*Journal of Integrative Research, Counselling and Psychotherapy, vol.2, no.1*
*February 2016*

# The Relevance of Gestalt Therapy To Clinicians Who Use Hypnosis Today

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## Abstract

This paper investigates how the principles of Gestalt therapy can be utilized by integrative therapists in clinical practice. The author pinpoints several principles of Gestalt therapy—for example, working in the 'here and now', one's awareness of body language, and behaving 'authentically'—and explains why these components are important in clinical practice. Implications of the utilization of these principles within a hypnotic framework are discussed.

Founded by Frederick and Laura Perls in the 1940s, Gestalt therapy is a phenomenological-existential treatment approach which focuses on the 'here and now'. Clinicians who have been trained to use this specific approach, for the most part, do not interpret or attempt to analyze past events of attitudes, but rather comment on feelings, perceptions and actions in the consulting room. The therapist comments on these perspectives and provides a safe environment where an authentic, experiential dialogue can take place. The aim of this is to encourage clients to become aware of their actions and feelings so that they can change and accept their behaviour.

The most striking difference between this therapy and most psychotherapies that were in existence at the time of its initial development (1940s) was that it focused on the present, whereas psychodynamic psychotherapy—Freudian, Adlerian and Kleinian—generally looked at the past, particularly early childhood, in order to analyze and work through unconscious conflicts. By contrast, Gestalt therapy focuses on the present day; indeed, any reference to the past or the future is often regarded as an example of resistance (Perls, 1947; Shostrom, 1965;

NCHP, 2011). Above all, therapists concentrate on moving forward rather than on resolution, and on re-assessment rather than on 'fixing' a problem (Brookhouse, 2011). Ironically, by doing this, the hope is that, by the end of the session, clients will have come to terms with a particular 'maladaptive' behaviour or perception.

Another important difference between Gestalt therapy and traditional psychoanalysis is that the dialogue between the therapist and client or patient is face to face. Many analysts encourage their clients to lie on a couch or sit away from them as this helps them, during the process of free association, to be honest about their feelings and desires. Gestalt therapists, however, in most cases, sit directly opposite their clients, and yet, still encourage them to be open about their feelings in the consulting room. Indeed, the therapist-client relationship is of paramount importance. The therapist, indirectly, seeks out problems in the client's early life, recovers lost potentials, and helps him to be more independent and autonomous, while, at the same time, repairing any 'unfinished business' or unresolved emotional situations of the past (Perls, 1947; Perls & Stevens, 1969; NCHP, 2011).

One of the most interesting features of Gestalt therapy is the acting or rôle play that goes on during sessions. In 1965, Fritz Perls was asked to demonstrate his approach to therapy on reel tape and, although this was originally intended solely for education purposes, it was subsequently broadcasted at the cinema. During the 30 minute session with Gloria (Shostrom, 1965), Perls asked her to act being the therapist and then encouraged her to say exactly how she felt to her therapist. Perls explained that it is important to act out 'alien feelings' in therapy and also to concentrate on non-verbal communication (Shostrom, 1965). He pointed out that, in this safe environment, which he described as 'the safe emergency of the therapy', individuals are able to act out, come to terms with, and complete unfinished business.

This form of communication is at the heart of Gestalt therapy. Buber (see Friedman, 2002) pointed out that the client ('I') only has meaning in relation to others: thus, Gestalt therapists prefer to place the client in a real dialogue rather than using 'therapeutic manipulation' (Youtef, 1993). Gestalt theorists (for example, O'Leary, 1992; Youtef, 1993; Clarkson, 1989) support this by explaining that contact is essential to the therapeutic process and that moving patients towards a directed goal, as in other psychotherapy approaches, takes the control away from the client. However, if he is given the opportunity to act as his 'true self', he will be able to effect change: during sessions, the therapist also says exactly what he feels and encourages the client to do the same.

Another significant feature of Gestalt therapy is the awareness of body movement. The importance of this is that it brings to the surface unconscious emotions and impulses and, once the client is aware of these feelings, he takes ownership of them. This awareness promotes a deeper understanding of real, authentic expressiveness (Zimberoff & Hartman, 2003). Thus, by allowing and accepting our somatic expressions, one begins to be able to release our inner conflicts and resistances so that one can move forward with momentum (Reich, 1949). In essence, Gestalt therapy, in its purest form, in its, say 1940s form, pre-empted the theories of psychoneuroimmunology (Watson, 1997), the main premise of which is the idea that there is a mind-body connection and that out bodies express our inner thoughts and perceptions—healthy or otherwise. Negative thoughts and 'unresolved business' can, therefore, lead to a plethora of psychosomatic problems including all the concomitant symptomatic features of panic disorder (Norton, Harrison, Hauch & Rhodes, 1985; Beitman, Thomas & Kushner, 1992) and other psychosomatic conditions such as IBS (Walters & Oakley, 2006), psychosexual problems (Walch, 1976; Araoz, 1980, 1983;), hyperhidrosis (King & Stanley, 1986; Kraft & Kraft, 2007), psoriasis (Shenefelt, 2000), and the list goes

on... Indeed, working under the premise that Gestalt therapy is a holistic approach par excellence, Becker (1993) pointed out that negative ruminations and unresolved anger work against the body and the interests of the total person. So, by coming to terms with our actions and somatisations, and by expressing our energy authentically, we experience closure while becoming an integrated and meaningful whole. Perhaps then, this important therapeutic approach may fall under the remit of 'body-oriented psychotherapy' (Perls, 1969).

Three further theories of Gestalt therapy are relevant in the light of integrative psychotherapy. The first is the cycle of awareness. The circle represents the self, while the outside represents social environment. Gestalt theorists explain that a healthy ego-boundary is a person who is neither stubborn nor too compliant, whereas an unhealthy ego boundary is a person who exhibits one or other of the two extremes (O'Leary, 1992). The clockwise movement around this circle represents a healthy flow of energy: individuals who use their energy appropriately are able to learn, to grow and develop as a person (NCHP, 2011).

Perls (1947,1969) also spoke about five levels of neurosis: (1) the cliché layer which consists of, largely, superficial interactions; (2) the rôle-layer in which individuals act in a way that befits their place in society—for example, being a parent, teacher, villain or victim; (3) the impasse-layer, where clients feel stuck, uncomfortable or resistant; (4) the implosive layer in which one feels that one is about to explode and (5) the 'authentic' explosive layer, in which one expresses one's true feelings such as anger, fear, orgasm, joy or grief.

The third important aspect is the fact that, although Perls rejected many theories of Freud, he still did a great deal of dream interpretation in his clinical work. The interpretation of dreams is integral to psychotherapy because we all dream in symbols. During a dream, we do not edit our thoughts so that they are acceptable to society, our friends or family: our

dreams represent our unadulterated wishes and hopes—our primordial desires and fears (Freud, 1913). However, unlike Freud who focussed on libidinal desires, present anxieties and childhood conflicts, Perls believed that every dream represented a part of the self which needs to be integrated (NCHP, 2011), and, moreover, he focussed on the here and now.

There are many aspects of Gestalt therapy that are relevant to hypno-psychotherapy—that is to say, to psychotherapists who use hypnosis as an adjunct to their work in clinical practice. However, the author believes strongly that Gestalt therapy, in its purest form, can often lead to irresolvable conflicts in the consulting room; but, nevertheless, some of its principles can be used, if it is felt to be appropriate, to enrich the therapeutic process.

Many therapists, particularly in the early stages of their career, employ a standard induction in order to facilitate hypnosis, and this is often followed by progressive muscle relaxation. However, sometimes, when treating more resistant individuals, more experienced practitioners encourage their clients (1) to focus on a specific problem and, in the first instance, to increase its intensity or (2) use negative suggestions before relaxation is introduced (Erickson, Rossi & Rossi, 1976; Emerson & Dupe, 2008). These two approaches are inextricably interconnected with Gestalt therapy in that individuals are able to face up to their fears and/or anxieties, and this becomes a 'bright Gestalt'. As the individual becomes more focussed on his inner feelings, the outside world moves into the background and, as he learns about his feelings and processes literally and without interference, he is able to feel and communicate more authentically. This safe but challenging environment, akin to Vygotsky's 'zone of proximal development' (Vygotsky, 1978), has obvious links with the Gestalt principles regarding concrete attention. In hypnosis, individuals have a heightened awareness of their emotional needs; and it is important for clinicians to promote this 'presentness' emotionally and viscerally during treatment.

The second induction technique (use of negative suggestions), just mentioned, focuses on the 'here and now' and on moving the client forward. So why and how does this work? The technique here is an induction which is mainly based on negative suggestion. Many clients in therapy are resistant to hypnosis, and they react in this way in order to maintain a sense of control; however, if used carefully and skilfully, negative suggestions can be employed to encourage clients to be positive (Yapko, 2003). For instance, if the clinician says, 'I wonder if your hand is becoming lighter', the client might disagree, saying that it is becoming heavier; or, if he suggests, 'You are becoming more relaxed', the client might express that he is becoming more anxious. Interestingly, one has to think of lightness if one is trying to do the opposite and one has to think of relaxation if one is deliberately trying outwardly to display anxiety. The relevance here to Gestalt therapy is that one is acknowledging and accepting the behaviour rather than labelling it as 'resistance'. Eventually, hypnosis is achieved because the client realizes that he does not have to react against the clinician in order to keep his sense of control.

The following example, which uses negative suggestion as an induction, might be useful in the treatment of a highly resistant patient suffering from generalized anxiety disorder. Notice that, although negative suggestions are used, there are still a large number of positive expressions that is embedded within the text.

*Today, you have come here to reduce your anxiety...and, yes, this can be changed...but I do not expect you to be aware of the ability that you always and already have at this time...at this time, right now, you can, if you wish...reject anything I say...you don't have to listen to the words that I say...you have the right to ignore my comments...you can't be ready to effect change yet...you can't be ready to listen and learn yet...and you can't be ready quite yet to change your life in the way that you want it to be, and the way that you want to feel, think and behave...until you have been given the chance to feel anxiety a little while longer...so don't pay attention to me yet...and don't let your eyes close yet...and don't begin to relax yet...and*

*some people find that they are able to ignore what I say...and don't hear about all the opportunities that they might have, and the different ways to feel relaxation...it is much too soon for you to begin to notice how relaxed and comfortable you feel...as you continue to stare and move in your seat...*

The importance of this is that no demands have been made, and, further, as the patient begins to trust the clinician more, he starts to be able to work together in a more positive fashion. The suggestions above are also truisms: the client will eventually realize that he actually cannot disagree with any of the points that had been made. After this initial stage, therapy can proceed and work on the following lines—the example below also includes some ego strengthening which incorporates poetic lines taken from Callow (1998, 2003):

*And now you have come to terms with your need for control, I wonder if you can think of all the outside influences that have caused you comfort...let us investigate your outside world together...and, as you focus on this...I wonder how soon it will be before you relax and focus on your inner needs and feelings of the here and now..[wait for ideomotor response]...Thank you..And now that you are ready to effect change in yourself in the here and now..you are ready to be in control of how you feel, think and behave..and, from moment to moment and from minute to minute, and with every moment and minute that passes...you are always and already becoming the person who you want to be....*

Of course, analyzing and discovering insights into one's past is often valuable and efficacious in therapy; however, this should not be done for its own sake. Many therapists who practise hypno-analysis spend a great deal of time delving into past events, only, certainly initially, to disturb or re-traumatize clients. Williamson (2008) has stressed how dangerous it can be to use traditional age regression in that, often, patients re-experience traumatic events with all the emotions that are attached to the events; she advises that one should use some form of dissociative imagery to make sure that the patient feels, in some way, detached and more in control. Levendula (1963) points out that Gestalt therapists do not 'strive to unearth the traumatic conflict'. Thus, as an integrative psychotherapist, it would be a useful technique to encourage your patient, in hypnosis, to express and tolerate the original situation and to complete it. Gestalt therapists and theorists (Perls, 1969; Clarkson, 1989)

have pointed out that it is important to organize perceptions and feelings into a meaningful whole, and that unfinished tasks should be completed. Clinicians have used hypnosis in a very similar way in order to produce closure. The 'Empty Chair' technique can be adapted in hypnosis in the form of part dissociation (Pickering, 1983), and ego state therapy (Torem, 1986, 1987); and, in addition, many therapists encourage their clients to re-frame past events so that they are in the winning position (Kraft, 1986). Another useful addition to this integration process is to encourage patients to consolidate their newly-acquired knowledge in order to move on in the near future.

The use of dissociation—specifically, part therapy—is a very powerful technique in clinical practice. One can suggest to a client that, 'Part of you is experiencing this', while, 'Another part of you is experiencing that', and this approach can be used effectively in therapy particularly if a Gestalt-type dialogue is also employed. For example, Vanderlinden and Vandereycken (1990) treated fifty young women with bulimia nervosa and reported excellent results using a multimodal approach. The first stage of the treatment prepared clients for change: patients were taught self hypnosis and were asked to keep a diary of their eating behaviour and of the emotions which accompanied each meal. In the second phase of the treatment, patients were asked to talk to and negotiate with the part of them which was responsible for the bulimia: the result was that many individuals were able to agree to adopt more appropriate ways of dealing with problems. Re-integration of both the healthy part and the destructive parts was achieved before disengagement.

Torem (1987) used ego state therapy in the treatment of a 17 year old girl with bulimia. He also encouraged his patient to record her feelings before, during and after each meal. When consulting these reports, he noticed that, on one occasion, her hand writing became erratic, and she commented that her bulimia was directly related to her self-defeating

attitude. During hypnosis, Torem then engaged the ego state which was responsible for her problem and a challenging and emotionally direct dialogue ensued between the therapist and the girl. As a result, the patient was able to negotiate with her therapist, to re-integrate and to adopt more adaptive—and, hence, more controlled—eating behaviour.

Degun-Mather (2003) reported the successful treatment of a lady suffering from binge eating disorder. The lady, Mrs Z, was confused about herself and commented that she did not feel that she had an identity; she also pointed out that she felt that there were parts of herself which seemed separated from each other. The treatment initially began with a cognitive-behavioural approach which, although had some initial success, resulted in her returning to her original binge eating behaviour. Degun-Mather decided to use ego state therapy which involved an inner communication with her 'addict self', and this helped Mrs Z to understand the cause of her compulsive bingeing: she followed this up by using an affect bridge which helped her to address the child part of herself who had a fear of abandonment and of starving.

The therapist explained that the aim of the therapy was to find 'ways of meeting the emotional needs of the separate parts, in a more adaptive way and thus to reduce conflict'. During the hypnosis, Mrs Z described her 'addict self' as 'powerful and destructive'. She also explained that she was 'a parasite' and that she fed on herself because she gave her somewhere to live. A powerful dialogue ensued between the therapist and the 'addict self'. Next, Degun-Mather encouraged 'the addict self' to confess to 'the healthy self', and it was during this stage that the 'addict self' expressed powerfully that she was a 'fraud' and was not needed in her life. Finally, both therapist and Mrs Z agreed to bury the 'addict self', and this turned out to be an important transition in the therapy. Interestingly, Degun-Mather quite rightly described this technique as being 'Gestalt'.

The examples that have been provided here have shown that communication between maladaptive parts can lead to recovery. Importantly, however, traditional Gestalt therapy does not seek to analyze, and yet the approaches described here all relied on some analysis. In the latter case study (Degun-Mather, 2003), for example, it was revealed that the patient's fat represented a protective layer and an outward expression of her anger; indeed, becoming aware of this helped her to come to terms with her binge eating. In conclusion, Gestalt therapy and its principles can be utilized by clinicians and can make a useful addition to the skill set of contemporary integrative therapists.

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