Chapter 1

Concepts and Misconceptions of Gestalt Therapy*

LAURA PERLS

In Goethe's *Faust*, Mephistopheles says to an eager disciple:

Denn eben wo Begriffe fehlen,
Da stellt ein Wort zur rechten Zeit sich ein.
(For, whenever there's a lack of concepts,
There at the proper time a word comes handy).

The Devil takes a hand in every human endeavor, not only in philosophy and theology. I see him at work in politics and education, in science and art, and particularly in our own field, the teaching and practice of psychotherapy, busily supplying not only words but ready-made formulas, techniques and gimmicks, a whole quick-change bag of tricks to whoever is needy, ignorant and credulous enough, and willing to pay.

The Devil is the master of short-cut, pretentious, seductive and deceiving, promising, coaxing, and relentlessly bullying. His tools are simplification, manipulation, and distortion.

Let us proceed now from myth to facts. At a meeting of the New York Institute for Gestalt Therapy, I put the question: What is your answer if

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somebody asks you: "What is Gestalt therapy?" Our Vice President, Richard Kitzler, who likes to play the Devil's advocate, mumbled under his breath: "The hot seat and the empty chair." Of course, like Mephisto, he said it tongue in cheek. But the naive and impatient disciple takes it at face value; he will always take the part for the whole.

The style that Fritz Perls developed in demonstration workshops for professionals during the last few years of his life has become widely known through films and video tapes of those workshops and through *Gestalt Therapy Verbatim* (1969), the transcripts of these tapes. The dramatization of dreams and fantasies is a beautiful demonstration method, particularly in workshops with professionals who have already had their personal analysis or therapy, and are themselves experienced in working with people. But it is only *one* aspect of the infinite possibilities in the Gestalt approach. It is not useful in working with very disturbed people and not usable at all with the real schizophrenic or paranoid patient. Fritz Perls knew this very well and simply by-passed workshop participants where he sensed the schizoid or paranoid disturbance.

Unfortunately, this workshop approach has become widely accepted as the essence of Gestalt therapy and applied by ever growing numbers of therapists to whomever they are working with. Thus, Gestalt theory is reduced to a purely *technical* modality which, because of its obvious limitations, then is combined with any other technical modality that happens to be available in the psychotherapeutic armamentarium. So we get sensitivity training *and* Gestalt, body awareness *and* Gestalt, Bioenergetics *and* Gestalt, art and dance therapies *and* Gestalt, Transcendental Meditation *and* Gestalt, Transactional Analysis *and* Gestalt, and something or other *and* Gestalt ad infinitum.

All these combinations show that the basic concepts of Gestalt therapy are either misunderstood or simply not known. Gestalt therapy is neither a particular technique nor a collection of specific techniques. Thus, it is not an encounter or confrontation method with a structured sequence of directions, demands and challenges. It is also not a dramatic-expressive method aimed primarily at the discharge of tension. Tension is energy, and energy is too costly a commodity to be simply discharged; it must be made available for making the necessary or desirable changes. The task of therapy is to develop sufficient support for the reorganization and re-channeling of energy.

The basic concepts of Gestalt therapy are philosophical and aesthetic rather than technical. Gestalt therapy is an existential-phenomenological approach and as such it is experiential and experimental. Its emphasis on the Here and Now does not imply—as is often assumed—that past and future are unimportant or non-existent for Gestalt therapy. On the contrary, the past is ever present in our total life experience, our memories,

nostalgia, or resentment, and particularly in our habits and hang-ups, in all the unfinished business, the fixed gestalten. The future is present in our preparations and beginnings, in expectation and hope, or dread and despair.

Why do we call our approach *Gestalt* therapy? "Gestalt" is a holistic concept (*ein Ganzheitsbergriff*). A gestalt is a structured entity that is more than, or different from, its parts. It is the foreground figure that stands out from its ground, it "exists." The term "Gestalt" entered the psychological vocabulary through the work of Wolfgang Koehler who applied principles derived from field theory to problems of perception. Gestalt *psychology* was developed further by Max Wertheimer, Gelb and Goldstein, Koffka and Lewin and their colleagues and students. For the development of Gestalt *therapy* the work of Wertheimer, Goldstein and Lewin became particularly important. Anybody who wants fully to understand Gestalt therapy would do well to study Wertheimer on productive thinking, Lewin on the incomplete gestalt and the crucial importance of interest for gestalt formation, and Kurt Goldstein on the organism as an indivisible totality.

Goldstein's organismic approach links up with Wilhelm Reich's theory of organismic self-regulation to become in Gestalt therapy the postulate of the awareness continuum, the freely ongoing gestalt-formation, where whatever is of greatest interest and importance for the urvival and development of the individual or social organism will become figure, will come into the foreground where it can be fully experienced and responsibly dealt with.

But Reich's most essential contribution to the development of Gestalt therapy is his recognition of the identity of muscular tensions and character formation. The character armor, epitomized in the obsessional character, is a fixed gestalt which becomes a block in the ongoing gestalt formation. The practical focus on body awareness, however, became part of Gestalt therapy not through Reich, but through my lifelong experience with eurythmics and modern dance, my early study of the work of Ludwig Klages "Ausdrucksbewegung und Gestaltungskraft" (expressive movement and creativity), and my awareness of Alexander and Feldenkrais methods long before the development of Bioenergetics and other body therapies. Working with breathing, posture, coordination, voice, sensitivity, and mobility became part of my therapeutic style already in the 1930's when we still called ourselves psychoanalysts.

The gradual shift from the psychoanalytical to a gestalt orientation is documented in *Ego, Hunger and Aggression* (Perls, 1969), published first in 1942. I contributed to it two chapters that are predominantly gestaltist: "The Dummy Complex," which is the *fixed gestalt* that prevents change, and "The Meaning of Insomnia," which is the *incomplete gestalt,* the un-

finished situation which does not let us sleep. In *Ego, Hunger and Aggression* we changed from the historical-archeological Freudian viewpoint to the existential-experiential, from piecemeal association psychology to a holistic approach, from the purely verbal to the organismic, from interpretation to direct awareness in the Here and Now, from transference to actual contact, from the concept of the Ego as a substance *having* boundaries to a concept of it as the very boundary phenomenon itself, *being* the actual *contact function* of identification and alienation. All these concepts, then still tentative, often confused and confusing, developed during the next ten years into a more organized coherent theory which was published as *Gestalt Therapy: Excitement and Growth in the Human Personality* (Perls, Goodman, & Hefferline, 1951). This is the basic book that I still consider indispensable for a full understanding of Gestalt therapy.

However, at the risk of repeating what some of you have heard before, but what seems generally not well understood, I want to confine myself to a few concepts which are interconnected and—for me—essential for the theory *and* practice of Gestalt therapy: the concepts of boundary, contact, and support.

Contact is the recognition of, and the coping with the *other*, the different, the new, the strange. It is not a state that we are in or out of (which would correspond more to the states of confluence or isolation), but an activity: I *make* contact on the boundary between me and the other. The boundary is where we touch and at the same time experience separateness. It is where the excitement is, the interest, concern, and curiosity or fear and hostility, where previously unaware or diffused experience comes into focus, into the foreground as a clear gestalt. The freely ongoing gestalt formation is identical with the process of growth, the creative development of self and relationship. If this continuum is interrupted by outside interference or blocked by the fixed gestalten of rigid character formation or of obsessional thoughts and activities, no strong new gestalt can emerge. The boundary experience becomes blurred and even wiped out by the fixed and incomplete gestalten. Excitement changes into anxiety and dread or indifference and boredom. The faculties of differentiation and discrimination are disowned and projected; attitudes, ideas, and principles of other people are misappropriated and introjected; energy that might be available for direct and creative action is deflected into dummy activities or retroflected in self-interference, self-reproaches, self-pity, and self-destruction. (For a more detailed phenomenology of introjection, projection, deflection and retroflexion, I recommend Erving and Miriam Polster's book *Gestalt Therapy Integrated* (1973).)

How does a gestalt therapist cope with this pandemonium of neurotic and psychotic pathology that we are faced with every day? Our aim is the awareness continuum, the freely flowing ongoing gestalt formation,

which can go on only when excitement and interest can be maintained. Contact can be relevant and creative only to the extent that support for it is available. By support I mean only to the smallest degree the care and assurance that I as the therapist provide through my availability and interest, but the self-support that the patient (or the therapist, for that matter!) either relies on or is lacking. Support starts with primary physiology like breathing, circulation, and digestion, continues with the development of the cortex, the growing of teeth, upright posture, coordination, sensitivity and mobility, language and its uses, habits and customs, even and particularly the hang-ups which were formed as support at the time of their formation. All the experience and learning that has been *fully assimilated and integrated* builds up a person's background, which gives meaning to the emerging gestalten and thus supports a certain way of living *on* the boundary *with* excitement. Whatever is not assimilated either gets lost or remains an introject.

The integrated personality has *style*, a unified way of expression and communication. He or she may not conform to what is regarded as "well adjusted," socially useful and desirable, or even healthy. He will be called "eccentric" or "irresponsible," "queer," "crazy," or "criminal," he may be an anarchist, a painter or poet, a homosexual or a hobo. But the person who has *style* does not come for therapy, at least not voluntarily. The people who want and need therapy are the ones who are stuck with their anxiety, their dissatisfaction, their inadequacies in work and relationships, their unhappiness. They lack support for the kind of contact that would be necessary or desirable and adequate to the situation they find themselves in.

Now any lack of essential support is experienced as anxiety. Usually anxiety is equaled with insufficient oxygen, but the reduction and even suspension of breathing and with it a reduction of excitement and interest may already be a reaction formation to a potentially dangerous situation (playing possum) or to the demand for "self-control." There is a whole scale of malcoordinations of support and contact functions ranging from occasional unease, awkwardness and embarrassment to chronic anxiety and panic. We have not enough time to go into the whole phenomenology of these malcoordinations. I only want to emphasize one point: awkwardness and embarrassment are potentially creative states, the temporary lack of balance we experience at the growing edge where we have one foot on familiar and one foot on unfamiliar ground, the very boundary experience itself. If we have mobility and allow ourselves to wobble, we can maintain the excitement, ignore and even forget the awkwardness, gain *new* ground and with it more support. We can see this graceful awkwardness in every small child before it becomes socialized and constrained by the civilized demand to "keep it cool." I know from my own experience

how difficult it is to rid ourselves of the introjects that we have remained encumbered with through most of our lives. At this point, I feel nearly always a little awkward and embarrassed. Right now I feel a bit uneasy not exactly knowing who I am talking to and rather talking *at* you. But I also know that I'll survive it. I have learned to live with *uncertainty without anxiety*.

How we do facilitate this development of more elastic support functions in our *patients* depends on the support we have in ourselves and our awareness of what is available in our clients. A good therapist does not use techniques, he applies himself in and to a situation with whatever knowledge, skills, and total life experience have become integrated into his own background and whatever awareness he has at any given moment. Thus, I would speak of *styles* of therapy rather than techniques. Nearly any technical modality is applicable within the framework of Gestalt therapy, if it is existential, experiential, and experimental only to the degree that support can be mobilized, e.g., if the patient is already or can be made aware of what and how he is doing now and willing to experiment with expansions or alternatives. So we start with the obvious, with what is immediately available to the awareness of therapist as well as client, and we proceed from there in small steps which are immediately experienced and thus are more easily assimilable. This is a time-consuming process which sometimes is misunderstood by people who are out for easy excitement and magical results. But miracles are a result not only of intuition, but of timing. I feel suspicious of the miracle worker and am weary of the instant breakthrough. More often than not, it results in a negative therapeutic reaction, a relapse or even a psychotic break. It shows a lack of respect for the patient's existential predicament, not accepting him as he is at this moment, but manipulating him quickly to where we think he should be. It does not contribute to the development of his awareness and his autonomy, nor does it contribute to the growth of the therapist.

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