Images of the “empty chair” or the “hot seat” come to mind when the uninitiated hear the words “Gestalt therapy.” This was the focus of much of Fritz Perls’s work in the 1960s and 1970s, but, with the contributions of newer Gestalt and other “process/experiential” theorists, Gestalt has become a rich and multifaceted therapy. Four aspects of Gestalt practice are particularly relevant to HIV-related therapy and are covered in this article: the client-therapist relationship, the “phenomenological method,” awareness as the goal of therapy, and “experiments” and role playing.

The “Gestalt experience cycle”—a model of how people get their needs met—defines healthy psychological functioning and is a useful paradigm for HIV-related therapy. The cycle begins when a person experiences the sensation of an emerging need and develops a cognitive awareness of the need. The individual then surveys the environment for possibilities available to meet that need. From these options, the individual makes a choice, mobilizes energy, makes contact with a person, place, or thing in the environment to implement that choice, and takes action. At that point, the need is either satisfied or, if the choice is found to be unavailable, inappropriate or unnourishing, the need remains unmet. If unmet, the need recedes from being the focus of the person’s awareness, but may remain in the background of the person’s awareness and feelings as unfinished business. (See diagram, page 3).

A simple example of this is a person noticing a dry feeling in the mouth, becoming aware of thirst, looking for a drink, finding water and milk, choosing the water, pouring a drink, drinking it, and satisfying the thirst. If the person were distracted and unaware of his thirst or bedridden and unable to go get a drink, or if no drinks were available, then the need for a drink would remain unmet. The person might ignore or suppress the need for the moment, but it would remain in the background of his or her awareness until it could be met.

In the context of this cycle, healthy functioning means being able to become aware of one’s emotions, needs, and desires, and to move freely—feelings of entitlement and competence—through this cycle. It means being able to express emotions and to act to meet needs in order to grow and fully be oneself. Pathology, in Gestalt terms, does not have to do with diagnostic labels of disorders, but rather with interruption of this process of self-regulation. An interruption might occur when a person, feeling a lack of entitlement, does not allow his or her needs to come into awareness; when he or she gets stuck at the point of contact or action, due to undeveloped social skills or fear of other people’s reactions; or looks in the wrong places for the satisfaction of needs, for example, by turning to addictive substances for soothing or nurturance.

Client-Therapist Relationship

Gestalt theory sees the relationship between client and therapist as an existential connection between two human beings in the here and now, a dialogue between equals. The Gestalt therapist’s “presence” is felt to be a powerful force, a conscious turning toward and attending to the client’s unique personhood with care and acceptance, an approach that seeks to be an antidote to the objectification, ostracism, stigma, and shame that can
Cognitive-Behavioral and Experiential Therapy

A small Dutch study found that cognitive-behavioral group psychotherapy and experiential group psychotherapy were equally effective in decreasing psychological distress in a sample of HIV-infected, asymptomatic gay men. Subjects in the groups did not, however, experience significantly greater changes than controls in coping, social support, or emotional expression.

Researchers recruited 39 seropositive asymptomatic men from a larger Dutch study. These men were not taking antiviral drugs or undergoing psychotherapy, were between the ages of 18 and 65, and had no history of substance dependency. The men were randomly assigned to one of two treatment conditions: a cognitive-behavioral therapy group, an experiential therapy group, or a waiting-list control group. Groups consisted of six to nine men and two group leaders, all of whom were gay men. Each group ran 15 sessions, each 2.5 hours long, and included an eight-hour workshop in the middle of the series. Researchers evaluated participants for mood, depression, and general health at baseline, immediately after the series, and again three and six months later.

Researchers chose cognitive-behavioral therapy because prior studies had indicated its effectiveness among people with HIV disease. They selected experiential therapy because it seemed to fit some of the pressing needs of seropositive gay men. Study interventions aimed at reducing psychological distress, improving coping with HIV infection, increasing social support, and increasing expression of emotions.

Cognitive-behavioral sessions were more structured than experiential ones, and therapists helped participants develop individually tailored behavioral action plans. Each plan included increasing physical exercise and practicing relaxation on a daily basis. At each session, leaders introduced a topic, led exercises related to the topic, and facilitated group discussions. Topics included: relaxation, enhancing of self-esteem, expression of intense emotion, dealing with sexual relationships, the importance of a social network, and developing communication skills. Leaders trained participants in cognitive restructuring, behavior change, and assertiveness skills. They also covered the optimal use of stress management: using problem-focused active coping strategies for controllable stressors and emotion-focused coping for uncontrollable ones.

The experiential therapy group was based on principles of the humanistic-existential therapy tradition. It sought to enhance clients’ abilities to act and speak from personal awareness of the inner experiential process and to develop an authentic understanding of their life situations. Therapists functioned to help participants become aware of inconsistencies among emotional, cognitive, and behavioral spheres and to reestablish congruence among them. Many members indicated an interest in becoming more emotionally expressive and developing a new life perspective.

The lack of difference in results between the two approaches may be caused by several factors. First, participants and therapists in both types of group shared similar qualities. Second, the approaches shared common elements: group support, therapist support, opportunity for emotional expression, and homework. Third, pre-intervention distress levels may have been too low to show subtle differences in improvement related to therapeutic approach. Fourth, group sizes may have been too small to register differences between therapies. Researchers did, however, find a difference in perceived benefits of the two groups. Participants preferred experiential therapy, perhaps because it allowed more group interaction than the cognitive model.
Editorial: Times Are Changing
Robert Marks, Editor

Therapy is about change—changes in behavior, attitudes, or beliefs, but ultimately about changes in awareness. Two contemporary theories of psychotherapy—Gestalt and Control-Mastery—conceive of the experience of change, not as a goal of therapy, but as a crucial part of the therapeutic process.

Adjusting to HIV disease, perhaps more so than facing other psychotherapeutic challenges, is about adjusting to a new reality: whether you are seropositive or seronegative, the epidemic forces shifts in perspective. At a time when viral load testing, protease inhibitors, and combination treatment have shaken what had become settled conceptions of AIDS, adjusting to new ways of living with HIV infection is as essential as adjusting initially to the presence of a life-threatening virus.

Both Gestalt and Control-Mastery rely on the ways in which clients experiment in therapy as an integral part of the therapeutic process. In Gestalt, according to Stephanie Sabar in this issue of FOCUS, the therapist encourages the client to “try a behavior on for size’ or to experience an unfamiliar or uncomfortable feeling or way of being.” In Control-Mastery, Joseph Grebel states in his article, that “testing” is a process by which “the client unconsciously reproduces traumatic experiences in hopes of achieving different outcomes and gathering new information that makes it safe to relinquish the pathogenic beliefs and their connected behaviors.”

Try It on for Size
These tools may be especially useful in individual therapy to help clients try on for size the new roles that confront them in the wake of successful antiviral treatment and to examine the ways in which clients might have responded to delight and disappointment in the past. But experimenting may also be a useful tool for any of us to test the new realities of AIDS, to see whether it suits us to begin to hope. Maybe we, as people working in and living in the epidemic, need to experiment more consciously with the new roles we may be asked to play—both professionally and personally.

Change is happening, and for many of us, it has been painfully long in coming. But most of us are unlike chameleons, ready to blend effortlessly into new surroundings. Each adjustment takes energy. Even a change for the better can be difficult, triggering a change in world view and requiring flexibility, imagination, and patience. And a willingness to try on for size the new roles that seem to come only in extra, extra large.

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accompany HIV disease.3 This relationship develops the client’s feeling of self-worth, supporting his or her confident movement through the “Gestalt experience cycle.”

Gestalt theory holds that the therapist’s appropriate self-disclosure can strengthen the therapeutic bond and furthers the goals of therapy. A tear in the eye or a hug after a particularly moving session may help the client know that the therapist has been genuinely touched.

In one case, a client with HIV disease was berating himself for his imperfections, as he had started drinking again after years of sobriety. After finding him drunk on a home visit, I told him I would only continue to see him on the condition that he not be intoxicated during our sessions. A few visits later, I detected alcohol on his breath, but somehow didn’t say anything, because he was not acting drunk, and I wanted to work with him towards enrolling in an alcohol treatment program. On a later visit I confessed that I had smelled the alcohol, but had decided nonetheless not to leave, because I wanted to be there with him. I said, “I guess I’m not perfect either, I didn’t follow my rule about leaving.” The client was totally relieved by my admission, both because he realized he had been testing my unconditional acceptance of him, and because I joined him in being imperfect, so he didn’t have to be perfect himself.

Gestalt theory does not suggest that therapists should disclose every experience to clients. For instance, it would not further therapy for a therapist to reveal that he or she was overwhelmed by what a client was going through, since the client, fearing that the therapist could not handle further revelations, might close up or withdraw from the process.

Phenomenological Method
The Gestalt therapist observes and describes, rather than interprets, a client’s behavior, expression, and experience, minimizing assumptions and preconceptions. This process is called the “phenomenological method,”4 and communicates trust in the validity and authority of the client’s subjective experience. This method is extremely important in working with people with HIV disease, particularly regarding medical treatment decision-making and issues around quali-
**Body-Oriented Therapy**


A body-oriented therapeutic approach combining psychodynamic exploration and dance movement responds to the HIV-related amplification of women's body-oriented conflicts, according to a report on Body Talk, a support group for seropositive women in San Francisco.

Started in 1989 by movement educator Anna Halprin, Body Talk focuses on three principles. “Integrating embodiment” allows group members to experience and work through internalized shame by identifying and attending to specific body sensations that need attention. “Practicing disorientation” is a survival skill crucial for dealing with loss. It teaches participants to “find their way by getting lost” and to make room for the “not-firm, not-cohesive, and even the not-vital part of themselves.” “Holding ambiguity” permits participants to experience physical vulnerability and fear of death as coexistent with bodily pleasure and engagement in life. It helps group members face death and the unpredictability of HIV infection.

A minimum of five and a maximum of ten women participate in a group, which are offered in three-hour sessions every other week. Participants commit to working with the group for at least four months.

Two concepts of self-psychology inform the theory behind Body Talk. First is that the relationship to the physical body is crucial to a sense of self. Second is that in order to develop a strong and flexible sense of self, children need to have mirrored by their caretakers the behaviors, qualities, and capacities that emerge in the normal course of development.

Among these qualities is exhibitionism, which arises as a physical expression of a sense of grandiosity and emerges during the developmentally crucial time—the “practicing” sub-phase of separation and individuation—when a girl has a strong need to let her sense of omnipotence thrive. Instead of validating this quality in girls, the environment is likely to discourage it, deflating the exhibitionistic self before adequate inflation occurs and limiting the child’s sense of body self. In addition, girls are taught to be exhibitionistic in one way—appearance—and to be sexually attractive but not sexual. Quoting one researcher: There is an “ambivalent focus on bodily appearance and body fragments, to the exclusion of other parts of the self,” and this leads to a less cohesive sense of the body and the lack of integration of the sense of body into self. The result is bodily shame.

In women, HIV infection amplifies body-oriented conflicts, representing the ultimate betrayal of the body. It also appears to confirm women’s pathogenic beliefs in the worthlessness and dirtiness of their bodies. HIV infection is linked to other concepts—perversion, promiscuity, contamination, and drug abuse—that can also evoke self-loathing and trigger fears of death and abandonment. In addition, for many women who have been socialized to organize themselves primarily around the care of others, taking responsibility for self can be disorganizing.

In response to this range of issues, Body Talk groups use interventions that operate simultaneously on verbal and physical levels. Although physical movement is central, language enables participants to describe the connection between physical sensations and affective states during the exercises. Linguistic associations can uncover psychic struggles and give way to repressed or denied elements of experience.

The group begins with a verbal check-in and a 10 to 20 minute guided visualization exercise. Next, participants engage in an improvisational movement exploration to increase their awareness of their immediate physical and kinesthetic experience. This may be focused on awareness of a particular part of the body, concepts such as expanding, contracting, rising, or falling, or the relationship to a movement partner. The movement activity is followed by a second verbal check-in to incorporate material that has arisen during the movement: physical sensations, affective responses, or thought or image associations.

Finally, each participant uses this material to create an “individual score,” an improvisation in which all participants then play a role. For example, participants might play the role of an ailing body part to give it a voice, an introjected image to identify and address attitudes and assumptions, or a person to bring in family members or social situations. After performing each score, participants discuss their experiences and insights.
The wise use of “creative adjustment” makes possible the synthesis of incompleteness and wholeness, contraction and expansion.

Authors
Stephanie Sabar, MSW, LCSW, is a social worker with Los Angeles Jewish AIDS Services—part of Jewish Family Services of Los Angeles—where she does counseling and case-management with HIV-infected clients and leads a bereavement group and a support group for family members of people with HIV disease. As a volunteer, she also provides individual counseling at the Pacific Center for HIV/AIDS Counseling and Psychotherapy. She was a trainee at the Gestalt Therapy Institute of Los Angeles from 1992 to 1996.

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Felberbaum S. Psychoanalytically oriented psychotherapy with the HIV-infected client full of resentment and frustration over a parent’s failure to support him or her through the illness might imagine that parent in the empty chair. The client would tell the parent everything the client expected from the parent and everything the parent failed to deliver. The client would then express the sadness or anger that the betrayal evokes. When such an exercise is effective, the client resolves the unfinished business “either by forgiving the other or holding the other accountable.” In terms of the goal of completing the experience cycle, the empty-chair work allows the client to let go of the unmet need that has disturbed him or her, attain closure, and return to a state of rest.

Conclusion
Applying the Gestalt ideals of self-regulation, wholeness, and growth to a person with HIV disease might seem an exercise in futility. The virus destroys the body’s most basic process of self-regulation, the immune system. Loss, contraction, and deterioration oppose expectations of growth. Yet, the wise use of “creative adjustment” makes possible the synthesis of incompleteness and wholeness, contraction and expansion, deterioration and growth. This process implies taking into consideration “what is,” the demands and limitations of illness and disability.

Yet equally apparent is the opportunity to learn, from the awareness of “what is,” and to imagine a way to go beyond adversity to grow in emotional maturity, spiritual awareness, and sensitivity and connection to others’ pain and suffering. These qualities may then come full circle to nurture and sustain the person in facing misfortune in a more fully supported way.
Control-Mastery theory asserts that psychotherapy clients unconsciously direct and structure their treatment in order to progress toward specific, healthy goals. It is a particularly useful framework for understanding why clients engage in unsafe sexual behaviors and how to intervene with clients to help them stop.

Developed by Joseph Weiss and his colleagues at the San Francisco Psychotherapy Research Group, Control-Mastery posits that people are inherently healthy and that problems arise in response to real-life traumas and interactions with parents and other significant caregivers. Weiss's theory sees people in treatment as fundamentally motivated to overcome internal obstacles standing in the way of achieving healthy goals. The therapist's task, therefore, is to infer the client's plan and to create a safe environment in which the client can examine and modify his or her internal process.

**Basic Tenets**

Control-Mastery theory conceives of clients as entering treatment with an unconscious, case-specific plan for overcoming what they perceive, again, often unconsciously, as preventing movement toward their goals. Empirical research has shown that when clients enter treatment, they lay out their plan in the first few sessions, albeit often indirectly through historical and other information, including family and personal history, and conscious concerns and frustrations. The plan consists of four components: the client's "Goals" (which may be unconscious); "Pathogenic Beliefs," that is, beliefs that act as obstacles to achieving goals; "Tests," or trial actions, whereby the client repeats past traumatic experiences in therapy with the hope of a different outcome; and "Insights" the client may have into the origins and impact of his or her maladaptive beliefs.

Psychopathology is thought to derive from pathogenic beliefs, which arise because children often infer personal responsibility for traumatic experiences and interactions with their parents and other caregivers. A child with a depressed parent, for example, will draw conclusions regarding what he or she has done to cause the depression. Similarly, a child with a parent who does not provide adequate care will conclude he or she does not deserve to be safe and nurtured.

Pathogenic beliefs also relate to both survivor guilt and separation guilt, which also arise from the child's motivation to maintain attachment with the parent. Survivor guilt is based on the irrational belief that the child's happiness and success come at the expense of others. Separation guilt derives from the idea that the child is hurting others by pursuing an independent existence. As a result of either, the child may unconsciously abandon healthy goals until he or she finds a safe opportunity to test and, ideally, contradict these beliefs in the context of another relationship.

**Testing**

The goal of therapy is to "disconfirm" such pathogenic beliefs, and testing serves this goal. In therapy, the client unconsciously reproduces traumatic experiences in hopes of achieving different outcomes and gathering new information that makes it safe to relinquish the pathogenic beliefs and connected behaviors. This process occurs in two ways: transference testing and passive-into-active testing.

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In transference testing, the client reproduces the original relationship with the therapist in the role of the parent. The client unconsciously observes both the therapist's statements and behaviors to see if the original trauma is repeated. In passive-into-active testing, the client portrays the role of the parent who inflicted the trauma and the therapist is placed in the client's role as a child. Passive-into-active testing can be less threatening to the client than transference testing, because he or she adopts the more powerful role but, simultaneously, it may be more difficult for the therapist to endure. Through this process, the client unconsciously hopes the therapist will model a response that is more adaptive and resilient than the client's childhood response. Both types of testing behavior serve the function of gathering evidence regarding whether or not it is now safe to challenge pathogenic beliefs and examine the painful behaviors, experiences, and memories related to those beliefs.

When a therapist's interventions in response to such testing are “pro-plan”—that is, when they reinforce what the client is attempting to accomplish without laying blame, inducing guilt, or assuming the client is resistant to increased health—the client is able to become more emotionally involved in treatment. As a result, the client often recalls new memories related to the maladaptive beliefs and feels safe enough to test these beliefs more vigorously.

Testing Safer Sex

How does all of this help to explain unsafe sexual behavior among gay men and suggest the best therapeutic response? A Control-Mastery case formulation would assume that unsafe sex, like any self-destructive behavior, arises in deference to unconscious pathogenic beliefs. The case-specific variations on these beliefs are infinite, but some general examples illustrate the possibilities: a general belief about self-worth, a belief that sexuality is shameful, or a belief about not deserving a healthier, longer life than one’s contemporaries. Further, Control-Mastery suggests that the client is motivated to abandon these beliefs because they are psychologically painful and stand in the way of healthy goals.

A case example illustrates these ideas. Jack entered treatment wanting to “fix” his relationship. He told his therapist that he had recently discovered that his boyfriend, Hal, was having sex outside the relationship and had lied about it. Jack was concerned about having unprotected sex with Hal, but felt unable to change this aspect of the relationship because he believed that he was doing something to cause Hal’s behavior. Instead of seeking to confront Hal, Jack sought to change himself.

In the course of the first few sessions Jack also explained that his parents’ relationship had been unhappy largely because his father was alcoholic and abusive. From this and additional information, the therapist made two inferences: Jack felt responsible for his partner’s actions in the same way Jack and his mother had felt responsible for his father’s drinking, and Jack wanted help confronting his partner and possibly leaving the relationship. Jack would test his beliefs by bringing up examples of his “flaws” and “mistakes” to see if the therapist would view this as evidence that he deserved mistreatment. When the therapist refrained from doing so and actively supported Jack’s right to protect his psychological and physical health, Jack appeared temporarily relieved and then brought up additional, stronger “evidence” to test his beliefs further.

By strongly and directly asserting his concerns that Jack was taking sexual risks in order not to displease his partner, the therapist was protective of Jack in a way Jack’s mother had never been. Further, the therapist suggested that Jack’s behavior represented compliance to the messages he had received in childhood about deserving mistreatment, being inherently unlovable, and being overly responsible for the actions of others. Through this process of testing, Jack was able to understand the role of maladaptive beliefs in sabotaging his healthy goal to protect himself from HIV, and to relieve himself of responsibility for Hal’s behavior, so that he could confront Hal with his desires for the relationship.

Comments and Submissions

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ty of life, where there are no clear objective criteria and decisions are based on the individual’s personal perspective.

Honoring the client’s defenses and resistances is essential to the phenomenological method. It means understanding and respecting what the client says or does, even when it appears to be unhelpful in meeting his or her needs. The Gestalt approach sees client defenses as adaptations or “creative adjustments” for self-protection. Once client and therapist accept such actions as valid in the context of the client’s past experience, then the client can evaluate whether this way of being serves him or her now.

Resistance within the therapeutic relationship needs to be supported as well. Some clinicians believe clients must “face reality” and may push HIV-infected clients to look at their pain and loss, when they are not ready to do so. A Gestalt therapist supports the resistance, acknowledging the difficulty of exploring such issues, but lets the client know that the therapist is open to such discussions when the client is ready. Forcing the issue can result in the client feeling, at best, not understood and, at worst, great anxiety.

Awareness

Awareness, not change, is the goal of Gestalt therapy. According to “the paradoxical theory of change,” “change occurs when one becomes what he is, not when he tries to become what he is not.” With this in mind, the client’s first task in adjusting to HIV disease is to incorporate the awareness that he or she is HIV-infected. Only when this is integrated can a person go on with life without going to the extremes of either denial of living (“I’ll die tomorrow”) or denial of dying (“I feel fine, so nothing’s wrong”). The cognitive dissonance between direct experience and biological reality can make integrating this awareness particularly difficult for an asymptomatic person, who must balance the knowledge that he or she feels well with the reality that a viral invader is destroying his or her body’s defenses.

An area of awareness of particular interest to Gestalt therapists is the client’s “process,” how a person moves or interrupts movement through the experience cycle. What does a person do to open up or close off awareness of experiences, feelings, and needs? How does he or she think, act or react? How does a person make or interrupt contact with others? In what ways does a client accept or reject help or support offered by others? Since therapy cannot change the content of the problem, in this case, being HIV-infected, looking at the way a client responds to this reality is more useful. With this awareness, clients can evaluate whether their process helps them meet their needs and if not, can experiment with other ways of thinking and acting.

For instance, therapy can encourage a lonely client to look at what he or she is doing to cut off contact with others. This behavior may be based on distorted assumptions that the client can check out when they are brought to his or her awareness. A closer look might reveal that this client has failed to return phone calls because he or she has mistakenly assumed that friends do not want to see him or her in a deteriorated state.

Experiments and Role-Play

“Experiments” and role play are distinctive components of Gestalt therapy. In the safe environment of the therapy setting, the client is encouraged to “try a behavior on for size” or to experience an unfamiliar or uncomfortable feeling or way of being. Such experiments can open up a deeper awareness and offer alternative ways of being and responding, so that a person can discover more effective ways to move through the experience cycle. The therapist might ask a timid person to walk across the room like a fearless warrior and then explore what that experience revealed to him or her.

This approach is also useful in working with dreams. A client with HIV disease dreamed he was on a desert island facing a frightening hurricane with a grass hut as

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