Learning Theory and Gestalt Therapy

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This article discusses the theory and operations of Gestalt Therapy from the viewpoint of learning theory. General comparative issues are elaborated as well as the concepts of introjection, reflexion, confluence, and projection. Principles and techniques of Gestalt Therapy are discussed in terms of learning theory paradigm. Practical implications of the various Gestalt techniques are presented.

Despite the large number of psychotherapeutic approaches now being practiced (1), basic to all of the theories is the assumption that much of our behavior is learned and shaped by our experience. Although different practitioners may debate the importance of their particular theoretical framework to behavior and personality change, few would dispute the principles or “laws” of learning and conditioning as they apply to animals or humans. Few, however, have seen fit to examine to what extent the principles of learning theory and social-learning theory may account for their particular theoretical rationale of psychotherapeutic change. As Matarazzo (2) has pointed out, what therapists of different theoretical orientations say goes on in therapy is not necessarily what they do in therapy. Without a doubt, learning occurs in therapy as in all other facets of life, whether or not the therapist is aware of it. To the extent that this learning is not congruent with what a particular theory tells the therapist “should” be going on, the patient’s behavior may be misinterpreted and the therapist may be unaware of his true influence on the patient.

With this point in mind, we have attempted to take a look at some of the theory and operations of Gestalt Therapy from the point of view of learning theory. Learning theory here will mean the principles of operant and classical conditioning, together with social-learning theory, which have been applied in therapeutic interventions by behavior therapists. Because

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we undertook this topic as a creative and, we hope, thought-provoking dialogue, intended for others interested in therapy, we make no claim for this as a formal scientific treatise. The results of our dialogue have been organized into five topics: (1) some general comparative issues; (2) four concepts of Gestalt Therapy: introjection, retroflexion, confluence, and projection; (3) the general principles of Gestalt Therapy; (4) techniques of Gestalt Therapy; (5) finally, some practical implications.

GENERAL COMPARATIVE ISSUES

If one examines Gestalt theory and clinical applications of learning theory in their emphases on different aspects of the therapeutic process, certain similarities emerge. First, both appear to be process-oriented rather than content-oriented as is traditional psychoanalysis. What is happening in behavior therapy and Gestalt Therapy is more important than why it is happening, the central issue in psychoanalysis. Both approaches place a heavy emphasis on the how aspect of behavior. The behaviorist-clinician is interested in the environmental factors now shaping his client's behavior; likewise, what the patient is experiencing and doing in the present is the primary area of focus for Gestalt therapists.

There are, however, some differences worth pointing out. Compared to the behavior therapies, Gestalt Therapy does place a heavier emphasis on one's awareness of feelings and behavior. The starting point in Gestalt Therapy is indeed "What are you aware of right now?" To illustrate this point, Gestalt therapists would conceptualize an act as follows: need, awareness, excitement, approach, contact, satisfaction. While behavior therapies do employ "awareness" techniques, such as self-observation (particularly when the problems involve habits such as smoking or overeating), the focus is primarily on the behavior and the antecedent and consequent events associated with it, rather than the "experiencing" of it. Thus, the basic learning paradigm is typically diagramed as follows: (discriminative stimuli) \[ \rightarrow \] operant response \[ \rightarrow \] consequence.

Consistent with its emphasis on awareness, Gestalt Therapy also places a heavier emphasis than behavior therapies on a person's cognitions and fantasies. Although desensitization and implosive therapy do rely on imaginal or fantasy material, the content matter is generally specific to the particular avoidance response (avoiding elevators or snakes, for example) and incompatible approach response. There is less freedom to "go with the feeling" than in Gestalt Therapy, an unstructured technique that is reminiscent of free association. Moreover, a patient's verbal "behavior" also attracts more direct attention in Gestalt Therapy than in the behavior therapies, in which it is considered more a medium for communicating descriptions of actions and consequences.
In a sense, the transactional focus between the patient and therapist is also more obviously a tool for change in Gestalt Therapy: the patient is challenged "to approach," corrected in not gossiping, and coached in the various "games" and "exercises" of Gestalt Therapy. Implicit is the assumption that these transactional dialogues and the new awareness will have application to the real-life situations and problems the patient is experiencing. In therapies based on learning theory, however, the therapist works with the patient in defining the presenting problems in explicit behavioral terms and then outlines, again with the patient, a structured plan directly focusing on eventual execution of overt acts. In particular, careful attention is placed on the limitational constraints that environmental factors place on behavior.

In learning theory "awareness" of new stimulus-response or operant relationships does not necessarily lead to behavior change. Implicit in Gestalt theory, however, is the assumption that there are emotional and behavioral blocks to one's need fulfillments, which, when removed, permit self-satisfaction. As Naranjo (3) has pointed out:

The immediate aim of Gestalt Therapy is the restoration of awareness. Its ultimate goal is the restoration of the functions of the organism and the personality, which will make an individual whole and release his potentialities. It assumes that awareness by itself will bring about development and change.

Although the patient may be temporarily dependent on the therapist to structure the therapy session, the Gestalt therapist's role is to insist that that patient assume responsibility. Clearly, the patient is seen as a potentially active agent, fully capable of effecting environmental changes resulting in need satisfactions. In learning theory the classically conditioned response is essentially a passive reaction to an environmental event, and the operant response, while initiated by the organism, is governed by the environmental response or consequence. Although verbal mediation and large response repertoires permit great behavioral flexibility, there is still no real construct of "free choice" for the patient in the therapeutic activities of a behavior therapist. For this reason, it seems justified to state that the "locus of control" in Gestalt Therapy is, comparatively speaking, more internal, while that of therapies based on learning theories is more external, even though both therapies, if successful, presumably "free" the individual to "higher," more independent modes of functioning.

In relating these observations, we have by no means exhausted all the possible similarities and differences worth noting, nor do we argue that they are absolute comparisons in any sense. The points made thus far, however, are intended to give the reader a feeling for some of the differences and likenesses in the two approaches that might not otherwise be apparent as
we attempt to "make sense" out of Gestalt Therapy in terms of learning theory.

**Some Basic Concepts**

Four concepts central to Gestalt theory are introjection, retroflexion, confluence, and projection. Because these phenomena are commonly manifested in human behavior, it should be possible to conceptualize them in terms more familiar to a learning theorist.

**Introjection**

Introjection, a term borrowed from psychoanalytic theory, describes parental characteristics and influences incorporated into the newly formed personality of the child. Introjection is similar to identification in that characteristics of another person are taken on, but it is a more primitive process, occurring earlier. Intros of typical interest to the clinician are parental values, attitudes, or behaviors that are not "intrinsically congruent" with the child's needs and "real personality."

Bandura and Walters (4) have described introjection as the acquisition of behaviors modeled by other individuals, especially parental figures. This does not, however, explain the clinical observation that the intros are often dissonant, unpleasurable features of the patient's personality. Therefore, we would add the following explanation. Assume that the model is "very powerful" (such as a parent) and is being reinforced for behaviors that may not be necessarily a means of satisfying the observer's (child's) own needs but are, in the observer's environment, either the only behaviors that are being rewarded (for the model) or the only behaviors capable of evoking certain kinds of rewarding consequences (for example, sex, attention). To the extent that competing behaviors are punished, this effect is strengthened, and behaviors that may otherwise better satisfy the patient's needs are inhibited. These competing behaviors may be punished in the observer or the model or both.

Such a pattern could theoretically result in "introjection" of behaviors that are paradoxically not particularly successful in obtaining rewards for the patient. For example, a young girl who has "introjected" her mother's passive, helpless attitude toward the father may have done so because of repeated observations of her mother's being "rewarded" (with positive consequences from the father, or termination of unpleasant events). Although this behavior may not be particularly rewarding to the girl, she may retain it because of the very strong modeling effect and because either she may have never learned alternative behaviors or they were inhibited.

**Retroflexion**

Retroflexion in Gestalt theory means a turning inward or holding back
of a need or impulse more appropriately expressed outward. Whereas Gestalt Therapy tends to emphasize the withholding of an impulse, at some loss of mental energy, social-learning theory may speak of inhibition of an approach response because of fear of punishment. An approach response to a particular environmental goal is not made because of punishment experienced either directly by the person or by a model.

Gestalt theorists have additionally noted that in retroflexion the "organism is expending energy in maintaining the tension from the impulse and resistance, both are quite typically alienated from the self and awareness" (5). To behaviorists, this might be seen as an "inaction" resulting from equally balanced action tendencies noted in both the person's verbal and physical behavior. This behavioral immobilization or inaction and lack of affective response to normally arousing stimuli could be viewed as a result of "learned helplessness." The individual, by virtue of his own classically conditioned fears and negative environmental consequences, is unable to respond in a way to obtain desired reinforcements and avoid negative consequences. The result may be an unresponsiveness to issues or events that typically arouse action and affect in normal individuals.

Gestalt theory, in describing retroflexion as a process, does not focus on what is causing the impulse to be withheld, while learning theory suggests that it is anxiety or fear of punishment of behavior that leads to the approach-avoidance impasse. Both approaches require expression of the act leading to satisfaction of need or reward, but the behaviorist appears to pay greater attention to the avoidance gradient and its inhibiting effect on approach behavior.

Confluence

Confluence in Gestalt theory occurs when there is a blurring of figures with ground or the confusion of interpersonal boundaries. For example, a psychic trauma to one's child might be experienced as an injury to oneself. To the learning theorist this might be seen as a simple lack of discrimination learning, but it does not account for the intensity and emotional involvement often observed in this process. Here our analysis from introjection using modeling can help:

\[
\begin{align*}
\text{Primary model 1} & \quad \text{Secondary model 2} \\
\text{(parent)} & \quad \text{(child)} \\
\text{Observer (as child)} & \quad \text{Observer (as adult)}
\end{align*}
\]

A child has certain behaviors modeled for him by the parent (primary model), which are introjected in the fashion described earlier. Subsequently in adulthood, when a significant other, either a child or spouse
(secondary model 2), models this same behavior, the ensuing consequences (either positive or negative) exert an undue effect on the observer. If Mr. A.'s father was rewarded for assertive need-achievement behavior and this behavior became an important model for success and happiness, later failure by Mr. A.'s son may cause undue depression or frustration in Mr. A., because of this "overidentification," or confluence in parent-child boundaries.

**Projection**

Through projection, disowned individual attributes are critically noted in others. Considered in behavioral terms, projection involves several "acts": (1) engaging in the (disowned and projected) behavior; (2) verbally denying or not recognizing that one performs the behavior; (3) acting critically of others who do. Point 1 is important because without this there would not be projection in the sense of attribution. Since point 1 encompasses behaviors such as privately wishing for sex or "forbidden acts," this behavioral definition should cover most projections, save perhaps the classical unconscious psychoanalytic model of projection as an attribution process.

Given this definition, how is projection "learned"? First, point 1 requires that the behavior first be performed (covertly or overtly). Consider that most behaviors capable of activating defenses, such as projection and repression, are employed to defend against such powerful drives as sex, affiliation, and aggression. It follows that behavioral expression of these drives (having sex, for example), would be "rewarding" in their own right; that is, external reinforcers such as social approval are not needed. Next, assume for point 2 that an individual (say, a child) observes a model (parent) who engages in these behaviors yet who disapproves or punishes others (particularly the observer) for doing the same things. It follows that awareness or public acknowledgment of the behavior would create anxiety (fear of punishment), leading to an avoidance response of nonrecognition or nonacknowledgment. Critical or hypersensitive behavior (point 3) can then be understood as a reflection of the critical or punishing behavior modeled previously. The original model and subsequently the observer would be rewarded for this critical behavior presumably through the social approval (from other potentially punishing agents) that condemnation of the behavior incurs.

In addition, the critical reaction would be also negatively reinforced by the anxiety reduction that occurs when the anxiety-arousing stimulus (the disowned behavior performed by someone else) is removed (the other person stops performing the behavior or leaves the situation). As an example, consider a sexually-acting-out hysterical female who is promiscuous but denies it, and is quite condemning of others who act seductively or promiscuously.
PRINCIPLES OF GESTALT THERAPY

Principle of the Now

One of the most important principles in Gestalt Therapy is the "principle of the now." According to Levitsky and Perls (6), "the idea of the now, of the immediate moment, of the content and structure of the present experience is one of the most potent, most pregnant, and most elusive principles of Gestalt Therapy." Concerns over what has happened in the past or what may happen in the future are viewed as therapeutic evasions or at best as subject matter to be related to what the patient is experiencing in the present. For it is the rule in Gestalt theory that all change take place in the present. Only in the present can the patient "own" the blocked feeling and exercise active responsibility in expressing it, releasing frustrated tension. Even in the case of "unfinished business," past frustrations or traumas are related to the present experience of the patient, often through a fantasy reenactment of the past event in which the patient deals with the present. The patient's "catastrophic expectations" for the future are also brought into the present by having him enact the dreaded event, eventually gaining control over his emotions and actions.

The concept of ownership of the behavior that occurs is an important corollary of the principle of the now. This involves an acknowledgment by the patient of how he is behaving in the therapeutic interaction. Resistance is dealt with by having the patient own his behavior, recognizing that "I am making myself afraid." If something is too difficult for him to discuss, rather than evading it with lengthy digressions, denials, or anxious silences, the patient may acknowledge what he is doing, with the implication that he may choose not to deal with the issue: "I am avoiding the issue, I do not wish to deal with it now because it makes me feel too anxious."

Seen from behavioral theory, the principle of the now and deviations from it evoke thoughts of approach-avoidance behavior. Avoidance behavior may be more than not wanting to discuss something or changing the subject. Focusing on the past or future issues and concerns is avoidance of the present. Since new actions or behaviors cannot occur in the past, there is close agreement between Gestalt and learning theories that past history is not of major relevance, and both would consider an excessive preoccupation with the past to be antitherapeutic. Although behavior therapy in a sense prepares patients to behave differently in the future than they have in the past, the learning of the new behaviors obviously takes place in the now. When neurotic catastrophic expectations are involved, the behavior of concern is an anxiety-reducing avoidance behavior that must be prevented for extinction to occur, which can also only occur in the present. This important point—that learning and unlearning or extinction occurs only in
the present—brings both Gestalt and behavior therapies into close accord.

A second behavioral point can be made concerning the idea of ownership of the behavior. This concept relates to our earlier discussion of "agency" or locus of control, in which a distinction was made between Gestalt and operant-learning theory. Gestalt theory, in forcing ownership of behavior, implicitly requires that the patient assume responsibility for his behavior. Put in more behavioral terms, if one assumes responsibility for one's behavior, even if the behavior is an avoidance response, he is still acknowledging the instrumental aspect of the behavior. Instrumental behavior is behavior that effects an environmental consequence.

The assumption of responsibility is incompatible with helplessness, which in behavioral theory occurs when an individual's responses evoke only unpredictable environmental consequences, that is, exert no control over consequences (7). The act of owning one's behavior is really a recognition that a response (even an avoidance response) has effected a predictable environmental consequence (if only anxiety reduction). At its most extreme, ownership of a behavior in the therapeutic context is a first step to control over one's environment. This is an important point that Gestalt Therapy has recognized and emphasized earlier and to a greater degree than therapies based on learning theories.

Awareness

A second important rule of Gestalt Therapy is the use of awareness, as an effective way of guiding the individual to the firm bedrock of his experiences and away from endless verbalizations, explanations, interpretations. Awareness of body feelings and sensations and perceptions constitute our most certain—perhaps only certain—knowledge (6).

Awareness in Gestalt Therapy is facilitated through the focused attention exercise. Let us take a patient who expresses a fear of something happening, perhaps based on a past experience—possibly a social rebuff in a dating situation. The patient expresses a fear about a similar rejection, possibly recalling the similar experience. His Gestalt therapist would ask, "How do you feel now?" "My legs feel weak, my palms clammy, my heart's racing." As the patient continues to focus on his present feelings, it is often observed (and reported by the patient) that the feelings subside in intensity.

From a behavioral standpoint, what is going on? Why the reduction in intensity, how is this verbalization effective? Ullman (8) has suggested that the "formulation may be one of extinction as in implosive therapy or flooding or it may be one of counter conditioning as in systematic desensitization. In both contact with the situation is required." Ullman proposes what would seem to be both extinction and an aversive conditioning paradigm, in which focusing involves contact with unpleasant stim-
ulation, such as anxiety or distress. In his procedure he uses a "worry chair," where the patient always goes and sits when experiencing distress or depression. In doing so the patient experiences several negative consequences: (1) a "time out from positive reinforcement," since sitting in a chair and worrying is no fun; (2) the unpleasant affect, "since people learn it is rare and difficult to maintain a disruptive level of tension for much more than five minutes." He later states:

I do not think focusing is anything like systematic desensitization. There must be a steady check of relaxation, a gradation of steps, a careful duration of exposure, and the like for systematic desensitization. In systematic desensitization we remove the image at the very first sign of tension, something not done in either focusing or the procedure I have just described.

Although Ullman makes several important points, we wonder if a Gestalt therapist should not question Ullman's assumptions that (1) focusing is necessarily or always on the unpleasant image and (2) disruptive levels of tension are generally not maintained for long durations. With respect to point 2, we note that the use of "contact and withdrawal" is frequently employed when the patient is allowed to make his own avoidance responses away from the anxiety-arousing stimulus. Concerning point 1, does the patient indeed focus on the unpleasant image?

Using some of Ullman's points, we would offer the following formulation. In classical conditioning a conditioned stimulus (CS) evokes a conditioned response (CR). In our example, the CS would be an image of social rejection by a female; the CR, the physiological reaction of anxiety. Initially, when the patient expresses his fear, he is presumably visualizing the CS (an image of rejection). However, when asked to focus on what he is experiencing now, the patient begins to direct his attention to his weak legs, beating heart, and so forth. Thus, his attention is directed away from the CS to certain aspects of the CR. While the patient is experiencing anxiety, we would expect some extinction to occur. As the attention is focused on the CR, however, there is a diminution of the patient's arousal. The reason, we think, is that the CS has been displaced with new stimuli, namely, what the patient is experiencing now. These would include initially the body sensations of anxiety, then presumably the sensations of relaxation as the CR diminishes, as well as other aspects of the therapeutic situation that the patient may focus on, which have not been paired with the CS (rejection). This shift in attention would be negatively reinforced by the reduction in anxiety that occurs as the CS is "removed" (by refocusing the attention to the now).

Assuming that $\overline{CS}$ stands for "CS absent" or those neutral, nonarousing stimuli that the patient focuses on, and that $\overline{CR}$ represents the state of relaxation or nonarousal eventually obtained by focusing away from the CS,
it is possible to diagram the situation as follows in the two phases described above:

<table>
<thead>
<tr>
<th>Phenomenological state</th>
<th>I</th>
<th>II</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS ⟷ CR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Experience of fear-arousing stimulus</td>
<td>Experience of (CR), body sensations, and other neutral stimuli</td>
<td></td>
</tr>
<tr>
<td>Kind of learning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Classical conditioning, extinction</td>
<td>Operant condition, negative reinforcement of focused attention to new body states</td>
<td></td>
</tr>
</tbody>
</table>

In addition, it is also likely that the patient, as he typically moves back and forth from phase I to phase II, is also learning to discriminate between the CS and CS, past and present experience, fantasy and present reality. Finally, there may be other kind of learning going on. To the extent that a patient becomes competent in focusing on his bodily states (experiencing the CR) he may be gaining greater control over his autonomic functions purely as a result of improved feedback. Only recently have we become aware of attentional states and bio-feedback phenomena, although Eastern cultures have long made use of focused attention in obtaining control over bodily functions.

In making these points, we are not suggesting that Ullman's analysis is in error. Rather, we are pointing out some additional aspects of focused attention by which anxiety and distress may be lessened. In those cases where the patient is exhorted to "stay with the feeling," it is quite possible that highly unpleasant levels of tension could occur, which would result in both extinction and aversive consequences for the behavioral-cognitive state leading to the tensions.

Polarities

Before considering some of the games or exercises of Gestalt Therapy, there is a third important aspect of Gestalt theory that warrants mention—the idea of polarities. Polarities are manifested in many of the patient's behaviors in therapy. Examples of common polarities would be "good—bad," "weak—strong," "nice guy—scoundrel." With a subassertive individual who is on the extreme weak end of the spectrum, therapy might be directed first toward having the patient personalize or verbalize his behavior on his end of the spectrum and then engage (in therapy) in assertive behavior representative of the opposite end. While doing this, the patient may frequently complain of feeling weak when acting strongly or of having inner violent aggressive feelings when engaging in submissive behavior.
After swinging from one extreme to the other in therapeutic transactions, sometimes often spontaneously and violently, the patient eventually obtains a better integration.

What can learning theory or social-learning theory tell us about this phenomenon? First, a learning theorist might be somewhat critical of the lack of situational specificity inherent in this polarity model. To him the question would be, "in what situations is the person weak or strong?" Although a patient may report a vague or nonspecific feeling of being weak, learning theory suggests that this feeling is probably a conditioned emotional response in reaction to some particular stimulus. By considering only the experience of the feeling, Gestalt Therapy would seem to limit its efficiency in dealing with this kind of problem. In other words, to the extent that conditioned emotions are associated with certain operant behaviors, it would seem that knowledge of the conditioned stimuli (which produce conditioned emotional reactions) and discriminative stimuli (which cue operant behaviors) would lead to a more systematic plan of action than a strategy of simple "focusing" on the conditioned emotional responses.

The next issue is how this phenomenon is explainable in terms of learning theory. Our example of a behaviorally subassertive individual tormented by violent aggressive feelings toward himself and others is of help here. (We assume this example typifies people seeking psychotherapeutic help but not necessarily those whose meek behavior evokes no personal dissatisfaction. These latter individuals would obviously have no intrinsic motivation to enter into therapy.)

In considering the polarities inherent in our subassertive individual, we can specify both the individual's behavior and associated emotion, and his reaction to the behavior. For example, when he is acting meek, our patient may be experiencing anger inside; when he is acting more aggressively, he may feel weak or scared. In addition, as the person is behaving, he perceives himself doing something compatible or incompatible with his idea of how he should act. These cognitions or self-perceptions in turn generate their own emotional consequences. Even though fearful (of negative external consequences) while acting strongly, our subassertive individual may reward himself for behaving in a manner consistent with his aspirations. Conversely, while probably relieved at having avoided negative consequences by behaving meekly, he will also feel disgust with himself on perceiving his acts. Thus, there is an overt behavior that presumably evokes environmental consequences, such as interpersonal responses from others, to which the patient reacts emotionally. In addition, there are cognitions (self-perceptions) that the individual also responds to emotionally. In conceptualizing this situation, one might describe a double approach-avoidance pattern, as follows:
POLARITY

<table>
<thead>
<tr>
<th>Behavior → Consequence</th>
<th>Feeling State</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Subassertive)</td>
<td></td>
</tr>
<tr>
<td>External (+)</td>
<td>Relieved at non-punishment</td>
</tr>
<tr>
<td>Internal (−)</td>
<td>Disgusted at self</td>
</tr>
</tbody>
</table>

(Assertive) External (−) Fearful of punishment Internal (+) Proud of self

When engaging in subassertive behavior, the patient is presumably reinforced by external positive responses from others (either a negative reinforcement, such as termination of social disapproval for acting any way but subassertively; or positive reinforcement, that is, social approval) but at the same time punishes himself for his perceived weakness. Conversely, when acting strongly, the individual has undoubtedly experienced negative consequences (external social disapproval from others, conditioned emotional fear responses) but also can reinforce himself for acting like an adult. Moving too far to either end of the behavioral spectrum will predictably raise anxiety associated with the negative consequences, and this will move the person behaviorally some distance to the other end of the spectrum. Our subassertive individual would predictably retreat from more aggressive actions as the negative consequences (or fear reactions in anticipation of negative consequences) increase in intensity. Conversely, in situations in which there are few situational demands for submissive behavior (therapy, for example), experimentation with more aggressive behaviors is more likely.

TECHNIQUES OF GESTALT THERAPY: GAMES

The games of Gestalt Therapy characteristically elicit approach-avoidance behavior in the patient. Basically, the games of Gestalt Therapy can be grouped into those involving verbal behavior and those requiring some overt behavior on the part of the patient. Games of dialogue typify this process. Polarities or “splits” are identified, and the patient is asked to have an actual dialogue between these two components of himself. In a sense, the incompatible behaviors and feelings noted in our previous analysis are identified (weak—strong, good—bad, and so forth), and the anxiety-arousing behaviors are approached in a symbolic verbal sense. By forcing the patient to label his actions, especially avoidance and feared-approach behaviors, their place on the approach-avoidance continuum is identified. By supporting or endorsing certain verbalizations on the part of the patient, the therapist can influence movement along the approach-avoidance continuum by offering either subtle or open encouragement.
Among the other games of Gestalt Therapy, we shall consider three involving verbal processes and three emphasizing overt behavior.

**No Gossiping**

Verbal behavior can be direct, with full disclosure of feelings, or indirect, obtuse, and detached, as in intellectualized discussion: "You know, it appears there are some people who out of their own weakness take satisfaction in verbally belittling others." Gossiping represents a less extreme form of verbal avoidance: Patient to therapist: "The trouble with Mary is she's always picking on me." A no gossiping statement would go as follows: Patient to Mary: "You're always picking on me." This statement satisfies the "I-thou" principle, which requires that every message have a sender and a receiver. In the first instance the message was sent to the wrong person.

Now, although this hypothetical patient obviously satisfied his feelings by directly expressing them to Mary, plus complying with this rule of Gestalt Therapy, a behaviorist might nitpick, as follows. The statement to Mary, "you're always picking on me," is probably technically not true and can be challenged if Mary can provide one example of her not picking on the patient. The patient's statement also provides little incentive for Mary to perform otherwise if she is perceived as always being bad. Thus, a behavior modifier might desire a more specific statement, such as, "Mary, I feel angry and resentful at you for saying that I have poor taste in clothes." Here the specific insulting comment is identified and the person's emotional response is described and directly communicated to Mary.

**I Take Responsibility**

Another manner in which one may avoid full confrontation with important issues is to describe one's reactions or behavior in such a way as to imply it is beyond personal control: "It makes me so weak and helpless to ask a girl for a date." In the game of I take responsibility the patient must restate the complaint so as to acknowledge that the reaction or behavior is something the person himself is accountable for. Attributing an emotional response to an "it" is a way of avoiding action or approach toward the threat. By taking responsibility for perceptions, emotions, and verbal responses, the patient is in a sense acknowledging his instrumental control over them. Helplessness and passivity, behavioral consequences of not having control over one's environment, are thus avoided.

**May I Feed You a Sentence?**

Here an interpretation or observation is made by the therapist, who then transmits it to the patient with a request that the patient verbalize it. In
doing so, the patient is brought closer to the realization of issues or behaviors that are being avoided. In other words, new stimuli are introduced into awareness. Stretching this point even further, the behaviorist Bem (9) has argued that our attitudes are the result of our self-perceptions of our own behavior.

Reversal

This procedure from a behavioral standpoint appears to involve elements of implosion as the patient is asked to behave in a completely opposite manner (for example, assertively rather than timidly). Also involved, however, is disinhibition of emotions incompatible with the typical problem behavior (the feeling of anger or aggression is incompatible with timid behavior). This technique still permits some degree of avoidance, however, which may be needed if the patient is to tolerate playing the game (recall our discussion on polarities). For example, even though a man may be generally timid and only "pathologically" so when dealing with his mother, boss, or wife, the therapist can choose to initiate a reversal in a situation role played in the abstract, or with a stranger or a friend, before having the person attempt assertiveness with the feared other(s), who typically elicit crippling amounts of submissive behavior. By getting the patient to engage in a reversal of his customarily meek behavior in a relatively neutral situation, feelings of fear are avoided, and incompatible feelings of aggression, anger, and strength are elicited and disinhibited. This in turn facilitates approach to the feared objects (by lowering the avoidance gradient).

Playing the Projection

This game also exemplifies Gestalt Therapy's emphasis on opposites, or polarities, in this case in the person's perceptions. Here the patient is required to act out his own accusation. If this accusation is a projection, we can then use our earlier analysis of projection: (1) performing a behavior; (2) disowning it; (3) criticizing others for doing the same thing. By definition, people who project engage in point 3 but do not admit to doing points 1 or 2. But when forced to play his projection in front of an audience (the therapist or a group), the patient is confronted with a situation in which he cannot possibly deny having engaged in the behavior. When punishment does not follow, some fear is extinguished, and it becomes easier for the patient to own his own feelings and actions without denying them. In turn, the patient will cease to criticize others for the obvious reason that by doing so he is also censuring himself.

Exaggeration

This game is generally employed when certain actions, body movements,
or verbal behaviors are noted to be inhibited or lacking in their fullest expression. By asking the patient to repeat the action in more exaggerated fashion, the meaning of the action becomes clearer. In particular, nervous mannerisms or constricted signs of grief or anger are highlighted and brought out and disinhibited. Although this would seem to be the primary use of exaggeration in Gestalt Therapy, there is another application that this game has for a learning theorist. Many of our "bad" or "psychopathological" behaviors have become "habits," which Hunt and Matarazzo (10) have described as behaviors that have become so automatic as to be out of our awareness, such as smoking. Since exaggeration of a habit requires some conscious effort, this behavior can be brought into awareness (of the stimulus situations evoking it) and then under control. This procedure thus circumvents the problem of instructing a person not to engage in habitual behaviors, of which, by definition, the person is unaware.

SOME PRACTICAL CONSIDERATIONS

In considering much of the theory and therapeutic operations of Gestalt Therapy, we were rather struck by the relative lack of attention paid to anxiety. Gestalt Therapy focuses heavily on the anxiety-avoiding defensive maneuvers the patient engages in during therapy. All of the therapeutic maneuvers we have discussed as examples (playing the projection, reversal, and so on) involve approach responses, coming into contact with new experiences, often potentially very frightening ones. Still, the question arises: What if the patient is unable to tolerate further approach to anxiety-arousing material or behaviors? It would seem that the assumption is that the patient can and will resist or protest attempts by the therapist to move toward greater awareness, that is, to confront threatening issues. While Gestalt Therapy does not attempt to uncover past traumatic experiences, discoveries "in the now" still occur that could be devastating to the patient. Patients with weak egos and borderline states or minimal defenses would appear particularly vulnerable to the therapist's expectations that they engage in games that might lead to disruptive insights or overwhelming levels of anxiety.

Although learning theory itself does not deal with psychological defenses and the purpose they sometimes serve in preventing overwhelming levels of anxiety and personality disorganization, (with the exception of the implosion therapies), it gives very careful consideration to anxiety in the programming of therapeutic change. The most obvious example is systematic desensitization when "no anxiety" is the goal. Other behavioral approaches, however, recognize that anxiety must be monitored and kept within tolerable ranges if progress is to occur. Generally, the goal is new pro-social or desirable behaviors to be learned in situations in which success and reward
are maximized and failure minimized and the focus is deliberately away from maladaptive behaviors. When anxiety inhibits normal desirable responses, it is deconditioned with the assistance of the therapist.

The point of this analysis is twofold. (1) Gestalt Therapy appears to be most useful when the patient engages in many therapeutic evasions characteristic of neurotic behavior. As Shepherd (11) has stated:

In general, Gestalt Therapy is most effective with overly socialized, restrained, constricted individuals—often described as neurotic, phobic, perfectionistic, ineffective, depressed, etc.—whose functioning is limited or inconsistent, primarily due to their internal restrictions, and whose enjoyment of living is minimal. Most efforts of Gestalt Therapy have, therefore, been directed towards persons with these characteristics.

(2) The lack of emphasis on the therapist's monitoring anxiety (and the assumption that the patient can) would seem to pose some risk for potentially psychotic individuals who might undergo psychic damage because of weak defenses or their desire to please the therapist. This pitfall would be present primarily for unskilled, unperceptive, or clumsy therapists, who might be dangerous using Gestalt techniques, whereas they would probably be merely ineffectual using behavioral approaches. Use of these techniques in groups would additionally raise the risks for especially vulnerable patients.

A second consideration is the assumption that once blocks are removed, the patient is able to gratify himself. As Ullman (8) has pointed out, "even with our normal outpatient clients, however, the problem frequently is they do not know what to do." In such instances, where there is a behavioral deficit, behavior therapy employs clear training procedures and carefully selected, graded tasks that are designed to maximize success and minimize failure. Gestalt Therapy seems to permit much more trial-and-error experimentation, with the patient's running risks or experiencing failure. While it might be argued that one has to learn how to experience rejection, we would claim that the problem for patients is usually that they have experienced too much rejection. A behavioralist's stance would be that the experiencing of success and acceptance in dealing with other people is the best treatment procedure for rejection.

A third question concerns responsibility. While it is important that patients exercise responsibility for their feelings and actions and not become dependent on the therapist, this rule again appears appropriate only for certain kinds of neurotic individuals. There are other patients, especially seriously depressed individuals, whose level of responding is so low that they are hardly capable of assuming responsibility for their actions. Often the first clinical step with such patients is to acknowledge their emotions of distress and despair and to do something for them, that is, to make some changes in their environment. Then, when their mood changes and some
activity and operant behavior begins to occur, the patients are encouraged to engage in their own instrumental responding. To take a depressed patient and to focus on his feelings of despair (instead of broadening his view of things) or have him take responsibility for his inaction and helplessness would obviously be inappropriate, and the experienced Gestalt clinician would not do this. But the point is again that Gestalt does not provide any rules for dealing with this kind of problem. Thus, again, Gestalt Therapy appears to contain some risks for the inexperienced therapist in that he may utilize the wrong approach with the wrong patient.

SUMMARY

The theory and practice of Gestalt Therapy are discussed from the point of view of learning theory. Similarities and differences between Gestalt theory and learning theory are outlined in the first section. In the next three sections, the central concepts, principles, and techniques of Gestalt Therapy are presented and correlated with therapy based on learning and social-learning theories.

A major difference in the two approaches is that in Gestalt Therapy the patient is seen as a potentially active agent capable of effecting environmental and personal change. Consequently, emphasis is placed on the patient as the locus of control, capable of dealing with his internalized conflicts. The problems and risks of the inexperienced therapist's utilizing Gestalt techniques without being sensitive enough to the patient's anxiety is emphasized in the last section.

REFERENCES

