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USE OF GESTALT THERAPY WITHIN A DRUG TREATMENT PROGRAM

STEPHEN I. SIDEROFF
Department of Psychiatry
School of Medicine
University of California
and
Veterans Administration Hospital Brentwood
Los Angeles, California

ABSTRACT

Traditional therapeutic approaches have not demonstrated great success with drug addicts. This article presents a Gestalt Therapeutic approach that has shown promise within a drug treatment program. The major issues discussed include: the acquisition of self-support, taking responsibility, dealing with anxiety, contact, and the expression of pent-up feelings. Also discussed is the manner in which these issues are approached. Focusing on what is happening in the present intensifies the feelings and process experienced, thus creating a more meaningful encounter. The role of the therapist-patient relationship is also presented. This paper attempts to combine the actual therapeutic procedures used with drug addicts, with the theoretical constructs on which they are based.

An effective therapeutic treatment for drug addiction is still being sought. In fact, it has been pointed out that the traditional approaches are not appropriate with the addict population [1, 2]. Recently there have been attempts to structure the therapeutic encounter and to explore new techniques. Switzer [3] for example, describes a procedure called "feeling therapy" that incorporates aspects of Reality, Primal and Gestalt therapy in working with drug addicts, while Bratter employs a heavy dose of confrontation along with Reality Therapy that he claims to be successful with adolescent drug abusers [4]. The present article describes the basis for using a Gestalt Therapy approach in drug treatment,

and an account of its use with individuals and groups within a drug treatment program.

While there are many treatments presently in use, it is possible to reach agreement on some important aspects of the rehabilitative process. In Gestalt terms these appear to be:

1. development of self-support and taking responsibility,
2. dealing with anxiety,
3. avoidance, primarily manifested in lack of contact.

In addition, I believe the relationship between the therapist and patient is a significant aspect of therapy. Although this does not exhaust the list, they will be the focus of the present paper.

THERAPIST-PATIENT RELATIONSHIP

The basic philosophy behind the Gestalt therapeutic encounter lends itself to working with drug addicts. Due to their previous experience most addicts are wary of people in authority. The Gestalt therapist, however, tries as much as possible, to relate on an equal basis, as well as fostering a trusting relationship with the drug addict. By not holding myself up as an authority figure, being completely honest, expressing my own feelings in the encounter, and in general being available to the patient, I am making myself believable as a person who can be trusted.

The Gestalt therapist also relies quite heavily on his own reactions to what is going on. By using myself as a resonating chamber I can tune in to the special way the person interacts. This approach has helped me with my drug patients. For example, I have been aware at times of being uneasy and confused while listening to a patient. Instead of ignoring this reaction I will express it. On some occasions my uneasiness was the result of the patient clouding over his feelings by trying to talk about three things at the same time. Even the patient was confused, resulting in a loss of feeling. As a consequence of confronting him with my feelings the patient became aware of how he avoided dealing with his own.

As a Gestalt therapist I try to avoid interpretations. I believe that the patient knows better than anyone else, the reasons for his actions. So instead of laying an interpretation on him I will ask him to tell me. Sometimes I will use this approach in relation to an observed behavior. A recent session went as follows:

Therapist: (noticing patient tapping fist with his hand) What are you doing with your hands?
Patient: (looking down and thinking) Ah . . . I don't know.
Therapist: Would you exaggerate the action.
Patient: (hitting fist harder) I'm beating on it. (he continues)

Therapist: (at this point I might have begun a dialogue between the two hands, with the assumption that they both represent parts of the patient, usually polarities within his personality. Instead the following occurred.) Give the hand a voice.
Patient: You bastard (referring to his other hand). You f____bastard. (as he continues to beat his other hand)
Therapist: (after awhile) Who are you really talking to.
Patient: (thinking as he continues to hit). My father, that bastard. He was always giving me shit, he. . . .
Therapist: Tell him directly.
Patient: I'm sick and tired of you dumping on me . . . etc.

I might, on occasion, have a hunch as to the cause of the patient's behavior, and check it out with him; but if he is being honest, I trust him when he says "no." This serves two functions. First, it puts at least part of the responsibility on the patient to understand his behavior and thus begin to break the habit of relying on others, in this case the therapist to interpret his behavior. And it helps to create the equal type of relationship we desire, as opposed to an authoritarian one.

SELF-SUPPORT

Perls [5] has called therapy the process of going from environmental support to self-support. This would certainly seem appropriate for the addict seeking help. Furthermore, the therapeutic process is actually a reflection of maturation, which also transforms environmental to self-support. Unfortunately, most addicts experience some form of early environmental rejection, rather than support. In many cases this has to do with the way they were treated by one or both parents. The patient in the above dialogue for example, referred quite frequently to being abused by his father. As a result, he felt alone and abandoned as a child and was never able to shake these feelings until our therapy. This type of antagonistic relationship exists between a number of my patients and their fathers.

I have found that by not receiving the normal environmental support as a child the development of self-support is inhibited, resulting in low self-esteem. It is like the construction of a building without the foundation. This development results in the addict still looking for environmental support as he becomes a young adult. On the other hand there is the fear and anxiety that what happened with his family and early experiences will happen again. This typically leads to an avoidance of family and other common ways of receiving support. Instead the prospective addict turns to drugs, as well as some form of drug subculture. Here he finds the support he never had: peer relations giving him some sense of security, identity as well as orientation and structure to his life.

He now has structure but still no foundation! As a result he becomes even more dependent on this lifestyle.

In dealing with the support issue and early environmental rejection in particular I frequently work with, or rather uncover, certain pent up feelings. Firstly (after trust has been established—a very crucial ingredient), many of my patients experience anger at one or both parents for abandoning them. As with the patient mentioned above the anger is typically directed at the father (note, all my patients have been men). The Gestalt approach is to have the patient express this emotion in the present. To facilitate this I have them imagine their parent sitting in a chair next to them. This way they can express what they are feeling directly to the parent. For most this is a very difficult procedure at first. Typical problems include: discomfort and self-consciousness talking to an empty chair; not being in touch with their feelings; avoiding the pain of uncovering these feelings; and residual fear of their parents as well as fear generalized to the therapist. And while these problems are common to most people starting Gestalt Therapy, they are a more formidable barrier with the drug addict.

Using the present-centered approach tends to increase the intensity of the addicts response. As a result they are able to more fully and completely experience the anger and get beyond it. What I frequently find at this point is the uncovering of a huge sadness. The patient fully grasping what he was deprived of, feels an emptiness and sometimes a hopelessness. I find that this opening up and expressing their feelings (and needless to say—becoming aware of these feelings) has facilitated a second important process—contact, to be discussed below.

Having the patient get in touch with his feelings and expressing them has the effect of a) releasing much pent up emotion—the unfinished business of Gestalt Therapy and b) start the process of realizing that "I'm okay, I didn't do anything to cause my parent's rejection and lack of love." This is necessary since the original assumption made by the abandoned child is that "I must have done something wrong (I'm bad, not okay) to deserve such treatment."

This is the first step in the acquisition of support. Once the patient is able to release his anger the underlying sadness emerges in full force. This also serves a necessary function. The sadness is the patient's realization that he was really never loved; that he didn't get what he needed from his parents. For me this is a very touching moment. It is the first time that they drop their defenses exposing their "weakness," and their souls, in a sense. Once the patient becomes aware of what he is missing, what his parents didn't give him, we explore ways that are nondrug related in which they can have the same needs for affection and love met.

It is important to note that the patient usually finds it very difficult to express or admit to the need for love and affection. This is due to the fact that their past, i.e., their history, is one of getting rejected whenever they reached out for

this. I see part of my role as therapist as being a teacher and model; in this sense I demonstrate my own warmth to the patient and encourage this behavior in the other members of the group. Thus the patients start getting positive reinforcement when they look for support, affection, understanding etc. and realize that this is possible outside of the group also.

On this issue, the therapist has two jobs. First is to help the addict find other types of reinforcement, nourishment and support. This means a) discuss and make the addict aware of various alternatives such as courses, training programs, sports, hobbies etc., b) help the addict discover where his interests lie, c) serve as a source of support and model—the most important aspect being lack of judgment, so fear of failure isn't perpetuated but instead minimized. The second task is to help the addict develop a sense of self-support. This is most important since it is the only type of support that will remain with them. All environmental support is transitory with the risk of being removed, thus placing the ex-addict back at square one. I believe that my patients remain addicted, not because of the physical addiction but primarily because they use the "fix" as their source of support. This was evident in the following interaction during a group session. The patient was describing a scene in which he had scored some heroin. He had prepared a "spoon" and was ready to shoot-up:

Therapist: Okay Bob, I would like you to talk to the needle, to the syringe.
Bob: (somewhat confused) Hey man, don't be crazy . . . talk to the needle?
Therapist: Well, if it wasn't crazy, what would you say to the needle. (after further discussion on this the patient agrees)
Bob: (to the syringe) Hey . . . com'ere. . . .
Therapist: Would you go through the motions as you talk.
Bob: (getting back into it and raising his hand as if the syringe was in it) You're really lookin good. I really need you . . . I want you to warm me up . . . Make me feel good. Yea, make me feel good all over . . . Just get inside me and I don't need anything else.

At this point I spent some time in dealing with Bob's dependence on heroin and use of it for support. Followed by:

Therapist: Do you see the empty syringe lying on the table.
Bob: Yea.
Therapist: I would like you to go over to the table and be the syringe. . . . (he goes to the table) now, talk to Bob.
Bob: (being the syringe) Man, are you a dummy. I just suckered you in again. All you had to do was see me and you fell. You just can't stand on your two feet.
Therapist: Switch back to Bob and respond.
Bob: (going back to his chair, sitting slumped over)

Therapist: What are you feeling.
Bob: Shitty . . . that god damn syringe is right.
Therapist: Well, what do you want to do about it.
Bob: What can I do. (he is expressing his helplessness)
Therapist: How are you feeling toward that syringe over there.
Bob: (looking over, in a low voice) Pissed.
Therapist: You don't sound pissed.
Bob: (again looking at the syringe; getting visibly upset) You god damn bastard. What the f_____ do you want from me. (he goes over to the table) I'm going to f_____ destroy you. (makes sounds of rage) That's the last time your going to trick me you f_____ Bastard.

This sequence was very important in that the nurturing fantasy of the heroin was juxtaposed with the aftermath or devilish nature of the habit. Also the patient was able to fight back, in a sense, and thus feel some kind of power over a habit that, for many years had all the power over him.

Another helpful exercise I utilize in the development of self-support is to have the patient express what he likes about himself. I find that after some coaxing, most are able to do this—after all, their street skills of hustling, conning, agility etc., when isolated from their role in getting heroin, can be very good assets. By appreciating their own skills and other qualities that they like in themselves they begin to build a support system and develop self-esteem.

ANXIETY

Related to the issue of support is the addict's weak ego development and how this leads to anxiety. The way I describe this in Gestalt "operational" terms is their inability to deal with the "topdog-underdog" conflict. The topdog (TD) in this case is that part of the patient setting up unrealistic goals. The patient then becomes involved in a double bind situation: he wants these goals yet doesn't have the tools with which to acquire them. This conflict leads to anxiety. In Gestalt lexicon, anxiety is excitement without adequate support. The addicts have the excitement, in terms of what they want. But they don't have the support or the tools, background, training etc. to make the goals a reality. In more simple terms, there is energy created without any behavioral outlet. Consequently, the formation of a goal and the attendent excitement produces anxiety. To control this feeling they turn to drugs. Thus when the TD sets up the unrealistic goals, the underdog (UD) sabotages the attempt to achieve them by taking heroin. The heroin makes the addict unresponsible, or "unresponse-able," affording an excuse for not reaching the goal. In addition, the UD uses the heroin as a substitute goal, a way of getting nourished.

Again, the first step in dealing with this problem is bringing this conflict to

the patient's awareness. The most straight forward method to achieve this is by having the person initiate a dialogue between his TD and UD. In this process I ask him to switch seats, i.e., in one seat he is his TD while in the other he is his UD. This procedure more clearly delineates the polarities and separate characters within himself. In general terms what is usually realized is the unreasonableness of the TD and at the same time the process used by the UD to sabotage the TD's plans and goals. By not attempting to reach the goal the addict avoids the possibility of failure.

Once the patient becomes aware that his goals are beyond his reach *at the moment*, he can start setting up goals that are more reasonable. The act of successfully seeking and achieving these new goals is the first step in breaking the "excitement-no support" attitude which creates the anxiety. The addict starts to realize he has other alternatives than shooting-up.

CONTACT

The last issue to be discussed is contact. During my initial work with drug addicts I had a very difficult time. While leading my group I felt uncomfortable, yet was unaware of the cause. One day at the end of a session I was quite frustrated and said to myself, "This is like beating my head against a wall." With that statement I discovered that I had been doing just that—beating my head against the invisible wall that my patients had set up between us. The following week, armed with this awareness, I looked for signs of the wall; but the process was a very subtle one. What I finally discovered was that my patients never really made contact with me—that was their invisible wall. Of course when this was mentioned they either denied it or were totally unaware of doing it. After much work on this it became clear that this avoidance of contact helped the addict to escape. Once this was acknowledged, we tried to uncover what they were escaping from.

In the course of this search it became obvious that many of the drug patients saw me, their therapist, as a judge; someone who was going to lay some kind of trip on them or in some way tell them they are no good. This could be expected since that has always been their experience, and it had been their experience long enough so that they frequently made the generalization to whomever they were dealing with. To overcome this I had them describe me and talk about me. This helped them discriminate between me and those who judged them in the past. Their relationship with me thus created the possibility that others might have positive responses to them, and for them to check this out. Again we return to the issue of self-support since this is usually a prerequisite for taking the necessary risk in making contact. Once the patients allowed themselves to believe that they can have positive contact, they began to recall previous instances where they had good interactions.

The personal issue relating to the therapist is just the beginning in approaching

the avoidance of contact. The drug addict still has other motives in keeping that wall between them and the therapist. And they have many techniques to accomplish this. Usually as the conversation approaches any type of feelings the patient quickly goes into story-telling and other forms of monologue. By going into the past, or talking about outside events, they avoid their feelings at the moment and avoid contact with me. When I become aware of what they are doing (which isn't always immediately evident) I ask them what happened to our contact. My job at this juncture is to keep them in the here and now, or make them aware of their flights away from the here and now. I am very direct in this approach, telling them "You are not staying with me"—or "Where did you go to." My most difficult task is being firm and not letting them get away with it. One of the most helpful tools I have employed at this point has been the tape recorder. Upon hearing their actual words on tape it becomes more difficult for the patient to deny his avoidance.

Once the addicts are able to acknowledge that they are avoiding their feelings, we begin to look at what was going on just prior to their loss of contact. One patient discovered that he was starting to get angry at his mother when he shifted to another topic. Upon reexamination he realized that part of him thought it was not right to be angry at his mother. In another situation a patient began getting sad prior to his loss of contact. This occurred a number of times, with me, the therapist, asking, "What was happening just before your eyes looked away," (my indication that he literally did go away to avoid the feelings starting to emerge). I could even add, "You looked sad just before you looked away." In this manner the addict eventually learns how he is avoiding his feelings, and the periods of time that they are with me, in contact, gradually increase. As a consequence, they are more able to get in touch with their elusive feelings.

CONCLUSION

I have briefly described some Gestalt therapeutic techniques that have been useful in working with drug addicts. Through this approach the issues of contact, avoidance, anxiety, self-support and responsibility are experienced by the addict in the present and thus become more immediate and intense. This facilitates growth and change in the patients. It should be emphasized that this approach is more than simply a collection of techniques but a unified way of approaching the therapeutic process. This process starts with the patient-therapist relationship, a non-authoritarian approach that employs trust rather than power as the basic motivating factor. It also focuses on the process rather than content. By exploring *how* the patient interacts with the therapist we get an idea of his process in other relationships and in dealing with other situations. This, along with the avoidance of interpretations by the therapist and relying on the patient to take responsibility places the emphasis on self-support which should extend beyond the therapeutic situation.

REFERENCES

1. E. Harms, Two Basic Defaults in the Present Psychotherapy With Drug Addicts, *International Mental Health Research Newsletter, 14*, pp. 1-2, 1972.
2. J. J. Platt and C. Labate, *Heroin Addiction: Theory, Research, and Treatment*, Wiley, New York, 1976.
3. A. Switzer, Drug Abuse and Drug Treatment, California Youth Authority, 1974.
4. T. E. Bratter, Treating Alienated, Unmotivated, Drug Abusing Adolescents, *American Journal of Psychotherapy, 27*, pp. 585-598, 1973.
5. F. S. Perls, *The Gestalt Approach and Eyewitness to Therapy*, Science and Behavior, Palo Alto, 1973.

Direct reprint requests to:

Stephen I. Sideroff
Department of Psychiatry
School of Medicine
University of California
Los Angeles, California