

A Gentler Gestalt Therapy: On Reducing Stimulation In Adult Survivors of Abuse

Andy Lapidés

Abstract:

Adult survivors of abuse require a slower progression in treatment. Profoundly abused patients suffering from pre-oedipal conditions may become overstimulated using gestalt methods. This paper will focus on reducing stimulation in the patient using methods borrowed from modern psychoanalysis, which was developed by Hyman Spotnitz. The author argues for a combined approach that emphasizes support rather than frustration in the development of the treatment process.

Key Words: adult survivors of abuse, gestalt therapy, modern psychoanalysis, stimulation reduction

This paper integrates concepts from Hyman Spotnitz' (1967) "modern psychoanalysis," with gestalt therapy in working with adult survivors of abuse. Spotnitz is arguably one of the first "relational" psychoanalysts, a newer psychoanalytic movement now widely popular. Despite its drive theory foundation, Spotnitz' modern analytic methods have much to offer gestalt therapy in working with profoundly abused patients, particularly in studying the resistance. Whether we call the unknown "out of awareness" or "the unconscious" we are dealing with a part of the patient in their environmental field. The reduction of stimulation practiced in Spotnitzian theory may benefit the sensitive work done with this population.

My focus in this paper is not to debate theoretical ideologies or concepts, but to present what works for me subjectively with clients who were profoundly abused as children. I've had the fortunate experience of studying both theories (gestalt therapy and modern psychoanalysis) and believe the synthesis of both theories has helped my work deepen. Throughout, this paper I am weaving together what has made sense for me and not what is purely gestalt or modern psychoanalytic. It may seem like mixing "psychodynamic oranges with phenomenological apples (Bloom, personal communication, November 2010)"

but this integration has become my own style and what brings me closer to my truth. Erving Polster (1956) states:

'A person must find a theory which is sympathetic to his best talents, whether they be interpretive, poetic, directive or such. If he doesn't do so, he will be inept, or more likely, phony. Each style has its advantages and disadvantages, and one must learn what particular problems are the consequences of his own style' (Pursglove, 1971, p.14).

These "consequences" I believe require a certain flexibility in letting go of the theory and just being present with the patient. I think when we try to fit a person into a theory, their humanness is taken away (and the contact is disrupted). Adult survivors of abuse are highly sensitive to methods used in the work and require a transparency where authenticity is primary.

The impact of sexual, verbal, and emotional abuse on children can have long-lasting impact. Survivors of abuse can suffer from narcissistic injuries that have a crippling effect throughout adulthood. This abuse can reverberate for many generations in the form of complex trauma. This can result in a life time of re-abusing of the self repeatedly in the form of substance abuse, overeating, and other self-punishment.

"Pre-oedipal" or "pre-verbal" patients are those that communicate through emotional induction and/or projective identification rather than through words (Spotnitz, 1976). Profoundly abused patients may not have the words to express or avoid expressing their experiences but they unconsciously induce the therapist in the transference. Due to the severity of some abuse, in my experience, the techniques used in gestalt therapy (enactment, chair work, experiments, etc.) may be ego-dystonic and potentially flooding for certain patients. Yontef explains that traditional gestalt therapy techniques may have "negative and minimal effect with patients with serious character disorders, especially the narcissistic personality disorders and the borderline patients" (Yontef, 1993, p.256). Greenberg (1992) states, "The clients who seemed to me to do most poorly with traditional Gestalt therapy seemed to be similar to the ones who did poorly in analysis; i.e. those who were described as having personality or character disorders" (pp. 4). Similarly, traditional Freudian psychoanalysis may also be limited in its effectiveness and impact on the adult survivor of abuse due to the lack of active involvement of the analyst.

Early, childhood relationships, primarily with an individual's caretakers/parents, shape need gratification throughout life. In other words, our desires and urges can't be separated from the environment from which they arise. It is the systemic interaction between a person and their relational world that influences how they meet their needs. On an unaware level, people recreate the relational dynamic shaped in their formative years and continue to replicate it. In gestalt therapy we call this a "fixed gestalt" and in psychoanalysis we call this the "repetition compulsion." Whatever you call it, this phenomenon can lead to frustrations and suffering in the survivor's adult life. The focus of relational work is on the relationship itself as the curative factor, rather than creating insight

through interpretation. The means of growth is fostered by what Winnocot (1965) called the “holding environment.” The holding environment is a healing relationship where re-parenting takes place.

I argue for a more supportive, narrative, and less ego-oriented approach to working with survivors of abuse. A person’s “story” is often the means for which we can understand their subjective experience of the world. Environmental needs are met through contact and language development. Intellectualization, a seemingly bad word in gestalt therapy, is often a necessary defense that needs to be encouraged rather than discouraged as “going up into your head.” Patients with traumatic life histories need to use intellectualization because it was adaptive and what helped them survive the pain. The aim of gestalt therapy is to have the client take responsibility for their own lives and make changes slowly through awareness, risk, and choice. In the adult survivor of abuse this can not always be done without a firm grounding in support while simultaneously reducing stimulation in the patient.

Gestalt therapy was created and developed as a response to psychoanalysis. It was F.S. “Fritz” Perls, a psychoanalyst, analyzed by Wilhelm Reich, who developed the theory along with Paul Goodman, a writer, philosopher, and anarchist. Perls found psychoanalytic technique needed to be revised through methods that address the dependency of the analysand on the analyst. He was opposed to enabling the patient to be overly infantile where the patient can not stand on their own two feet. He used the metaphor of dental aggression in his book, *Ego, Hunger, and Aggression* (1942), where infants develop teeth to chew and bite. The natural need for food arises and we eat, savor the flavor, and digest. Often the savoring experience is rushed and we swallow things too quickly and don’t process or eliminate this food. We get stuck. This stuckness becomes rigidified and fragments/distorts our sense of self and our perception of the world around us. This blocks us from being adults and taking responsibility. Perls emphasized frustrating rather than supporting the client and avoiding re-parenting because it is a manipulation in the moment (Perls, 1965).

Aggression is particularly important in regulating the adult survivor in treatment. Survivors of abuse had to find creative ways to discharge their aggressive feelings toward their caretakers. The concept of “creative adjustment” refers to the adaptation that occurs in the human in interaction with his/her field. According to Perls, Hefferline, and Goodman (1951) in their seminal book, *Gestalt therapy (hereon referred to as PHG)*:

‘The process of creative adjustment to new material and circumstances always involves a phase of aggression and destruction, for it is by approaching, laying hold of, and altering old structures that the unlike is made like. When a new configuration comes into being, both the old achieved habit of the contacting organism and the previous state of what is approached are destroyed in the interests of the new contact. Such destruction of the status quo may arouse fear, interruption and anxiety,

the greater proportion as one is neurotically inflexible;' (Perls, Hefferline & Goodman, 1951, p. 279).

Developmentally, the infant is discouraged when biting during breast feeding, despite the child's need for sustenance. Perls (1965) saw this as a metaphor for psychological life in that the "inhibition of the biologically appropriate destructive action of the teeth." Is this aggression in-born? Does it become more rigid with harsh parenting? Perls warned that this aggression runs the danger of "later manifest(ing) in harmful ways such as killing, cruelty, warring or self torture and suicide" (Perls, 1965).

Just as the child in the womb is connected to the mother, we strive for this completeness throughout our life. As a natural process, people are driven to complete, process, and integrate experiences. When this processing is repeatedly disrupted it leaves "unfinished business" that blocks/stunts growth. Gestalt therapists believe that the processing and "chewing on" our experiences helps us to find real meaning in the world and live more complete lives. By slowing down process and establishing good contact, we allow the natural development of healthy functioning to emerge. By not rushing the patient's experience and appreciating his/her uniqueness, we can become more fully integrated.

The "dialogic" relationship in gestalt therapy is a unique dynamic where two people, client and therapist, meet as equals. One is no more knowledgeable than the other. The therapist is not an expert on the client, but the client is an expert on himself. The therapist puts aside all judgment and is real with that person, often called "bracketing" in phenomenology. The therapist is simply present and open to what might occur in each moment. The therapist works with the unknown, including changes in language, affect, posture, breathing, and movement (that may or may not be in awareness).

The "self" is seen in gestalt therapy as constantly evolving and being influenced by the environment, other relationships, and time. In gestalt therapy, defenses are respected. We all have ways we protect ourselves from feeling an emotion, thinking a thought, or facing something painful. Often people stop themselves from trying new things for fear of what they might find or feel in the process.

Laura Perls, an important figure in the development of gestalt therapy, felt support was crucial in establishing the therapeutic relationship. She states, "the strengthening and expansion of the support functions mobilizes the alienated emotions and potentialities for contact, and makes formerly repressed depth material easily accessible" (Pursglove, 1968, pp. 45). In the case of an adult survivor of abuse, this reparenting is crucial. The building of trust and safety is initially the supportive feature that gives the person grounding to face the unknown (Yontef, 1993). With clients who have been abused this supportive process needs to be extended considerably. The client is encouraged to embrace the part of the self that has been pushed away as to not overwhelm the ego. If the client resists, the more he/she doesn't "try" to change, the more the

arising ideas, feelings, experiences will naturally produce change over time (Beisser, 1970). This requires patience and willingness to “stay with what is happening” in the moment of connection.

The adult survivor of abuse requires a slower progression in treatment, emphasizing more time building supports (both self-supports and external social support). By attending to the quality of the relationship and this process itself, gestalt therapy facilitates re-parenting. The traditional present-focus of gestalt therapy is flooding for patients who are suffering from pre-oedipal conditions. They creatively adapted to their environment by resurrecting blockages to protect from feelings of danger and death. The task is to ground the client in a feeling of safety and trust through consistency, empathy, acceptance, suspending judgment, joining, and mirroring.

Spotnitz’ “modern psychoanalysis” is a theory that rests on the idea that during the pre-oedipal stage of development, self-hate is resurrected in response to unattuned parents not tending to the child’s needs. Naturally, the child introjects the abuse and continues self-attacking behavior continually due to the narcissistic injury. Children are naturally narcissistically-focused on themselves and there is no differentiation between self (infant) and object (mother). The abused child resurrects defenses to protect against the object represented internally. During this time period, infants are unable to have their needs met without dependency on the mother (object). She has the difficult task of attending to the child’s needs before the child has words or ways to communicate. An attunement between mother and child is dramatically affected by abuse and neglect. The mother’s own childhood is unconsciously communicated through her actions. The resistances of such patients manifest as a way to combat underlying psychotic, homicidal and suicidal rage (Spotnitz, 1967).

In modern psychoanalysis, the therapist first tries to achieve a “narcissistic transference,” where the therapist is considered part of the patient’s mind and feels merged. The therapist strives for narcissistic transference so the patient can go back and repair this early emotional trauma. By listening to the patient, accepting his/her perceptions without contradiction or explaining another viewpoint, this bond is created and the therapist can feel the patient’s pain as closely as possible. This “induced feeling” can be studied through supervision. The therapist becomes an object for the patient because they are available and present. The patient transfers feelings he/she had about their parents in a process called “object transference” in modern analysis (Spotnitz, 1967).

The patient’s ego, like that of an infant, is merged with the therapist, an object, by “following the contact functioning.” This means that the therapist does not speak until the patient speaks. The therapist gives the patient the lead role and waits till they are ready to say whatever is on their mind. The purpose of following the contact function is to respect the patient’s need to be isolated until he/she feels it is not dangerous to begin a relationship. The patient can easily feel overwhelmed by questions from the therapist that he/she may experience as intrusive. This sense of perceived control allows the patient to slowly connect with the therapist on their own terms (Margolis, 1983).

“Object-oriented questions” are used to decrease stimulation in the patient by moving them away from the ego and self-attacking. An object-oriented question avoids the word “you” and directs attention outside the person. This is used to reduce stimulation and mirror the patient in the moment. “The object-oriented question is usually one of an impersonal nature which addresses events, people, thoughts and feelings outside of the patient’s ego (Cela, 2004, p. 208).” By moving the patient away from a self, “it regulates stimulation and insulates the patient’s fragile ego from exposure to more tension than it can tolerate” and helps to “facilitate the therapeutic verbal discharge of aggression (p.208).”

Reducing stimulation in patients helps to prevent leaving treatment prematurely or creating overwhelming experiences in the patient. According to Cela (2004), “preoedipal patients are terrified of their capacity for destructive impulsivity (p. 209)”. This can be seen in patients that “act out” rather than utilize the process to explore their experiences. “The object-oriented question helps to regulate and reduce the amount of stimulation which reduces the chances of impulsive discharge (p. 209).” Early in treatment, the patient may “attack his/her own ego or may end the treatment” because the negative feelings can be intolerable (p. 209). This is known as the “narcissistic defense.” The therapist asks a question to mirror the feeling state, agrees with the client, and never changes the subject. “The object-oriented question is used to regulate, intensify or diminish frustration and negative stimulation, as needed. It acts as a feeding, preventing too much hunger or satiety. The analyst strives to achieve the optimal balance between frustration and gratification (p. 209). If the patient expresses an opinion, the therapist also has the same feeling. This is known as “mirroring,” in modern analysis. The patient feels the analyst is part of him/herself and is in the presence of a twin (Cela, 2004).

When the patient is withdrawn for a long time, the therapist may feel ignored, annoyed, or rejected. Whatever the therapist feels in the room in response to the patient is a rich source of information about them. This is called “the induced feeling.” If the therapist has a need of their own, this can interfere with the therapeutic process. The need must be contained or it contaminates the work.

In modern psychoanalysis, narcissism is seen as self-hatred and not self-love. Severe physical or psychological symptoms may erupt in the therapist if he/she can not verbalize the feelings aroused by the patient. This is why supervision is so crucial to the treatment of patients, particularly those narcissistically injured repeatedly. The healing power of hate is often avoided and misunderstood. In modern psychoanalysis the patient is encouraged to express everything especially hateful feelings toward the therapist (Spotnitz, 1967). When rage is turned against the self rather than against the object, modern psychoanalysis calls this “the narcissistic defense.” If the defense fails and breaks down, the rage can no longer be repressed and it erupts against others or acting out.

In attachment with the therapist, the process of internalization occurs. This is when an image of the object becomes part of the mental life of the patient. Identification with the internalized object produces an attachment bond that helps protect the patient from the impact of self-hatred. The patient returns to the therapist to re-fuel and connect with themselves usually going over the same experiences repeatedly. This eventually serves to help the patient feel more secure in their lives and live a more meaningful existence with others.

Early relationships with our parents or other caretakers, shapes much of what we experience in the world. Attaching to the parent for support, nourishment, positive feedback, and acceptance establishes future functioning. Being abused makes this more complicated and difficult because the child hears the message that he/she is essentially "bad."

Adult survivors of abuse are often left without the proper tools to live fully in the world. Feeling victimized, helpless, tormented, abandoned, powerless, empty, and alone are common complaints of such patients. The fragmentation and splitting-off of both "false" and "real" selves are a direct result of the psychosocial impact on adult survivors of abuse. Children do "the best they can" based on what was modeled by their caretakers, but as they become adults they are left short-changed. Anger, difficulty in relationships, and an internal continuation of the abuse is commonly seen in survivors of abuse (Farmer, 1989).

For diagnostic reasons, adult survivors of abuse have personality disorders or traits of these categorizations. Greenberg (1992) points out that a client with a personality disorder is "overly-dependent on others for support." Developmentally, they have "failed to separate and individuate from their parents" and "claim their true selves" (p. 2-15). As a result, these individuals re-create the original relationship failure and unmet needs continually in relationships with others. This repeated pattern causes a continual suffering of pain, which erects more and more defenses. As a result, they "tend to take much longer to form a therapeutic alliance and the alliances that they do form are often more fragile and subject to disruption" (p. 14).

The introjections of parental abuse continue in the form of self-hatred and self-punishment. In abused individuals, childhood deprivation and trauma influence maladaptive behaviors that become a fixed gestalt in adulthood. Despite having outgrown certain behaviors, the fear of survival and safety are attached to ritualistic avoidance of facing their pain. Defenses are erected to protect and block the person from feeling overwhelming anxiety. A "psychic numbing" occurs to shield the inner child from the harsh world. This child needs comfort, consistency, love, and additional safety to come out of hiding.

Our social connections and life experiences establish our values and belief systems. As we age, these values evolve to form a different gestalt. By having freedom to make choices, we take responsibility for the outcomes in our lives and can live more authentically human. The strength we require to make difficult choices is paramount to our growth. Managing overwhelming feelings that arise through courage and sensible risk-taking is the work of psychotherapy.

In gestalt we use anxiety as the energy-producing element to motivate the client and restore balance where it may never have been before.

Adult survivors grow by being re-parented in the therapeutic relationship. This can only occur within the context of the relationship over time. This time, taken to slowly rebuild the clients ego functions, helps restore dormant unmet needs. Adult survivors of abuse have a strong desire to understand what happened to them yet they are hesitant to talk about it in detail.

A process of creating a holding environment, object constancy and mastery, are crucial to building the foundation of trust. "As they work through the many stage-posts of their journey, the client gains emotional resources, security and freedom, and the counselor comes to be seen more and more as a 'real' person" (Clarkson, 2004, p. 19). By separating the therapist's perception, awareness, and interruptions to contact, the client is given more opportunity to experience their own. Transference and counter-transference are studied in the various aspects of the relationship between therapist and patient. This distortion in the relationship can be worked with in the evolving encounter between client and therapist.

By incorporating modern psychoanalytic concepts with gestalt therapy, understanding the relationship with an adult survivor of abuse becomes clearer. The unmet needs from the abusive parenting (in which these clients are often arrested) can complete the unfinished developmental gestalt. Eventually, a tear in the relationship occurs because the therapist is not perfect and can not fulfill all of the caretaking needs (Hycner & Jacobs , 1995). This negative transference is experienced as a failure and brings back the pain experienced during their relationship to the original object (mother). The therapist recognizes this disruption and attempts to rebuild the relationship. These negative breaks in the relationship are important in the repairing of trust and the development of self-soothing and calming in the client.

Triggering shame in the therapeutic relationship is of great concern due to the projection of parental authority figure onto the therapist. The therapist's attitudes, values, expressions, emotional sensitivity, and matching are all possible shame triggers in the work (Yontef, 1993). Patients can become reactive to the parental projection and it may bring about a harsh, abusive, or neglectful introjected parent who used shame to bring about compliance in the family of origin. This shame may cause an adult to develop self-attacking, rejecting, and self-sabotaging behaviors.

Gestalt therapy emphasizes being with that person in the moment here-and-now through encounter and contact. The simple presence of the therapist can have a lasting effect on the client. Just by being there, a client is forced to recognize that "I am" as opposed to being invisible. This validation of being seen and understood can cause a shift in the person's life by making subtle changes in perception. However, being seen and having eye contact can be overwhelming for certain patients and it may benefit the patient to close their eyes or have them lie on the couch. Although this is controversial in gestalt therapy, having a patient lie on the couch may produce a safer contact to emerge. In face-to-face contact

the affect of the patient may be overly stimulating for the therapist and patient. The therapist can shift their focus away and then back to the patient as to not overflow the patient with anxiety, however, this can be challenging and tiresome for the therapist.

At the heart of gestalt therapy is phenomenology, the attempt to understand the subjective experience as it is without preconceptions or notions about what is right or reality. It is about understanding a person holistically rather than fragmenting the personality. We encounter the person in the present moment and are really with them. A phenomenological therapist tries to remain present in the room while helping the client define and redefine his/her feelings, sensations, thoughts in the moment with awareness. I believe this can be done by studying the transference and counter-transference reactions. Patients who were abused need to tell their story and feel understood rather than overly exposed to the present moment, which early gestalt therapy espouses. After the person feels understood, the therapist helps to create meaning in the relationship itself. This validation of subjective experience allows a client to act on their personal belief system. Phenomenological efforts ask that the therapist put aside his/her belief systems and accept the person as they are despite differences and negative feelings brought up in the work. The therapist stays present and makes an effort to experience what the client may be experiencing without losing a sense of who they are in the moment. In gestalt therapy, this is referred to as "inclusion." The patient is considered an expert on themselves and they know what's best for themselves.

The existential philosopher, Martin Buber, contributed to gestalt therapy in the distinction between "I-thou" and "I-It" in relationships. The I-It relationship is the more everyday, superficial connections we have with people. The I-thou, on the other hand, is the genuine, present connection between two unique people having a mutual experience of depth and meaning. During these experiences, a togetherness and excitement is experienced where both parties are validated and feel more alive. By balancing these two aspects of relationship (I-It and I-thou) in one's life there is a "creative tension" which is the "hallmark of healthy living (Hycner & Jacobs, 1995)." By letting the relationship move naturally there is a making space for whatever emerges.

One can not ignore the impact on pure presence in the therapeutic relationship. Yontef (1992) uses the terms "transparency and humility" to describe the presence in relational gestalt therapy. In terms of connecting to the client, Yontef also describes the work of the therapist as "commitment to dialogue" and "The Between." (p.220) This "between" is what emerges in the moment between client and therapist in the dialogue. In this frame of reference, the therapist as well as client will grow from the experience. The paradoxical theory of change is used by not aiming to change the client but being available and supporting growth (Beisser, 1970). By embracing the polarity of change (not changing), a client will feel validated to eventually explore what is not known. The safety experienced helps them to experiment with who they think they really

are and not feel stuck in rigid roles or ways of thinking, feeling, and perceiving the world.

Our lives do not have one clear path but many which are defined by the person's experience in and of the world. This experience is what shapes our sense of self and meaning in the context of the environment. The therapeutic relationship is at the heart of this growth. Through consistency, joining, empathy, warmth, a supportive/caring stance, a re-parenting occurs in the relationship. Kepner (2003) argues:

'The development of support is in itself and essential healing process; and for survivors in particular, it is major therapeutic work. It builds the ground conditions on which everything else in human functioning must rest. It generates the internalization of a healthy and functional interpersonal field from which other self structures can grow and be tested. (p. 15)'

I believe the movement toward self-support in working with adult survivors is unusually slow and requires patience, normalizing, validating, and decreasing stimulation. Clients who have been abused may not respond to the ideal goal of awareness through contact because the feelings of danger, vulnerability, and mistrust may become figural. This requires a more relational stance where the therapist must use talk as a means of connection. I have found that when I truly "like" a part of the patient or find that likeable part of them it shows through in my affect and the client is supported. I also believe in using humor as a means of unbinding the self-attack. By encouraging their defenses, and joining with them, something unique occurs. The client is reborn.

For the purposes of understanding the application of modern analysis with relational gestalt therapy, I will use the example of a forty four year old female client named Lisa (disguised name for confidentiality purposes). Lisa came to me in 2007 due to "anxiety and depression" and "a lot of stuff I've never dealt with." When she called she explained that she could only afford a small fee and was continually rejected by therapists.

After meeting with Lisa, she described difficulty focusing, generally overwhelmed, unmotivated, and stuck in her life patterns. Medically she has a seizure disorder, asthma, macular degeneration and ADD. Her complicated medical history and being defined as the "sick child" in her family of origin was a source of great pain for her. She also explained that she has a history of suicide attempts, impulsive behavior, self-mutilation/cutting, addictions (reformed alcoholic and currently cigarette smoking), sexual abuse by a brother as a child, domestic violence by ex-husband, and unsuccessful psychotherapy in the past. She is the mother of a twelve year old daughter which is her "reason for living" and struggles as a single mother due to a private business that is "failing." She describes herself as "perfectionistic, shy, angry, the family loser" and is very critical of herself. She has difficulty sleeping, limited support system, and describes her family of origin as a "bad family." Additionally, she has not paid taxes in three years, hoards, moves her home often, and feels "people don't like

me.” Initially, Lisa’s affect was flat and eye contact was poor. She denied suicidal/homicidal ideation but described a history of it so I contracted for safety.

Lisa continually victimized herself and clearly introjected the role as the hated child, which she played-out in the world. She would show up each week and dissociated and become withdrawn in sessions. By asking questions, trying to understand her life, I came to sense her alienation from people and her aloneness. She described a disconnection from people she works with, has few friends, and is not speaking with her family.

As we worked together, my sense was that she had a strong need to just tell her story. Attempts to propose gestalt experiments resulted in flooding her and difficulty breathing/grounding. Due to her resistance, I decided to just let her talk and would check with what she became aware of as she spoke. My interruptions were experienced as intrusive and she would completely block me out as if I was not even in the room with her. I realized as time went on that she needed me to really hear her, understand, and empathize with her experiences.

In terms of understanding Lisa’s process, I found aspects of her “story” reflective of a borderline personality type. Although I dislike labeling (because people don’t usually fit into a diagnosis completely), I find it helpful as a starting point in the relational dynamic.

In several sessions, Lisa would stand up in the middle of the session to look at herself in the mirror on the wall, where she would fix her hair. Silence would fill the room as she adjusted her hair and blankly stared at herself in the mirror. It was as though I was not in the room at all. I felt a sense of being violated and pushed away as though it was she and she alone in the room. I began to have feelings that I wanted to get rid of the patient and felt enormous rage welling up inside of me.

Meanwhile in my own therapy I addressing my own long-standing issues of abuse were emerging. I had some insight into what might work in Lisa’s therapy. As my therapist did with me, I encouraged her resistance to being helped. This benefited her by creating an emotional insulation or barrier from the trauma. My client’s struggle with negative introjects was also my struggle. Watching her painfully rip herself apart was similar to my own self-abuse. I planned to reframe these experiences for Lisa and help build a positive substitute (to counteract the negative introject). As I noticed these features, it effected my own therapy.

This feeding-off one another in the relational dynamic is a powerful tool for self-growth. In essence the work became a mirror, where I saw what I was doing to myself through her experience. My supervision and therapy deepened the sense of pain experienced by my client and highlighted what was needed in the treatment, a slow holding.

With regard to transference and counter-transference, modern analysts believe that they are always occurring in the relationship between patient and therapist. This does not discount or pathologize the patient or simplify the dynamic. How can one deny that moment-to-moment we assume that the other is what we make them out to be. Few therapists completely disclose information

to the client about themselves. The patient can't help but fantasize, project, and wonder about the therapist's life. The therapist, on the other hand, has a reaction to this because of what they bring to the work. In my case, having survived abuse, I react to saving the client when there are feelings of hopelessness and helplessness brought up inside of me. As a gestalt therapist, I have had the most impact when I was real and true to myself in the working relationship. Clients pick up on my feelings toward them, especially in conveying that I am human and suffer the same plight in life. When we dehumanize them, or they us, both parties impede growth instead of promoting it. My humanity comes through in my effort to be present myself as warm, nonjudgmental, accepting, and available.

In gestalt therapy, contact boundary work is helpful in bringing about a stronger relationship with the client through contact. The contact boundary is the point at which one experiences the "me" in relation to that which is "not me" through the relationship. Both are more clearly experienced by recognizing the separation and distinction of each being in the moment. By using humor, not letting the client get away with things, and recognizing the space between, are all ways to highlight difference (Polster, 1974).

Most of us are interested in incorporating various disciplines to bring about growth in our clients. Psychoanalysis and gestalt therapy appear to be evolving on parallel plains, where the relationship is center stage. Why do we divide ourselves from each other? I believe a combined approach strengthens the work done in gestalt therapy. This "eclecticism" is what makes us flexible and more beneficial to the people we serve. Yontef (1993) states:

'Effective state-of-the art treatment requires the kind of characterological and developmental descriptions that some new psychoanalytic approaches provide. They are extremely valuable for knowing patients better (p. 256).'

We introject aspects of theory that fit our experience and what works well with clients given our personality and experiences, and the rest becomes ground. In work with adult survivors of abuse, Spotnitz' modern psychoanalysis complements gestalt therapy by promoting growth on the client's own terms. Interestingly enough, Spotnitz credits PHG in his book *Treatment of the Narcissistic Neurosis* (1976) for the similarity between analysts and writers. What better way to combine our approaches then through the artist with his many layers.

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Author:

Andy Lapides, MSW, LCSW is in private practice in Morristown, New Jersey and New York City. He is a graduate of The Gestalt Center and Psychotherapy in New York City and a current student at The Academy of Clinical & Applied

Psychoanalysis in Livingston, New Jersey. He can be reached at andylapides@gmail.com

References

- Beisser, A. (1970). *Paradoxical Theory of Change*. Retrieved 21 09, 10, from Gestalt Therapy Page: <http://www.gestalt.org/arnie.htm>
- Bloom, D. (November 2010).
- Cela, J. (2004). The object oriented question in treatment and everyday life. *Annals of Modern Psychoanalysis*, 2(2):207-229.
- Clarkson, P. (2004). *Gestalt Counseling In Action*. 3rd ed. London, UK: Sage Publications.
- Farmer, S. (1989). *Adult Children of Abusive Parents*. New York: Random House.
- Greenberg, E. (1992). An Introduction To Personality Disorders. (pp. 1-17). New York, NY. (unpublished).
- Hycner, R. and Jacobs, L. (1995). *The Healing Relationship in Gestalt Therapy*. Gouldsboro, Maine: The Gestalt Journal Press.
- Kepner, J.I. (2003). *Healing Tasks; Psychotherapy with Adult Survivors of Childhood Abuse*. New York, NY: Routledge
- Margolis, B. (1983). The contact function of the ego: Its role in the therapy of the narcissistic patient. *Psychoanalytic Review*, 70(1), 69-81.
- Perls, F.S. (1942, 1947, 1969). *Ego, Hunger, and Agression*. New York: Random House.
- Perls, F., Hefferline, R., & Goodman, P. (1951). *Gestalt Therapy*. New York: Julian Press.
- Polster, E. and M. Polster (1974). *Gestalt Therapy Integrated*. New York: Vintage Books.
- Polster, E. in Pursglove, P.D. (ed.) (1968). *Recognitions in gestalt therapy*. New York, NY: Harper & Row.
- Spotnitz, H. (1976). *The treatment of the narcissistic neurosis*. Lanham, Maryland: Rowman & Littlefield.
- Spotnitz, H. (1967). *Psychotherapy of Preodipal Conditions: Schizophrenia and Severe Character Disorders*. Northvale, NJ: Jason Aronson.
- Spotnitz, H. (1997). The Goals of Modern Psychoanalysis: The Therapeutic Resolution of Verbal and Preverbal Resistances for Patient and Analyst. *Modern Psychoanalysis*, 31-40.
- Winnicott, D.W. (1965). *Maturational Processes and the Facilitating Environment* London, England: International Universities Press.
- Yontef, G.M. (1993). *Awareness, dialogue, and process: Essays in Gestalt Therapy*. Highland, NY: The Gestalt Journal Press.

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