to hypothesize a specific cause, for example, a form of inadequate mothering, in order to prescribe an intervention.)

Mobilization-Specific Phobia

The second phase of the experience cycle occurs with the generation of emotional energy around sensation. If the energy gets trapped in the body and there is no muscle release, anxiety occurs. The way that the individual deals with this trapped emotional energy has historically been labeled psychoneurosis and, more recently, anxiety disorder. DSM-IV lists within this category such disorders as obsessive-compulsive disorder, panic disorder, and various phobias such as agoraphobia and specific phobia. One can also add to these a vast array of psychosomatic problems that result from this chronic blocking of emotional energy.

To illustrate mobilization dysfunction, specific phobia has been chosen. The characteristics are outlined in Table 19.2.

TABLE 19.2. DSM-IV Diagnostic Criteria for Specific Phobia

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- A. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).
 - B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack. **Note:** In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.
 - C. The person recognizes that the fear is excessive or unreasonable. **Note:** In children, this feature may be absent.
 - D. The phobic situation(s) is avoided or else is endured with intense anxiety or distress.
 - E. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
 - F. In individuals under age 18 years, the duration is at least 6 months.
 - G. The anxiety, Panic Attacks, or phobic avoidance associated with the specific object or situation is not better accounted for by another mental disorder, such as Obsessive-Compulsive Disorder (e.g., fear of dirt in someone with an obsession about contamination), Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor), Separation Anxiety Disorder (e.g., avoidance of school), Social Phobia (e.g., avoidance of social situations because of fear of embarrassment), Panic Disorder with Agoraphobia, or Agoraphobia without History of Panic Disorder.
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Phobias involve either the investment of too much emotion around an apparently appropriate figure (a person will not visit the South because of a fear of poisonous snakes) or the mobilization of emotion around an apparently inappropriate object (a person avoids all heights but has no experience with trauma connected with them). In the second case, the sensation is given the incorrect meaning because the individual cannot tolerate the correct labeling of earlier sensations. (For example, sensation and affect generated by heights might be similar to those the individual first experienced as a young child when her/his parents would fight.) The labeling of a sensation is one way in which meaning is given to experience. Phobia involves the avoidance of the accurate meaning that could lead to a completion of the cycle that is appropriate to the sensation. Instead, a distorted (symbolic) or incorrect meaning is given to the sensation.

Phobias are maladaptive because they do not lead to satisfactory completion. They do, however, often serve to discharge or deflect emotion, thus temporarily controlling it so that the individual can tolerate it. For example, as stated above, one may label certain sensations associated with intimacy

(increased heartbeat, tightness in the chest, sweaty palms, etc.) as “fear of heights.” This incorrect attribution of meaning allows the individual to function in a relatively anxiety-free manner as long as heights are avoided. However, if therapy produces the understanding that these sensations are attached to an avoidance of intimacy, then the patient is faced with a conflicting duality. Now it is possible to move toward emotional closeness with another, but only with an awareness of the heightened tension that such intimacy may create.

The two major manifestations of phobias are a distorted or exaggerated response to an appropriate object to be feared (e.g., a poisonous snake) that is generalized well beyond the object and a distorted or exaggerated response to a metaphorical, symbolic, or psychologically linked object that has little or no correlation with the appropriate sensation. Treatment involves the symbolic or in vivo matching of the correct events or patterns with the stimulus so that completion can occur. Since much of what we call psychotherapy deals with the above, it might be best to categorize the approaches briefly.

Certain techniques lead to diminution of anxiety so that the person can reexperience the situation and attach the correct meaning to the sensation. These include many desensitization and cognitive approaches. Others, such as meditative and breathing techniques, help the individual to tolerate the sensations so that a less distorted meaning can emerge. Still other approaches provide support so that people do not have to bear their pain and anxiety alone, thus helping them complete the cycle. In the United States, the financial, psychological, and ideological support that our society is beginning to provide for Vietnam veterans and victims of sexual and psychological abuse are examples of this support. It should be noted that if a specific meaning emerges but the behavior does not change and the anxiety does not diminish, then the patient may be diagnosed as suffering from posttraumatic stress disorder, which is described in a later subsection.

In summary, to move through the mobilization stage of the cycle means to express the blocked emotional energy so that a contactful figure that may lead to completion can be created. As with other stages, the work must be done over and over again in order for the emotional energy to be available for the generation of appropriate and adequate contact. The Gestalt approach allows the therapist to draw from a wide range of techniques to craft a procedure that fits both the patient and the symptomatology (Melnick, 1980).

Contact Phase: Histrionic Personality Disorder

The fourth stage of the experience cycle occurs when awareness, supported by appropriate emotional energy, results in a flexible and meaningful meeting of the self and the environment, usually in the form of an other. To meet phenomenologically implies that not only do I see but also I am seen; that not only do I speak in order to reach you but also I am heard. In the mo-

ment, each notices that the two individuals together are qualitatively different, a “we” that is different from either alone.

Disturbance of contact results in experiences that do not fit within the range of “good enough,” but rather are too little or too much for a specific environmental context. An example is a hug that either has too little energy or is not warm enough or is inappropriately passionate given the environmental situation. Either extreme is jarring and incompatible and does not result in a joining experience. Both extremes are contextual disturbances in that the evaluation of too little or too much is made in relation to the other, to the self, to the situation, to the total phenomenological field. The expression “too little energy,” which typically involves the pulling back from another, has been historically labeled as retroflection, whereas “too much energy” has been traditionally called hysterical or histrionic.

It should be noted that disturbances of contact, rather than reflecting characterological issues, might instead be a function of inadequate behavioral repertoires. (Repertoire evaluation can also occur at the third phase, movement or action, which was discussed earlier.) Traditionally, inadequate repertoires have been analyzed and increased by education, including behavior modification. Furthermore, the increasing and refinement of repertoires had, until recently, generally not been considered as falling within the domain of psychotherapy. However, if the therapeutic dilemma is not one of inadequate repertoires but, instead, one of fixed repertoires that limit and narrow a person’s ability to make contact with the environment, then the behaviors do fall within the diagnostic guidelines of disorders.

Histrionic personality disorder is an example of disturbance of the contact boundary, as described by DSM-IV. Diagnostic criteria are outlined in Table 19.3.

TABLE 19.3. DSM-IV Diagnostic Criteria for Histrionic Personality Disorder

A pervasive pattern of excessive emotionality and attention seeking, beginning in early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

- (1) Is uncomfortable in situations in which he or she is not the center of attention
- (2) Interaction with others is often characterized by inappropriate sexually seductive or provocative behavior
- (3) Displays rapidly shifting and shallow expression of emotions
- (4) Consistently uses physical appearance to draw attention to self
- (5) Has a style of speech that is excessively impressionistic and lacking in detail
- (6) Shows self-dramatization, theatricality, and exaggerated expression of emotion
- (7) Is suggestible, i.e., easily influenced by others or circumstances
- (8) Considers relationships to be more intimate than they actually are

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The stereotypical model of histrionic functioning is that of the flamboyant actor. This stereotype is often true for the histrionic character, wishes to be seen, heard, appreciated, and applauded but is not very interested in others in more deep, complex ways. Thus, if a therapist attempts to prematurely create for the patient a more contactful experience, the therapist may encounter indifference at best and difficulty at worst.

The emotional energy in histrionic patients is inner determined, undisciplined, and exaggerated, and does not keep in tune with the environmental field. They are perpetually in action without benefit of an accurate awareness. Thus, the existential work with histrionic people is to help them bear the truth of their overly large existence. They are fated to take up a lot of room, to say a lot, and to do a lot. Even though they may suffer from an energy disturbance, it would be a mistake to attempt directly to teach them to be aware of or change their energy. Histrionic people are only minimally interested in awareness, for it complicates life and makes it less exciting.

Thus the dilemma for the therapist is how to help these patients slow down as well as become interested in the environmental field. Experiments that deal directly with slowing down the action, such as reading a menu completely before ordering food or counting to 10 before acting, may be utilized. Further, having the patient learn to go inward before acting heightens the probability that the forthcoming action may be truly contactful. Thus, directing the patient to notice tension, breathing, and so on might ultimately lead to a slowing down of movement.

To help these patients trade in their wish for simplicity for a more complex orientation to the world is difficult at best. However, experiments that teach them to notice environmental contexts, including other people, are beneficial. Examples include having the patient ask the therapist questions as well as notice and articulate physical and psychological boundaries.

Demobilization Phase: Posttraumatic Stress Disorder

The last stage will be labeled demobilization, as it incorporates both the resolution/closure and withdrawal stages of the experience cycle previously discussed. The purpose of demobilization is to allow for the absorption of an experience into the ground of the individual, principally by making meaning of it, so that it will not be elicited inappropriately.

As with other stages of the cycle, when there is a synergy between the experience of the individual and the individual's capacity to deal with it, demobilization proceeds in a smooth and graceful manner. The person is able to disengage from the experience, to chew it over, and absorb and digest it. Ultimately, the individual becomes somehow different and wiser in a subtle way. If the experience is too charged to be easily absorbed into the ground, then a form for expelling or using up the excess emotional energy must be initiated. If this is not done, then the old figure will not be properly inte-

grated and will have a perpetually distorting and disproportionate effect on the current and future experience of the individual.

This need to demobilize is a complex process that has been largely ignored by Western society as well as by Gestalt therapists. Society supports a cultural bias against demobilization by underestimating the amount of time needed to understand and integrate experiences. Among Gestalt therapists there is often a bias against “talking about” experiences. Furthermore, as a culture we do not value aloneness and movement inward. When one mobilizes, it is movement outside the skin toward contact. However, demobilization involves a movement inward to a nonpublic place where one may be alone.

Gestalt therapists, too, have ignored and had difficulty in articulating the demobilization process. In the past, it has been taught as a less significant part of the experience cycle than in fact it is. The difficulty in understanding this process is connected with its largely intrapsychic nature. As indicated previously, it is harder for others to see. Thus, like the sensation stage of the experience cycle, the process of the individual must often be inferred rather than actually observed.

Furthermore, demobilization is often unpleasant. When the event is large and negative, the experience is a grief reaction. Thus, demobilization is associated with death, illness, divorce, and defeat. However, demobilization is also a positive process, such as falling off to sleep, dreaming, fantasizing, and celebrating.

Hypothetically, demobilization can be broken down into four substages: *turning away*, *assimilation*, *encountering the void*, and *acknowledgment*. By describing the experience cycle as reflecting larger experiences in the life of the individual, one expands beyond the original definition of the cycle as a description of present experiences. Describing demobilization in terms of substages should, we hope, be useful despite the distorting and stretching of the cycle experience.

The first substage involves either a turning away or a being turned away from a figure in which energy is still invested (e.g., respectively, stopping drinking; death of a spouse). The need of parents in our society to diminish their interest in their children as the children grow older is a common experience of turning away. The relationship begins in confluence and progresses into the stage where the child introjects the parents' ideas and values. In some cultures, children may continue to introject for much of their lives, but in Western society, which values autonomy and independence, an increasing psychological separation between parent and child is preferred. For children to develop integrity—that is, to experience boundaries cleanly and clearly—they must detach from parents and create other interests. As a child leaves, so must the parents distance themselves, or they will be faced with one of two equally sad alternatives: either a hard rupturing of the child–adult boundary resulting in mutual trauma, or a type of deadly confluence

that restricts developmental maturation. One aspect of maturity is the capacity to move away from a boundary gently.

To turn away when one still has energy invested requires much support. It can come in many ways, in the form of either self-generated or external support. To be self-supportive, to rely only on one's own resources, is difficult and runs contrary to the natural inclination to move toward energized objects in the environment. Not only does self-support incorporate an intellectual and emotional introjection of values, it also includes an invoking of an internalized rhythm sadly absent for many in our society. For to have faith, to hold one's hand, to gently rock and talk softly to oneself, to soothe oneself—this ultimately involves the introjection of good nourishing parenting.

The generation of external support often involves placing oneself within a structure that provides highly detailed procedures for leading one's life while in the process of turning away. Therefore choice, as well as temptation, is minimized. Examples of this type of structure are Alcoholics Anonymous and similar organizations that deal with addictive behaviors. These organizations articulate both the techniques for and the potential pitfalls in the turning-away process.

Another external option utilized in turning away involves the creation of a large and compelling figure to which to transfer unspent emotional energy. Love on the rebound and some born-again religious conversions are examples of this type of figure substitution. The problem with moving quickly toward something large and captivating is that it does not allow for the next substage of the demobilization process, assimilation, to occur. Consequently, little is ultimately learned, and the person may be doomed to skip from one love or religious experience to another.

Assimilation involves a chewing over of the experience in order to drain emotional energy. The process is difficult for many therapists in that the work may appear redundant and boring. Furthermore, because our society underestimates the amount of time necessary to chew over experience, patients may be faced not only with doing the hard work but also with having to deal with the embarrassment engendered by the intensity of feelings and the surprisingly long time that their interest remains. It is the therapist's task to normalize the experience and support the process. However, if a patient's restlessness with the duration and intensity of feelings is joined by the therapist's boredom, blockage may ensue.

The third substage, encountering the void, can be terrifying. Our society does not value or provide much training for the experience of feeling emptied of interest, of caring, of figures. The void consists of a segment in time when nothing matters. Often we avoid it by creating artificial engagements such as self-talk and noncontactful activities. Ultimately, it is the fear of the unknown that keeps many locked into either painful or nonnourishing figures. And it is this inability to turn from the old, the painful, and the nonnourishing to the unknown that is a precondition for many of the "ad-

dictions" so prevalent in our society today such as workaholism, love addiction, and codependency.

The fourth substage, acknowledgment, involves a soft, low emotional energy and an owning of how the experience has changed the individual. It is during this time that individuals are able to articulate the learnings, both good and bad, from the experience as well as to express and live out the changes in their lives. Thus the patients have gained a piece of wisdom and are able to interact with the environment in a fresh and more profound manner.

An example of an instability to demobilize can be found in posttraumatic stress disorder (PTSD). Criteria are outlined in Table 19.4. The first therapeutic task in the demobilization of PTSD involves helping patients accept that a turning away must occur. Once this acknowledgment takes place, then the work of draining the interest can begin. However, since trauma can be mesmerizing, we must help patients acknowledge both sides: that they both wish to lose interest and wish to stay interested in the traumatic event.

A second therapeutic task involves helping patients find forms through which they can express their feelings in a small way. These forms usually involve repetitive actions that cause no harm. Talking is the primary method utilized as a form of "doing" without a large mobilization. The patient must feel supported in the expression of a feeling without an external outcome or without an aim to change anything.

When demobilization from powerful events associated with PTSD is dealt with, sadness is often elicited naturally as the seasons of the year and anniversaries trigger affect-laden memories and sensations. When the sadness is evoked, the task is then to softly talk through the events. However, the therapist may get stuck and experience difficulty in helping patients move beyond the traumatizing event. There are several possible reasons for this. The first is pacing. Demobilization is a slow process that must be supported. The therapist must struggle to not become impatient or judgmental regarding the redundancy and amount of time involved. Second, patients will sometimes become frightened by emotions that are engendered. It is the therapist's job to provide adequate support for the patient to tolerate the emotional arousal as well as to help keep the emotions at a level that can be absorbed into the individual's ground. Third, patients may have an inadequate repertoire with which to drain the energy. To "sing the blues," protest, light a candle, or plant a flower are rituals that are socially sanctioned for dealing with trauma and can be used to expand patients' repertoire.

Lastly, the therapist must carefully monitor his/her own interest. One must learn to be interested just enough. Too little interest will not provide enough support, and too much interest on the part of the therapist will generate energy that fuels the patient's attachment and prevents demobilization. When demobilization is being worked on, a real danger is created if the therapist is more interested than the patient.

TABLE 19.4. DSM-IV Diagnostic Criteria for Posttraumatic Stress Disorder

- A. The person has been exposed to a traumatic event in which both of the following were present:
- (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
 - (2) The person's response involved intense fear, helplessness, or horror. **Note:** In children, this may be expressed instead by disorganized or agitated behavior.
- B. The traumatic event is persistently reexperienced in one (or more) of the following ways:
- (1) Recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
 - (2) Recurrent distressing dreams of the event, including images, thoughts, or perceptions. **Note:** In children, there may be frightening dreams without recognizable content.
 - (3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). **Note:** In young children, trauma-specific reenactment may occur.
 - (4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
 - (5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
- (1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma.
 - (2) Efforts to avoid activities, places, or people that arouse recollection of the trauma.
 - (3) Inability to recall an important aspect of the trauma.
 - (4) Markedly diminished interest or participation in significant activities.
 - (5) Feeling of detachment or estrangement from others.
 - (6) Restricted range of affect (e.g., unable to have loving feelings).
 - (7) Sense of a foreshortened future (e.g., does not expect to have career, marriage, children, or a normal life span).
- D. Persistent symptoms of increased arousal (not present before a trauma), as indicated by two (or more) of the following:
- (1) Difficulty falling or staying asleep.
 - (2) Irritability or outbursts of anger.
 - (3) Difficulty concentrating.
 - (4) Hypervigilance.
 - (5) Exaggerated startle response.
- E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than one month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
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It should be pointed out that we are describing an ideal, for one can never demobilize fully. If one is lucky, most figures will naturally be assimilated into background and the remaining energy will be used in a productive way.

The last substage of demobilization is an acknowledgment of the process. If patients have learned well, they will know something that they never knew before. If demobilization has proceeded correctly, patients will be able to answer the question: "How am I different?"

In sum, the work in dealing with problems in demobilization is to help the individual create small experiences to reduce the level of emotional arousal. The danger is in creating a remobilization experience. It should be pointed out that, as with other stages of the cycle of experience, an inability to demobilize might be a function of the person's inability to experience or integrate sensations, to mobilize, or to make contact. If this is the case, then the work must include dealing with these other aspects of the cycle.

SUMMARY

In this chapter a basic human dilemma is posed: How is one to know and describe another? To answer that query, the issues faced by Gestalt therapists in attempting to meaningfully diagnose and assess patients and the Gestalt experience cycle and its utilization for describing character have been discussed. Finally, an effort has been made to fit a few common DSM-IV diagnoses into the paradigm of the experience cycle as well as to prescribe appropriate methods of intervention.

Diagnosis is an art as well as a science, for its purpose, after all, is to provide a useful model of experience. As Gleick (1987) so aptly writes:

The choice is always the same. You can make your model more complex and more faithful to reality, or you can make it simpler and easier to handle. Only the most naive scientist believes that the perfect model is the one that perfectly represents reality. Such a model would have the same drawbacks as a map as large and detailed as the city it represents, a map depicting every park, every street, every building, every tree, every pot-hole, every inhabitant, and every map. Were such a map possible, its specificity would defeat its purpose: to generalize and abstract. Mapmakers highlight such features as their clients choose. Whatever their purpose, maps and models must simplify as much as they mimic the world. (p. 279)

In retrospect, this attempt at mapmaking is but a rough beginning filled with contradictions and exceptions. But this is how it should be, for Gestalt therapy is phenomenologically based theory grounded in the celebration of the uniqueness of the individual.

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NOTE

1. Historically, Gestalt therapy held an implicit assumption that increasing awareness and changing behavior in the present would lead to permanent change. How this was to be accomplished has remained somewhat vague. This belief has been challenged by a number of contemporary Gestalt therapists (e.g., see Melnick, 1997; Wheeler, 1991).

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