Gestalt Therapy and Post-Traumatic Stress Disorder: The Irony and the Challenge[1]

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The purpose of the present study is to review the theoretical, strategic, and tactical/technical contributions of Gestalt therapy to the treatment of post-traumatic stress disorder (PTSD), and to examine its contributions to the professional literature. From a theoretical point of view, the conceptualization of PTSD as a special case of "unfinished business" posits Gestalt therapy as a treatment of choice for this syndrome. From a strategic point of view Gestalt therapy offers phenomenology and I-Thou dialogue as effective therapeutic components. Finally, from a tactical point of view, Gestalt therapy offers unique mechanisms for surfacing trauma-related conflicts from the past and solving them in the present. These mechanisms include: attending to the "here and now," body movements and non-verbal behavior, insisting on retelling the traumatic event as if it were happening in the present, the use of fantasy and visualization, the creative enhancement of body language, two-chairs and empty chair work, graded experiments, and psychodrama and enactment. In spite of all these assets of Gestalt therapy, a thorough literature search yielded a meager testimony to the utility of Gestalt therapy for treating patients suffering from PTSD. The author challenges Gestalt therapists to document and report case studies of Gestalt therapy applications with PTSD patients, and to take part in quantitative stud-

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ies on PTSD to enable the practice of Gestalt therapy to actualize its full potential, and gain its appropriate status among therapeutic approaches.

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The surge of mixed emotions aroused by the news of the events in Washington and New York on September 11, 2001 brought into the foreground issues related to post-traumatic stress disorder (PTSD). The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorder* (DSM-IV, American Psychiatric Association, 1994) provides six criteria for PTSD. The first criterion relates to the traumatic event that preceded the condition. It defines the trauma as involving a confrontation with threat to the physical integrity of the self or others, or to actual death or injury of others. Three criteria deal with the impact of the event on the person (*e.g.*, persistent re-experiencing of the situation, avoidance of trauma-associated stimuli, or indications of increased arousal and distress). The last two criteria deal with the intensity of the impact (*e.g.*, impairment of normal social and occupational functioning) on a temporal dimension (*e.g.*, for more than a month).

Symptoms of PTSD may be viewed as two-dimensional polarities. One dimension is arousal, which ranges from extreme arousal and agitation to low arousal and numbness. The other dimension is approach–avoidance, which ranges from over–involvement with the trauma (with accompanying flashes of images, memories, and rumination) to total avoidance or fear of any stimulus that generates associations with the trauma. Other issues that relate to PTSD are dissatisfaction with one's extreme response to the unusual circumstances, or an existential reminder of one's mortality. In addition, when the incident involves the death of others, sometimes the victim feels guilty for surviving the episode.

The first section of this article will include a review of Gestalt therapy's conceptualization of PTSD and a discussion of its utility in the treatment of this condition from theoretical, strategic, and tactical points of view. The second section will include an examination of the professional literature in order to evaluate the evidence for the efficacy of Gestalt therapy in treating PTSD. While Gestalt therapy is in the foreground of this paper, the prevalence of research on cognitive therapy and evidence for its efficacy will serve as the background.

"Unfinished business" is an important aspect of the theoretical background of Gestalt therapy (Korb, 1984). Thus, from a theoretical perspective, the characteristics of PTSD may be viewed as "unfinished business" related to the traumatic event. Indeed, Greenberg, Rice and Elliott (1993)

identify several classes of "unfinished experiences," among which are a class that "arises in traumatic, stress-inducing situations or victimization experiences involving tragic loss, violent death, disaster or abuse" (p. 242). More specifically, the symptoms of PTSD seem to demonstrate: (1) an attempt to assimilate an experience that is impossible to assimilate; and (2) the expression of an underlying organismic need to finish some unfinished aspect of the trauma (Elliott, Davis & Slatic, 1998) or, in more general terms, repeated unsuccessful attempts at completion of the "experience cycle." The experience cycle is the process by which a healthy organism processes figure formation and destruction. The individual phases of the cycle are: sensation/awareness, mobilization, movement or action, contact, resolution/closure, and finally, withdrawal (Melnick and Nevis, 1998; Polster and Polster, 1973: Zinker, 1977).

Melnick and Nevis (1992, 1998) offer an original attempt at viewing PTSD from a Gestalt therapy perspective. According to these scholars, PTSD symptoms are manifestations of the individual's inability to absorb and digest an experience in order to achieve disengagement. They argue that PTSD symptoms are caused by disturbances in the final stage of the "experience cycle," namely, the demobilization stage that incorporates the resolution/closure and withdrawal phases. The demobilization stage, they suggest, includes four sub-stages: turning away, assimilation, encountering the void, and acknowledgement. Thus, the various PTSD symptoms represent an interruption of a smooth movement through the stages.

According to this formulation, therapy should focus first on enabling the client to turn away from the traumatic figure (perhaps the memory of a loved person, an addiction, or the concept of invulnerability). In the second stage, therapy should take the client slowly through a process of assimilation in which emotions will be discharged at a proper pace, simultaneous with the development of a proper repertoire of rituals for energy draining. The third stage—encountering the void—relates to feelings of emptiness where nothing matters. Working through this stage is the most difficult task, but when completed, leads to the final stage—acknowledgement. The acknowledgement stage involves the emergence of a new understanding about the self. Thus, according to Melnick and Nevis, following a successful course of therapy, the client will be not only symptom free, but will acknowledge a gain from the traumatic experience. In addition, Melnick and Nevis offer specific suggestions and caveats for the treatment of patients with PTSD. They point out that while patients wish to lose interest in the traumatic event, trauma may have a mesmerizing effect, a polarity that should be acknowledged. They discuss the importance of support for repetitive expressions of feeling without expectations of an external outcome or any effort to change anything. They advise therapists to be aware of pacing and tempo, and the need to modulate the level of emotional arousal. They prescribe the buildup of an adequate

repertoire of energy draining rituals such as lighting candles, singing the blues and similar ceremonies. Finally, Melnick and Nevis urge therapists to maintain an optimal level of interest in the patient. Too little interest will not provide enough support, while too much interest may fuel the patient's attachment and hamper the demobilization process. Thus, we see that from a theoretical point of view, Gestalt therapy offers a unique perspective on the PTSD syndrome. The next section includes the strategies that enable Gestalt therapists to translate the hypothetical construct of "experience cycle" into a therapeutic process.

Resnick (1995) posits that the main attributes of Gestalt therapy are: field theory, phenomenology, and dialogue. In each of these attributes, Gestalt therapy offers a unique view for the treatment of PTSD. The traumatic event is so poisonous and hostile that the person cannot assimilate it. The phenomenological approach leads to the slow, minute-by-minute process of examining the original experience, and to the process of assimilating it, together with identifying how the patient interrupts the process. In this manner, the phenomenological approach allows for the proper assimilation of the experience. The I-Thou dialogue— including presence, inclusion, commitment to dialogue, and confirmation (Buber, 1965; Friedman, 1991)—is a *sine qua non* condition for enabling patients to withstand the therapeutic experience in general, especially for patients who suffer from PTSD. Indeed, in the Treatment Considerations section of the *Guidelines of the International Society for Traumatic Stress Studies* (2002), the authors stress the therapeutic alliance as an important factor in the treatment of PTSD, in view of the patients' difficulties in trusting others. These guidelines stress the importance of the therapeutic alliance in particular among patients who experienced interpersonal traumas, as these patients are characterized by vulnerability, the need for reassurance, and a strong need for safety and security.

Thus, we see how the Gestalt therapy strategies of phenomenology and dialogue enable the translation of the theoretical aspect of Gestalt therapy into the therapeutic process. The next section includes the tactical aspects, namely the mechanisms that Gestalt therapists can use in the treatment of PTSD patients.

The mechanisms of Gestalt therapy specific to the treatment of PTSD relate to the unique contributions of Perls (Perls, Hefferline & Goodman, 1951) to psychotherapy; namely, the invention of therapeutic techniques that help the individual to surface unfinished situations, traumas, and trauma-related conflicts (Clarkson & Mackewn, 1993) from the past, and to resolve them in the present. These techniques include: fantasy and visualization, creative enhancement of body language, two-chair work, graded experiments, psychodrama, and enactment. For example, in their process–experiential model for PTSD, Elliott, Davis and Slatick (1998) include the following techniques: two-chair dialogue for self-conflict

splits, two-chair enactment for self-interruption, and empty chair work for unfinished emotional business.

The literature review above indicates the unique value that Gestalt therapy brings to the conceptualization and treatment of PTSD. Furthermore, this review demonstrates the powerful techniques that Gestalt therapy offers both for resolving issues that characterize PTSD and for the therapeutic process of this syndrome. Moreover, therapists trained in Gestalt therapy have a specific advantage in the treatment of patients with PTSD. This advantage relates to the issue of exposure.

Manuals of the mainstream approaches to the treatment of PTSD, especially approaches that stem from a cognitive behavioral model (Foa, Keane & Friedman, 2000; Foa & Meadows, 1997; Foa & Rothbaum, 1998; Meichenbaum, 1994; Padeski *et al.*, 2002; Paunovic & Ost, 2001), focus on exposure as a major tool for treating PTSD patients. Exposure treatment for PTSD involves repeated reliving of the trauma under controlled conditions, with the aim of facilitating the processing of the trauma. The rationale for this technique from a cognitive–behavioral perspective is to achieve habituation and to enable emotional processing. Leahy (2001) argues that exposure with response prevention, *i.e.*, avoiding escape, allows the person to recognize that emotions and images are time limited and that he or she can tolerate the difficulties without "going crazy." Translating these terms into Gestalt therapy terminology, enactment is *in vitro* exposure of the trauma during the therapy session, or re-experiencing the trauma in the here and now. Similarly, Gestalt experiment is an *in vivo* exposure to trauma-related issues in the real setting, or revisiting the traumatic scene. Thus, a therapist who uses exposure as a therapeutic technique operates within the realm of Gestalt therapy. Furthermore, a well-trained Gestalt therapist is especially well-equipped to handle exposure successfully. Indeed, a Gestalt therapist may use: attending to the here and now, body movements and non-verbal behavior, and insisting on retelling the traumatic event as if it were in the present with the use of empty chair and two chair techniques, together with the phenomenological methods of describing, equalizing, and bracketing accompanied with an I-Thou dialogue. All these aspects will enable a slow minute-by-minute process of examining the original experience, as well as the process of assimilating the experience, and will lead to an efficacious "exposure." Furthermore, the reader should note the contrast between the cognitive therapy terminology—"exposure"—*vs.* the Gestalt therapy term "re-experiencing." "Exposure" denotes a mechanical act, while "re-experiencing" implies an impact on a human being. The *Merriam-Webster Dictionary and Thesaurus* (Bookman II model MWD-1440) offers another meaning for "exposure" which includes the synonyms hazard, jeopardy, risk, and peril. In view of the nature of PTSD, it seems paradoxical to use the term "exposure" as a therapeutic technique for the treatment of this syndrome.

In a discussion of issues that prevent successful exposure during cognitive therapy, Leahy and Holland (2000) indicate the inability of the patient to become anxious during exposure (through deflection), and the inability to habituate (due to retroflection) as major obstacles to successful exposure. Similarly, Paivio and Greenberg (2000) consider that overcoming avoidance is the main goal in the middle phase of therapy. Gestalt therapists are efficient at working with and ameliorating these difficulties by focusing on process rather than content, by insisting on the here and now in the re-enactment of the trauma, by their attunement to nonverbal communication, and by the special Gestalt conceptualization of resistance (see Polster and Polster, 1973; pp. 51-97). In fact, in one standard training video for behavior therapists on exposure, the viewer may see a behavior therapist encourage her patient to do the "exposure," and fail to relate to the nonverbal responses of the patient and to here-and-now issues that may indicate resistance. From a Gestalt therapy point of view, this failure is clearly not an effective therapy.

The above theoretical discussion about the potential utility of Gestalt therapy in the treatment of PTSD leads to the logical conclusion that Gestalt therapy should be the treatment of choice for this condition. In view of this conclusion, it is intriguing to examine how these theoretical implications are expressed in reality. Indeed, most Gestalt therapists who have treated patients with a diagnosis of PTSD would attest to the utility of this approach to that syndrome (Burley, 2002). One reviewer of an earlier version of this article summarizes this testimony by relating to the issue as, "the obvious and clinically-supported relationship between Gestalt therapy and the treatment of PTSD clients," a fact which "most clinicians know" (Anonymous, 2002). In view of all of the above characteristics of Gestalt therapy, it is not surprising that Gestalt therapy principles are called to the rescue when an urgent need to train therapists in PTSD emerges. Thus, when the need emerged to train mental health professionals in Bosnia in the wake of war traumatization, the UNICEF Psychological Training Project employed Gestalt therapy principles together with cognitive therapy (Butollo, 1996).

In view of the advantages of treating PTSD from a Gestalt therapy perspective, I decided to explore the professional literature and find out to what degree the contributions of Gestalt therapy to the treatment of PTSD are documented in the professional literature. A search in the Gestalt therapy literature yielded some support for the efficacy of Gestalt therapy among patients with a diagnosis of PTSD.

Elliott, Davis, and Slatick (1998) report the only quantitative study on the effect of process-experiential therapy, a subset of Gestalt therapy, among PTSD patients. Elliot *et al.* report an improvement on various clinical measures of psychopathology among six patients who suffered from crime-related PTSD and underwent short-term treatment. These findings,

however, were tentative, as no tests of statistical significance were performed. Another indirect indication of the effect of process-oriented therapy may be found in Paivio and Greenberg's study (1995). These researchers report significant changes in patients who participated in process-oriented therapy. Furthermore, this group's improvement was superior to changes in patients who participated in psycho-educational therapy. It must be noted, however, that not all patients in these groups met the formal diagnosis of PTSD.

Other demonstrations of the use of Gestalt therapy with patients suffering from PTSD are available in qualitative studies. Serok (1985) reports on two case studies of Gestalt therapy. One of these cases describes a 40-year-old Israeli woman who suffered from anxiety and depression and who had been traumatized when the Nazis separated her from her mother when she was five years old. Through re-enactment of the scene again and again in the here and now, and through countless imaginary dialogues with the dead mother, the patient was able to re-live the experience. Eventually, after many tearful and exhausting sessions, the patient was able to let go of what had been left unfinished. Following the one-and-a-half years of therapy, the patient reported an amelioration of her depression and relief from anxiety, which were accompanied by improvements in many areas of her life.

The findings of these studies are encouraging. Nevertheless, one swallow does not make a summer, and a few documented studies can hardly serve as unequivocal proof for the efficacy of any therapeutic approach. Therefore, I undertook a thorough literature search of the Psych Info database (up to June 2002). This search yielded 29 citations with the terms "Gestalt therapy" and "trauma* or PTSD" (the * indicates the inclusion of all forms of the term "trauma"). Of these, 14 are chapters in books, one is a dissertation, and only 14 are journal articles. Of the journal articles, only three were related specifically to the treatment of PTSD using Gestalt therapy. Two were case studies (Serok, 1985; Slackin, Weller, and Highton, 1989) and one was related in a general way to the treatment of PTSD among Vietnam veterans using Gestalt therapy (Crump, 1984). One source was related to the treatment of children in general (Oaklander, 1997), and the rest of the articles focused on eclectic approaches to the treatment of PTSD, where Gestalt therapy was also employed. Of these 14 journal articles, four appeared in Gestalt journals (*Gestalt Journal* and *Gestalt Review*) while the remaining ten appeared in journals in the low impact index (the index is based on the number of times articles in a journal are cited in other journals). As a frame of reference, please note that the combination of the terms "cognitive therapy" and "trauma* or PTSD" yielded 609 citations of which 409 were journal articles. A similar search through the Medline database, which covers mostly medical journals, yielded a ratio of 0 to 67 between Gestalt therapy and cognitive therapy.

Another prestigious source of information about the treatment of PTSD is the *Expert Consensus Guidelines for PTSD* (Foa, Davidson and Frances, 1999). These guidelines were developed by 52 experts on PTSD treatment from all over the United States and abroad. In their guide for patients and families, this team of experts recommends three types of psychotherapy for the treatment of PTSD: anxiety management, which includes relaxation training, breathing retraining, positive thinking and self-talk; assertiveness training and thought stopping; cognitive therapy; and exposure therapy, both in imagination and in reality. For the treatment of children with PTSD the team suggests play therapy. The team also recommends the use of education and supportive counseling for patients and their families. The experts indicate that Eye Movement Desensitization Reprocessing (EMDR), hypnotherapy and psychodynamic therapy may sometimes be helpful, but they don't consider these approaches to be as effective as the approaches mentioned previously. Needless to say, the term "Gestalt therapy" and its specific components— awareness, assimilation, empty chair, re-enactment, unfinished business, body-process, here and now, or process—do not appear in these guidelines, nor do the concepts of experiential therapy or emotion focused therapy, whereas exposure appears more than 60 times. [For further review of the references to Gestalt therapy and PTSD in additional mental health databases, see Appendix A.]

Of course, these grim findings do not indicate that Gestalt therapists fail to treat patients suffering from PTSD. They do indicate that Gestalt therapists do not bother to report their work and they appear to refrain from sharing it with their colleagues. Thus, Padeski *et al*. (2002) can proudly summarize, "In sum, mental health professionals can be heartened by cognitive therapy research on PTSD," while Gestalt therapists did not earn even the "Dodo bird verdict." The Dodo bird verdict refers to Lewis Carroll's statement, "Everyone has won so all shall have prizes." This statement is often cited as the outcome of meta-analyses of comparisons of active treatments. It indicates insignificant differences among psychotherapies (Luborski *et al.*, 2002). Thus, by not being cited, Gestalt therapy fails to win even the Dodo bird prize.

As I documented above, it is obvious that Gestalt therapy has a lot to offer to the treatment of PTSD, from its theoretical to its technical aspects. Furthermore, one of the main goals of Gestalt therapy is to promote growth and self actualization. Thus, it is ironic and frustrating that Gestalt therapy has not actualized its own potential and made its mark on the professional literature on PTSD treatment.

We note that the low publication rate of studies relating to Gestalt therapy and PTSD, as well as its lack of inclusion in discussions of therapeutic issues and PTSD in the professional circles, are not just a matter of prestige. This lack of recognition may lead to financial implications for therapists who practice only Gestalt therapy.

One way in which the International Society for Trauma Stress Studies (2002) tries to help clinicians in evaluating the use of various treatment approaches to PTSD is by offering a six category code for the strength of evidence for the utility of each approach. These categories are: Level A, randomized controlled clinical trails; Level B, well-designed clinical studies without randomization or placebo comparison; Level C, service and realistic clinical studies combined with clinical observations; Level D, long-standing and widespread clinical practice, which has not been subjected to empirical tests; Level E, long-standing clinical practice by circumscribed groups of clinicians, which has not been subjected to empirical tests; and Level F, recently developed treatment that has not been subjected to clinical or empirical tests. By applying this code to the status of Gestalt therapy in the treatment of PTSD, it seems that it should be ranked on level E. This rank is indeed not a complimentary one. Greenberg, Elliott and Lietaer's (1994) plea for more research on experiential and related humanistic therapies remains unheeded. Greenberg *et al*. note that previous research in this therapeutic mode focused "on populations with general self-esteem or interpersonal problems, rather than on populations with specific disorders." However, they posit, "for political and economical as well as for scientific reasons, it is now important to invest more energy in assessing treatment outcome for specific conditions and disorders" (p.531). In view of the earlier discussion about the theoretical contributions of Gestalt therapy to the conceptualization and treatment of PTSD, I suggest to therapists who want to follow Greenberg *et al.'s* recommendations, and focus on research in a specific disorder, that they focus on the impact of Gestalt therapy on PTSD.

While specific recommendations on improving the poor state of research in the area of Gestalt therapy among PTSD patients are beyond the scope of this paper, some general recommendations may be in order. The first requirement is to ascertain that there is a formal diagnosis of PTSD. The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorder* (DSM-IV, American Psychiatric Association, 1994) together with the Structured Clinical Interview (SCID) for DSM-IV Axis I (First, Spitzer, Gibbon & Williams, 1995) enable most therapists to obtain a reliable diagnosis of PTSD as well as most other diagnoses.

Another aspect of research relates to the methodological characteristics of a study. In this regard the turn of the 21st century is characterized by a paradigm shift in social sciences from the total tyranny of positivistic quantitative research to the acceptance of qualitative research as a legitimate approach to the study of human nature (Banister, Burman, Parker, Taylor & Tindal, 1994). Thus, case studies (Yin, 1988), case reports, and phenomenological studies are acceptable in most respectable journals. For example, *Psychological Methods*, a publication of the American Psychological Association and a prestigious journal, has recently pub-

lished a one-subject study about a woman's experience of work-family conflict using a phenomenological approach (Hein & Austin, 2001; see review in Cohen & Daniels, 2001). Gestalt therapists experienced in the phenomenological approach, but unfamiliar with the mysteries of psychometrics and statistics, may write case studies and reports on their therapeutic experiences. They can describe the course of treatment as well as what they have found unique about PTSD patients and their therapy. Another approach that a clinician may use for therapy research is a single case experimental design (see Barlow & Hersen, 1984) in which inferences can be drawn about intervention effects by utilizing the patient as his or her own control. Thus, a therapist may ask a client to complete a standard questionnaire of PTSD symptoms before each session and, in this manner, observe the unfolding of the recovery process. As to studies of more than one subject, we should keep in mind Kazdin's position that "studies of small samples are particularly important in psychotherapy research to examine complex interaction sequences between therapist and patients" (1994, p. 28). In addition, Gestalt therapists may collaborate with teams of therapists who apply different approaches in the practice of therapy with PTSD patients who may serve as a control group for their approach. Clinicians who would like to explore doing a research on PTSD may do so by responding to the Call for Traumatic Stress Prevention and Intervention Programs available from http://www.istss.org/ISTSSD/ NREPP.htm. I hope this article will encourage Gestalt therapists to respond to this challenge.

In conclusion, although Gestalt therapy is the treatment of choice for PTSD theoretically, strategically and tactically, it fails to achieve its proper status and recognition among the various approaches for the treatment of PTSD. Though disconcerting, this unfortunate disparity will prevail as long as Gestalt therapists continue to hold the view that "the obvious and clinically-supported relationship between Gestalt therapy and the treatment of PTSD clients" exists without any attempt to validate this claim with well-established research-based data. The current rules of the game in psychotherapy are documented "proofs" of efficacy. If we as Gestalt therapists maintain our unwillingness to play by these rules, we may find ourselves out of the game. I hope that this article will stimulate and encourage Gestalt therapists to document and report case studies of therapy with patients who suffer from PTSD, and to take part in quantitative studies of this condition.

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APPENDIX A

In view of the scarcity of research on PTSD and Gestalt therapy in the standard sources, I decided to explore the documentation of the efficacy of Gestalt therapy in PTSD treatment in a venue dedicated to PTSD research, the National Center for PTSD (http://www.ncptsd.org). Nevertheless, disappointment ensued. The catalog of the center contains 18,000 abstracts that relate to PTSD, of which only 14 contain the term "Gestalt therapy," in contrast to 808 citations of the term "cognitive therapy." Furthermore, among the studies supported by the center, only two mentioned the term "Gestalt therapy" and then only in a casual manner, in contrast to 106 studies that mentioned "cognitive therapy."

Another source for information about mental health issues is the National Institute of Mental Health (NIMH). I used the agency's Computer Retrieval of Information on Scientific Projects to discover how many research projects the agency had funded on Gestalt therapy and PTSD. This search indicated zero projects, versus 114 projects on PTSD and cognitive therapy (National Institute of Mental Health, 2002). Furthermore, a press release from this agency states, "Studies show that people can

improve with cognitive-behavioral therapy, group therapy, psycho-education, or exposure therapy" (National Institute of Mental Health, 1999).

A more popular and less professional source for information on mental health issues is Mental-Health-Matters.com, an internet site that offers information and resources for consumers. Following the assumption that perhaps a less academically oriented source would be more welcoming to Gestalt therapy, I have searched this source as well, but alas, even in this popular site, the tyranny of cognitive therapy and exposure prevails as the main therapeutic approach to PTSD.

A search in a more internationally oriented site, the International Society for the Treatment of Stress Studies (2002), yielded the practical guidelines to PTSD treatment. These guidelines include 12 approaches to therapy, ranging from cognitive behavioral therapy to EMDR. I could not find any trace of Gestalt therapy or its related terms even in the section for pediatric PTSD or among the creative art therapies.

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