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Original Contributions - Originalbeiträge

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Gestalt Theoretical Psychotherapy – A Clinical Example

Introduction

The aim of the paper is to outline some essentials of Gestalt theoretical psychotherapy (GTP) and elucidate the manner by which these essentials contribute to a certain clinical approach. The case of a young woman with an eating disorder can illustrate the connection between a certain epistemological approach, theoretical assumptions concerning the perceptual level and clinical understanding of eating disorders and – emerging from these considerations – a certain conception of establishing the therapeutic bond.

Let us imagine a more or less typical[2] case of an anorectic young woman, 20 years old, student and living in her own apartment since the beginning of her study one year ago, weighing 38 kg with a height of 168 cm, which results in a body mass index of 13. So, this seems to be a severe case of anorexia – leaving aside for the moment other diagnostic criteria (Dilling & Freyberger, 2016). The woman comes into therapy because there is pressure from her family and friends to do so, but her own initial commitment to therapy is low – rather typical for anorectic patients (Reich & Cierpka, 2001, p. 73). They consider their starvation often as a solution, not as a problem.

In dealing with anorexia nervosa, one has to answer these questions: What are the motives to starve? Why are starving, controlling nutrition and body weight the solutions for a psychic problem?

Often there are first answers on the biographical 'surface': when she hit puberty, the young woman may have been a little bit overweight and someone made a remark: her sports coach, a teacher or a friend. Often one remark at a certain time, place or from a certain person can provoke the beginning of a starving process, at first typically accompanied by honouring comments. Then starving goes beyond a certain point and other people declare it no longer as 'good-looking'. However, the patient herself has already developed a need to starve. Starving 'feels

[1] Based on the lecture at the 21st International Convention of the Society of Gestalt Theory and Its Applications 'Motion – Spaces of Human Experience', 13–15 June 2019, Warsaw, Poland.

[2] Other phenomenal manifestations of anorectic disorders (e.g. in men or in connection with sports in which body weight plays an important role) are not dealt with here.

good', because it means being able to control something no one else can take over control.

What is suggested here is that the motive to starve is more or less the motive to gain control, because control got lost in the first place (which implies that control already played an important role because there is possibly no trust between the family members). In many cases, we are talking about loss of control over the role within the family (Bruch, 2000), often characterised by a symbiotic relationship with the mother (Selvini Palazzoli, 1984) and – due to marital problems of the parents and a forced compliance with the mother – an emotionally stressed relationship with the father (Buchholz & Dümpelmann, 1993). Puberty plays an important part in this process, because it challenges the girl on different levels of cognitive and somatic developments; under these conditions, leaving childhood and becoming a woman is threatening. So starving means in a way to stop this development – another possible motive (Boothe, Becker-Fischer, & Fischer, 1993). At the beginning of the therapy, most patients are not aware of such motives to starve. All they know is that eating is threatening, and that it creates fear and panic.

These biographical details may have contributed to the anorectic development, but the current, present balance of field forces is always decisive for the maintenance of the symptomatology (Lewin, 1936). In the here and now of the therapeutic encounter, the patient's outward appearance, including her gestures, facial expressions and manner of speaking, immediately comes to mind; it seems necessary for the therapist that the patient changes her eating habits as quickly as possible. This tempts anyone – as the above description of the symptoms shows – to reduce the patient to the anorectic symptomatology. This tendency is often supported by the patient herself – she seems to live in a world where everything is determined by diet and weight. Moreover, she lives – in the Central European cultural area – in a society where considerable moral pressure is exerted with regard to nutrition, fitness and appearance.

It is therefore a therapeutic challenge, especially at the beginning of treatment, to counteract this thematic narrowing. This is not done by ignoring what is obvious (and sometimes life-threatening), but by accepting, understanding and placing the symptoms in the patient's overall world. This can have a liberating effect, and, if successful, the therapeutic encounter can become a model of how the patient can regain vitality precisely by (re)discovering aspects of herself that are beyond a narrow world of control of food intake.

The following considerations will therefore concentrate on what seems to be the fruitful and distinguishing contribution of the Gestalt theoretical approach to accept and understand the anorectic development in order to overcome the inherent narrowness.

The View on the Patient's Body

In working with anorectic patients, every therapist is faced with the challenge of establishing a trustful therapeutic relationship. There is a pressure and ambivalence on both sides: The patient knows, that she can't go on like this forever, but she feels the strong forces that will prevent her from eating enough. She simply cannot and will not give up control. This controlling side is experienced as an 'inner critic' (cf. Henle, 1962), who seems to be 'harsh, unfair and without humanity' (p. 402). The therapist on the other side is confronted with the skinny body and the urgent demand that the patient has to gain weight for health reasons. Often the skinniness comes along with a deprived emotionality, a mimical depletion and a slowdown of movements which makes the whole expression of the patient somewhat unlively; the patient obviously can't care for herself, and therefore a therapist is likely to adopt a helping and caring attitude and will be blind for the potentially encroaching effect on the patient. Alternatively, the patient will have an aggressive impact on the therapist in the first place, which often leads to more or less aggressive interventions like threatening the patient, forcing her to gain weight by therapy contracts or suggesting that the patient is not telling the truth.

However, probably the most obvious conflict from the very beginning arises from the totally different perception of the patient's body.

To begin with the last point, we find the underlying phenomenon described in diagnostic manuals as 'distorted body image' or 'body scheme distortion' (Dilling & Freyberger, 2016), which means that the patient will describe her skinny body as 'fat', 'too fat' or 'too big' etc.

The encounter between patient and therapist is therefore characterised by a different perception: in the phenomenal field of the therapist the patient has a skinny body. The patient herself states her body is too fat. This is illustrated in the 'egghead' picture illustrated in Figure 1.

One can ask now, does the patient really perceive (i.e. 'see') her body as fat? Does she 'feel' it? Or is she simply denying her own realistic perception by stating 'fat' and actually seeing 'thin'?

From what derives from a critical-realistic view (Sternek, 2021), the perceived body is part of the phenomenal world. The own body is a perceived object like everything else. Perception can be distorted under certain conditions (very high or very low emotional arousal like being in love or suffering under pain or depressed feelings), but this will affect the whole phenomenal world: everything is coloured grey for the depressed person, and the person with pain lives in a 'painful' world (Stemberger & Sternek, 2019). It is hardly possible that a single object of the perceived world is distorted while everything else appears to be of normal size and position. Therefore, it is very unlikely that an anorectic

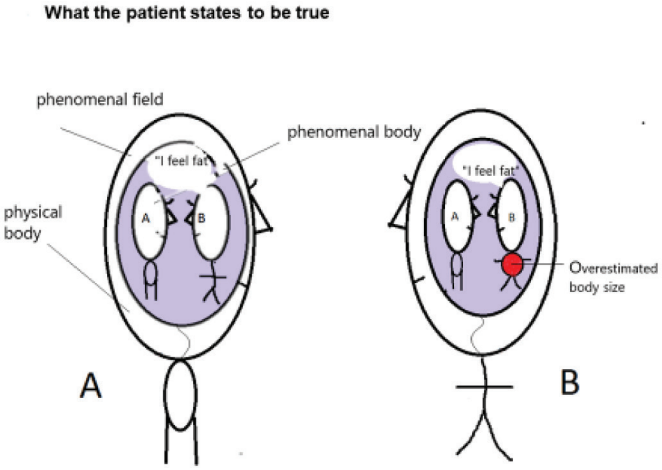

Fig. 1: The two 'eggheads' representing the physical bodies of the therapist (A) and the patient (B) and their corresponding phenomenal fields coloured in violet. The statement of the patient ('I feel fat') would indicate an overestimated body size (coloured in red). In the phenomenal field of the therapist both bodies appear in their more realistic dimensions.

person perceives her own body as 'fat', while all other persons are perceived in their normal size (Cash & Deagle, 1997). If this is correct, then we can assume that the anorectic patient is aware of the contradiction between her own perception and what she states about her body size. To put it briefly, they are aware that they are stating something that is not true. 'Not true' is meant here in a critical-phenomenal sense (Bischof, 1966) – the patient knows intellectually, that it cannot be true. However, she is experiencing something different (the so-called naïve-phenomenal view). Therefore it is not a simple lie; patients cannot help themselves other than putting it this way (Fuchs, 2010). When seeing, for example, a photograph – especially with a friend beside her – the patient will 'admit' that she is actually thin. All therapeutic interventions that lead to a reinforced body perception will therefore put the patient under stress, because she is confronted with this contradiction. Those interventions may be nevertheless helpful in therapy.

Figure 2 tries to show this.

Patients suffer because of this contradiction and because of the everyday-pressure to live with it, because in almost all cases they themselves don't understand why they have to state something that is definitely not true for the rest of the world. This contradiction has severe implications on an emotional level; a person who is experiencing something and who is aware of the fact that all others see and experience something totally different will suffer from a very uncomfortable tension, which is often displayed by an inner restlessness.

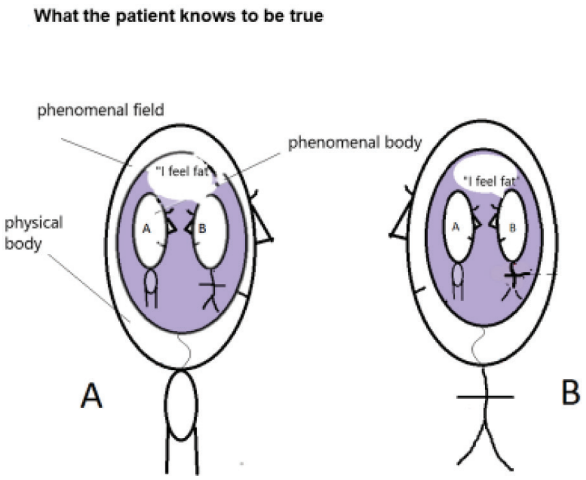

Fig. 2: The phenomenal fields of therapist and patient (coloured in violet) both indicate a realistic perception of the body sizes. The patient is aware of her skinniness in a critical-phenomenal sense; that means she knows that she cannot be fat.

However, what the patients know to be true does not mean that their phenomenal worlds look like what is indicated in Figure 2. There must be something else that 'forces' patients to state that they are feeling fat.

A possible theory explaining this phenomenon can be derived from the following Gestalt theoretical assumptions: At some certain point or in a certain developmental phase in the life of the patient a 'centering' (Galli, 2010) occurred in the phenomenal field around the patient's perceived body. Many of us are familiar with cases of centring, for example, when we suffered an aching tooth. The tooth is small but the pain is big and so our whole phenomenal field will be centred around this aching tooth.

Presumably, the bodily changes in puberty together with the psychodynamic conflicts mentioned above may be responsible for this centring of the phenomenal field around the body. The young woman may experience the situation described above as being too present, too much, disturbing and not fitting anymore in the family constellation (or another social system). The accompanying feeling will be shame (Wurmser, 1993). Shame as an emotion usually demands disappearance. However, at this time there will be no insight into such conflicts and no language to express them. As a consequence, the girl 'translates' this experience as 'being too fat' and the logically emerging method will be to start starving in order to turn back time and to undo the threatening bodily changes.

It is important to have in mind that motives to starve can change during the course of time. What has been a motive in the past, for example in puberty, must

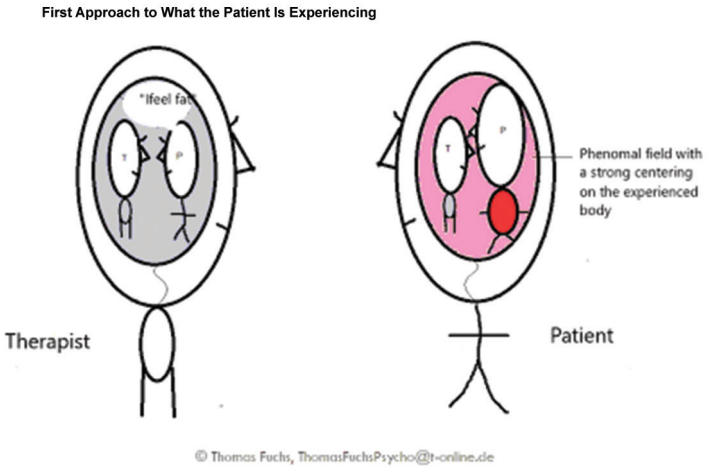

Fig. 3: The pink colour indicates that the phenomenal field of the patient as a whole is affected by a centring around her body. She experiences herself as being 'too present, too much, disturbing, not fitting' in the world she lives in and 'translates' this experience as being 'too fat' (overestimated body size coloured in red).

not be a motive in the present. Often the experience that it 'feels good' to control will lead to the strong need to control with own demands even if the original social system with its strong impact for the girl has changed. It is likely that the patient develops a compulsive manner with a high need to control and little trust in others that will influence new relationships in a way that intensity is avoided by keeping up a certain distance to others. It may be helpful for patient and therapist to have theories about possible motives in the past. For a successful process of change in therapy, it is inevitable to look for the actual forces in the 'here and now' in the phenomenal field of the patient.

Reference Systems

The above-mentioned 'translation' of the experience of 'being too present, not fitting' in 'being too fat' needs further investigation. It can probably be best understood by analysing it in regard to the concept of reference system (dt.: Bezugssystem), which is central in the tradition of Gestalt theory (Metzger, 1963; Galli & Trombini, 2013). It deals with questions such as: What refers to 'each other'? What is the perspective on the reference system? What is 'constant' and what is 'variable'? Metz-Göckel investigated different variants of reference phenomena, including the so-called thematic field as a referring system. Different fields induce different meanings of an issue (*Die Bedeutung eines Sachverhalts ist durch das jeweilige Feld induziert*; 2014, p. 364). A simple example for this could be words with a double meaning:

Prizes are too high in this exclusive shop!

Everybody has won and all must have prizes!

The central referring system for the pubescent girl is her family. However, if family dynamics resemble what is suggested above (marital problems between the parents, a symbiotic relationship with the mother, a coerced betrayal of the father), important needs of the girl will not or not sufficiently be satisfied (needs for stability, safety, approval, the need to be understood etc.). Furthermore there are stress-enhancing duties such as to be a partner for the mother, being responsible for a good atmosphere in the family and coping with the bodily and mental challenges in puberty.

In therapy, it will be important to understand if a need, a wish or a goal has its origin in the patient or if it is induced by others (parents, peer-group, society). In any case, all this leads to an inner state of tension (Lindorfer, 2021). In the experience of the girl, this special and stressing role and the accompanying tension will be more or less self-evident, given the situation she grew up in. The potentially threatening forces emerging from this system will not be conscious. Therefore, these forces are functional – in opposition to phenomenal, experienced forces. Metz-Göckel stated 'Even if the fields can be made conscious, having thus phenomenal character, they often act only functionally, that means implicit or unconscious, having then in common with reference systems in the narrower sense their inconspicuousness' (2014, 364; transl. ThF.).

The family system (or another social system) – as a thematic field – has a narrowing, demanding and paralysing effect. The 'space of free movement' (Lewin, Lippitt, & Escalona, 1940) is constricted, an effect of which the girl is not aware on a conscious level. Consciously perceptible and tangible are emotions such as guilt, shame and fear, and bodily sensations such as exhaustion, strain, tiredness and narrowness. These emotions and sensations will coerce a switch. The family as the reference with the described demand character is fixed and not changeable, for which reason the girl inevitably is pushed to areas in which control and regulation are possible. Intellectual and sportive achievement (anorectic patients often are good pupils or students and sometimes sporty in a compulsive manner) and dealing with one's body and nutrition play a major and predominant part. Cultural impacts such as the dominating ideal of beauty and morally charged notions about what is understood to be a healthy nutrition will strengthen these tendencies (Reich & v. Boetticher, 2017).

The existentially important need is an ability to steer and control shifts from a (fixed, invariable) reference system of family relationships to a (better manageable, variable) reference system in topics such as achievement, body and nutrition.

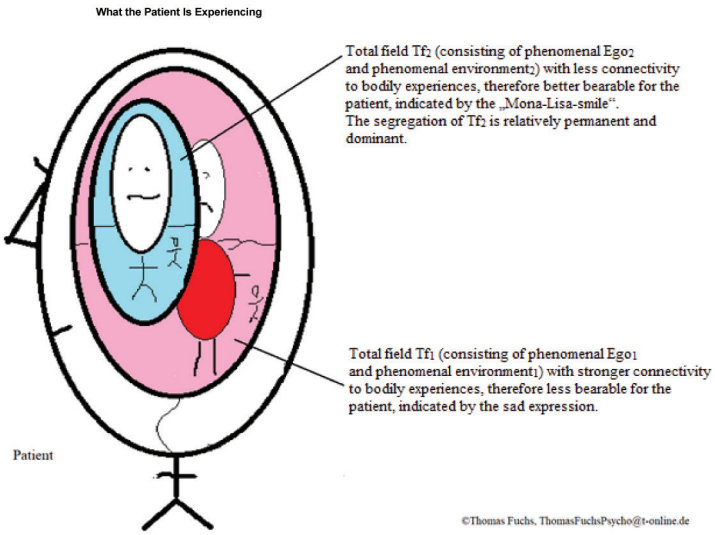

Fig. 4: Segregation of a second phenomenal total field Tf_2.

The shift to another thematic field is experienced as a kind of liberation. This is why anorexia is seen as a solution, not as a problem.

Obviously, this liberation ends up in a new confinement: a phenomenal world dominated by (often compulsive) thoughts and behaviour which are concerned about weight and nutrition together with mental, bodily and social problems. This will lead to the segregation of a secondary total field (Tf_2) from the primary total field (Tf_1; cf. Stemberger, 2009), a split which makes it possible to cope with all the tantalising effects of anorectic symptoms (Figure 4).

This centering of the body – as indicated in Figure 3 and similar to Tf_1 in Figure 4 – not only relates to the experienced body as an isolated part in the field, but the centring 'colours' the entire field; it is a world dominated by one's own body. The unbearable experience of not fitting, disturbing and being too dominant is tied to the body. Starving should make the body disappear, or at least minimise its physical presence.

At the same time also applies – as sketched in Figure 2 –the patient's awareness of her actual (emaciated, painful, threatening) physical and (constricted, oppressive, overwhelming) mental state. This awareness is not lost, but it is incompatible with the control motive. This incompatibility is overcome by segregating a second phenomenal field.

Such segregation always takes place when circumstances arise that, as a whole, are incompatible.[3] This usually happens completely informally and automatically,

[3] A general introduction to the Multiple-Field-Approach is given by Stemberger 2021.

for example, when reading a book, during a film showing in the cinema or when visiting the theatre; the primary phenomenal field with more physiological anchoring ('I sit in the cinema seat and look at a screen.') moves into the background, and a second phenomenal field of a more virtual nature ('I become an active participant in a captivating film plot.') dominates my experience. When the lights turn on again in the cinema, the secondary total field collapses and I am back in an undivided primary total field. The lawfulness of such processes was described by Rausch (1982) in connection with looking at images and transferred to psychotherapeutic processes by Stemberger (2009).

Elsewhere (Fuchs, 2010, 2014), the assumption was made that anorectic patients develop a second phenomenal field relatively permanently, because this is the only way to endure the painful and threatening physical and mental states. This also explains why the confrontation with their own body (physical exercises, mirrors, photos, films) are very uncomfortable for the patients because they are then forced to switch to their first phenomenal field.

Not the phenomenon as such, but the persistence of the segregation and the relative dominance of Tf_2 over Tf_1 is to be recognised as a significant pathological characteristic of anorexia. Mere weight gain will do little to change that. We must therefore agree with Bruch, who recognised as early as 1962, that 'without a corrective change in the body image, however, the improvement is apt to be only a temporary remission.'

Such a correction means that the patient can endure her own body in terms of the first phenomenal total field.

However, this will only be the case when it – as described above – can no longer be experienced as 'disruptive' or 'not suitable' in the overall frame of reference. This, however, requires a deeper understanding of the effective systemic forces and the entire underlying psychodynamics in order to better understand and experience one's own position in the system.

A recently published clinical study (Moccia et al. 2021) also assumes the specific self-perception and body perception among anorectic patients as a determining pathological characteristic and confirms this assumption by showing the direct connection between this specific self-perception and the development of anorectic symptoms. The authors differentiate a 'narrative' from a 'minimal' or 'basic' self (a distinction that is not identical to the distinction between Tf1 and Tf2, but has similarities) and state:

„From a phenomenological perspective, one could speculate that body image may be adversely related in AN-R [Author's note: Anorexia nervosa-restricted subtype] to a hyper-reflexive (i.e. objectified) experience of the bodily self, whereas ED [Author's note: Eating disorder] symptoms may entail compensatory

aspects attempting to reconnect with a sense of bodily presence, as well as enforcing identity when the basic self is unstable and challenged (S.7)".

From a phenomenological perspective too the philosopher and psychiatrist Fuchs[4] speaks even more pointedly of an alienated body:

„…the actual conflict in anorexia consists in a severe alienation of the self from the body, which is increasingly experienced as an external, alien object and subjected to an authoritarian regime." (Fuchs, 2021, S. 2). Such an 'objectification' or 'alienation' of one's own body is only possible under the more 'virtual' conditions of a secondary overall field.

Hints for a Therapeutic Strategy

In working with anorectic patients, some of Metzger's 'characteristics of working at the living' (1962; Böhm, 2021) become a demanding and challenging sound, for example, 'shaping the process by using the forces inherent within the living being' (Metzger, 1962, transl. Böhm, 2021). Böhm states that 'psychotherapy will only succeed when it is founded on the acting forces within the patient' (Böhm, 2021). This may appear somewhat absurd in dealing with anorectic patients, but there is a deeper truth in it nonetheless. For therapy with anorectics, this is a first initial strategy: Supporting the patient by helping her to understand what she is doing and that there is a certain logic in what she is doing. The implied messages may be that 'You are not crazy and you're not a liar and I accept that you have to state that you "feel" fat.'

In working with anorectic patients, it can be useful to highlight this contradiction right from the beginning of the therapy process. It can be done – more or less – by explaining to the patient what has been explained here. It is not that difficult to understand and, in almost all cases, anorectic patients are quite smart and intelligent – thus, that will help too.

That implies a kind of perception-centred strategy at the beginning of therapy, but it will possibly help the patient to approach the strong affective side of her problem. The explanations concerning critical realism and perception will help the patient to understand her inner conflict on a perceptual level and why it implies that she feels ashamed.

It is definitely useless to argue with the patient intellectually about what is right and what is wrong, neither on the topic of nutrition or gaining weight nor on the topic of body perception. The aim which is suggested here is to

[4] To avoid confusion, please note: The author quoted here is Prof. Dr. Thomas Fuchs, philosopher and psychiatrist at Heidelberg university, same name, same topic, but not identical with the author of this paper.

establish an atmosphere in which 'it is allowed' to speak out loudly what she is experiencing. At this point the therapist has a very important task that has to come along with his empathic efforts: Supporting the patient to find the right words that can express what she is experiencing. If it is true that most of effectual forces are functional, meaning not conscious, we can't expect that there is an established language that helps to discover, to name and to express the sensations and emotions accompanying the exploration of her phenomenal world. This necessitates therapists to adopt a rather active position. The next step has to be to find out more about the possible motives to starve. However, this will hopefully happen under the condition that the patient feels more accepted and more understood and is motivated to further explore her phenomenal world. In common with a certain therapeutic attitude (Böhm, 2021), this perception-centred strategy can facilitate empathic processes, not only for the therapist in understanding the world of the patient but also vice versa. By feeling understood, the patient may gradually adopt the therapist's way to 'look' at the patient's inner world (cf. Fuchs, 2020). This requires an empathic effort by the patient, which will possibly alter her perspective in relation to herself and others and modify the harsh attitude of her inner critic (Henle, 1962, p. 402).

Zusammenfassung

Am Beispiel einer anorektischen Patientin soll veranschaulicht werden, wie unter kritisch-realistischer Perspektive bekannte symptomatische Phänomene wie das einer vermeintlich verzerrten Körperwahrnehmung zu verstehen sind. Daraus können weitere theoretische Überlegungen abgeleitet werden, wie ein Motiv zu hungern entsteht, ohne dass dabei komplizierte psychodynamische Annahmen gemacht werden müssen. Hierzu wird auf genuin gestalttheoretische Konzepte wie "Zentrierung" und "Bezugssystem" zurückgegriffen. Daraus ergeben sich Hinweise auf eine therapeutische Beziehungsgestaltung mit zunächst wahrnehmungszentrierter Ausrichtung.

Schlüsselwörter: Anorexia nervosa, Gestalttheorie, Kritischer Realismus, Zentrierung, Bezugssystem

Summary

The case of an anorectic patient is presented to demonstrate how well-known symptomatic phenomena such as a supposedly distorted body perception can be understood. Further theoretical suggestions are made to explain the motive to starve, without making complicated psychodynamic assumptions. To do so, genuine gestalttheoretical concepts such as 'centring' and 'reference system' are used. This leads to hints for a temporarily perception-focused formation of the therapeutic relationship.

Keywords: Anorexia nervosa, gestalttheory, critical realism, centring, reference system.

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