THEORY, APPLICATION AND EFFECTS OF GESTALT THERAPY:

A COMPARATIVE STUDY UPON PSYCHIATRIC DAY HOSPITAL PATIENTS

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Theses submitted to the University of Surrey for examination for the degree of Doctor of Philosophy.

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1979


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Gestalt therapy, a combined treatment for a constellation of neurotic conditions, has commanded increased attention in psychological literature since the early 1950s. In addition, due to a growing interest in its application it has stimulated the creation of many training institutes.

Chapter I of the thesis will construct a perspective of Gestalt therapy from Humanistic Psychology, and includes a mosaic of ideas from phenomenology and existential thought, communication theory, communication through symbols, body expression and language, and behavioural theory.

An experimental enquiry to the effectiveness of Gestalt therapy as compared with traditional psychotherapeutic methods is the subject of research, introduced in Part II.

Work for this study was accomplished at the Marlborough and Paddington Day Hospitals, both "psychoanalytically oriented" psychiatric hospitals of the National Health Service, London, through a survey of the literature, discussions with Gestaltists and participation in the hospital life as a clinical psychologist for two years.

The author wishes to thank Dr. D. Bannister, Dr. L. Haward, Dr. J. Goodburn, B. Morris, J. Heron and the entire staff of both hospitals for their immeasurable kindness and commitment in combining diverse traditions.
SUMMARY

The thesis sets out to examine the way in which Gestalt therapy methods have been developed and to analyse the theoretical arguments which underpin them.

An empirical study was undertaken in which Gestalt training methods were applied over a period of six months to a group of psychiatric day hospital patients who were simultaneously recipients of orthodox psychoanalytically oriented treatment. Their progress was compared with that of a matched group who were receiving the same psychoanalytically oriented treatment, except that painting sessions replaced the Gestalt therapy sessions. Outcome for both groups was measured pre and post treatment using the Personal Orientation Inventory (Shostrom), a form of repertory grid test (Kelly) and the Target Complaint Scale (Battle). Results generally indicated that the patients had benefitted from the Gestalt therapy. These benefits were variable and different between the experimental and the control group.

A further study was undertaken, designed to explore the effect of Gestalt training (in a therapeutic form) in a different culture and with non-psychiatric subjects. A group of Belgian mental health professionals received Gestalt training over a period of one year and change was measured using the Middlesex Hospital Questionnaire (Crown and Crisp), the Personal Orientation Inventory, a form of repertory grid test and the Semantic Differential (Osgood). Similar benefits to those noted for the patient population were evident.

The usefulness of Gestalt theory is argued to rest primarily in its ability to induce time competence (the capacity to experience actual here and now stimuli) and its value in resolving antagonistic forces within the person (toward achieving personality integration).
INTRODUCTION

Gestalt psychology developed in the 1920s when it was confined to the study of sensory perception. The experiments generated interest in: (a) the concept of holism, and (b) the study of how perception is organised.

'Holism' refers to the idea that a whole is greater than the sum of its parts. This macrocosmic viewpoint was upheld by researchers like Wertheimer (1921), Kohler (1929) and Koffka (1935) as a protest against elementarianism and atomistic methods of data collection. The research instigated a movement against "knowing more and more about less and less...." Writing in the same spirit, Henri Bergson (Murphy, 1968 p. 285) comments:

The perceptual experience on a starlit night includes an integration of everything from the stars we observe to the brain processes with which we observe them.

One aim in studying perception is to gain understanding of a most fundamental life process. By focussing on the process and organisation of perception, the Gestaltists were ensuring that they did not fall into elementism (structuralism). They made the important assumption that the basic root of experience is perception and that to break perception into element parts - e.g., to analyse the structure or function of a single sense organ - would block the capacity to understand the whole experience.

The methodology used by the Gestalt school in the 1920s revealed some basic laws of perceptual organisation known as the laws of form, proximity and closure, and studied the relationships between self, environment and insight (Woodworth, 1967 p. 214-238).
The Gestalt psychologists studied mainly external perceptions, concentrating their efforts usually upon visual and auditory phenomena. They tended to ignore the background aspect of perception, i.e., the non-form, non-visual, and temporal aspects of the field. The Danish psychologist, Rubin, brought attention to the "holes" or nothingness which exist around and in the midst of the form, i.e., the shapes that exist in the spaces between the branches of a tree. This concept of "ground" was quickly assimilated into the main body of Gestalt theory by demonstrating that "reversible figures" could alternate between the figure of perception and between the background of non-form. Lewin's field theory pointed out that the background could take on figural attributes, producing shifts in perceptual organisation.

Koffka attempted to develop these laws of perception to incorporate memory, will and action. He unfortunately had to refer to an ambiguous "silent organisation" within the human experience because the Gestalt psychologists never went beyond the visual implications of the form and field phenomena.

Perhaps the Gestalt psychologists were over-concerned with creating an object-oriented "scientific psychology" and limited their scope of study to exclude the phenomenological approaches.

Thus, Gestalt psychology dealt mostly with external visual and auditory forms, but disregarded those principles in relation to organismic perceptions, i.e., to one's own emotions, body sensations, and feelings (Wallen, 1957). In this way, the early Gestalt psychologists failed to integrate the facts of motivation with the facts of perception.

Gestalt psychology did not develop any further toward applicable psychotherapy until Frederick Perls applied the principles developed by the early Gestaltists into a unifiable theory of psychotherapy.
Perls (1947), a German-born psychiatrist, conceptualised a theory of health and neurosis based upon studies of Gestalt psychology and psychoanalysis with particular emphasis on the phenomenological and existential view. By utilising the present moment philosophy of Zen Buddhism, Perls succeeded in combining the above discipline into a holistic theoretical framework.

The Therapeutic Process

Wertheimer (1912) demonstrated experimentally that when an observer sees two lights projected from a distance on a screen, flashing at a certain speed in rapid sequence, the observer would perceive a light moving from one point to another rather than separate images (the phi phenomenon).

He developed this phenomenon into the idea of 'closure', the process of bridging incomplete patterns. This 'bridging' process allows the individual to organise his experiences into the form of complete patterns of what are called 'Gestalts', a figure pattern dominating a diminishing background.

The above experiment suggests how one individual sees a phenomenon as a different event than another individual. For the researcher, the observer is presented with two separate flashing lights; but to the subject the image is seen as one light in motion. The question arises as to whether there are two separate phenomena or whether there is one phenomenon perceived differently. It might be argued that the researcher's description is more accurate by the very nature of the controlled procedure. Experimenters might agree that there are two separate images projected towards the screen. Yet the observer will report that he sees one moving light.
An acknowledgement of this state of affairs is central to Gestalt psychology in that the therapist's task is to recognise the patient's observations and to consider these perceptions as the patient's reality.

The Gestaltist maintains that the opposition between the objective and subjective approximations is inadequate when seen separately and atomistically. They put forward that synthesis and integration of both views are essential for understanding.

Various therapies view the action of the therapist and perceptions of the patient in different ways. The behaviour therapist utilises the scientific theory of learning to modify his patient's behaviour, sometimes without consulting the observations and personal experiences of the subject. Whilst observing the patient's present ongoing behaviour he places the images, sensations, and perceptions outside his operational definition.

The Freudian and members of other analytic schools provide a description of the problematic psyche but fail to integrate the patient's own phenomenological standpoint. Thus, the analyst's perception and understanding of the patient's phenomena is theoretically isolated from the world view of his patient. The analyst's task is to show the patient how the patient's experience corresponds with the theoretically derived preconceptions of psychoanalysis. Therefore, the analyst often fails to work within the patient's own phenomenological world.

The Rogerian approach focusses on the patient's perceptions and concerns, but the therapist rarely intends to present the patient with conflicting views. He therefore refrains from communicating his own feelings and experience of what is occurring between himself and the patient. Hence, the name 'client-centred' therapy.
The reader will find that the following chapters will be concerned with the trend of thought that surrounds the Gestalt therapeutic position. Understanding the ethos of humanistic psychology and Gestalt therapy is the goal of Part I of this thesis.

It is not the purpose of this work to critically analyse this theory, but to provide a background of understanding from which these clinically based concepts have emerged.

The reader is reminded that the concepts under discussion originate largely from clinical observations. These observations have been organised into a matrix of ideas concerned with the functioning of a so-called "healthy optimum man". The integration of ideas is merely a convenient view of psychological health and as such has little scientific evidence to support or substantiate its validity.

In summary, the purpose of Part I is to provide the background and source for hypotheses. Part II will pick out in detail essential aspects that are significant and testable. Here, a critical analysis of the concepts will be made and subsequent evaluation will be presented.
CHAPTER I

THEORETICAL ORIENTATION

To understand Gestalt therapy it is necessary to comprehend the Gestaltian outlook on behaviour by clarifying several concepts: 'growth', 'presentness', 'balance' and 'figure/background'.

The concept of growth may be considered to be composed of several dimensions:

"Risk - Safety" (Rogers, 1961). Risk-taking is seen as a means by which the individual moves towards developmental progress. Risk-taking is usually a first step toward growth. Gestalt therapy is designed to engender an attitude of risk-taking; the individual is encouraged to take risks where before he would have opted for safety.

'Safety' is considered an attitude that limits the exploration of creative alternatives. When safe an individual stays just as he is. He does not experiment with new ways of behaving or new ways of relating with others which would ensure minimal development of his full potential by not placing himself in a situation that might test, stretch and strengthen his capabilities in new and different ways. The fact that he has arrived at the therapeutic situation assumes that he is at a stage where he wants to take risks.

The patient's choice for safety leaves the Gestalt therapist with several choices. He could attempt to remove the barriers, as in behaviour therapy; he could explain them to the patient, as in analysis; or, as a Gestalt therapist, he could increase the patient's frustration by exaggerating the barriers.

"Frustration - Satisfaction". The term 'frustration' is used to mean the behaviour whereby an individual prevents himself from...
achieving self-fulfilment. Frustration provides motivation for the individual to take risks, for it develops more energy to aid him to surmount the added difficulties in his need for satisfaction. It is considered facilitating to provide skillful frustration (Perls, 1969).

For example, the therapist can demonstrate, show and elucidate the patient's self-defeating behaviour by having him exaggerate this behaviour and skillfully 'teasing' and frustrating him. This is often found to provide added motivation toward risk-taking to the point where the individual surmounts the therapist's superimposed frustration and then surmounts his own obstacle. This has been repeatedly demonstrated both in therapy and in daily life (Perls, 1969).

"Self-Support - Dependence". With frustration the attempt is to re-orientate manipulative and dependent behaviour by stressing that self-support arises from taking responsibility for oneself. Responsibility here means the ability to respond to the situation by utilising and relying on one's own resources.

Dependency and lack of personal responsibility is shown in the constant seeking of approval from others. The individual is often unaware of his chronic dependency and reliance on others. We seek to modify this behaviour by encouraging the individual to take responsibility and support himself. We do this by suggesting that he takes part in activities that promote self-support, such as asking him to make a statement seeking support from each member of the therapeutic group upon whom he feels dependent. The other person might reply in the following manner: "I'm responsible for myself; don't make me responsible for you".

The opposite situation occurs when the individual is found to be excessively autonomous and self-supporting to the point of isolation (Shostrum, 1966). We then point out that there are needs which cannot be
adequately satisfied by oneself, such as the needs of love, warmth and companionship. Methods similar to those described above are used to modify excessively autonomous behaviour. Here the individual might be asked to state to each member of the group how autonomous he is and how he needs no-one but himself. Other members might reply: "I have warmth for you and can offer you companionship".

(Other methods for providing self-support will be quoted further on in the section on psycholinguistics.)

"Inner direction - Other direction" (Shostrom, 1966). The inner-directed person possesses an internal programming that grew from parental influence and developed in relationship to specific figures of authority. Whilst apparently acting independently of outside influences, he is following this internal value system, giving the appearance of an autonomous set of values.

The other-directed person, on the other hand, responds to a wider range of influences in childhood and is excessively indecisive when confronted with conflicting possibilities. This person is likely to conform to the wishes of others in order to gain their approval. In extremes, this insecure, outer-directed person may manipulate and seek to control others as a way to ensure acceptance. His insecurity often results in a constant need for acceptance and reassurance.

The therapeutic intent is to find a balance between these two extremes. A person realising this balanced orientation would remain self-directed yet sensitive to other people's reactions and responses. Shostrom (1966) determines that for self-actualising behaviour, the ratio would be 1 : 3, where three parts would be self-directed and one part other-directed.
The self-actualising individual would therefore maintain a critical inner dialogue in order to prevent his inner value system from becoming rigid or stagnant. He also tests his inner value system in relation to others and modifies it, intuitively approximating the ratio described above. In essence, there needs to be this giving and taking, ebbing and flowing from inner-directed to outer-directed.

"Presentness" The most basic concept to comprehend in Gestalt theory is that of time-orientation. In Western culture we perceive time as an object. We label time, mechanise it, and orientate our total experience around this invented notion. Time which comes before "now", we label "past"; time which follows "now", we label "future". With this practice of separating past and future from the present we cut time into segments which can be manipulated and fantasised upon. This practice is done instead of contacting actual experience of the present moment.

Other cultures treat time as a unified time or a unified continuum. Breckner in his study of the Xinga Indians in Brazil states:

"Their sense of time, too, is quite different from ours - they use the same word for yesterday and tomorrow".

The therapeutic aim in keeping one's attention in the present is to help the individual to maintain contact with the physiological experience of being in the world.

It is considered that the organism has an innate wisdom of its own. This organismic wisdom responds appropriately in any given situation if left to function naturally. This is different from

(1) Self-actualisation is a term coined by Maslow (1955). Shostrom (1966) defines: "A self-actualising person is one who is more fully functioning and who lives a more enriched life than does the average person. Such a person is developing and utilising his unique talents to the fullest extent. It is generally agreed that a self-actualising person might be seen as the desired result of the process of counselling psychotherapy". (Personal Orientation Inventory, 1966).
consciously forcing one's attention towards a given object. The difference between the two is that in free, spontaneous activity the individual is drawn excitedly to the object of attraction with a total involvement; because the object of attraction is, by definition, need-fulfilling.

Forced concentration, on the other hand, requires the individual to suppress his natural psychological and biological functioning. He therefore divides his attention by focusing on a stimulus that may not be directly need-fulfilling. Forcing one's concentration is strenuous and does not contain the element of exciting vitality. This results in a three-way division of energy with forced concentration (Perls, Hefferline and Goodman, 1951): toward the item of spontaneous interest, suppressing this interest, and toward the object of forced concentration.

The diagram below illustrates this division.

Organismic energy is divided in three different directions....
An example of forced concentration is a situation where a child in school is required to sit still and direct his attention to the subject matter presented. Essentially, three activities are occurring:

(a) He is aware of spontaneous interests such as an aeroplane flying past the window or the activities of the child next to him

(b) He suppresses this natural interest, and

(c) Forces his attention on the subject presented to him.

The reinforcement of this process ensures that it becomes a habitual mode of functioning for the individual. As a result, he constructively uses only a small part of his total energy resources and hence inhibits the development of his full potential.

In spontaneous concentration, the organism is attracted and drawn to the object of interest, resulting in a total expression of need satisfaction. In other words, the individual is attracted, interested, fascinated, or absorbed in the process of excitingly attending to his natural functioning. As a result, all his energies are at his disposal to meet the demands of the moment (Perls, 1951).

**Time competence.** Related to presentness is the issue of time competence, the ability to stay in the present, an item of clinical importance. Shostron (1966) considers the average self-actualising person to be operating a a ratio of 1 : 8, i.e., for every one part spent recalling past and anticipating future events, there are eight parts spent in contacting present experience. A person functioning excess of 1 : 8, say 1 : 10, would only be present-oriented. Such a person would not recall and picture the past or future sufficiently and therefore would fail to develop an adequate appreciation of the continuum between past, present and future.
In Figure 2 we illustrate both the ability to stay in the present and the ability to recall past experiences and anticipate future events as a healthy function of fantasy. Here the individual learns from his past experience and plans for the future. However, when fantasising about the past and future more than one-third of the waking day (Shostrum, 1966), there is a tendency to lose contact with one's present experience. This is an example of "time incompetence". Figure 3 schematically presents the partitioning of past, present and future in a "time-incompetent" individual.
present by fleeing the "now" and picturing or anticipating a future moment such as anticipating failure and catastrophe or success and popularity. These fantasies act as displacements of the present moment.

(2) The term "actuality" here refers to the physical environment surrounding the individual.

The past-oriented individual spends most of his time thinking about the past and does so in the present. These thoughts of the past are experienced as real to the individual and hence only allow him a partial contact with actuality. Any possible nourishment that the environment can offer is therefore lost to the individual since he flees the present by recalling past events in fantasy.

Similarly, a future-oriented person escapes the present by thinking and fantasising about future events. This is done in the present by fleeing the "now" and picturing or anticipating a future moment such as anticipating failure and catastrophe or success and popularity. These fantasies act as displacements of the present moment.

(2) The term "actuality" here refers to the physical environment surrounding the individual.
On the other hand, the individual who is excessively present-oriented fails to recall or picture the past and future. These individuals fail to develop a meaningful appreciation of the past-present-future continuum. Consequently, they rarely learn from their past experiences or realize the consequences of their action in the future.

Criticism is often voiced against the Gestaltian concept of working in the "here and now". Some Gestalt therapists suggest that the therapeutic process must remain at all times in the present experience. As noted above, this strict dogma would produce time-incompetence, since a meaningful continuity between past, present and future would fail to be explored. The present writer assumes that the "here-and-now" concept is valid and beneficial in establishing the necessary contact with present experience, but to use the "here-and-now" notion exclusively might hinder exploration of the time-continuum.

The therapeutic goal in relation to time orientation is to help the individual to find a meaningful process of movement between past and future, while remaining in the present as the foundation for developing healthy experiences.

"Balance" The concept of balance can be seen as analogous to the biological concept of homeostasis. The body attempts to maintain homeostasis on all levels. For example, in the biological need for water (thirst) the body senses a negative supply of fluid. To compensate it mobilises energies for the exploration and assimilation of a water supply which exists in the environment. This returns the organism to a state of balance: a zero point along the continuum of too much or too little water (Perls, 1979).
This zero point can be seen to be a position of creative indifference or creative pre-commitment (Perls, Hefferline and Goodman, 1951). It is called this because the zero point is a state where the organism is free to move in any direction. This state of equilibrium is the necessary starting point of spontaneous natural functioning, for it allows new needs to surface and be met whenever necessary. For example, the relationship between a man and a woman may exist along a continuum. The man could lose his emotional balance by falling "head over heels for her", thus making his need for love from the woman more important than his own self-esteem.

As another example, a girl may be led to believe that she is worthless and disfigured. She may overcompensate by creating fantasies of beauty or fame to re-balance her emotional state. This may lead to difficulties, too, because fantasy is a poor substitute for a healthy real self-image.

The dichotomising of experience is evident in Western language systems. This relates to the way we order the world. We tend to categorically evaluate in dichotomies (Kelly, 1955): good - bad; right - wrong; pretty - ugly; with the different degrees of goodness and badness in between: beautiful, plain, uninteresting, ugly.

This system of dichotomising exists in almost all expressions of value judgement. With these expressions there is a zero or neutral point, where the construct is neither plus nor minus. This is the point of indifference

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<thead>
<tr>
<th>Forward</th>
<th>stationary</th>
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<tr>
<td>High</td>
<td>medium</td>
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<tr>
<td>Past</td>
<td>present</td>
<td>future</td>
</tr>
<tr>
<td>Happy</td>
<td>indifferent</td>
<td>sad</td>
</tr>
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The middle term in each case is important for it expresses the point of observation where one is free to move in either direction and
allows a creative opening for the development of spontaneous concentration.

In therapy there exists a dynamic of opposites. For instance, in striving for a desired goal it is necessary for the therapist to keep in mind that there is always a dismetric opposite. Once this is considered, the balance between the two extremes can be found. This allows a creative-indifference to develop, giving rise to freedom of movement in either direction.

The importance of the need to integrate opposites and thereby achieve balance can perhaps be highlighted by consideration of what occurs when an individual becomes fixed on one side of a conceptual polarity. During an introductory lecture on the principles of Gestalt therapy, an argument arose concerning the importance of verbal expressions versus emotional expression. One psychologist argued that in his experience verbal expression was an adequate means of working through psychological difficulties. He also felt that the speaker was disparaging and dismissing verbal expressions and was favouring the importance of the process of "acting through" experiences. A number of psychologists argued that the experimental approach of humanistic psychology was in direct opposition to their approach of using verbal expression: thus they polarised the issue and became fixed on one end of the construct of "words versus feelings".

The speaker responded to the argument by again emphasising the principle of balancing opposites. It was pointed out that by a bias to one side of the construct of feelings versus words, an imbalanced perception was becoming the focus of attention; that as long as the critics were unprepared to consider the opposite of their argument, no integrated resolution could be achieved.
When the critics acted on the concept of balancing opposing forces they began to see that working through the experience along with verbal expression could be the most effective means of working through psychological difficulties. With this, the argument diminished, and the problem was resolved.

In conclusion, an imbalance exists when one adopts one pole of a polarised construct. For an integrated viewpoint, it is necessary to consider both poles of the construct at the same time.

"Figure/Ground" The most widely researched area in Gestalt psychology has extended from the basic premise of "figure/ground", the basic elements in the organisation of perception. In Gestaltian terms, perception occurs when one shape, pattern, structure, or "figure" emerges from the surrounding shapes, patterns, structures or "ground". The total relationship between figure and background is known as a "Gestalt".

"A Gestalt figure is something to be found rather than something given"  
(Wertheimer, 1950, p. 64)

The perceiving of a figure against a background is the action of the observer. To see an object, one must first distinguish it from its environment, be it visual, auditory, tactile, olfactory, palatal or proprioceptive. This focussing process produces a "good Gestalt", a good figure/background relationship, by attending and concentrating on the figures as they form. (Perls, Hefferline and Goodman, 1951).

"This principle applies not only to the momentary whole but to the flow of experience as well. There is no starting or stopping; there is a constant readjustment in the structure of the complex experience".  
(Bain, 1898, p. 325)

For example, one is reading this material and the telephone rings. The perceptual figure/ground changes. The "ring" of the telephone will
disturb the figure/ground relationship. As a result, the clarity of
figure, ie., the printed words, become background because the ring of
the telephone now becomes figure.

This moving concentration is called awareness. Awareness is the
ability to focus one's perceptual energy on the experience that is emerging
in the moment. Essentially, the is contacting and highlighting
perceptual shapes from their backgrounds. This is a process by which
needs come into focus, accompanied by physiological and psychological
excitement and elan vital.

"Contact" is the process of focussing one's perceptual energy
consciously upon emerging thoughts, fantasies, objects, sensations and
sometimes even upon "nothingness". The action of contacting a figure
as it emerges from the background produces a clearer, brighter, more
definite perception. One cannot be fully aware of a perceptual figure
until one is in contact with it.

The opposite to a clear figure/ground formation is called
"confluence". In confluence, one distorts the process of defining
clear figure/grounds to such an extent that figure and background
swim together, producing an "out-of-focus" contact. The individual
who is in confluence loses contact with the boundaries delineating
the figure from the background and allows the background to flow
together with the figure. As a result, a clear Gestalt does not form
and the person is said to be confused.

When observing an incomplete figure, there is a tendency for the
individual to fill in the missing parts. This process is called
closure, the moment of insight when one is able to perceive a
situation as a whole. (Wertheimer, 1945). This completing or
"closing the gaps" of an unclear or hazy perceptual figure seems
to be an automatic process (Kohler, 1947).
Motivation

The following deals with the Gestalt theory of healthy motivation, regulation and expression of energies. This model is seen to be applicable to healthy biological functioning in the human organism. It is intended to treat the human being simply as an organism functioning within his environment as a unified body/mind (Perls, 1973). Criticism of this approach will be discussed in a later chapter (cf. Infra).

Organisms have basic needs which must be fulfilled to promote flourishing growth experiences and maintain healthy functioning.

Maslow (1954) suggests the following hierarchy of needs (3):

(a) Biological needs of eating and waste elimination
(b) Needs for safety within the environment
(c) Needs for love and belongingness
(d) Needs for self-esteem
(e) Self-actualising needs

These needs represent a hierarchy of development where the fulfilment of an advanced need is dependent on the adequate fulfilment of a lower need. The organism cannot develop self-esteem, for instance, until its needs for love and belongingness are fulfilled. The organism cannot feel safe in the environment until its biological needs are fulfilled, nor can it develop self-actualising behaviour until its needs for self-esteem are fulfilled.

In this way, need-fulfilment and the progression from one need level to another is the process of growth. If the organism is allowed to explore, experiment, and integrate its need impulses, it will evolve spontaneously towards its own self-actualization.

(3) Maslow was increasingly concerned with combining the discipline of biology with that of psychology. Thus, one can see that the concept of "needs" is quite similar to the biological notion of "drives".
As an example: a baby will cry out for biological need satisfaction. Once these needs are fulfilled, the organism again will return to its exploration of its environment.

When the organism feels secure within the environment, it will strive toward merging, belonging, and loving with others. Once this is achieved, the organism seeks to develop self-support and esteem, a sense of having a worthwhile identity. Upon fulfilment, needs for self-development will emerge. This will drive the organism toward developing its own essential characteristics of potential (see also Maslow, 1969). Experiencing needs force the organism to contact its environment.

Upon analysing this concept of need-fulfilment, one might consider the earlier approach of instinct theory. Having noted that there were common drives existing among living creatures, the idea of "instincts" was proposed as a means of explaining the motivating forces in animal behaviour. Freud considered that neurosis is the result of repressing instincts (the id). When we consider the concept of balance we see that need-fulfilment is a more appropriate idea than the instinct concept. When organismic balance is said to be upset, a need would surface to correct such imbalance. In this way, we can explain practically all human behaviour in terms of need-fulfilment instead of instincts. The idea of needs is more viable to a creative psychology than a theory of instinct motivations.

"Self-regulation" The need-structure is self-regulating. The most important need surfaces first. (Perls, 1969). For example, whilst an organism may be in the process of fulfilling a need, a biologically lower need may clamour for attention. This new and dominant need will change the organism's perceptual figure to mobilise energy toward
An individual may be absorbed in watching a play on television when he smells smoke. His biological self changes his perceptual focus and forces the need of environmental safety to mobilise energies towards the new need, thus motivating the individual into action. This self-regulating process allows the organism to respond to situations in the most appropriate way, by allowing his perceptual figure/grounds to develop freely.

In the self-regulation of an organism, emotions play an important part. Emotions inform the organism of what is important and assist biologically by quickening or slowing down the metabolic rate to the proper level for dealing with a given situation.

A high emotional reaction indicates that an important need is surfacing. This accelerates activity and increases metabolism, thereby providing energy for the organism to respond. This may flare up instantaneously, as in the emergency situation of first noticing a fire in the corner of the room. The figure becomes fire and the organism will respond with the added energy of increased metabolism. Once the need for safety is fulfilled, the metabolism will re-balance and the organism will be ready to cope with the next emerging figure, which may be to return to the previous activity.

In the same way that the accelerator controls the speed of a car, emotions tell the organism in what degree to respond to a particular experience. Through gaining experience we develop a subtle proprioception telling us which activities are important, which activities can be passed by what is nourishing or toxic, friendly or hostile, beneficial or detrimental. In healthy functioning, emotions tell us what needs are important, how strong to respond to these needs and what methods might be employed to its self-regulation.

The therapist draws the patient's attention to how the latter is physically responding to his emotions and his experience. This
leads the patient to an awareness of the actions and responses he makes during his emotional experiences. This increased awareness creates a unified "Gestalt" that he can see as well as feel.

The act of interpretation is thus unnecessary, since the patient is beginning to experience himself as his emotions. Through experience he begins to produce his own links with his personal background.

In healthy functioning, emotions (inner movements) motivate the organism to contact and directly act upon the environment. This activity "discharges" the emotional energy into the environment. The "inner-world" experience of one's emotions (Laing, 1967) can only be genuinely revealed to another person through emotional discharges. For example, one loses a loved one through death. Grief swells until an organismic explosion of crying discharges these emotions. This will continue until the loss is sufficiently expressed and the death moves slowly from figure to background.

Perls (1970) has called the emotional discharges explosions, and has noted that there are four basic types of explosion:

Laughter,
Crying,
Anger,
Orgasm.

Discharges occur in different intensities and in direct proportions to the importance of need-fulfilment. In healthy functioning, a need of great importance (e.g., where actual survival is the issue) will produce a high emotional tone and a high discharge of energies (e.g., fighting or running away). A need of minor importance will produce a lower emotional tone and here the discharge of energies will be of a lesser degree (e.g., walking and seeing).

Until now, the writer has been attempting to discuss behaviour that constitutes healthy growth and healthy experience. This is
considered to be basically the process of contacting the ever-changing, present-moment, figure/ground formations. Needs organise the figure/ground formations. Emotions regulate the degree of activity, and discharge produces the interflow of organism and environment. This whole process is self-regulating.

This natural functioning can become misdirected in the following ways. (Perls, 1947; Perls, Hefferline and Goodman, 1950)

Organismic energy that is turned back upon the organism and fails to achieve a change in the environment is called retroflection. This usually begins when behavioural tendencies are stopped or prevented from expression. For instance, there are cases where parents repress their child’s anger. This prevents the child from contacting the environment with his emotions. His holding back process becomes directed back upon himself.

The retroflector does to himself what he would have liked to do to others. He has stopped directing energy outward to manipulate and bring changes in his environment that would help to satisfy his needs. Instead, he now re-directs his energy inwards and substitutes himself as the target for his anger. Figure 4 shows misdirected behaviour. The energy is retroflected and turned back on the organism.

Figure 4

In Figure 4, the organism attempts to contact and discharge energies into the environment to satisfy needs. The environment
punishes the organism for these attempts toward need-fulfilment. As the diagram illustrates, the impulse does not disappear because it still clamours for satisfaction, i.e., the punishment does not destroy the energy but merely re-directs it and in retroflection the organism becomes his own object of need-fulfilment. For example, the individual's need to express anger to another may be retroflected in the form of biting his own nails or digging his fingers into his own flesh.

**Introjection** Using the analogy of the assimilation of food, we can see how individuals digest and make use of their emotional, psychological and intellectual experiences. In the healthy organism, food is bitten off, chewed and broken down into easily digestible morsels which can then be swallowed and accepted by the digestive system. This process is called assimilation. On an emotional level, the material of experience must also be worked on and broken down before one can adequately assimilate the experience and grow through the process. Under introjection the emotional experiences or concepts are not digested, but swallowed whole.

Culturally, we have been forced to accept material which we have not adequately broken down. This occurs by swallowing ideas whole so that they lodge uncomfortably within us and prevent free functioning. From early childhood, it is probable that we have been taught to accept things as they are, and above all, not to question the material set before us. For example, a young child may be taught to eat at the "proper time", although this may not coincide with his organic need for nourishment. He is told to wait rather than "spoil" his supper and, when food is finally available, he gulps down his food whole, hardly stopping to chew or taste it. This may be reflected in his attitude to emotional experience as well. He will accept concepts emotionally that are not truly part of himself and may even hold firmly
on to them.

For example, many people in our society have introjected the idea that interpersonal tactile contact is bad. Whilst this introjection remains, the individual will re-direct his impulses so that the need for tactile contact remains unfulfilled. In essence, the organism is actually preventing itself from fulfilling its own needs.

**Projection**  As has been discussed earlier, retroflection is the turning back of energy upon oneself instead of directing it into the environment. Introjection is the incorporation of material that has not been adequately discriminated. Projection is the disowning of one's own behaviour or attitudes. The individual, when he becomes aware of his impulse, does not identify with it but alienates himself from it. The impulse, although alienated, still exists and is still experienced. Due to his alienation from the impulse, and to the fact that the impulse nevertheless still exists, the person believes the impulse to be coming from the environment and not himself. Moreover, he experiences the impulse as being directed against himself. For example, the angry individual who projects, experiences objects and persons in his environment as being angry with him.

As this process of projection continues, the individual alienates more and more of his own functioning and attributes more and more of his own energy and responsibility to the environment. He experiences himself as a passive recipient to an active environment, instead of seeing himself as the active agent manipulating the environment to satisfy his needs.

(4) **Confluence** is also a form of misdirected behaviour. This occurs when the individual blurs the figure/ground formation. This is his way of avoiding reality and staying "out of focus" in his existence.
These three concepts, retroflection, introjection and projection are used as keys to understand misdirected behaviour. They operate together to form systems that prevent natural figure/grounds from forming. They also prevent the expression of emotion and the closure of finished situations. To remedy misdirected behaviour we need to dislodge the introjection, reverse the retroflection and own the projection (Perls, Hefferline and Goodman, 1951).

An intermediate goal of Gestalt therapy is to enable the individual to own and identify with all his parts and to see that he is the one who responds and initiates activity toward need fulfilment in his environment. The ability to do this is called "taking responsibility for oneself". The concept of responsibility in Gestalt therapy emphasises the autonomy of the individual to the extent that he is a self-functioning, self-initiating and self-regulating organism functioning within the environment.

At this point we can see how Gestalt therapy connects with other psychotherapies. If we attempt to understand the basic assumption in Freudian psychotherapy, we meet what Freud called the "Oedipal complex". This is basically "patrilocal": centring round the father figure. When the patient discovers that it is impossible to destroy the father, he accepts the parental figure and eventually models himself after him.

Jungian psychology, on the other hand, tends to be "matrilocal": centring around the female figure. This is expressed in terms of the "intuitive" and "feeling" nature that is thought to be inherent in the female side of each of us.

Gestalt therapy can be seen as based on the idea of the autonomy of the individual. Here self-support can be considered a goal in the therapeutic process. But the autonomy model has certain disadvantages.
which are exhibited as an individualistic stance. Similar to the solipsistic viewpoint, the autonomy model often tends to over-emphasise inner-directed behaviour. Interpersonal relationships require a balance between inner and outer directedness. A very real danger is that the autonomy model creates self-sufficiency instead of self-support. If used to extremes, the Gestalt therapy position could hamper the ability to maintain any close relationship, producing an imbalance along the inner-other directedness continuum.

Until this point, the writer has attempted to discuss Gestalt therapy in its broadest terms. This can be summarised by the following concepts:

A. **Figure - Background Relationship**

The term "Gestalt" refers to the way perception forms a figure against an uninteresting background. This experimentally derived assumption states that only one figure can be adequately perceived at a time. To attempt perception of two or more figures at one time would divide attention, producing an unclear, hazy perception of the environmental surroundings.

To achieve perceptual clarity, or what is commonly called a "good Gestalt", there needs to be a focusing of attention and a concerned contact with the environment.

B. **The Here and Now Continuum**

This time-orientation offers the practitioner a diagnostic and therapeutic setting where he can focus his attention on emotional and behavioural interaction. This is similar in practice to the behaviourist view of providing positive reinforcement (in Gestalt terms, 'support') or negative reinforcement (in Gestalt terms, 'frustration') at the very moment of behaviour modification.
C. The Therapist's Position

The therapist presents himself as an individual who possesses his own perceptions (and projections) and who makes these explicit in his relationship with the patient. He would not offer himself as an "expert" who has all the answers; nor is he an understanding "ear" who listens to the problems and worries of the client. Instead of only listening to the content, he mainly focusses on the how of communication: the non-verbal indications of the ongoing process.

(i) The therapist assumes that the patient frightens himself by thinking or imagining threatening situations or what is called catastrophic expectations. The therapist deals with these by applying frustration and/or support as the situation demands.

(ii) The therapist works also with the assumption that there are several mechanisms which interrupt the patient's ability to flow along with the continuity of his experience. These have been described as introjection, retroflection, projection and confluence.

(iii) There are also aspects of the patient's experience which are unfinished. These are to be relived in the present moment via the use of present tense language, fantasy and body expression (to be discussed later).
CHAPTER II

APPLICATION OF THE THEORY

It is possible for an individual to replace actual contact with the experiential by "thinking". In this paper, the term "thinking" will be defined as the process of manipulating verbal symbols. In thinking, an individual causes his thoughts to become the perceptual figure whilst causing his proprioceptive feelings and sensory input to become background. In the process of thinking, the experience of the moment shifts from direct contact with the environment to contact with verbal symbols.

This is not to say that thinking is necessarily an unhealthy functioning. However, for there to be a healthy thought process, certain conditions need to prevail. First, in healthy thinking, the individual is fully aware that he is thinking, i.e., he is giving his undivided attention to his process of thinking thoughts. His thoughts form clear, bright, perceptual figures and he is fully focussing on his thoughts. This is most efficient when the thoughts are the object of "spontaneous concentration".

As a result, thoughts will recede into the background whenever a more important need arises. For example, an individual might be concentrating on an interesting problem when the need for relaxation surfaces. In healthy functioning, the individual would respond immediately, his thoughts would recede into the background and the process of relaxation would become foreground.

In contrast, in misdirected behaviour, the individual is not fully aware that he is thinking. His attention is divided between other
functions and thinking. Hence, his thoughts form unclear, hazy figure/grounds and so do his other life experiences. As a result, the individual who is neither focussing on his thoughts nor his experience is unable to work through his problems or respond satisfactorily to his needs. By dividing his attention he does not focus on any one thing at a time and hence nothing becomes clear, bright, sharp or defined. Perls would say that such a person remains in an intermediate zone.

To give an anecdotal example, a woman was shopping in a department store, lost in thought concerning what to buy next. She "woke up" to find herself standing at the bottom of a "down" escalator, waiting for all the people to dismount in order for her to ascend.

Such misdirected behaviour can become chronic to the degree that the individual is almost totally unaware of the world in which he lives. The chronic thinker replaces actual need fulfillment with a symbolic process that only partially satisfies needs.

To a great extent, the problems of individuals who find themselves undergoing psychotherapy are perpetuated by their linguistic thought programmes or patterns. A thought pattern is the individual's own habitual construct system whereby he continually links certain ideas together in a certain order (Kelly, 1955).

Just as a rat follows the same patterned course through a maze over and over again, so does a patient think the same patterned thought over and over. By so doing, a patient can experience sensations of pain or anxiety by just recalling certain patterns of thought (Korzybski, 1943). Such thought patterns, due to their continued repetition and sometimes hurtful content, are repressed. Hence, the patient is only dimly aware that he is thinking these thoughts.

People learn how to respond in life by the process of living through their experience. Experiences that have been uncomfortable
or too difficult to cope with are avoided and instead converted into language and held in memory. A patient can recall these memories by recalling the related thoughts. For example, "My parents didn't take care of me. Why should I?" In this way the patient can re-cultivate the old, unfinished situation and thereby conjure up and re-experience the pain, anxiety, frustration and helplessness which the unfinished situation represents. It should be noted that because these thoughts are chronic, the individual becomes desensitised to them and hence becomes only dimly aware or unaware of these thought processes.

Attention will not be turned to the topic of language and how it is used within the Gestalt therapy session. Various techniques are used to assist in the clarification of expression and the discharge of chronic thought patterns.

The use of semantics

It is considered that the function of words in Gestalt therapy is to enable therapist and patient to describe non-verbal experience. The aim is to ensure that every word spoken in the therapy represents something that is actual rather than abstract (Perls, Hefferline and Goodman, 1951). This means that factual objects, places, sensations, feelings, fantasies and unified experiences are the focus of attention, while concepts that rely on verbal description are eliminated or held to a minimum. Consider the process of projection in operation. The patient might project her anger upon the therapist. To communicate: "You are projecting your own anger on me...." is a correct interpretation.

(5) Memories of early experience are also stored in the muscular tissues (Rolf, 1958; Reich, 1949; Boyesen, 1974). This aspect of muscular recollection will be discussed in the chapter on body expressions.
but the word "projecting" carries no experientially felt meaning because the word is purely intellectual.

Alternatively, one might say, "I feel you would like me to be angry with you..." Here the therapist is intensifying and directing the patient to become aware of the sensations and feeling currently in the session. These sensations become the focus of attention, not the content of the words.

By keeping statements and questions focussed on the elements of experience, the patient is less likely to move towards abstracting and intellectualising his feelings.

The use of present tense

As Freud (1938) made clear, re-living "painful" situations as first experienced would clarify the experience and aid in the patient's recovery. To bring these situations into closer actuality, the patient is encouraged to express past experiences in the present tense, e.g., "I used to be frightened of my father" can be converted into, "I am frightened of my father". The present tense is thus used to catalyse and clarify past experience.

The patient is encouraged to express the experience in a more complete and meaningful way and to appreciate the significance of being in the here and now (Perls, 1969).

The state of being "here and now" is an experience of heightened sensations and feelings. When a whole group is able to maintain a state of being here and now, the group situation fosters a mutual exploration of feelings. This takes the participants directly into their experience as opposed to purely talking about their experience on a purely intellectual level.
The use of "I-Thou" (Sopher, 1935; Naranjo, 1977)

In our society, individuals habitually refer to themselves in the grammatical second person, e.g., "Of course 'you' have to do this in my job", instead of "Of course 'I' have to do this in my job". Alternatively, individuals use the impersonal: "'One' doesn't normally speak in terms of oneself". In this way, an individual maintains a distance and desired objectivity away from his experience. In Gestalt therapy, by asking the patient to speak in the first person, he begins to appreciate his uniqueness and individuality.

In addition, when speaking to other people, individuals tend to refer impersonally to the other in the form of "he" and "she", thus speaking about the person instead of speaking directly to the person. In the Gestalt therapy session we encourage participants to speak in an "I-Thou" configuration, that is, to speak directly to one another as individuals.

Direct person-to-person statements encourage expression to one another, rather than about one another. The impact of clear, direct, communication develops a genuine relationship between the two individuals concerned.

By discouraging the use of generalised, verbal statements, the Gestalt therapist heightens the feeling level to the point where the primary function becomes a genuine sharing of experience and emotion. In group work, this would produce a high degree of intimacy and common support amongst the participants.

The integration of the use of semantics, the present tense, and the "I-Thou" relationship produces an effect which is illustrated pictorially below.
Levitsky and Perls (1971) offer the following additional information on the use of words in Gestalt therapy:

"It" to "I". For example: "It" does not feel right" might be changed to: "I don't feel right (in relation to that)". "That doesn't feel right (in relation to me)". As can be seen, the process of changing 'It' to 'I' personalises abstracts. By using 'I' the patient produces stronger contact with his feelings and realises that the statement refers to his own feelings.

"Can't" to "Won't". For example: "I can't go out of my house" becomes "I won't go out of my house". This puts greater responsibility upon the abilities of the patient. When the individual states that he "can't" do such and such, he is verbally reinforcing the belief that he has no power, ability, or strength. The words "I won't go out of my house" will establish for the patient his refusal to do this activity. Now the focus can change, allowing the patient to explore how he prevents himself from undertaking involvement in particular activities.

"But" and "If" to "And". For example: (a) "I like you but I am afraid of you", can be changed to "I like you and I am afraid of you".
As the example illustrates, the word "but" can be often used to avoid certain statements, usually where a "positive" statement is being expressed. The "but" acts to negate the initial statement. To change the "but" to "and" allows the ambivalence of the expression to be worked on and discovered; (b) "I would leave my mother if I could" can become: "I would leave my mother and I could". With the word "if", the individual is saying something about what he would like to do.

By changing "if" to "and", the full impact of the statement can be felt. In this case, he is refusing to accept what he can do and what is possible. The individual is led to see that his fantasy is an actual possibility. The new awareness is integrated by the individual and emerges as a new alternative for behaviour.

"would", "want", "should", "must", "have to" and "ought to" are changed into either "need" or "like to". For example: "I should be grateful to my therapist" is changed to either "I need to be grateful to my therapist" or "I like to be grateful to my therapist". This conversion works towards dispelling the introjected values and demands the patient makes on him or herself. With this, the patient experiments on whether a desired goal comes from his own needs or is an implanted, external need designed to please someone else. When we experiment with the word "need" instead of "should", "must", "have to" and "want", we refer to survival and the urgencies that accompany biological fulfillment.

The words 'like to' are applied to most of the other desires and satisfactions which are not as urgent as survival. There is often confusion between imposed needs and actual needs. When the therapist suggests to the patient to use the word 'need' or 'like', he is providing a structure for the patient to investigate and discover his own needs and his acquired attachments.
The example cited above, "I should be grateful...." implies a mode of behaviour and language that demands the individual to feel in accord with certain ideal standards and attitudes. The "'need' to be grateful..." is an exaggeration of debt and is not a primary need for survival. On the other hand, by experimenting with "I'd like to be grateful..." the patient expresses adequately a statement which exhibits self-support and integrity.

Changing "Why?" into "How, What, Who, Where, and When?"

For example: "Why do you do this to me?" could become "How do you do this to me?" This technique helps to dissolve rationalisations by emphasising the importance of how one is experiencing his behaviour. To this end, change occurs once the patient fully realises that he is responding to the situation. This is how misdirected behaviour (of which the patient is unaware), can slowly be acknowledged and accepted.

The therapeutic direction is not to discover the reasons for a patient's behaviour, but on how he behaves in the present moment. There is an underlying assumption that the actual discovery of how we behave automatically brings about change. The aim is to help the patient accept his behaviour as his responsibility and his way of responding to the world. In "The Paradoxical Theory of Change", Beisser (1970) asserts that one does not change until the undesirable activity is fully understood and acknowledged as being one's own responsibility. In this way, questions are working towards the probing of feelings and their related actions and not the reasons behind them.

With experience, the therapist will be able to modify subtle phrases into more intense experiences. This will help the patient to focus more directly on the present situation. For example: "Now I'm at the beach" can be changed to "Now I am the beach". Although this
sounds foreign to the ear, in the therapeutic experience, the subject "becomes" the beach, and can experience the properties of calmness and space which were originally seen as properties outside himself.

The modes of expression

Very often it can be observed that an individual's mode of expression (tone of voice, accompanying gestures, etc.) does not coincide with the content of what is being said. For example:

"I am angry", said in a small tight voice fails to produce an angry expression. The therapist might suggest to the patient: "Say this with your whole body" or "Can you say this as though you mean it?" This might produce a unified statement-experience that feels angry to both patient and therapist. This is a fuller expression which aids in relieving internal pent-up feelings, and provides the patient with an awareness of his angry feelings. This would lead to the exploration of to whom, and in what situations, does the patient feel angry.

There are several other "expression techniques" that aid in the Gestalt therapeutic process.

Appreciations are used to offer reinforcement to behaviour and feelings that one is expressing or exhibiting. Usually, actions are overlooked when appropriate and only criticised when inappropriate. By expressing appreciation, the therapist provides reinforcement of the behaviour that he finds healthy. This increases the likelihood that this behaviour will occur again, e.g., "I appreciate the way you speak directly about yourself".

Behaviour that is toxic and experienced as painful or uncomfortable is very often harshly criticised. When this is done, the individual learns that a certain behaviour is disliked and may
act toward this particular behaviour as his critic would: punishing his own impulses. This is the way retroflections originate from verbal stimuli. Instead of allowing this harmful language structure to persist, the therapist encourages the expression of "resentments" and the "demands" that are often implied, e.g., "I resent the way you speak so softly and I would like you to speak more forcibly". In this way, negative reinforcement is implied, but a positive alternative is expressed for assimilation and integration. By expressing "regrets" the individual is usually able to accept a situation and let go of what has occurred in the past.

Often, the integrated expression of appreciation, resentments, and regrets produces a means by which the therapist can assist a patient to complete an "unfinished situation", resulting in a completed gestalt, which is an aim of the therapy. For instance, an individual may be grief-stricken over the death of a loved one. In the therapy session, the therapist can suggest that the patient expresses all his appreciations, resentments, and regrets that he holds for the dead loved one. In this way, the patient will find greater ease in discharging grief and anger, with the added possibility of being able to say goodbye to his loss and complete the unfinished gestalt.

Most people hold "expectations". By clearly defining and expressing these fantasies for the future, an individual can convey to others what his expectations are of them. They, in turn, can decide whether to live up to these expectations or to reject them. In this way, he is able to let go of the expectations and to allow his experience to develop spontaneously.
Few patients say exactly what they think, feel, or what they would like to do. This is due to the principle described in the paragraph on resentments. By asking patients what they are thinking or "rehearsing" to say they are often allowed to: (a) become aware that there is an internal dialogue going on; and (b) realise that this holding back of speech is unhelpful to the spontaneity of the therapy session. After intense moments, patients are asked to "feed-back" any thoughts they may have had during the session and to share their internal dialogues or "rehearsals". This also helps patients to "play-through" their accustomed roles of behaviour, and to experiment with new alternatives in the session.

When a patient expresses an aspect of himself that seems "improper" or "out of context", the therapist can suggest to the patient that he says the opposite. The effect of this "reversal" may reveal where the patient has failed to integrate a part of his personality. The reversal can demonstrate to the patient how he has overcompensated for a situation which he could not cope with at an earlier time (Perls, Hefferline and Goodman, 1951).

A verbalisation of a feeling may often conceal a wish or need to express the opposite, e.g., "I hate you" reversed becomes "I like you very much and would like you to like me". This often produces surprising insights for the patient. It may enable him to see how he may overcompensate emotionally in threatening or difficult situations by doing the direct opposite of what he would like to do.

If the therapist employs these techniques too often, the patient may feel crowded by techniques and feel confused by the therapist. It is suggested then that these verbal techniques be used as a means to clarify and focus expressions in the search for accurate meaning.
There is a large body of knowledge and theory which relates to the above language techniques. The work of I.A. Richards (1927), Korzybski (1943) and Perls (1948), for instance, has been concerned with the word-object confusion and the effects that language produces on thought and resultant behaviour.

The verbal techniques of Gestalt therapy (Levitsky; Perls, 1972) are particularly related to the splits and dichotomies which are considered to be rooted in the Aristotelian two-value system of thought and meaning. Analysing this system, Korzybski (1943) and Kogan (1973) both considered that modern Western language is so constructed as to split the conception, understanding and description of experience into polarities. This split is characterised by the polarisation of dualistic forces, e.g., right-wrong, rich-poor, body-mind, self-others. Kelly (1955) calls these polarities "constructs" and developed a psychological theory named "Personal Construct Theory" (1955). This theory demonstrates how the relationship between constructs can be measured and plotted in order to give a picture of personal thought construction. (6)

The therapeutic aim in using the word conversions described above is to help the patient to create a "unitary language" (7), and thereby to create a more unified personality (Perls, 1948).

By helping the patient to distinguish between thoughts and feelings, and to encourage a greater precision of meaning, the therapist assists the patient to differentiate between feeling emotions and intellectually explaining the meaning of the emotions.

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(6) This tool will be discussed in greater detail in the chapter on research into the effects of Gestalt therapy.

(7) This term was coined by Perls (1948) in his paper "Personality Integration". This means that each word expressed in the therapeutic session relates to a non-verbal experience.
Apart from language and the way it is expressed, the Gestalt therapist is also concerned with spoken fantasy. Spoken fantasy can be seen as a role or game (Berne, 1969) one plays to replace actuality. This can take the form of discussing abstractions, or what Perls (1967) called fitting games. These fitting games are socially acceptable activities that depart from experiencing the present moment. Perls notes that the chronic intellectualiser avoids present experience which results in hampered ability to feel his own emotions and contact actuality. Since this individual is causing his thoughts and ideas to become perceptual figures, his sensations and the experiential world around him become background.

This does not mean that intellectualising is any less real than actuality. On the contrary, for personal integration, intellectual pursuit may be a main mode to find meaning in one's existence. The purpose of creating a division between abstraction and actuality is to provide the therapist with a means to differentiate the 'shared experience' and the patient's 'individual experience'; thus providing a clear basis for working with the patient.

Any spoken communication that is not concerned with the present situation is seen as fantasy in the therapeutic situation. For example, "I saw my brother today" can be seen by the therapist as a verbal fantasy that places actuality in the background. In this way, the focus changes from "being here" to "seeing brother", thus referring to some other moment in time.

There is a likelihood that the change in focus from present actuality to fantasy also produces a change in the patient's feelings of self. His feelings are now "charged" with the experience of being with his brother. This can be seen as a form of unfinished situation. Due to his divided attention, the emotional tone of "being with
brother" will now exist as a latent experience in the patient's background. By saying to the patient, "Imagine you are with your brother now", the emotional experience will move to perceptual figure and become a clear gestalt. This leads the patient to enact a role-playing interaction between himself and his brother in fantasy.

This is similar to Moreno's (1916) 'psychodrama' method of re-enacting psychologically charged scenarios by using other members of the group. The only difference is that in Gestalt therapy, the individual patient 'acts through' the roles himself. Thus, he would imagine and speak for his brother or mother or teacher and so on. This aspect of the therapy requires the patient to "work" on his own charged relationships. This could bring a patient to speak out loud with a dead father, an over-powering mother, a lost lover, or even the therapist. It requires a patient to 'project' onto an empty chair the person in question and then speak to this fantasy person. After a short while, the patient would switch seats and imagine himself as the person in question.

Playing his mother, or whomever, is in question, the patient would then speak to himself, saying the same things that were said to him or what he believes the person did say. This type of dialogue often produces a top-dog versus under-dog conflict (Perls, 1967).

The 'top dog' aspect of the conflict is characterised by righteousness, authoritarianism, rigidity and punitiveness. The 'under-dog' part of the conflict is characterised by weakness, passivity, chronic apologising, complaining, and a tendency to defer. The 'top dog' speaks downward to the 'under dog', telling the 'under dog' what must be done, said or accomplished. 'Top dog' may also threaten the 'under dog's' position by speaking in terms of "catastrophic expectations" (p. 56). These catastrophic expectations
are used to manipulate the 'under dog' by presenting an image of imminent disaster.

An example should help clarify these roles:

Top dog: "If you don't study for your exams you will fail and not graduate"; or, "If you don't clean your room, father will punish you when he returns from work". 'Under dog' might reply: "I know I should study, but I don't feel like it, maybe tomorrow"; or, "I'm sorry for not cleaning up, it's too hard to do by myself".

In this encounter the 'top dog' never meets the 'under dog' and the 'under dog' never openly criticises the 'top dog'. As a result, the patient experiences conflict within himself between these two opposing forces.

In therapy, the therapist awakens both polarities by applying skillful frustration. In this way, the 'top dog' and the 'under dog' actually negotiate with one another. A skillfully directed dialogue between the two will create a greater likelihood of their reconciliation and integration (Perls, 1967).

It is interesting that Jung wrote a similar description of Gestalt therapy in 1916, some thirty-two years before the technique was developed:

"The ego takes the lead but the unconscious must be allowed to have its say too ....... The shuttling to and fro of arguments and affects represents the transcendent function of opposites. The confrontation of the two positions generates a tension charged with energy and creates a living, third thing - not a logical still-birth in accordance with the principle 'tertium non datur', but a movement out of the suspension between opposites, a living birth that leads to a new level of being a new situation. The transcendent function manifests itself as a quality of conjoined opposites. So long as these are kept apart - naturally for the purpose of avoiding conflict - they do not function and remain inert".

(Jung, 1916, The Transcendent Function)
In summary, the foregoing has been a general synopsis on the theory and practice of Gestalt psychotherapy. The theory is based upon the model of healthy human perception along the lines of Gestalt formation and distinction. Any interruptions along the process of healthy perception, Gestalt formation, physical mobilisation and expression, assimilation and Gestalt dissolution, are explained via the concepts of introjection, retroflection, projection and confluence. Linguistic techniques common in the Gestalt approach have also been discussed along with the method used to resolve polarising forces within the personality.
CHAPTER III

MENTAL IMAGERY

Using the same methods as described earlier, the therapist would also work with the patient's visual fantasies. These visual fantasies are the result of day-dreams, night dreams or spontaneous "drifting" into reverie.

The therapeutic literature abounds with references to mental imagery. For instance, in the work of Breuer and Freud (1895), the occurrence of spontaneous imagery is classified as "hynagogic" imagery. Freud later wrote:

"It is possible for thought processes to become conscious through a reversion to visual residues (and) in many people, this seems to be a favourite method.... Thinking in pictures.....approximates more closely to unconscious processes than does thinking in words, and it is unquestionably older than the latter both ontogenetically and phylogenetically".

(Freud, 1927)

Silberer (1905) offered a description and method of eliciting and observing symbolic hallucinations which he called "auto-symbolic phenomena", but only hinted at a possible therapeutic use. Frank (1913) evaluated hynagogic images under deep relaxation in a report on the "cathartic method".

Jung (1916), in a paper called "The Transcendent Function", described in detail the use of imagery for a psychotherapeutic purpose. In it can be found the foundations for the theory of the use of visual symbolism and of Perls' self-encounter technique used in Gestalt therapy. That Jung's paper is quoted throughout this discourse is a tribute to his accuracy and insight into the subject.
Kretschmer (1922) also noted the occurrence of spontaneous imagery in his psychotherapy sessions, and called them "Bildstreifendenken" meaning thinking in the form of moving pictures.

A systematic method calling for the use of hypnagogic images was created by Desoille (1945). Naming this technique the "Directed Daydream", Desoille offered to the patient a progression of six images described as "symbolic themes". The themes were designed to re-enact specific psychoanalytic principles, such as the Oedipal Complex or to come to terms with a parent of the opposite sex. The following is a short description of Desoille's method and techniques.

Prior to introducing the symbolic theme, the subject would be asked to close his eyes whilst lying on a couch. Relaxation would be induced by suggesting body weight to gain muscular relaxations or body warmth to produce vascular relaxation. Once relaxation was achieved, the therapist would guide the patient progressively onto the symbolic themes.

Theme 1. For a man, the suggested image is that of a sword; for a woman that of a vessel or vase. These images are thought to suggest the "confronting of one's more obvious characteristics". A sword, when imagined by the patient, is thought to indicate the psychological state of his masculinity. The same is considered true with the image of the vase for the woman patient.

Theme 2. This image is used for both sexes. The therapist guides the patient into the depths of the ocean. The purpose of this theme is to help the person to "confront his more suppressed characteristics". Desoille found that "out the depths" of the ocean would surface unaware material and that uncomfortable feelings could surface as well. He

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(1) "Unaware is the Gestaltian alternative for the term "unconscious". The patient is said to be "unaware" when he has lost contact with parts of himself through repression or scotoma."
cautions that these images coming from the "depths" represent repressed material and need to be handled carefully.

Theme 3. For a man it is suggested that he descends into a cave to find a witch or sorceress. For a woman it is suggested that she descends into a cave to find a wizard or magician. The purpose of these themes is to come to terms with the parent of the opposite sex.

Theme 4. The therapist guides the patient, if a man, into a cave to find a wizard or magician; if a woman, she is guided into a cave to find a witch or sorceress. The purpose of this theme is coming to terms with the parent of one's own sex.

Theme 5. For both sexes, the therapist would suggest a descent into a cave to find the "fabled dragon". The purpose of this theme is to come to terms with the constraints of society upon the individual.

Theme 6. For both sexes, a visit to the castle of the "Sleeping Beauty" hidden deep within a forest would be suggested. The purpose of this theme is to come to terms with the Oedipal situation.

When one attempts to relate Desoille's work to the Gestalt approach several areas need criticism. First, Desoille's work is based on psychoanalytic theory. The starting themes hold to that conceptual framework and preconceptualise the patient's expressions. In Gestalt work, we attempt to deconceptualise expressions in order to ensure that they are firmly rooted in a "psycho-physical" experience, as opposed to a purely intellectual understanding. Secondly, Desoille's Guided Fantasies are story-like and demand a logical conclusion. Should the patient be unable to work through to such a conclusion or should he be unprepared for that particular aspect of integration or refuse to see himself in a "fairy-story", the use of imagery as a technique may easily become threatening for the patient.
Leuner (1969) presents a method that is more suitable for use in a humanistic approach. The method is called "Guided Affective Imagery" (GAI). His approach is different to Desoille's in that it is more open to the creative imagination of the patient. For example: a meadow is always suggested as the starting point to the patient; this image elicits the person to create his own scenario. For instance, the meadow may be associated as a fresh new start as in the "Garden of Eden", or may reveal the inadequacies of the inner, uncontacted self, e.g., a rock-filled meadow. The technique allows the uncontacted parts of the personality to surface into awareness in a self-regulating process. Thus, the therapist need not direct a specific course of activity (as in Desoille's work) for the self-regulating system does that automatically.

"Since the psyche is a self-regulating system, just as the body is, the regulating counteractions will always develop in the unconscious".

(Jung, 1916)

Swartley (1965) described a procedural system for diagnosis, utilising what he calls "Initiated Symbol Projection" (ISP). This is a complete manuscript that provides step-by-step descriptions of the application of ISP for diagnostic purposes. He argues that the ISP has certain advantages over conventional diagnostic tools such as the Thematic Apperception Test (TAT), Rezenzweig's Picture Frustration Test, and Jung's Association Test. He writes:

"The great limitation of most psycho-diagnosis is that the raw test responses must be interpreted into scientific terminology, which must then be retranslated into a therapeutic goal. The value and necessity of such a process which imposes several intermediary steps between diagnosis and therapy, is open to question. Ideally, a diagnosis would indicate treatment without intermediary steps. Symbol Projection, because it is equally a diagnostic and therapeutic technique, offers a rare opportunity to obtain a diagnosis in symbolic terms which is immediately applicable to therapy conducted on the symbolic (non-analytic) level".

(Swartley, ISP, p. 4)
Swartley concludes that ISP will provide diagnostically meaningful projections in many cases since the choice of symbols was made pragmatically from a clinical setting.

When using mental imagery in Gestalt work, there is a more spontaneous methodology. Instead of offering images of pre-established meaning, as in the GAI or ISP, the therapist will operate in rhythm with the therapy session. This rhythm is the ever-changing figure/ground formations that develop in interaction between the patient and the therapist. Thus, spontaneous imagery would occur as part of the patient’s own ongoing process.

Traditionally, imagery in Gestalt therapy has been best demonstrated through the work on dreams. The effectiveness and simplicity of the approach has been documented by Perls (1967) by working through night dreams. Freud once wrote that the dream provides a "royal road" to unconscious expression. The terminology of "unconscious" is operationally excluded from the Gestalt approach because the Gestaltists were mainly concerned with the perception of the patterns. Perls developed upon Freud’s discovery and stressed the fact that the importance of dreams contain a royal road to "integration", a term used to mean the bringing together of different parts to produce a new whole.

Perls maintained that the dream was an existential message, and if handled correctly would provide the patient with a significant amount of psychotherapeutic insight. This is, as Perls believed, due to the very nature of the dream. Each element of the dream, each object, person and setting is considered a projection of the patient’s own psychological state.
Once an image is contacted, the therapist might suggest a psycho-drama role-play between the image and the patient. When working with dream material, the therapist will encourage the patient to focus upon one element of the dream at the time. He would suggest to the patient to imagine himself as the image and to describe himself in terms of structure and function. For example, the image of a tree would be examined in terms of the surrounding soil, the roots, the trunk, the branches and the leaves. A dialogue between two significant elements might be suggested as a means of contacting the relationship between these elements.

Jung writes:

"It might be objected that this treatment of the dream involves suggestion. But this ignores the fact that a suggestion is never accepted without an inner readiness for it, or if after a great insistence it is accepted, it is immediately lost again."

(Jung, 1916)

If the patient resists these suggestions, then the resistance becomes the focus of attention. A resistance might be approached with: (1) a mode of dialogue to discover its nature and function; or (2) to apply frustration and increase the resistance; or (3) to ask the patient to physically exaggerate the resistance. All three methods are designed to bring the resistance into a clear, well-defined perception so that the patient may observe and experience his resistance in full operation. To work against the resistance, i.e., to encourage the patient to do or say something whilst he is resisting, would work against the process of developing full potential. This is demonstrated by the principle of divided attention (cf. Supra).

As the dream is further explored by the patient, the therapist also seeks to uncover conflicts. Should a conflict emerge, the elements will take the form of a top dog versus under dog conflict (cf. Supra). Skillfully, the therapist would tease the top-dog to
become more understanding and frustrate the under-dog to become more demanding.

Jung writes:

"It is exactly as if a dialogue were taking place between two human beings with equal rights, each of whom gives credit for a valid argument and considers it worthwhile to modify the conflicting standpoints by means of thorough comparison and discussion or else to distinguish them clearly from one another".

(Jung, 1916)

As the patient directs his full attention towards these emerging images, his increased focus produces a new clarity for introspective inquiry. His outer-world experience (i.e., the other group members, objects in the rooms, sounds and distractions) become part of the patient's background whilst his introspective foreground (i.e., his mental images, and physical sensations) would intensify. In other words, the patient is working towards introspective observation and will focus and relate to these processes.

"Introspective observation is what we have to rely on first and foremost.....the looking into our own minds and reporting what we discover."

(James, 1890, p. 185)

Interpretation of the dream is left entirely to the patient's own psycho-dynamic process. He is asked to examine his own mental images by means of identification and psycho-drama. The method of interaction then becomes existential and the understanding becomes phenomenological. Phenomenologically, the patient accepts what is, not what is meant interpretively. This means that no interpretation is applied and no conceptual understanding is sought.

What is valuable, both therapeutically and behaviourally, is the process of confrontation and dialogue directly with the symbolic images. In this way, an undistorted integration of the dream imagery
can be assimilated as the patient's final process.

Should an individual fail to recall his dreams, this would indicate a denial of some aspects of his inner-self process. The failure to recall one's dreams can be worked on by confronting and developing a dialogue with the absent dream. Once the individual comes to understand the process of his denial, the ability to recall his dreams will be reinstated and the renewed awareness tends to produce a sharper, more vivid and precise dream content.

The rationale behind the non-interpretive position of the Gestalt therapist is as follows: as the conflict approaches resolution, the integrating process begins to unify the opposing forces. The result is a form of psycho-physical reintegration. The physical tension that stemmed from the conflict (described in greater detail in Chapter IV) begins to dissolve, and is replaced by the ability to feel in a once insensitive area. This produces a basic goal in Gestalt therapy; a feeling of heightened physical awareness, a perceptual clarity of the outside environment and a loosening of body tensions.

The following chapter will discuss body tensions in greater detail.
Wilhelm Reich (1969) was concerned with the effects political and social establishments had upon psychological growth. His most important and influential work focussed on how the social environment distorts and inhibits the physical structure of the human body. Reich (1949) concerned himself with the physical manifestations of psychological disorders. He arrived at this perspective by asking the question: "Where is the unconscious?" He discovered that the musculature, when deeply massaged, would cause an individual to recall past emotional events.

Developing from this observation, Reich found that individuals who suffer from emotional discomfort also have muscular rigidity, which he labelled muscular armour. He found that individuals who chronically repress certain emotions develop a specific pattern of muscular tension that forms rigidness and peculiarities in the posture. For example, a child may get angry at his father. If he expresses his anger and he is punished or scolded, the child might in future restrain his anger from expression. He would do this by activating the muscles that are antagonistic to the physical expression of anger.

(1) Ida Rolf (1958) developed a technique of deep tissue massage which works to loosen the fascia surrounding the body's muscular structures. The results of this work enable an individual to move more freely and experience increased vitality. Through her work, which is called Rolfing, Rolf reports that individuals recall past emotional traumas whilst certain areas of the body are massaged or deeply stimulated. This might suggest that memories are also stored in the body's muscular system and systems connected to muscles, e.g., glands, organs, etc.
For instance, in the arm the triceps extensor is used to push the arm forward. Should the child refrain from expressing the emotional need to reach out for love or hit out in anger, the biceps flexor muscle would act in opposition to the triceps extensor, thus inhibiting the emotional expression by reducing the arm's movement and flexibility.

Presumably, other muscular structures would also mobilise to help toward an integrated emotional expression. Here, too, there would be antagonistic muscles inhibiting the emotional expression. For instance, instead of breathing deeper as the situation requires (cf. infra), antagonistic muscles would contract in the chest to inhibit free breathing; muscles in the abdomen would constrict and restrict the diaphragm from free movement; muscles in the legs which are normally used to support emotional expression would be inhibited by other muscles to restrict the expression; and muscles that support pelvic movement would also be affected as well as muscles surrounding the genitals, anus and so on. Thus, an integrated "bio-psychology" of physiological as well as emotional responses make up the psychologically "charged" situation.

Recalling that genuine needs fail to disappear until completely fulfilled (cf. Supra), we can suspect that the conflict between the movement and the constraining "counter-movement" will continue until the need to express the emotion is a completed gestalt.

"When a need is met, the gestalt it organised becomes complete, and it no longer exerts an influence - the organism is free to form new gestalten. When this gestalt formation and destruction are blocked or rigidified at any stage, when needs are not recognised and expressed, the flexible harmony and flow of the organism/environment field is disturbed. Unmet needs form incomplete gestalten that clamour for attention and, therefore, interfere with the formation of new gestalten".

(Yonteff, 1971, p.3)
Through this "active" inhibition, the emotion is first suppressed from expression, then later repressed out of awareness; but the need to express this emotion will still "clamour" for attention in the individual's background and still activate the musculature for expression. At this stage of inhibition, the individual either refuses to respond emotionally altogether or responds with anger as a means of defending against expressing some other acceptable feeling or emotion (i.e., acting angrily instead of feeling sad and crying or asking for love).

In the course of time, the continuation of tension will desensitise the area, further diminishing the original impulse from awareness, thus turning the once soft muscles into muscular armour, inhibiting free movement, expression and sensitivity. In short, the individual becomes insensitive and "armoured" against feeling his own emotions.

Taking this premise further, we could see the eyes developing a vacant "faraway look" (Reich, 1969), inhibiting their weeping, fright, or anger from contacting the environment; or the shoulders held rigid and still from exhibiting any hint of wishing to take the world and make it know one's anger; or the pelvis held firm to prevent any incriminating display of sexual attraction.

In this way, one can observe the movements of the body that might suggest: "Look here! Can you see my arm needs to hit someone?"

Naturally, an individual would rarely communicate this through speech, partly because of the expectation of punishment, and partly because the impulse has been repressed out of awareness into the background. Nevertheless, the Gestalt therapist, like the behaviour scientist, will allow his attention to focus upon the physical ongoing behaviour, enabling him to read the body language of the
patient instead of concerning himself with hidden motives and unconscious mechanisms.

Adopting some of Reich's methods and ideas, Lowen (1967) founded a school of therapy known as bioenergetic analysis. In this work, the "body" therapist notes the peculiarities of chronic tension in the posture of his patient. Then he recommends certain physical exercises that aid in the release of the chronic tension. These exercises are designed to stretch and loosen the rigid muscular armour and to provide at the same time the possibility of re-experiencing the emotions that accompany the muscular extensions. Consequently, the bioenergetic therapist would encourage his patient to yell and beat pillows or mattresses to help release the tension, or to scream and cry out or to rock and suck one's thumb. This depends, of course, on what emotion the exercise is designed to release.

Lowen suggests that his work is threefold: first, he works toward bringing the patient to full breathing. The purpose of this is to provide sufficient oxygen to the patient to help increase his metabolism and emotional excitement. The rationale for this is that a healthy individual, when he experiences genuine sadness, laughter, anger or orgasm, would breathe fully with his expression. Think for a moment of how one breathes during a funny joke; or how one might speak loudly when angry. The capacity to breathe deeply during an emotional experience is one characteristic of healthy emotional discharge.

By referring to our analysis of muscular armour, and our operational definition that anxiety is held-in excitement, we find that the unactualised individual holds in his breath instead of breathing deeply as the situation warrants. Thus Lowen's first (2) A detailed description of some of these exercises can be found in Lowen's "The Betrayal of the Body" (1967).
concern is to ensure that the patient is breathing adequately.

Lowen secondly suggests that the patient should be capable of moving freely. This implies that through treatment, the patient would be free of muscular armouring and physical blockades. This is basically achieved by skilfully applying bioenergetic exercises and other similar activities (3) to heighten physical awareness and loosen those parts of the body that are rigid.

For example, one common location of rigidity is the pelvic region. This is an area where the sexual "pleasure" taboo may have affected some individuals to desensitize and rigidify their free pelvic movements. This "cuts off" their sensations from the genitals and, consequently, diminishes the feeling of support provided by the legs.

By applying energetic exercises, the pelvic region loosens, so that the patient can experience streaming: a subjective sensation of feeling one's energy (blood) flowing throughout the entire body. Other exercises are used to work toward grounding the individual, giving him a heightened sense of having his feet and legs "firmly on the ground". By enhancing free movement, the patient will begin to experience himself as his body. He will be able to remain in conscious contact with his organismic energy and sense the physical support the ground under him provides.

Lastly, Lowen suggests that through the course of therapy, one would become free to express emotions adequately. To achieve this, Lowen encourages his patients to make sounds and actions that express the emotions they are feeling. For example, if a patient should feel

(3) Yoga is another method that is used to help loosen the body's rigidity and aid in heightening physical sensations. This is one possible explanation for yoga's recent popularity within psychiatric day hospitals. (Another attribute is that yoga also strengthens the individuals ability to focus his attention.)
angry, the therapist would encourage the expression to the full. Thus, a patient might scream and pound a cushion or mattress with his fists, arms and shoulders, or use a tennis racket for the same expression. To express sadness, the patient might be encouraged to cry loudly. To express helplessness he might be encouraged to lie on his back, kick his legs, hit the floor with his fists, shake his head violently back and forth and scream.

The purpose of all the above is to bring about an "unarmouring" of the patient's musculature, helping him heighten his sense of vitality and to express the repressed emotions completely.

Several aspects of Lowen's approach require criticism. First, the bioenergetic therapist often activates the emotional discharge before the patient actually knows who he is directing the emotion toward. Therefore, the patient rarely discharges the original emotional expression. Consequently, one often finds that the emotional and physical blocks return some days after the acting-out experience.

Secondly, the bioenergetic therapist usually directs his patient to do one or another exercise that meets with the therapist's own idea or expectation of what the patient needs. This results in the patient becoming dependent upon the therapist, often waiting to be told what to do.

Thirdly, the exaggerated yelling and physical violence often develops into an exercise rather than a genuine expression. This tends to push the patient's "target" unfinished situation further and further away from awareness, since the exercise now become the figure of importance.

All three of these criticisms are relative to the degree in which the bioenergetic therapist focusses on a standard approach. A skillful
bioenergetic therapist would work within the patient's own phenomenological world and ensure that the emotional discharge reaches a psychologically appropriate target.

Another important factor is that the patient should not be psychotic. (This applies also to Gestalt therapy). The psychotic patient cannot discriminate between fantasy and actuality. Thus, he would first need to work on discovering the difference between his magical (psychotic) world and the real (actual) world around him.

Working also from Reich's basic "body" perspective, Gerda Boyesen (1974) devised a method of vegetive therapy called psycho-peristalsis. This work concentrates on loosening the muscular armour by applying a faint, light massage to specific areas of the body. Boyesen utilises bioenergetic exercises also to heighten the patient's awareness of his muscular tensions before applying her vegetive massage.

Whilst working, Boyesen often noted a "gurgling" or "rumbling" sound within the abdominal region of the patient's body. Noting the occurrence of this sound, Boyesen suspected that her vegetive massage affected the abdominal region, a specific area that is sensitive to emotional distress. By working to loosen biological tension, a reversed psycho-peristalsis occurs where the muscles around the small and large intestines release and become relaxed and calm. Boyesen comments that her work is most effective on emotional difficulties that directly affect the patient's physiology.

Here we can note two types of body expression. The first type is voluntary movements of, for example, the head, neck, arms, shoulders, chest, pelvis, legs, feet and so on. This is the realm where body language and body communication originate (cf. infra).
There is a second type of body expression which is a result of the bioenergetic therapy method, loosely called vegetive responses. This mode of expression is involuntary and is denoted by streaming, trembling, psycho-peristalsis effects (as reported by Boyesen) and the involuntary "jerking" movements of the body. These involuntary actions are considered a letting-go or explosion of the fixed muscular armour. Known as abreactions, these involuntary movements tend to relieve the musculature of armouring and, at the same time, lead the hitherto unexpressed emotions to discharge. This leads to a loosening of the personality structure and the reported relief of muscular tension. The successful abreaction is similar to an involuntary temper-tantrum, or in other words, a totally irrational explosion of body movements and sounds.

This can be further clarified by describing Perls' (1967) model of the five layers of behaviour occurring during Gestalt therapy.

These layers of behaviour are called:

1. The cliche layer
2. The roles and games layer
3. The impasse layer
4. The implosive layer
5. The explosive layer

The cliche layer is thought of as behaviour which attempts to make initial contact with others. The statements are usually in question form, thus seeking for a response from the other. The questions appear as well-worn gambits such as: "Hello! How are you?" or "Nice day, isn't it?" or "Excuse me, do you know the time?", and so on. The cliche layer is seen as the first layer of interpersonal behaviour because these interactions are usually methods of contacting others, but are characteristically shallow and emotionally neutral.
The role and game layer is considered the second behavioural level and its conceptualisation refers to role-games of Eric Berne (1969). This type of behaviour can be seen as acting specific types of interpersonal relationships such as playing "sexy" or playing "sweet little girl", or "good boy", or "student" or "doctor". The game behaviour develops into an interpersonal relationship where the top-dog versus under-dog neurotic conflict is the usual result. For example, there are teacher and student games, husband and wife games, doctor-patient roles, parent-child roles, employer-employee role expectations, owner and borrower, etc., etc. Instead of behaving as one's self, the tendency is to develop a caricature where the expected behaviour results in an accepted and repeated behaviour pattern. This saves the person from any authentic emotional investment with the people he relates to and thus avoids the risks and involvement of being accepted or rejected. The game player can be seen as one who characteristically refuses to acknowledge his own statements and also applies a characteristic denial to the behaviour of others.

Within the process of the therapeutic encounter, the first two layers indicate at what level the client is operating. Should the therapeutic interventions in the role games be successful, the client will soon realize that the sham nature of game behaviour prevents him from becoming authentic with others. This acts as a motivation for the client to transcend the artificiality of his game behaviour but is usually thwarted by catastrophic expectations, i.e., "If I become myself, something terrible will happen".

This point of the therapeutic encounter is called the impasse. The client cannot retreat back into his game behaviour (due to the therapist's interventions) and also cannot move ahead because he
expects a catastrophe to occur, should he truly feel like behaving angrily, or defend his rights, or say "No" to someone, or behave in a way that requires maturity, self-support and authenticity.

In Gestalt terms, the impasse represents the fixed Gestalt, the fixed notion, idea, value or catastrophic expectation that prevents growth and need fulfillment. In terms of bodywork, the impasse represents the armouring that serves to maintain the fixed personality as it is, and to keep the world stable and unthreatening. In other words, the impasse is the fear to explode from one's muscular armouring and experience emotional discharge.

As the therapist applies the skilful motivation device of frustration (some therapists also apply solidarity and support where appropriate), the individual is motivated to move out from the "stuck" position of his impasse, and move toward what is called the implosive layer.

The implosive layer is thought to occur when the individual retreats into himself in order to gather his resources for his eventual explosion of authentic expression toward the environment. The retreating and gathering of resources is thought of as a natural process, e.g., the tides ebbing and then flowing, the calm before the storm, the deep reflective sigh before attempting a difficult physical labour. Should the process be successful, the individual would move to the explosive layer and discharge the emotion and complete his unfinished situation.

It is common to find, especially in the "body therapies", that some individuals become fixed or "stuck" in the implosive layer. This leads them to explode inwardly (implode) instead of expressing emotions outwardly (into the environment). This results in excessive amounts of retroflective pain and physical discomfort.
Since the individual fears his explosion of either sadness, anger, laughter or orgasm, he continues to suffer physical pain until he can express it from his body. Thus, the body therapist encourages the individual to "kick, shout, cry and scream out his feelings", until the emotion is discharged.\(^{(4)}\)

Taking this issue of working directly with the body, one can see that repression of impulses occur on the muscular and vegetive systems. To place emphasis on pulmonary and other body movements can bring about an alleviation of emotional discomfort whilst easing the freeing and opening process of revealing one's inner thoughts, feelings and actions.

Body awareness in Gestalt therapy. The Gestalt therapist can observe the patient performing many physical gestures and actions during the therapeutic process. For example, while talking, the client might clench his jaw, suggesting some form of oral aggression (Perls, 1951); tighten his fist, suggesting the wish to hit or grab; shake his head back and forth, communicating "No"; hold on to his legs, suggesting the wish to have support; shuffle his feet, suggesting the wish to kick; touch his pelvis, suggesting sexual desire; or other non-verbal communication.

All these observations are not interpreted to the patient directly, but are pointed out to him as something to focus his interest upon. By asking the patient: "What does this particular movement communicate?", the therapist might enhance a process of action that actually expresses what the patient truly wishes to do. For example, the patient might move his arms in a gesture. The therapist could

\(^{(4)}\) A word of caution: as mentioned earlier, it is common for patients to develop a fixed Gestalt on expressing anger (or another emotion) as a defence against expressing other feelings. Here, the author would place a limit upon the amount of anger a patient expresses, by asking the patient what other feelings are behind the anger.
ask the patient to "Make this movement again". By exaggerating the movement, a body-language communication might be discovered.

After this activity energizes the patient, the therapist could ask: "To whom do you wish to communicate this gesture?" With this knowledge, a self-encountering psychodrama (as described earlier) could be enacted.

One intermediate goal is to reverse the retroflected energy back to the original target that initially stimulated the emotional impulse. For example, to re-direct the "child's anger" back to the father, using modes of language, fantasy, and body expression. This finishes the unfinished business, so that the retroflected energy and muscular armour can loosen in the body and finally free the patient from emotional and physical conflict.

The patient also needs to learn how to find a healthy way to express himself and fulfill his needs. This will be discussed in the summary chapter on the "Integrated Process".
Up to this point the writer has been discussing the theory and techniques of Gestalt therapy along with the application of symbolic visualisation and body approaches to therapy. Although these approaches are considered separate and distinct from each other, it is possible to combine them (Stattman, 1975). This chapter will be concerned with the combined application of the above theories and techniques.

The basic issue that the Gestalt therapist is concerned with is that of the present ongoing process. The theories and techniques are secondary to this. The ongoing process is the most basic and clearest existential phenomenon that occurs in the therapeutic setting.

By using the term 'process', the writer is referring to a whole series of continuous actions. This continuous series can be easier described by referring to the earlier discussion of form and content (cf. Supra). Form is considered synonymous to process. This represents the frame, scheme, or container which acts as the medium or go-between for content. Content represents the meaning or essential significance that is enclosed within the form. When, for example, one begins to explore a new book, one is first attentive to its form; the size, the shape, the physical composition, the quality of paper, the style of print, and so on. But once one begins to read the book and begins to grasp the meaning which lies within the medium of the printed page, the quality of "bookness" in and of itself becomes background and ignored and the content becomes foreground.
This is a marked distinction between traditional psychoanalysis and Gestalt therapy. Traditional therapeutic methodology concerns itself with the content of the individual, aiming to analyze, interpret and construe the patient's psychodynamic arrangement. Thus, the therapist becomes a builder, a constructor, the one who "brings improvement" by showing the patient how to understand his psychological content.

On the other hand, Gestalt therapy is concerned with the process or style of continuous activity. In this sense, the "medium becomes the message" and by working with the fundamental medium or framework of the individual, therapeutic change and growth occur in a more complete and integrative way. By focussing on process, we make our reference point how the patient organises his life activity within the ever-pervading present. This offers a clearer, more accurate appraisal of the person in front of us. This does not mean that the content of the therapy session is ignored. Our basic principle of "balancing opposed forces" (cf. Supra) prohibits us from disregarding content. Form and content must represent a unified field, but the therapeutic importance of attending to the ongoing process cannot be overly stressed.

When a therapist focusses upon anything other than the present ongoing process, for example, when he focusses upon the history of the patient, he ignores the quality of experience. In this sense, quality of experience refers to the fashion or style of the patient's awareness. For example, a patient may speak in a dull, lifeless, stunted fashion, and therefore the therapist will experience a dull, lifelessness in himself when with the patient. This then is the quality of experience that is being shared by both therapist and patient. Should the therapist ignore this most basic process and concern himself
rather with the abstracted concept which the patient's words are describing, the experience of dull lifelessness will be reinforced and thus persist.

There are two activities which are an inherent part of the ongoing process. The two parts are, firstly, the focusing of awareness and, secondly, the mobilising of energy. When the therapist fails to attend to the ongoing process, the patient will not focus his attention or mobilise his physical resources. When the therapist attends to the ongoing process, he can be in contact with the extent and quality of his patient's awareness and the movement of organismic energy. Awareness and energy are considered basic components of healthy organismic functioning. This functioning occurs in the therapeutic session as well as in daily life. The therapy session represents a slice of the patient's experience. Should the therapist wish to affect the patient in his daily life, he needs to affect him in the therapeutic session. The effect the Gestalt therapist wishes to produce is that of fostering an individual who is self-supportive, alert, radiant, and brilliantly alive. These qualities are the result of clarity: the focusing of attention and the freedom to spontaneously mobilise one's energy. For instance, a male patient may be unable to ask a woman for a date. The patient's attention is not directed clearly toward the object of his interest, i.e., the woman in question. Instead, the focus of his attention may be shifting from catastrophic expectations to fantasies about the woman to fantasies about himself. Meanwhile, his organismic energy level is increasing in order to activate his motor system and approach the object of need-fulfilment, i.e., the woman. While part of his body is mobilising to approach the woman, another part is mobilised to hold back his motor system. Meanwhile,
his intra-psychic experience shifts from his original excitement to fear, then to anger, and so on.

What also occurs is that his heart rate increases in his excitement, and his abdominal muscles begin to tighten in order to hold back his excitement. His chest may also become constricted and his diaphragm tighten to impede the free flow of oxygen. This retroflecting activity occurs in order to hold on to the energy which wishes to contact the environment. Thus, his energy fails to flow freely into the environment and he begins to feel anxiety; the holding of breath and the withholding of energy discharge.

The aim of the Gestalt therapist is to get the patient’s process to function smoothly and efficiently. To accomplish this, the therapist works to get the patient to focus his attention clearly on what he is feeling and to discover how he uses his energy flow. This is done by firstly observing the patient’s physical movements and bodily attitudes. For example, the patient may be looking at the floor. The therapist might comment, "The floor must be very interesting". In this way, the therapist is immediately attending to the process of how the patient focusses his awareness. Thus, one function of the therapist is to heighten the patient’s awareness of the ongoing process.

Since the patient’s ongoing process is by definition always with him, the therapist is training the patient in the ability to focus on his own natural functioning.

To the therapist’s comment, the patient might reply, "The floor is not very interesting, in fact, it’s boring". With this, the therapist might reply, "By imagining you are the floor, what would you reply to this?"
Having the patient imagine he is the floor, the therapist is:

(a) providing a situation whereby the patient can focus his attention (without at first identifying with it as himself); and (b) enabling the patient to mobilise his energy.

The patient, imagining he is the floor, might say, "I'm not very interesting. I'm always being trodden on". Then the therapist may encourage a dialogue between the patient and the patient imagining himself as the floor. This enables the patient to focus his awareness clearly on his intra-psychic problems, whilst providing the therapist with the opportunity to observe the patient's active behaviour.

Now, for example, movements could become the focus of attention. The movements could lead the patient to recall certain imagery, the imagery could lead to a dialogue and so forth.

Attending to this ongoing, continuous process, the therapist is free to allow the perceptual figure/ground to develop in his own awareness structure. Attending to his own perceptual awareness, whilst observing the ongoing activities, allows the therapist to work freely in process therapy. Should the patient exhibit material of a linguistic nature, the therapist would be free to shift and attend to that aspect of work. The same would be true for imagery and for body expression. One aspect holds constant: the ongoing process determines what is important and of interest and what may recede into background. In other words, the process we are referring to is the process of gestalt formation: the formation of figure-background relationships (cf. Supra).

Operating within the therapy "process" mode, other disciplines and techniques can now be integrated in the therapeutic session. For example, behaviour therapy is similar to Gestalt therapy in the respect
that both operate in the "here-and-how" process of observing present ongoing behaviour. The well-researched method of free operant conditioning used in behaviour therapy is highly compatible with aspects of Gestalt therapy.

Hart (1964) demonstrated that the chronic attention-getting device of crying episodes from a 5-year old child could be controlled through the free operant method. A school teacher in a university kindergarten ignored the child when he cried, but reinforced all verbal behaviour. Within 5 days of this kind of treatment, the child's crying was nearly extinguished.

Ayllon and Haughton (1965) demonstrated another example of free operant conditioning. Their experiments worked toward controlling the psychotic verbal behaviour of a chronic schizophrenic patient. By offering the reinforcements of social attention and cigarettes for normal, every-day speech, and withholding social attention and cigarettes for psychotic verbal speech, psychiatric nurses were able nearly to extinguish the psychotic verbal behaviour of their patient.

Reese (1966) concludes in her analysis of human operant conditioning that the social reinforcers of sympathy and attention are the most desirable reinforcers (p. 54).

In Gestalt therapy we employ free operant conditioning within the therapeutic process. By offering sympathy and attention when the patient demonstrates self-supportive behaviour, we reinforce the likelihood that such behaviour will occur again. The same holds true for ignoring and withdrawing interest when chronic "support-seeking" behaviour is offered by the patient.

Negative reinforcement can also be employed in the therapeutic session. This would take the form of "teasing" the patient and in
applying "skillful frustration" (cf. Supra). Several areas where "teasing" and "skillful frustration" could be applied are crying, whining, under-dog role-playing, environmental support-seeking behaviour, etc.

There is a possibility of danger in the application of "teasing" techniques as a negative reinforcing control. Since the response to negative reinforcement is often the removal of such stimuli, a patient might exhibit, in the case of excessive teasing, escape behaviour. In other words, a patient might leave and never wish to return to a therapy session. This escape conditioning effect is highly undesirable for the psychiatric patient. A confronting approach to chronic environmental support-seeking behaviour would be more effective and beneficial in long-term therapy. One example is to confront the patient when whining instead of applying teasing techniques. For example, a teasing frustration might sound like, "You're whining - whining, whining. You sound like a baby - bah, bah, bah". A confrontation statement might sound like this, "You're whining. How much do you think you can achieve by whining?"

The points made in the preceding chapters concerning the attitude adopted by the Gestalt therapist show that the therapist is exposing himself to the same process that patients are encouraged to undergo. The therapist, indeed, functions as an integrated, whole, responding individual attempting to use all his potential within the therapeutic setting. This is a primary point difference between Gestalt therapy, on one hand, and analytic, behaviouristic and Rogerian models, on the other hand, where the practitioner may primarily be a theoretician who offers interpretation, an observer who attempts to explain the phenomenon he observes or a listener to problems. It is interesting
to note that practitioners in the field often express discomfort with
the separation of the man and the practitioner. In Gestalt therapy
there is a stronger trend toward integration of the man and the
practitioner, so much so that the therapist's experience of therapy
is seen as an integral part of his own life process.

The therapist also adopts a particular attitude within the
therapeutic session. Some of the characteristics of this attitude are:

1. The elimination of critical attention. This means that the
therapist refrains from consciously attempting to classify and intell-
ectually analyse the psychodynamic aspects of the patient's condition.
By freeing and enabling his spontaneous concentration to develop, the
therapist permits a rapid flow of figure/ground formation. This
heightens his receptivity to visualisations, allows him to focus on
the moment-to-moment process and on the therapist/patient interaction.

2. His language is natural and direct. The more direct and
natural his answer is, the more valuable it will be to the patient.
Also, the directness and naturalness guarantee a more total reaction
in response from the patient. In this way, the therapist offers a
model to the patient.

3. The therapist is prepared to allow unrestricted and uncensored
expression. This means that the therapist will permit a free-floating,
spontaneous, even joyous or humorous, climate to develop rather than to
create a serious, formal, restrictive therapeutic setting. This ensures
that the patient, instead of censoring self-punitively his spontaneous
behaviour and thoughts, will permit his less-contacted parts to emerge
and become the focus of process.
4. The therapist refrains from placing himself in the role of "expert" or "doctor" or "top-dog" or "helper", who provides a solution for the patient. Instead, he strives to become himself; a being who is genuinely human, capable of being empathetic with another person, and at the same time able to provide non-possessive regard toward the human-ness of his patient.

The Gestalt therapist is basically much more active than the Rogerian therapist in the sense of continually pointing out awareness of perceptions that form in the movement. The client-therapist relationship is seen more on the level of teacher/pupil or, to be more precise, like a guide and a traveller.

The nature of a complaint as presented by the client can be defined in several ways. For example, in Rogerian therapy the complaint is seen as a failure to actualise, in learning theory as the acquiring of maladaptive learned habits, in psycho-analysis as unresolved psychodynamic conflicts. In Gestalt, the complaint is basically seen as an interruption of the process of Gestalt formation and dissolution and as an interruption in the natural figure/ground process.

The complaint presents interferences of the healthy Gestalt formation in three ways. First, there is poor perceptual contact with the external environment and with the body itself. For example, the inability to concentrate and focus. Second, the open expression of needs is blocked. Third, the complaint represents a repression of the motor processes, indicating the holding-back of impulses and producing musculature that is armed against expression. This results in the suppression of activity in the motor responses and the creation of an inability to satisfy needs.
All these symptoms are seen as disruptive of the basic process of Gestalt formation, i.e., the flowing process of differentiating between figure and ground. This takes the combined forms of projection, retroflection, confluence and introjection which were discussed earlier in Chapter II.
CHAPTER VI

DRAWBACKS AND BLIND SPOTS IN THE GESTALT APPROACH

Many aspects of the Gestalt approach are based upon techniques and procedures that can be used by the therapist in extremely effective ways. Nevertheless, there are drawbacks.

The first blind spot is that the use of many techniques requires outside directiveness and this tends to make the patients too dependent on the therapist. Instead of responding from his own initiative, a patient might be told to wait for the therapist to "invite" work. Or a patient might be told that he must learn to question himself instead of questioning the therapist when he doubts the therapist's directiveness. Or, a patient might be told to remain silent and not interrupt the therapeutic process. Due to some therapists' over-concern with techniques, they attend too little to how they, the therapist, relate to the patient and how the patients relate to one another.

Because of this many Gestalt therapy sessions tend to be alienating and separate from real-life experiences. It is common to hear individuals say that too much Gestalt therapy is artificial and too removed from their own "real" world, and some find the experience an "overplayed theatre game" or even a "circus".

A second drawback that usually occurs in short-term Gestalt work (i.e., the weekend workshop) is that therapist tends to neglect the important fact that growth and personal integration take considerable amounts of time. Many well-known therapists aim for short-term successes instead of attempting to initiate long-lasting integrative
processes. They sometimes push and tease a patient when the patient is unwilling or unable to take the step the therapist suggests. For example, some therapists attempt to "force" a decision before the patient is ready and equipped to take such a step in his own life circumstances. This is often a demoralising experience for some patients, and not very different in results from applying a cold, matter-of-fact interpretation of another person's life and experience.

Many Gestalt workers only focus on a patient's problem within the group setting. This procedure tends to ignore the phenomena that occur at a group (dynamics) level. Thus, all group occurrences are reduced to an individual's "problem" and the "group" problem is hardly seen.

The drawback of just focussing on individuals in a group setting is that the group members rarely meet one another sufficiently to learn to trust and support each other as a group. Instead, the patients are permitted to interact with the therapist (should he choose to allow this) and the therapist responds to individual patients in turn.

Although there does exist a feedback technique, it is often controlled by the therapist in both duration and content. Subsequently the basic building of group interaction is ignored and individuals find themselves alone, embedded in an individualistic environment, ruled by an all-powerful therapist.

By exaggerating this individualism, many therapists place excessive importance on individual autonomy as a therapeutic goal. Perls' poem "The Gestalt Prayer" states:
"I am I, and you are you.
I do my thing and you do your thing.
I am not in this world to live up to your expectations,
And you are not in this world to live up to mine.
If by chance we meet, that's beautiful!
And if not, it can't be helped."

By examining the last line in this poem and referring to Perls' and Levitsky's language ideas (cf. Supra), we find three contradictions: The first is to change "it" to "I": "I can't be helped". The second is to change "can't" to "won't": "I won't be helped". The third is to change passive to active: "I won't help".

This "I won't help (you)" attitude further stresses the need to develop self-sufficiency. Due to Perls' idiosyncratic personality, many Gestalt therapists confuse a charisma with therapeutic technique. Obviously, there is no need for a therapist to behave in a self-sufficient manner in order to provide good therapy. Yet many therapists confuse self-sufficiency with self-support.

The poem does state an important and valuable assumption: that one has the right to refuse "to live up to" other people's norms and expectations. At the same time, such an all-encompassing refusal is totally unsuited for a balanced life, because it focuses only on the separation of people and not on the union of individuals. This attitude is a common Gestalt therapy blind spot. For good relationships to develop, one needs not only separation but union as well, and many therapists only focus on autonomous separation and neglect the many forms of union.

This separation aspect can be further exaggerated by examining the power the therapist could employ by stressing individuality. He could further his top-dog therapist role by quoting the above poem. "I do my thing, and you do yours. If you don't like what I'm doing just leave".
This attitude blatantly reduces any discovery of how to live with others in a mutually satisfying way, and also contradicts a living and learning experience. What a patient learns from such an experience is either to accept the therapist whole or reject him whole. Thus, the patient learns how to avoid working on bettering relationships (with the therapist) and the autonomy model in the group is strengthened. This gives the therapist a greater licence to project his own inadequacies on the group without being aware of his projections, since any interaction that the therapist dislikes, he would just dismiss by arrogance, i.e., "If you don't like it, just leave".

For a therapy to be truly liberating and emancipating, it should lead to actual changes and not just adjustments. Therapy needs to accomplish two things. First, it needs to make people aware of: (a) who they are; (b) who others are; and (c) how they are repressed by others. Second, it needs to show them how to: (a) support themselves; (b) support others; and (c) how to be supported by others in order to change the source of repression. A group of mental health workers and psychiatrists (Agol, 1971) give three basic equations for describing the above:

\[
\begin{align*}
\text{Repression} + \text{mystification} &= \text{isolation} \\
\text{Repression} + \text{awareness} &= \text{anger} \\
\text{Awareness} + \text{support} &= \text{liberation}
\end{align*}
\]

For example, repression in mental hospitals can be mystified by telling the patients they are hospitalised for "their own good", or mystified by the terminology of symptoms and illness. This leads patients toward alienation and isolation and inhibits their improvement.

If the repression becomes evident and the patients become aware of their social position, this awareness leads to enormous amounts of
anger. This applies to all oppressed groups, be they patients, negroes, women or political minorities.

In Gestalt therapy, the focus is on the heightening of awareness, the expression of emotions, and the acquisition of self-support. Rarely is the focus on the development of support between individuals. The focus is on developing self-support and never on social support without dependence; in other words solidarity.

In Gestalt therapy, all too often the patient is led to believe that he should be self-sufficient. But this leads to an "individualistic libertarian society", in other words, a "fight-for-one's-self" society, instead of a "humanitarian" society in which a mutual giving and receiving of support instead of competition is a central value.

This fighting for oneself is in line with the present-day competition and achievement motivation which our society exhibits. For example, it is common to hear from a Gestalt therapist that he is the best Gestalt therapist in the world. This autonomous and individualistic attitude is often reinforced and stressed as "desirable" in many Gestalt therapy workshops.

A more effective method would involve helping a group to learn to support one another, and work toward solving the same kinds of problems together. This would create enormous amounts of liberation and emancipation in the group, and at the same time develop independence from an autocratic therapist's control. In this way, a therapist can learn to transcend the neurotic "top-dog versus under-dog" role mechanism, thus synthesising the patient-therapist dichotomy and creating an integrated gestalt experience with one's self and others. For example, instead of behaving as an "all-knowing therapist", one can stimulate leadership in other group members and encourage mutual interaction and supportive acceptance.
Is Gestalt therapy for all patients? Until this point in time, Gestalt therapy has been used mostly with neurotic defence mechanisms (e.g., projection, retroflection, confluence and introjection). These conditions exist in the so-called neurotic patient but also in "normal" individuals, and Gestalt therapy has been found useful for those who want to live their life in a more effective and integrated way. Gestalt therapy has also been seen to be useful in treating psychosomatic disorders (1) and in many forms of living problems (Perls, 1969). The method is also applied in family and partner therapy (2).

Modified forms of Gestalt therapy can be found in many diverse areas of human development, such as in organisational development (i.e., confrontation meeting methods) in human relation training, in leadership development programmes and in educational settings (3).

Full Gestalt therapy is not applicable with the so-called "psychotic" patient since it involves the therapeutic use of healthy imagery, controlled acting through fantasy and capacity to modify language formation. A modified form of Gestalt therapy, i.e., perceptual awareness training and reinforcement programmes in the here-and-now of present experience can prove useful in reaching and treating the dysfunctionally hallucinating schizophrenic (Close, 1970) p. 226). This form of Gestalt work has been seldom applied and requires far greater exploration and development.

THE EXPERIMENTAL BASE

Gestalt Psychology has an extensive experimental base as noted before. Gestalt therapy, however, has no research tradition and is, in fact

(1) Cohn, R.C., A Child with a Stomach-ache: In Gestalt Therapy Now, p. 226

(2) Kempler, W., Gestalt-Experiential Family Therapy

in fact, still in an early stage of development. Its founders have emphasised the immediacy of experience in the here-and-now and in the heightening of non-verbal expression, and have purposely avoided any encouragement toward wordiness and abstractions (discouraging "aboutism" and the over-use of the mental computer").

Some of the advantages of Gestalt therapy over other humanistic approaches such as client-centred therapy, rational-emotive therapy, transactional analysis and so forth, relate to the fact that the Gestalt position is not restricted to therapy alone. Its principles apply to many other situations, thus producing, in some ways, more sound living and working attitudes. For example, one can focus attention to the here-and-now and be more aware of what is needed in the immediate situation. Or use the principles of perceptual training and apply these at any time on one's life. The principles also make one aware of how needs are blocked or unfulfilled. In this way, Gestalt therapy provides a philosophy for living as well as a psychotherapeutic treatment and, in this sense, Gestalt can add to other humanistic approaches.

There remain several internal contradictions in the Gestalt argument. There is a trend among therapists to label their patient's unacceptable behaviour as games and, in this way, they try to make patients more aware of their behavioural patterns. Although this might work as a frustrating device, it does not fit the basic ideology of the humanistic approach in that it works almost like a diagnosis as in more traditional object-oriented or de-humanising psychotherapies. This kind of labelling, may freeze the patient in his behaviour pattern by adding a new verbal construct to the already existing inappropriate self-concept.
Another contradiction in Gestalt arguments is that between the ideology that the organism "knows best" what is good for natural functioning on the one hand, and the use of prescribed rules and games on the other hand. These rules imply shouldisms such as: people should be free and spontaneous; they should not be defensive and rigid; they should not examine the reason and cause for their present behaviour, and so on. This kind of shouldism creates a paradox in Gestalt therapy between natural functioning and the proposed way to reach it.

The danger in this is that the rules and games of Gestalt therapy have all too often been uncritically adopted by Gestaltists directly into their daily lives to the extent of producing a "cult" of followers, thus losing their uninitiated families, friends and other important meanings to life. Thus, their defence mechanisms shifts from one shouldism to another, producing just another fixed behaviour pattern that never leads to personality change. This is the kind of person who "knows all about Gestalt therapy" yet nevertheless uses his knowledge as a defence to remain superficial and aloof.

The paradox can be avoided if the list of "do's and don'ts" is taken as a list of suggestions for experiments that one might perform in order to enhance one's natural functioning. As soon as the list is taken dogmatically, the paradox is evident.
PART II

A COMPARATIVE STUDY OF THE
EFFECTS OF GESTALT THERAPY UPON PSYCHIATRIC DAY PATIENTS

1. INTRODUCTION

There is a body of literature pertinent to the beneficial effects of therapy. Some of it is relevant to this thesis and will be briefly reviewed.

Eysenck (1952) summarised the results of five psychoanalytic outcome studies conducted between the years 1930 and 1941. By including "psychopathic states" Eysenck arrived at an overall improvement level of 44% for the psychoanalytic treatments and of 64% for eclectic treatments. (within these figures are not included the slightly improved cases and the patients who left treatment). Eysenck argued that the proportion of neurotic individuals who never entered psychotherapy and appeared to improve through spontaneous remission within a two-year period was 72%.

Bergin (1969) re-evaluated Eysenck's data, but eliminated premature dropouts from the sample, arguing that individuals tend to leave for many reasons. As long as there is no clear record of what these reasons are (perhaps in some instances related to the therapy, sometimes not), Bergin argued that it was better to eliminate these premature dropouts from the sample. He also counted the successful cases as "improved" and eliminated non-neurotics from the figures. Bergin (1971) arrived at an overall improvement rate of 91% (p. 237), demonstrating that the results from different criteria can produce an entirely different interpretation. Seen in this perspective, Eysenck's conclusion that counselling and psychotherapy are statistically ineffective is questionable.
Frank (1961) reported that approximately two-thirds of all neurotic patients who improved after treatment did so regardless of the type of therapy they received, but found the same improvement level for those individuals who never received psychotherapy at all. Levitt (1957) reported the same results when he compared overall improvement levels between therapy treatment and no therapy treatment results with children.

Concerning the above enquiries, Bergin (1971, p. 228) comments that most recent outcome studies:

"...generally do not specify the precise nature of the therapy, nor do they usually consider specific limits to its applicability. Thus, most of these studies are quite gross in character. They are tests, for the most part, of whether therapy has any effect at all, but they usually do not examine whether specific methods have specific consequences, nor do they examine the notion that only a small proportion of therapists and patients may be accounting for the positive effects when they do occur on averaged data".

The studies quoted thus far attempted to present evidence of the effectiveness of psychotherapy in terms of gross statistical therapeutic effects. These broad tests of therapy efficiency tend to provide results which are difficult to interpret and almost impossible to use in enhancing therapeutic practice.

Concerning this issue of devising more informative research, Kellner (1965, 1967) found that when researchers: (i) homogenised patient samples; (ii) considered the effects of better therapists; (iii) specified the outcome in terms of specific criteria; or (iv) used precise definitions for control groups, the results became clearer and more usable.

The following are some demonstrations of employing more defined and specific criteria in research. For example, Truax (1963) found
that in treating schizophrenics the therapist's: (i) empathetic understanding; (ii) non-possessive positive regard; and (iii) ability to present himself as a genuine person in the therapeutic encounter, positively influenced the results. The patients of therapists low in the above criteria deteriorated instead of improved. Rogers et al (1967) came to the same conclusion. Horowitz (1969) offered this same type of validation for the importance of the therapist possessing warmth and accurate empathy.

2. AIM OF STUDY

The aim of this study was to determine whether Gestalt therapy could be beneficial within a hospital setting. By conducting interviews with the entire hospital staff of the Marlborough Day Hospital, one of many psychiatric "day" hospitals incorporated within the National Health Service, the investigator discovered that the psychiatric staff as well as social workers and nurses had the following opinions:

Firstly, a majority feared that the experimental method employed in this research would produce a relapse into psychosis or violence with certain patients, due to the emotional element of the therapy. Questioning whether the therapist had the ability to control such acting out episodes compounded their mistrust. Secondly, several expressed fear or worry that their own roles might be affected should the experimental method prove more successful than their own treatments. This was expressed as an actual distrust of the value of that opening of the expression of feelings and emotions which is the aim of the Gestalt treatment.

Those who were interested in the Gestalt method felt that the treatment would produce new openness amongst the staff as well as the
patients. They approved of the results of the Gestalt technique as seen and imagined from other sources. Lastly, many looked with approval on any new and different technique that could be made available to the hospital.

Through the encouragement of Dr. Alan Horsom, consultant of the Marlborough Day Hospital, and Dr. Julian Goodburn, consultant of the Paddington Bay Hospital, research was initiated to discover: (i) what effects the Gestalt therapeutic process would have on psychiatric "day" patients; and (ii) whether it could be successfully used within a hospital setting.

3. HYPOTHESIS

1. A combination treatment by psychoanalytic and Gestalt methods will produce more self-actualisation, as measured by the Personal Orientation Inventory (POI), (cf. Intra) than treatment by psychoanalytic methods alone. This implies that Gestalt therapy could be utilised in the present day-hospital setting in conjunction with other therapeutic methods, to provide changes in the directions of increasing self-acceptance, self-support, independent and flexible behaviour, sensitivity to one's own needs and feelings, acceptance of healthy aggression, greater self-regard and increased capacity for intimate contact.

2. A combined treatment by psychoanalytic and Gestalt methods will produce a greater coherence between self-concept and ideal-self concepts as measured through the Kelly "Role Construct Repertory Test" than a treatment of a psychoanalytic type alone.

3. A combined treatment by psychoanalytic and Gestalt methods will produce greater symptom-complaint improvement, as evidenced through the clients' self-reports in terms of the Target-complaints technique of Battle (1966) than a treatment by psychoanalytic methods alone.
4. PROCEDURE AND DESIGN

The method used for investigating the comparison between psychoanalytic methods only and the combination of Gestalt therapeutic methods and psychoanalytic methods was as follows:

First, all patients from both hospitals were informed that research was to be conducted on several forms of treatment. All patients who were willing to participate in this research were then asked to fill in the Middlesex Hospital Questionnaire (MHQ) and the Mill Hill Vocabulary Scale. From these two tools and taking into account criteria of age, sex, socio-economic class, and national origin of parents (cf. infra), all voluntary patients were divided into two "equally matched" groups of 12 patients each. No patient had choice of group, thus there was no self-selection.

One group, which we will call the "experimental group", met for approximately 2½ hours per week for Gestalt therapy, in addition to the other standard treatments offered in the day hospital programme. The other standard treatments consisted of approximately 1 hour of individual counselling and approximately 6 to 8 hours of community and small group sessions per week with a traditional 'object-relations analytic model'.

The second group, which we will call the "control group", consisted of 12 patients selected and tested to the same criteria as the experimental group. They received the traditional methods of treatment but had no exposure to the Gestalt therapeutic method. The control group received approximately 1 hour of individual counselling and approximately 6 to 8 hours of community and small group sessions. The control group spent an equivalent amount of time in a painting workshop instead of attending the Gestalt therapy session.
The treatment programme lasted for 6 months. Before the programme of treatment began, all 24 patients were tested with the FOI, the Kelly Repertory Grid Test and the Target Symptom Scale (to be discussed in greater detail later). These three tests were also administered when the treatment ended.

**The Design:** The investigator chose to use a before (pre-test) and after (post-test) design using two equally matched experimental groups. This classical research design was used to compare one form of treatment with another by measuring the change over time.

Expressed exponentially:

\[ Y_b \times X_1 \times Y_a \text{ (experimental 1)} \]
\[ Y_b \times X_2 \times Y_a \text{ (experimental 2)} \]

\[ M = \text{matching of the groups} \]
\[ Y_b = \text{pre-test (measurement before)} \]
\[ Y_a = \text{post-test (measurement after)} \]
\[ X_1 = \text{experimental treatment 1} \]
\[ X_2 = \text{experimental treatment 2} \]

This design assumes that any non-treatment sources of change (e.g., "spontaneous remission", "maturation") will be (in probability terms) equally distributed between the two groups and differential change can therefore be attributed to experimental effects.

Another advantage of this design is that it enables us to compare the two groups before the treatments start and check whether the matching of the groups was balanced for a number of variables.

There is one troublesome aspect to this design. There may be a sensitising effect occurring from the pre-tests. For example, answering the FOI questionnaire may alert the subjects to certain aspects of their behaviour that they might not ordinarily notice. So their scores in the post-tests might reflect in an uncontrollable way their increased sensitivity to the issues of the experimental treatment. This need not trouble us if this sensitising effect is
present in both groups in the same way. But it is possible that some interaction effect could occur, i.e., in the experimental group that received the Gestalt treatment, the sensitising effect could be longer lasting than in the other group because of the content of the POI which relates to Gestalt therapy. We were not able to measure this kind of 'sensitising' effect.

5. MEASURES

The POI: Patients were given the Personal Orientation Inventory (Shostrom, 1966) to assess their progress towards self-actualisation. The tool consists of 150 either/or questions designed to produce a statistical profile comparing the subjects' attitudes and values with those of self-actualising persons. The self-actualising person is defined as "one who is more fully functioning and who experiences a more enriched life than the average person". (See Appendix B).

The test scores:

**Time competence** - the degree to which the subject lives in the present;

**Independence** - the degree of independence and self-support;

**Feeling** - the degree of sensitivity to one's own needs and feelings and the ability to express these feelings behaviourally;

**Self-perception** - the levels of self-regard and self-acceptance;

**Interpersonal sensitivity** - the degree to which one accepts his feelings of anger and aggression and his capacity for intimate contact.

According to Shostrom, the items on this questionnaire have been chosen because they reflect value orientations which are commonly held to be significant to one's approach to living. They were selected
from the observed value judgements of clinically healthy and clinically troubled clients by psychotherapists in private practice over a 5-year period. Many items were also derived from the research and theoretical formulations of humanistic, existential and Gestalt psychotherapists, including the ideas of Maslow, Riesman, May and Perls.

Individuals answering the POI require between 20 and 45 minutes to complete the questionnaire, but no time limit is suggested. Scoring is accomplished with an answer key, after which the raw scores are converted to standard scores drawn from normative groups. The raw scores given in the Manual are for a sample of 2,607 college freshmen (1,517 males and 1,093 females). There are also profiles, means and standard deviations for 66 male supervisors, 64 student nurses, 62 Peace Corps volunteers, 150 male college juniors and seniors, 2,046 entering college freshmen, 412 high-school students, 135 hospitalised psychiatric patients, 84 delinquent males, and 20 alcoholic males.

The test-retest reliability coefficients were obtained from a sample of 48 college undergraduates who were given the POI twice, one week apart. The reliability coefficients for all the sub-scales of the Inventory ranged from .55 to .85 with a medium of .74. The degree of reliability for the sub-scales within the POI is thus marginal; only 4 of the 12 scales show test-retest reliability scores over .80.

The validity studies that have been carried out on the POI are more extensive. Shostrom (1964) compared 29 self-actualised with 34 non-self-actualised adults who had been judged so by clinical psychologists. Eleven of the twelve scales in the POI had been able to discriminate between the two groups significantly.

Fox (1965) gave the POI to 100 hospitalised psychiatric patients and found that all the scales in the Inventory were able significantly
to differentiate between the hospital sample and both a self-actualised and normal adult sample at a .001 confidence level.

Knapp (1965) administered the POI along with the Eysenck Personality Inventory to 136 undergraduate students, assuming that the latter would measure introversion-extroversion and neuroticism-stability. The scores of 94 subjects were analysed for correlation between each of the 12 POI sub-scales with the two Eysenck sub-scales. The POI profiles were separated into two subgroups, one "high-neurotic" and the other "low neurotic", along with the upper and lower 27 percent of the total sample scores on Form A of the Eysenck Inventory. Ten of the POI sub-scales statistically differentiated between the two subgroups at less than .01, the remaining two sub-scales at less than .05. No other criteria was used to measure neuroticism other than the Eysenck Inventory.

Shostrom and Knapp (1966) administered the POI along with the MMPI to two groups. The first group of 37 clients were just beginning psychotherapy while the second group of 39 clients had a mean time in therapy of 2.2 years. Both groups were representative of patients in therapy at local clinics with respect to age, sex and education. Four of the MMPI scales differentiated significantly between the two groups beyond the .01 level. Of the two groups, the advanced in therapy group exceeded the therapy beginners significantly in all the POI scales.

The predictive validity of the POI is tentatively established in the sense of a gross ability to differentiate between relatively healthy and less well-functioning groups. This seems to provide sufficient validity to use the POI for research and group prediction.
However, there is no evidence available to suggest particular validity for the separate POI sub-scales. This would constitute a serious defect in the instrument if it were to be used for differentiate individual clinical diagnosis or prognosis.

Concerning the Personal Orientation Inventory, Bergin (1971) writes:

"...we are impressed with the potentialities of the Personal Orientation Inventory (Shostrom, 1963; Shostrom and Knapp, 1966; Knapp, 1965), which measures life-orientation, self-actualising tendency, inner-direction and similar dimensions usually considered to be in the domain of values and health-orientated qualities. A series of studies relating it to the HAPI, the Eysenck scales, therapeutic change, and differences between diagnostic groups reveal both its validity and its ability to measure important dimensions not tapped by traditional scales. A good measure of values is sorely needed in psychotherapy research, and perhaps this is it".

(p. 263)

The POI measures are defined as follows:

(1) The Time Competence (TC) scale measures the degree a subject lives in the present as compared with the degree he lives in the past or future; (2) The Inner-Directedness (I) scale measures the degree of independent self-supportive behaviour as opposed to being dependent on and seeking the support of other people's views; (3) The Self-Actualising Value (SAV) scale measures the degree the subject holds the values of self-actualising people as compared with his degree of rejecting these same values; (4) the Existentiality (EX) scale measures how flexible the subject is in his application of values as compared with how rigidly he applies his values; (5) The Feeling Reactivity (FR) scale measures how sensitive the subject is to his own needs and feelings as compared with how insensitive he is to his own needs and feelings; (6) The Spontaneity (S) scale measures how freely the subject expresses his feelings behaviourally in comparison to how fearful he
is to express his feelings behaviourally; (7) The Self-Regard (SR) scale measures the subject's degree of self-worth; (8) The Self-Acceptance (SA) scale measures the amount of acceptance the subject has in terms of accepting himself in spite of weaknesses; (9) The Nature of Man, Constructive (NC) scale measures the degree of how the subject sees man as essentially good as compared with how he sees man as essentially evil; (10) The Synergy (SY) scale measures the subject's degree of seeing the opposites of life as meaningfully related as compared with seeing the opposites of life as antagonistic (e.g., that one can be both selfish and selfless); (11) The Acceptance of Aggression (A) scale measures the degree at which a subject accepts his feelings of anger and aggression as compared with his denial of aggressive impulses. Lastly (12), the Capacity for Intimate Contact (C) scale measures the degree of ease the subject has in developing and sustaining warm interpersonal relationships.

THE RANK-ORDER REPORATORY GRID TEST

George A. Kelly presented an elaborate and sophisticated theory of personal psychology that concentrates upon the matrix or template or "map" one projects upon the given world in order to describe and deal with one's experience. The way in which one conceptualizes his reality is the focus of Kelly's theory of personal constructs (1955). Kelly challenges many current psychological concepts such as reinforcement, motivation, drives, ego, emotion and unconscious by arguing that a person's construing can open new channels of psychological movement and action can follow.

Kelly sees the "construct" as the basic element of creative thought. He writes:

"In its minimum context a construct is a way in which at least two elements are similar and contrast with a third"

(Kelly, 1955)
The ability to articulate similarities and contrasts is the major characteristic of language.

A result of the well-formed use of language is a number of constructs joined together to form a web-like structure wherein ideas link together with one another to produce a personal construct system of identification and acceptance or alienation and rejection. For example, a patient might link his thoughts together in the following way: to maintain permanent interest yields friendliness and understanding; to be understanding means being open.

Written graphically:

<table>
<thead>
<tr>
<th>Permanent Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding</td>
</tr>
<tr>
<td>Friendly</td>
</tr>
<tr>
<td>Open</td>
</tr>
</tbody>
</table>

The object of administering the Repertory Grid Test is to diagnose these paths of thought construction and to understand their qualities and implications.

There exist many forms of Repertory tests, and within these forms there exists the possibility of creating further variations to cover a wide range of contexts. Some tests include or exclude the self-construct, others vary in either eliciting or presenting ready-made constructs, others vary in administrative procedure, or are designed especially for individual or group use. The aim of all of these forms is to seek or "elicit" from the client those personal major templates which he uses to construe reality. The basic procedure used in the present research implemented is called the Rank-Order Grid.

Patients were asked in an individual interview to place on 3" x 5" cards the name of a person known to them who fitted the
role-title given on the card. (The number of the role title element was placed on the back of each card).

1. Mother  
2. Father  
3. Friend of the same sex  
4. Partner (i.e., husband, boyfriend)  
5. Teacher you liked  
6. Teacher you disliked  
7. Therapist  
8. Somebody, once friendly with, with whom you have now fallen out  
9. Person you don't feel comfortable with  
10. Boss or supervisor

No repeat names were allowed. Once the cards had been filled out, the examiner chose three cards at random and presented them to the client, asking: "In what important way are two of them alike but different from the third?" The client's response was recorded in the form of a construct (the way two were alike) and a contrast (the way the third was different), e.g., secure-insecure. This procedure continued until eight constructs were elicited from the client.

Next, all ten element cards were placed face-up on a table. The client was then asked to select the card which represented the person who was, for example, most "secure" in relation to the others. The first card chosen was removed from the table and the number inscribed on the back was noted down on a grid form. Then the client was asked: "Who is the next most secure person of those which remain?" This procedure continued until all ten cards were rank-ordered for the construct in question. Then the remaining elements were rank-ordered on the seven elicited constructs, using the same procedure.

In order to measure specific psychological areas and to explore the client's self-concept, the following eight constructs were given
to the client on which to rank his elements using the same procedure as described above. The eight constructs were numbered as follows:

9. Feels free (in way) to touch people - unwilling to touch people  
10. Like myself as I am now  
11. Who approves of sex  
12. Friendliness - unfriendliness  
13. Like myself as I used to be  
14. Willing to talk openly - secretive  
15. Like myself as I'd like to be  
16. Who seems to be most spontaneous in the moment - rigid in the moment

Thus a grid, as exemplified below, was elicited from the client.

<table>
<thead>
<tr>
<th>Constructs:</th>
<th>1</th>
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<th>12</th>
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<td>Elements:</td>
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<td>4</td>
<td>3</td>
<td>7</td>
<td>1</td>
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All 24 subjects were administered the Rank-Order Construct Grid technique before the experimental treatments began, after 3 months of elapsed time and after 6 months when the experimental treatment was concluded.

The notion of reliability in terms of the Role Construct Repertory Test appears to be misleading, and should be replaced by the concept of consistency within construct usage. For example, Kelly (1955) refers to two separate studies. In the first, hospital patients were tested on two separate occasions, and showed an average agreement in construct use of 69 per cent with standard deviations.
of six per cent. In the second study conducted with college students, on two separate occasions, the average agreement in construct use was 70 per cent with standard deviations of eight per cent.

Fjeld and Landfield (1961) administered the Repertory test to eight "normal" individuals during a two week test-retest study. Their findings showed a correlation of .79 between constructs elicited by the same elements and a correlation of .80 between constructs elicited through new elements. With regard to element role titles, Fjeld and Landfield found that when subjects chose their own elements, they repeated 72 per cent of the role title occupants. Pedersen (1958) found similar results of 77 per cent between persons chosen for role titles during a test-retest study conducted one week apart.

Bannister and Mair (1968, p. 180) reported that the Grid form of the Role Construct Repertory Test showed consistency correlations to fall within the range of .60 to .80. Having 10 subjects use the Grid form to rank-order 10 photographed persons during a 6-week test-retest study resulted in correlations of .86. In three other test-retest studies, normals were found to produce .60, .72 and .80 consistencies, whilst schizophrenics showed test-retest consistencies of .33, .35 and .18.

The Repertory Grid Test is a tool for determining the constitution of personal construct systems and is thus usually applied to individual case studies. For example, Kelly (1955) does not present evidence of validity for the Repertory Test. Instead, he analyses a subject's test results and then presents to the therapist questions which were formulated from the test analysis. The therapist's response was based upon six sessions with the client, and the striking points of similarity and comparison between the two analyses—illustrated the usefulness of the tool.
Bannister and Hoir (1968) provided evidence drawn from individual case studies of an agoraphobic, a frigid woman, an arsonist and an opposite-sex identifier, all of which emphasised the influences of the specific individual focus of the Repertory Grid Test.

Bannister and Hoir (1968, pp. 191-194) report several validity studies. First, the voting behaviour of 74 subjects was successfully predicted by analysing the correlations of Grid scores on the "sincere" construct with those of "Conservative", "Liberal" and "Labour" elements. This provided adequate evidence to predict the individual's voting preference.

In a second study on the influence of verbal reinforcement, Bannister and Hoir found that the subjects whose Grids showed a close relationship between "like me" and "needs approval", as well as to "like I'd like to be in character" and "like the experimenter" were more easily conditioned by verbal reinforcement than those whose Grids showed low correlations between the above constructs.

Thus the Repertory Grid Test appears to possess the capacity to examine and verify individual cognitive categorisations. Due to the emphasis on individual personal constructs and the utilisation of the subject's own rank-ordering system, the Grid test offers a more individualistic way of checking the experimental hypotheses.

THE TARGET-COMPLAINT SCALE

As mentioned above, the Personal Orientation Inventory and the Kelly Repertory Grid Test both represent relatively objective and well-documented measures. However, in the following experimental inquiry, the researcher found the need to also incorporate the patient's own spontaneously expressed complaints as a criterion for the evaluation of treatment.
The use of target-complaints as a criterion for outcome studies has been widely documented in psychopharmacologic research (Freyham, 1959). One of the primary problems when using the target-complaint approach in group studies is the problem of comparing patients who have differing complaints.

Weiss and Schaie (1964) have developed a method to deal with heterogeneous populations. They have devised a system based on the Q-sort, where the patient sample of target complaints are jointly analysed by both patients and therapists. Their aim is to sort the target-complaints into homogeneous groups.

Richard (1965) developed another approach aimed at determining outcome results by tailoring the outcome criteria to each individual client. The client would then act as his own control.

In an out-patient psychotherapy evaluation programme Pascal and Zax (1956) used the same tailored criteria method. Their procedure was to determine for each patient one to four specific target problems. Their review of these target problems and the degree of improvement was formulated retrospectively in each of the individual cases.

In order to prevent bias, Battle et al. (1966) devised a method of defining and rating the severity of target complaints prior to the onset of treatment. Their method evolved from three studies on the target-complaint scale at the John Hopkins University School of Medicine in Baltimore, Maryland.

In their first study 40 psychiatric out-patients were selected for short-term psychotherapy. Four psychiatrists treated ten patients each for a 4-month period. At the initial screening interview, the patients were asked: "What three problems do you want most help with in psychotherapy?" The answers were rated after the 4-month period
on a 5-point scale from "Worse" to "No change", to "A little better", to "Somewhat better" to "A lot better" (scored 1-5). The mean scores were analysed and compared with the following criteria:

1. The patient's own rating of overall improvement

2. The therapist's rating of overall improvement based upon a 5-point scale of "Worse", "No change", "Mild improvement", "Moderate improvement" and "Marked improvement"

3. A Social Ineffectiveness Scale rating as assessed by a research sociologist after a one-hour interview

4. A Discomfort Scale score based upon a 50-item checklist of anxiety, depression, and somatic complaints. (The Social Ineffectiveness Scale and The Discomfort Scale; Stone, Frank, Nash and Amber, 1961).

Their results showed a significant correlation between the four outcome measures and the Target-Complaint Scale. Patients gave an average of 2.2 complaints with 40 per cent related to specific interpersonal problems, 31 per cent to anxiety or depression, 12 per cent to physical complaints, and 17 per cent to increasing self-knowledge and higher achievement.

Their second research was a test-retest reliability study of the target-complaint scale. A box scale (see Appendix E) and a line scale were administered to 20 consecutive subjects applying for evaluation during an interview for outpatient treatment. The subjects were asked to rank the severity of their target complaints from "Not at all", "A little", "Pretty much", "Very much" and "Couldn't be worse".

The results produced a mean of 2.8 complaints for the pre-interview and 3.6 complaints for the post-interview. (Subjects were allowed to add target complaints in the post-interviews). Test-retest reliability correlation for the original pre-complaints was .68. Thus, the report on severity for the original target-complaints had not changed a great deal between pre and post interviews. It was also discovered that 65 per cent of the subjects preferred the box scale to the line scale. Due to this, it was decided to adopt the box scale as the standard rating scale in future studies.
Their third study compared target complaints which were elicited by two different interviewers. In this test-retest study, 20 subjects gave an average of 1.5 complaints each. This was due to the interviewers seeking a complex of symptoms based on a specific life situation.

The mean severity ratings for the main complaint in the pre-interview was 9.3 and in the post-interview it was 8.8. This showed an insignificant difference of only half a point on a 12-point scale. When the severity of all target complaints was averaged for each patient, a difference of only .4 of a point existed between the pre and post interviews.

To evaluate the pre and post interview target complaints for congruence, six members of the staff were used to judge the complaints for similarity of content. For 12 of the 20 patients, all judges agreed that the contents of the pre and post reported complaints were identical. The remaining six had main target complaint congruency but differed in some reported somatic symptoms and interpersonal problems.

An added control was utilised by having staff members who were not involved with the patient or with the study to summarise the complaints from the patient's case history. The results showed a congruence between target complaints and case history reports.

The Target Complaint Scale is a rather superficial measure which: (i) can be influenced by the interviewer; (ii) does not include how the positive assets of the patient change; and (iii) fails to cover the basic personality changes which occur in psychotherapy. Yet the approach does allow the patient to respond to his own criterion of improvement, and this offers the researcher a method of measuring psychotherapy change based on the patient's own evaluation.

Thus, the Target Complaint Scale of Battle (1966) was used as a third criterion measure for evaluating the results of the treatments.
All subjects were interviewed either by the investigator or two other colleagues who were instructed to say:

"I'm .......... and we are interested in learning more about what problems or difficulties people who come to our clinic want help with. What problems or difficulties do you have that you would like our help with? .......... Anything else? .......... Anything else? ........

The interviewers were asked to write down each problem that the patient mentioned in the subject's own words. Subjects were then asked to rank the problems for importance. ("Which of these problems do you want the most help with?") After all target complaints were ranked, the subject was asked to rate the amount of discomfort he or she had with each problem. The discomfort rating was made on a Box Scale (see Appendix E).

During the post-treatment interview, the patients were shown their original target complaints, but the results of the first box scale were covered by a double-thick sheet of paper. The top sheet now contained an unmarked new box scale in place of the previous one. The subject was asked to rate the amount of discomfort associated with this complaint on the new unmarked box scale. Thus, the results between pre and post interviews could be compared for changes in degree of discomfort.

THE SAMPLE

The subjects who participated in the experiment were patients from the Marlborough Day Hospital and the Paddington Day Hospital, both situated in London.

All patients within the hospitals who were willing to participate in the experiment were first tested with the Middlesex Hospital Questionnaire (MHQ) and the "Mill Hill Vocabulary Scale" (Raven, 1962). The MHQ.
produced six symptom group categories, which were:

(i) free-floating anxiety
(ii) phobic anxiety
(iii) obsessive-compulsive traits and symptoms
(iv) somatic symptoms
(v) depressive symptoms
(vi) hysteria

The Mill Hill Vocabulary Scale yielded a verbal I.Q.

Selection and matching for experimental and control group equality was done under the following criteria:

1. Age - the experimental and control groups averaged 30 and 31 years respectively
2. Sex - each group consisted of 9 males and 3 females
3. Verbal I.Q. - the Mill Hill Vocabulary Scale revealed that both groups had the same intelligence level of "verbally average III (-)"
4. Socio-economic class - both groups comprised an equal ratio of residents from working and middle-class areas of the Greater London Council
5. National origin of parents - all patients were British subjects
6. Symptom diagnosis - from the Middlesex Hospital Questionnaire (MHHQ), as can be seen in the table following, there were no significant differences between the two groups on each of the six diagnostic scales

| TABLE 1 |
| MIDDLESEX HOSPITAL QUESTIONNAIRE RESULTS |

Experimental and Control Group Mean Scores

<table>
<thead>
<tr>
<th></th>
<th>Experiment</th>
<th>Control</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free-floating anxiety</td>
<td>5.9</td>
<td>6.0</td>
<td>N.S.</td>
</tr>
<tr>
<td>Phobic anxiety</td>
<td>4.0</td>
<td>4.1</td>
<td>N.S.</td>
</tr>
<tr>
<td>Obsessive-Compulsive traits and symptoms</td>
<td>4.2</td>
<td>5.2</td>
<td>N.S.</td>
</tr>
<tr>
<td>Somatic symptoms</td>
<td>3.1</td>
<td>4.0</td>
<td>N.S.</td>
</tr>
<tr>
<td>Depressive symptoms</td>
<td>4.05</td>
<td>4.3</td>
<td>N.S.</td>
</tr>
<tr>
<td>Hysteria</td>
<td>5.7</td>
<td>5.0</td>
<td>N.S.</td>
</tr>
</tbody>
</table>

1 t-value = 1.46, with difference = 22, not significant
2 t-value = 1.76, with difference = 22, not significant
N.S. means: difference between mean scores not significant
Konald B. is a 27 year old homosexual who had completed 2 years of technical college. Several years earlier he had taken LSD once, and since then he has had a series of flashbacks. He reports that since then he has become shyer. His diagnosis is anxious-depressive with personality disturbances. He was administered Fentazin 2 m.g.m. q.d.s.

James K. is 23. He had attempted suicide 4 years earlier, complaining of excessive concern over masturbation. His diagnosis is anxiety concerning sexual phobia. He was given medication of Trimipramine 100 m.g.m. o.n.

Steven R. is 49 years of age. He is a homosexual who, at one time, was self-employed at an antique shop. Diagnosis: anxiety and depression.

Peter B. is 28 years of age with a successfully completed educational background. His complaints are of feeling too insecure to work and of contemplating suicide. Diagnosis: depression.

Hugh H. is aged 23. He is married but complains that his marriage is failing because of his own sexual inadequacy. His diagnosis is that of depression.

Kathy V is 30, with a long history of poor health. Her appearance reflects ill health as thin and under-nourished. Her diagnosis is that of frequent attacks of depression and she is delusional with underlying psychotic tendencies. She was given Serenid at 200 m.g.m. per day.

Brian M. is aged 40. He has been unemployed for 3 years and complains of excessive gambling as well as domestic friction with his wife. His diagnosis is that of personality disturbance and depression.

Richard M. is a 43 year old bisexual. He is a musician of excellent talent but finds difficulty in coping with work. He complains of sexual and relationship difficulties, as well as feelings of inferiority. His diagnosis is written as follows: Anxiety state; inability to make decisions and make deep relationships; depression; confusion about sexual identity.

Hazel R. is a 27 year old female. She complains of feeling physically nervous, socially inadequate, having loss of memory and feeling depressed. Her file diagnosis is psychoneurotic: severely depressed; self-denigrating, repression; demanding and potentially destructive inability to control greed.

Doris G. is a 25 year old woman. Her diagnosis is social phobia: anxiety and avoidance. She appears in a panic-stricken state and complains of being unable to cope with studies, people in general and her boyfriend.

Jane S. is 26 years old and an unmarried mother. She has a history of psychiatric hospitalisations. Her diagnosis is that of personality disorder: hysterical, tense, sado-masochistic relationships and violent acting-out. She complains of having problems with other people's stupidity and cannot live alone, but when with others, feels exploited.
A detailed description of the control group population sample is as follows:

David F. is 19 years of age. He complains of an inability to show himself to others and feels unable to find himself. He has a history of shoplifting and burglary, which he says is his way of showing himself to others. Diagnosis: character disorder and social inhibition.

Ronald T. is a male of 38 years, has been an RAF Steward and complains of social isolation and insomnia. His brother committed suicide in 1964 and, immediately afterwards, the patient spent 6 months in psychiatric hospital. His diagnosis is depression and suicidal risk.

Robert R., aged 30, is a homosexual who suffers from ill health and the inability to work. His complaints are lack of concentration, inability to adapt, no definite aim and too emotional. His diagnosis is anxiety and depression.

Geoffrey T. is a male of 26 who spent one year in a psychiatric hospital. He mostly fantasises about being big, powerful and independent, due to a preoccupation with his small size. Diagnosis: character disorder with mixed neurotic symptoms - phobic anxiety, depression and social inhibition.

William H. is a male, aged 32. Complains of an inability to work, concentrate or think ahead. Diagnosis: personality disorder.

Sasha M. is a female of 20 years. She complains of being unable to study and feels anxious about school and her relationships. Diagnosis: psychoneurosis.

Melvin B., male, aged 30, complains of the inability to work or make relationships. He appears highly intelligent. Diagnosis: personality disorder.

Rosemary C. is a female of 39 years. She has a history of attempted suicide and appears to be very anxious, fearful and insecure. This condition is aggravated by her new marriage and malignant melanoma. Diagnosis: recurrent depression.

Jeanette G. is a female of 19 years. She complains of nightmares, sleeping poorly, irresponsible with drugs and family problems. Diagnosis: adolescent identity crisis in an obsessional introvert personality; aggressive, nervous and has sexual fantasies.

Harry A. is a male, aged 57. Diagnosis: depression, obsessional personality disorder, perfectionist. He complains of work problems, headaches, difficulties with sleep, and sometimes he is incoherent in speech.

George W., male of 59 years. Diagnosis: endogenous depression. This man is a heavy smoker, suffers from poor health, appears tense, over-conscious and a depressed personality.
The experimental population consisted of patients who attended the above psychiatric day hospitals. These individuals characteristically suffered from anxiety, depression and the inability to work. However, they were capable of living in their own homes and also of travelling unaccompanied. They attended the day hospital 5 days a week, were given travel expenses, lunch and unemployment benefits.

The heterogeneous population attending psychiatric day hospitals have diverse diagnostic classifications which represent a wide range of psychoneuroses. Personality classifications such as hysteria, sadomasochism, mild anorexia nervosa, and the like, are seen as treatable in the day hospital setting. The disorders more difficult to treat with psychotherapy, such as those labelled psychosis and sociopathic behaviour, are more often referred to full-time in-patient psychiatric units.

The patients who exhibit personality disturbances represent the largest attending majority within the day hospital setting. These personality disturbances include those labelled with depression, self-denigration, ambivalence, the inability to make decisions, confusion over sexual identity, inability to develop deep relationships, anxiety states, panic states, and many various phobic states, including social phobia, sexual phobias, inability to regulate eating, various compulsions, suicidal tendencies and so forth.

In order to give a more detailed picture of the experimental sample, the following are case file descriptions of each individual patient in terms of personal complaint, history and diagnosis.

Experimental group population:

David D. is a 24 year old male who had a history of receiving prior psychoanalytic treatment. He was referred to Paddington in 1972 with a diagnosis of overt depression, given to violent acting-out, and unable to work at his profession of carpentry. He was put on medication of diazepam 10 m.g.m. t.d.s., which was later changed to chlorpromazine 100 m.g.m. nocte.
Kathleen G. is a female aged 24. She complains of having a lack of self-confidence, frightened to travel on her own, no friends, and family problems. Diagnosis: depressed, obsessional personality disorder.

The range of problems the above patients suffer from vary widely, but usually constitute a handicap that is social in nature. The difficulties could be called "living-one's-life" problems, where the patient is fully aware that he or she is having problems, and struggling to overcome them.

THE SETTING

The experiment took place within the normal day-hospital setting. The day and time of the experimental and control group meetings were the same throughout the duration of the inquiry. The same room was used during the 6-month time periods, and the group meetings in no way interrupted other functions within the hospital structure. Group members were informed at the beginning of the programme that the group would meet for a 6-month duration and the last 3 weeks were spent working on the eventual separation of the group.

Group members were never forbidden to communicate their experiences to the rest of the hospital and, on occasion, their feelings about the group sessions were discussed in the community meetings.

The investigator led the Gestalt Therapy sessions and an occupational therapist led the control group painting sessions.

At no time were any of the group members requested to leave the therapy sessions.
Patients treated at psychiatric 'day' hospitals typically suffer from anxiety, depression and the inability to work. The cases accepted in day hospitals are not of the severity to warrant 24-hour patient treatment. The treatments available to day-hospital patients usually consist of individual counselling; small-group therapy of an analytic type; large, unstructured community groups; occupational therapy workshops using music, poetry and art therapies, and the administration of anti-depressants or tranquilisers in certain cases, to modify anxiety, depression and aggressive behaviour.

Both control and experimental groups received the above treatments. In addition, the experimental group received approximately 2½ hours of the Gestalt therapeutic treatment per week. This consisted of mainly focussing upon the patient's neurotic mechanisms (see mis-directed behaviour), working on awareness training of the present moment in time continuum, and working through dreams on Gestalt lines.

The control group received normal day-hospital care, but no direct exposure to the Gestalt method. The control group did receive approximately 2½ hours per week of equal time in a painting workshop organised by an occupational therapist.

The treatment used with the experimental group was carried out in six phases:

I - Trust Exercises
II - Body loosening and Bio-energising
III - Focussing and Awareness training
IV - Developing Imagery and Fantasy faculties
V - Gestalt Dreamwork
VI - Termination of Treatment
Phases I through III consisted of three sessions each in duration. Phase IV lasted for two sessions. Phase V lasted approximately 12 sessions in length. Phase VI occupied the final three sessions.

Exact detailed descriptions of every event occurring during the entire 6-month period would be tedious and uninformative. The writer instead wishes to describe the basic procedures used in the researched experimental group. This will be accomplished by giving direct examples taken from the experimental group setting.

**Phase I - Trust Exercises**

The first phase, Trust Exercises, aimed to develop group cohesion and trust between group members and the therapist. In the first session the group was asked to sit on cushions in a circle on the floor. Then, each person was asked to introduce themselves and to speak about their feelings at the moment. Following this, the group was requested to stand and select a partner to accompany each other in several exercises. The first exercise was to stand and touch one another with eyes closed. This was in order to explore the person with the sense of touch and to discover the other person without looking or talking to them.

This continued a long time for some, as well as a very short time for those who rather feared keeping their eyes closed or touching other people. The group was asked to share with their partner the feelings that occurred during the exercise and to attempt to verbalise what they may have discovered by direct contact instead of verbal or visual means.

Next, the group was asked to pair in new partnerships and to decide between themselves who would be the active explorer, and who would be the passive receiver. Once the pairs had made a choice between themselves, the passive receivers were asked to lie on the carpet and relax as much as possible.
The active explorers were asked lightly to touch their partner in such a way as to explore the physical perimeter of the head, face, shoulders, arms, torso, hips, legs and feet. In doing this, the active explorer was to keep their eyes closed, and to remember that the passive receiver was feeling every touch and taking this sensation into his body.

A good deal of time was spent in this exercise, after which the roles were reversed between partners. Later, the pairs were requested to discuss how they felt to be both active and passive, what they felt when the exercise was in progress, and how much they could trust one another and the group.

The remainder of the session was left to discuss the feelings that developed from the exercise and to give the patients time to get accustomed to one another.

The second session continued with trust exercises, only this time the exercises started slowly to grow into more physical and energetic activity. First, the therapist asked the patients to sit upon cushions and to take a few moments to focus their attention on their breathing and the feeling of being in the room. Next, the participants were asked to take their hand and, on exhalation, to stroke their chest, starting from the neck, travelling slowly down until they reached the lower abdomen. They were asked to continue this until they felt relaxed and comfortable in their body.

Now, the therapist asked if there were any effects or feedback the participants would like to share with the rest of the group. Several minutes were spent in dialogue discussing the nature of touching oneself and other people.
On conclusion of feedback, the group was asked to pair so that partners were of roughly the same size and weight. They were asked to stand one behind the other, and to allow the one standing forward to fall backward into the catching arms of their partner. The therapist demonstrated this exercise as part of the instruction.

When the group of pairs began to carry through the instructions, the therapist visited each pair, ensuring that the "faller" and "catcher" were actually following the exercise correctly. The aim in the exercise, the therapist instructed, is to see if you can trust your partner enough to catch you. The group was instructed to continue the exercise until one felt secure in falling backward with all their trust. Once accomplished, change roles and allow the falling person to catch.

As the activity finished the group was asked to sit with their partners and to describe to one another the feeling of falling, first at the beginning when the exercise was possibly fearful, then as the exercise became more automatic. As well as describing the feeling of falling, the participants were requested to share the feeling of catching another person, and to discover whether they felt fearful, powerful, responsible, numb or exhilarated by the activity.

The group was then asked to sit in a circle and share whatever they wished with all the members together. This time also allowed the patients to relax and regain steady breathing.

The request was then made to select new partners and to sit back-to-back. In time, the members were asked to slowly rock back and forth in unison with their partner, so that a rhythm developed. Then the group was requested to make sounds that went along with their feelings and to make the sounds in unison. This exercise continued for some time, then concluded in quiet breathing and soft humming.
The therapist then requested all participants to stand with hands clasped together in a circle. The members were asked to release hands and to note how it felt to stand in a circle with the others. The patients were asked to verbalise these feelings.

The patients were then asked to turn their backs on the circle and to look toward the walls of the room. They were requested to verbalise this new perspective and to explore what these feelings meant to them. The group was then asked to turn one quarter to the right and verbalise how one felt when one person stood behind and another in front. The patients were then asked to close their eyes and note what this act did to their feelings.

The remainder of the group sessions was spent in talking about the difficulties of trusting those in the group, those in the hospital and those in one's private life. This session helped to verbalise the closed-in feelings sometimes present in a group therapy situation.

The third session began as a form of game. All participants stood in a circle holding hands. Then one participant was asked to walk across the circle while still holding his partner's hands, and to go under between the arms of the people on the opposite side of the circle. The adjoining partners followed, and in a short time the whole group became a human knot of entangled persons. The therapist suggested not to let go of holding one's partner's hand and to continue until the confusion became untangled. This lasted until the circle returned to its original form, and proved both exhilarating and trust-promoting.

As the spontaneous discussions slowly ended, the therapist suggested that the patients should form themselves into self-chosen groups of three. Once accomplished, they were asked to sit in triads and to share with one another how much they could trust the others in the triad. The patients were also asked to try and create stories or fantasies concerning the degree of trust they could have in the other partner.
After 15 minutes the group members were asked to discover how many secrets they might be holding from the other individuals in their triad, and to see if it were possible to share any of these secrets at this time. If an individual was unable to share his or her secret could they now tell the others how one might respond to the learning of such a secret.

After approximately 10 minutes had elapsed, the therapist stated that the group members should take an additional 5 minutes to finish whatever else they needed to say.

The group then met together as one standing circle. The therapist suggest each now select one new partner with whom they had not worked before. They were asked to stand back-to-back with their new partner and to decide who would be the one to lift and who would be lifted. In this exercise, called the back-lift, the "lifter" bends his legs, places his arms around the arms of his partner and bends forward, pulling his partner comfortably to rest on the centre of his back. The lifted partner is to remain for several minutes dangling his arms and legs and breathing deeply. While the instructions were given, the therapist demonstrated the exercise with one of the group members. When the lifted person had had enough, he would be let down and the roles would be reversed.

Once again, the group members were highly excited and energised by this exercise. The therapist then suggested that the couples should sit quietly back-to-back. The instruction was given to slowly move backward and forward in unison and to hum together with one's partner. This continued until both partners felt warm, comfortable and relaxed.

The session concluded with the group gathering together in a circle on the floor. The therapist suggested that each person share verbally the feelings that this experience produced and also share past memories aroused by these feelings.

Critique of Phase I

As noted above, the first phase of work consisted of entirely therapist-directed activities designed to promote trust in the group members for one another. Most of the above trust exercises were implemented by following the directions of Lewis and Streitfeld (1971). One criticism concerning this approach is that all the activities were therapist-initiated, thus excluding patient self-assertiveness. This may be a valid criticism of the method which tends to make the patients dependent upon the therapist to tell them what to do next.

Since the present therapeutic technique was designed as a progressive programme, spanning a 6-month period, this fault can be corrected as the programme continues. The reader will find that the directiveness of the therapist will call for a wider range of responses. By applying well-defined and limited activities for the initial sessions we can aid the developing of trust within the group setting.

Phase II - Body Loosening and Bio-energising

The fourth session began the second phase of work - body loosening and bio-energising. The purpose of this phase was to bring about a more dynamic unfolding of the personality both by freeing physical expression and increasing body awareness.

The session began by asking the patients to take off their shoes and any loose jewellery they might be wearing. The group members were
asked to select a partner who was about their same size and weight, and to face each other at a 2-foot distance.

The first exercise asked the individuals to hold hands by interlocking fingers and to push one another while shouting "No", "Go away", or "Leave me alone". The patients were encouraged to do this as fully as possible, but to sense how much the other partner could accept in their pushing without being over-whelmed. This continued with much laughter, until tiredness developed.

The therapist then suggested that the same partners now hold hands and pull their partner instead of pushing. The patients were requested to shout "Come here", or "Come to me", or "I want you near me" throughout the exercise. After the therapist had demonstrated the procedure the patients engaged in the exercise and continued until natural tiredness ended the activity.

Then the therapist asked the patients to change partners and to stand back-to-back with their partners. The therapist demonstrated that now the patients should push one another by applying pressure backward into the person standing behind them. They were requested to shout "Get off my back", or "Get away", as well as to push their partner with different parts of the back in order to stretch and stimulate all the areas of the neck, shoulders, back and legs. This exercise continued until fatigue concluded the activity.

Now the back-lift was initiated for a second time to stretch the body as well as to stimulate trust between group members. This time, the exercise was prescribed as a slower activity, to be done several times, back and forth between both partners. The therapist requested that patients should try and discover where they might still be holding tension in their body and to attempt to let that tension release. This was done in order to heighten the sensation of flowing
blood (the feeling of energy) into all regions of the body.

When this exercise concluded, the patients were asked to make additional movements that would help loosen any other physical stiffness and to heighten proprioceptive sensations. They were also asked to make sounds that went along with the movements, such as humming or singing, or the like.

After several minutes the patients were asked to stand with their legs apart about 2 feet in distance. They were requested to bend their knees, let their arms hang, and to close the eyes to concentrate on the feeling of energy flowing throughout their bodies. This lasted for about 3 to 5 minutes. The patients were then asked to bend forward from the pelvis and to allow their arms, chest and head to hang freely. They were told to breathe deeply, to allow the knees to stay flexible and unlocked, and to relax in this hanging posture.

When the patients were ready to stand erect, they were requested to lift their back one vertebrae at a time and to allow the head to be the last part of the body to stand straight.

The remainder of the session was spent in discussion, sitting on the floor. The patients were asked to describe what tensions appeared chronic in their own everyday physical experience. This led to a discussion on what kinds of emotional attitudes might produce certain physical pains and rigidity. During this time, several yoga positions were introduced to demonstrate how to loosen tensions in the neck and shoulders.

The fifth session began with an exercise asking each individual to describe his or her awareness. This was done by requesting the patients to make a stream of sentences starting with "Now I am aware...". The patients were required to complete the sentence with observations.

* From Gestalt Therapy, Perls, Hefferline and Goodman (1951)
of their emotional and physical awareness, as well as statements concerning the people and objects around the room. This was done in a circle and each patient gave at least three or four statements.

When this exercise concluded, the patients were asked to stand and to shake their arms and shoulders in order to produce a tingling sensation throughout these regions. Once this was done they were asked to shake each leg individually to accomplish the same goal. Then, the patients were asked to stand in a circle and to vigorously pat the back of the person in front of them to stimulate energy flow. They were then asked to turn around and pat the back of the one who had stood behind them.

When this was completed, the patients were asked to lightly jump up and down. When landing on the ground the patients were requested to bend the knees and make a deep, low sound from within their stomach.

When fatigue developed, the patients were requested to stand with their legs apart and to bend the knees and feel once again the sensations of tingling throughout the body.

They were then asked to stretch their arms, one at a time, straight up into the air, as though they were picking grapes which grew above their reach. With each stretch upward they were asked to inhale deeply. When they could not breathe in any more air they were to exhale and allow their torso, arms, shoulders and head to hang freely by the pelvis, keeping the knees bent and flexible. Once ready to inhale again, they were to resume the activity of "picking grapes". This exercise continued until fatigue slowed activity; then the patients were asked to rest in the hanging-over posture.

After remaining in the "relax hang" posture for several minutes, the patients were requested to jump up and down, landing on both hands and feet. They were asked to make deep sounds on impact and to look
at one another throughout the exercise. This continued for several minutes with great laughter and fun. Some patients found the exercise difficult to do.

When exhaustion slowed down the activity, the patients were asked to lie upon the carpet on their backs. They were requested to keep their feet flat on the floor, with their knees up in the air, and to breathe very deeply and rhythmically.

After about 6 minutes had elapsed, the patients were directed to lift their arms from the ground to above their heads when inhaling, and to bring their arms down to their sides on exhalation. They were to continue doing this as though swimming on their backs, only to stretch as much as possible on inhalation and to press out as much air as comfortably on exhalation. They were told to do this rhythmically and comfortably.

After several minutes, they were told to continue the exercise, but to now spread their knees apart on inhalation and to bring the knees together on exhalation. At the same time, they would roll their lower back up off the ground when inhaling to increase the amount of air going into the stomach, and to bring the pelvis toward the chest on exhalation to force the air out.

The patients were told the exercise was called the "gilly fish", and that they could co-ordinate the total body to move as though through water. The therapist then went around to individual patients who had trouble in co-ordinating the movements and gave these individuals instruction while the others were doing the exercise.

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* Taken from A. Lowen (1967)
The therapist told the patients to continue the exercise until tired, and then to rest with feet flat on the floor and knees spread apart. After feeling rested, they were to continue the exercise again, but not to push while doing the exercise. This point was stressed twice.

After this rhythm of exercising and rest for about 20 minutes, the patients were asked to form a circle and to comment on the exercises. After a discussion, the awareness continuum exercise "How I am aware.." was again performed. Each patient in turn now gave more than five to six statements, where most of the comments pertained to physical awareness. The session ended after a concluding discussion on physical risk-taking in the therapy situation.

Session six began as a feedback discussion. The patients were asked to share with the group how they felt in the moment about themselves being in the therapy room. After a discussion, the therapist asked the patients to once again remove their shoes and any loose jewelry that might break during the physical exercise.

The group was then requested to select new partners who were approximately their size and weight. Then the same sequence of exercises was initiated as in session four. First, the forward pushing with partner’s fingers intertwined was initiated and the patients were again encouraged to shout "no", "Go away", or "leave me alone". Then the therapist engaged the patients to pull one another by the hands while shouting "Come here" or "Come to me".

Next, the therapist asked the patients to change partners and to push one another with the back, while shouting "Get off my back", or "Get away". In concluding the sequence, the therapist asked the patients to "back lift" their partner and then to switch roles.
After these initial warming-up exercises, the patients were asked to stand in a circle and to acquire enough space so that they could swing their arms in all directions and yet not intrude into another person's space. Once this was done, the therapist demonstrated the following sequence of exercises.

First, the patients were asked to raise their hands, arms and elbows to the same height as their shoulders. Then to inhale as deeply as possible while pushing the arms as far back as possible, so the elbows could almost touch. This was done so that the chest could fill to full capacity with air. On exhalation, the arms were pushed forward, attempting to press the air out from the lungs and to stretch the shoulders, neck and back. This exercise continued for about 2 to 3 minutes.

Now the patients were asked to place their left hand on their left hip. During inhalation, the group members were to bend toward their left side as far as possible, while inhaling as much air as they could into their lungs.

The patients were asked to bring their right arm over their head, pointing their right hand to the left and to inhale even more air until they could not press another drop of air into their lungs. On exhalation, the patients were asked to leave the left arm on their hip, but to return to a vertical stance with their right arm returning to their right hip.

This sequence was performed ten times, then the reverse was initiated. The patients were told that the purpose of the exercise was to expand the chest and lungs so that more oxygen could be brought into their metabolism.
Now, the patients were again asked to perform the "picking grapes" exercise. They reached as high as possible, breathing more and more air into their lungs, then exhaled and hung their head, arms, and chest from the pelvis. They were asked to bob their knees up and down and to keep to very subtle movements occurring during exhalation. Then inhalation again, continuing the exercise for about 10 minutes with rest periods of hanging from the pelvis.

After the patients had completely rested in the hanging from the pelvis posture, they were asked to again raise themselves to a vertical position by lifting one vertebra at a time until the head was raised last in the sequence.

The patients were now asked to shake their legs several times so that awareness and energy could be felt in the leg regions. The patients were then asked to jump as high as they could into the air and to land flat on their feet, bending the knees and making a deep sound on impact. They were asked to continue this for as long as possible, and when it was impossible to persist any longer, to fall on the floor.

When the group fully recovered from the jumping exercise, they were asked to lie on their backs with their feet flat on the floor and their knees off the ground. They were told that the next exercise involved the legs and pelvis in order to stretch and bring added awareness into these areas of the body.

The first instruction was to lift the legs off the ground into a vertical position. Then to lift the heels of the feet higher than the toes to stretch the back of the knees. They could support the pelvis in this position by placing their fisted hands under their buttocks.
During this exercise, the group members were told to continue to breathe fully and deeply and to make soft sounds to help concentrate on breathing, as well as to release tension. They were also told that the exercise would begin to cause their legs to tremble uncontrollably, but that they should not worry because the trembling was a desirable effect of the exercise. The trembling would help reorganize energy in the legs and pelvic regions. The patients were told that if they became fatigued with the exercise, they could rest by placing their feet flat on the ground and their knees apart. They could then make subtle movements of the pelvis to loosen any tensions in the area of the sacrum.

This exercise lasted for about 20 minutes, after which the group was asked to form a circle and to sit on the floor. The patients were asked to sit quite still and to feel where in their body they still felt rigid and tense. Several participants commented that their neck and shoulders remained as regions of tension or pain.

The group was then invited to place both hands on the floor and to stand on the knees. They were told to make as much sound as possible and to try and push the floor away from them. They were given the added instruction to imagine that whatever might bother them emotionally should be externalised on the floor where they were pushing. With this, they were told to get as angry as they possibly could and attempt to get their problem out of their systems.

For several minutes a considerable amount of energy was released into this exercise. The therapist kept encouraging the patients to allow their expressions to continue. This helped the more inhibited patients with the exercise. When the activity finally slowed down, the patients were directed to continue only subtle movements that were soft and
comfortable. They were also encouraged to breathe softly and deeply
during this resting period.

After about 15 minutes had passed, the group was again invited
to sit in a circle and to give feedback about their present feelings.
The patients were also encouraged to imagine to whom and in what
situations their anger might be directed. They were asked to share
these thoughts with the other group members.

After the discussion the patients were asked if they could leave
the therapy situation and feel comfortable to continue their other
activities. The response indicated that there were no immediate adverse
effects from the intensive physical exercises. The therapist concluded
the session by asking the patients to remain with their physical
sensations and to concentrate periodically on their physical awareness.

Critique of Phase II

As one can note, the patients were brought from inter-personal
games aiming toward trust and security within the group atmosphere to
activities that concentrated on physical awareness and tensions within
the body. The range of exercises began first by lightly freeing the
tensions of muscular armouring in the shoulders, neck, chest and legs.
Later, the work became focussed on specific regions of chronic tensions
and rigidity, as in the arms, shoulders, chest, diaphragm and pelvis.
The expressions of aggression and tenderness was the final exercise
toward freeing muscular expressions.

One can notice throughout the procedure a flow between extension
and relaxation. The greater the physical expression, the longer and
deeper the recovery and relaxation. Thus, the amount of energy
invested in holding back physical expressions was directed toward
expressing free movement, sound, sexual pleasure and aggression.
In this way, the degree of free expression was programmed from a
light, playful exercise toward implementing deep muscular de-armouring techniques. The purpose of incorporating bodywork in the therapy programme was to promote a more total unfolding in the ability to express emotions to begin a process of heightening physical awareness.

Phase III - Focussing and Awareness Training

The next three sessions dealt mainly with keeping physical awareness as a fluid background to sensitivity training.

The patients were first asked if there were any feedback related to the last session. Some patients reported that they felt less tense and aggressive since the session. Others stated that certain muscles in the back and legs felt tender for several days after the exercise. One or two individuals commented that the work was very threatening, but they also felt the group safe enough to continue attending. These patients implied that they needed to be more physically angry but feared being so.

After this discussion, the therapist informed the patients that the work would now focus on awareness training. The patients were asked to first stand up on one foot and to bend the leg at the knee. They were requested to breathe deeply, to attempt to imagine that their foot was 2 feet below ground, and to balance by allowing their weight to become as heavy as possible. With their other leg, the patients were instructed to rotate the foot at the ankle, and then later to rotate the leg at the knee. After several minutes leg position was reversed and the same instructions were given again. This exercise was given twice for each leg.

Once completed, the therapist asked the patients to sense if there were any changes in perception from the exercise. Several patients said they were closer to the ground and felt more physically secure. The therapist stated that relating to the physical sensations
of standing on the ground would promote greater feelings of security. Chronically to think thoughts which had little to do with one's present situation would lead to feelings of insecurity.

The next activity was to ask the patients to select a partner and to sit facing one another. The patients were told to talk to each other in the present tense by stating what visual, auditory, or feeling experiences they were in contact with. The patients were told that at every moment a different awareness was present, and by contacting this flowing awareness they would be able to continue the exercise for long periods of time.

After approximately 15 minutes, the patients were directed to stand with their partner and to "mirror" their partner's actions. They were instructed to do this in very slow motion, to breathe deeply, and to make sounds that expressed the feelings the movements produced.

After several minutes, the patients were asked to change roles and the leading partner would now follow. When several minutes passed, the group members were instructed to follow each other as in the form of a dance, but to move very slowly, breathe deeply and attempt to move together. As the group members continued this exercise, they were requested to feel their movements and to concentrate on breathing deeply and rhythmically.

In time the group was asked to change partners slowly and to dance in this slow-motion fashion with another person. When fatigue became evident, the patients were asked to sit in a circle on the floor.

Feedback was then requested from the group concerning how they felt in the exercise. A discussion developed on the problems of co-ordinating one's breathing, one's movement, and the ability to follow another person's movement. The therapist informed the group that being able to switch perceptions rapidly would allow for periodic awareness of breathing,
then sensations in one's own body, and then viewing another person's movements. By viewing one perception at a time, a flow can develop, incorporating all the functions together. An example was given concerning the co-ordination of many different functions when learning to drive a motor car.

Following this discussion, the group was asked to face the person next to them and to hold one palm against the palm of their partner. They were asked to feel the sensations and to attempt to describe the experience to their partner. After several minutes, the patients were asked to create a space between the palms and focus strongly on the sensations occurring in the space. They were requested to continue the exercise but to move more slowly and see whether the sensations altered in any way whatsoever. Finally, the patients were directed to communicate the experience to their partner and compare how each individual viewed the experience differently.

After some time, the patients were directed to stand once again. They were asked to jump as high as possible and land on the ground with flat feet and knees bent. This time they were asked to pause and focus their attention on what occurred to their body immediately after impact. They were asked to feel where in their body the shock of landing could be felt, and where in the body the shock had no effect whatsoever. The patients were told to continue the exercise until they could feel the shock of landing in every corner of their body; then to sit down when fully energised with the familiar feeling of energy and blood flowing throughout their body.

When everyone was finally seated, the patients were told to pat lightly with their fingers and hands the top of the head, ears, neck and face. Then to continue the patting on the shoulders, then down each arm in turn. After this, the patients were asked to pat their chest and sides until a tingling feeling developed in those regions
of the body. Once completed, the patients were directed to pat the thighs, legs and lastly the soles of the feet. When finished the patients were asked to pat the back of the person sitting next to them, in order for a tingling sensation in their partner's back to develop. They were asked to also reciprocate the back-patting with their partner.

The group members were told that for homework they should attempt to maintain awareness of their physical movements. When walking, they should concentrate on walking; when sitting, to concentrate on the feelings of chair meeting body; when doing any physical labour, to maintain awareness of the feelings of movement.

If the body awareness became too low or confusing, the patients were told they could engage themselves in movements and actions that would re-energise the feeling of blood flowing throughout their bodies. This would help bring back heightened physical awareness. The patients were also asked to pay close attention to their breathing process and to discover when and under what circumstances their breathing became shallow or restricted.

Session eight was devoted to focussing and concentrating on external and internal stimuli. As described on pp 53-72 of Perls, Hefferline and Goodman (1951), the session followed the format of this reference. The patients were first shown a painting and asked to trace the primary shapes from the background. Then they were asked to look at the foreground, then mid-ground, and lastly the background. They were asked to continue to look at the painting and see whether they could discover anything which they may have missed.

After considerable discussion a second painting was introduced and the patients were asked to do the same exercise with this new picture. Finally, a third painting, entirely different from the first two, was revealed. In each case, the patients were asked to perform
the same exercise of visual de-structuring and re-constructing.

After a lengthy discussion on the process of gestalt formation and destruction, the group members were asked to turn their attention to a symphony being played on a tape-recorder. The patients were asked first to listen to each individual instrument, one at a time. Then they were asked to listen to the background instruments. After this instruction, they were requested to listen to the melody. Later, they were asked to listen to the harmony of certain different instruments. Then they were asked to look for any hidden melodies or harmonics which they might not have expected in the composition. In summary, they were asked to listen for the individual figure/ground formations that were within the music.

A second recording was played to the patients. They were asked to perform the same figure/ground structuring/de-structuring process as before. Only this time, they were asked to attempt to attend to the spaces between the sounds of the music.

The same perceptual experiments were performed with the use of a fruit. Every group member was given an orange and then asked to feel the texture and temperature of the outside layer. They were asked to close their eyes and just smell the orange. They were then directed to feel the weight and consistency of the object. In time, the patients were asked to slowly peel the orange and look at the intricate construction lying beneath the skin of the fruit.

Next, the orange was split into small pieces and the patients were asked to notice the texture, colour and consistency of the individual segments. Then the patients were asked to place one segment of fruit in their mouth and to focus on its size and temperature. Lastly, they were asked to chew the food slowly and to follow the changes of temperature, taste and consistency as they worked on destructuring the fruit. They were encouraged not to swallow the orange until
completely liquified and destructured. This exercise then continued for the rest of the fruit.

A spontaneous discussion then occurred where many of the patients commented that they had never known such an active process of awareness was feasible. Others commented that they had been introduced to a similar activity in art class, but never knew it could be applied to every-day functions. The discussions continued until the therapist asked the patients to lie down and feel specific parts of their body.

First, the patients were asked to feel the inside of their foot and to trace the inner perimeter of that region. They were asked to discover how wide, how long and how deep they could feel their inner environment of the foot.

The same instructions were given for these additional parts of the body: the legs, thighs, pelvis, genitals, abdomen, chest, back, shoulders, arms, hands, neck and skull. They were then asked to feel the inside of their face and to discover what was the expression on their face from inside the body.

The session concluded with instructions for homework: to practice looking at the world with this destructuring and restructuring process; to concentrate on specific parts of the body at different times of the day; to look at one colour at a time for 10 or 15 minute intervals, and to attempt to engage oneself in active observation of objects, sensations, and emotions.

Session nine began with feedback concerning the homework. Several patients commented that the activity of conscious gestalt formation was very interesting because it allowed an alternative perspective of the world to develop. Others found the exercise promoted security feelings and gave the impression of "knowing where one stood". A few individuals
agreed that the exercise was too difficult to continue for any length of time, and felt they could only do it for small periods of time.

After this discussion, the patients were asked to make statements starting with the words "Now I am aware..." or "At this moment I am aware.....", in order to verbalise a stream of clear perceptual figures. When each patient began a stream of statements starting with the "Now I am aware....." sequence, the therapist might occasionally assist to help sharpen and refine the focussing process.

After each patient completed the experiment, the therapist requested the patients to group themselves into pairs and find a private place within the room to sit. They were instructed to take the roles of "traveller" and "companion" and have the traveller re-visit the path he took to the hospital that morning. The patients were instructed to describe in full detail the sights, sounds, colours, trees, people and the feeling tone that was present during the journey. The dialogue between the pairs was to remain in the present tense, as though the traveller and companion were journeying together. The companion was instructed to keep the traveller in the present tense and to ask questions such as "What do you see now?", "Can you feel yourself doing this?", "Is there any smell?", "Can you describe that in greater detail?" and so forth. The travellers were told they could close their eyes if that would help, and to describe their perceptions in clear figure/ground formations.

The patients were given 15 minutes to do this experiment. After this time they were to discuss how clearly and totally the traveller was able to see, feel, touch, smell, taste and genuinely contact his journey. After the discussion the roles were reversed.
When the whole process was complete, the pairs were asked to return to the group and to feed back how they had felt doing this experiment.

After the feedback, the patients were told that they would undertake a second journey, but would first have a recess of about 10 minutes. The patients were given time for tea and to relax before the next stage of work began.

When all the patients returned to the group room, the therapist asked everyone to remove their shoes and any loose jewellery that might break, because several physical exercises would be performed. The patients were then told to stand and shake their arms, shoulders, legs and head, each in turn. This was done to loosen the musculature and start a flow of energy. Then the patients were asked to jump up and down, landing flatly on the feet and bending the knees on impact. They were told to do this in pairs and make a loud, deep sound on impact. When finished, the patients were asked to stand with their legs apart at a 2-foot distance and point the toes slightly inward. They were instructed to raise their arms out to shoulder height and to open their jaws and breathe deeply.

They were asked to continue in this posture until they could not stand it any longer, and then to fall on the floor. When the last person lay down, the patients were given the instructions to select a new partner and find a space in the room where each pair could be free to move.

Then they were told to select who would be "traveller" and "companion". The traveller would now journey to a favourite place where he or she felt good and happy as a child. This time, the patients were told to lie on their backs and cover their eyes with a cloth or sweater to subdue the outside light. They were instructed
to make a journey to various places of childhood and describe fully what they see, hear, smell, touch, taste and feel. The "companion" was told periodically to ask the traveller "what do you see now?" "where would you like to go now?", and so forth.

The patients were told they had between 20 to 30 minutes to work on their ability to contact clear figure/ground formations. After this time, they could journey back to the hospital and then discuss with their partner how the journey felt in total. The patients were informed that they were working on improving their sense awareness and that it was important to describe in the present tense as though the scenes were occurring here and now. The patients were encouraged to do the best they could in reporting their experience. During this time the therapist visited the pairs and listened to the progress of the journey.

After both partners had the opportunity to travel, the patients were requested to form a group again and to give feedback about their journeys. After sharing the experiences and discussing the technique of fantasy journeying, the therapist reminded the patients to work on improving their sensory awareness of the present moment. The awareness continuum exercise, "Now I am aware...." was used to conclude the session.

Critique of Phase III

The last three sessions attempted to train the patients in awareness techniques which support the Gestalt figure/ground methods. The awareness training was first introduced to heighten physical awareness and later moved to the domain of sensory awareness. The therapist presented this transition as a continuum from inner physical sensations to outer sensory awareness. The worked touched upon a field
of activity that could easily warrant more time for presentation to
the patients. In fact, one can use the above theme to constitute a
programme of 6-month duration on its own. The present writer found
the necessity to shorten this important training so that other basic
Gestalt methods could be researched.

The last aspect of work, the fantasy journey, has to be reserved
for the non-psychotic. With this method, a patient would need to
clearly differentiate between what is fantasy and what is actuality.
Should a patient be unable to do this, the method could prove dangerous
and unproductive.

Phase IV - Developing Imagery and Fantasy Faculties

The next two sessions were devoted toward helping the patients
develop fantasy and imagery capacities. This was done to facilitate
the primary phase of work, the Gestalt dreamwork.

In session 10, the patients were informed that for the next two
sessions the use of fantasy journeys would be employed to help stimulate
both dreams and sensory awareness. The patients were given bio-energetic
exercises to re-stimulate an energetic metabolism. The exercises
dealing with breathing and jumping were given at the start of the
session. Then the patients were asked to stand with their legs 2-feet
apart, knees unlocked, toes slightly pointed in, and arms held at
shoulder height. They were asked to breathe deeply and to stay in this
posture for as long as possible. When they could not stand any longer,
to allow themselves to fall on the floor.

The therapist then asked for a volunteer who would help demonstrate
how to travel in a self-guided fantasy. A man volunteered and was asked
to lie on his back and breathe deeply. A sweater was placed over his
eyes and he was asked to picture a meadow. He was then asked to describe his meadow and the patient began to give a vivid account of this picture.

After his description the therapist asked "where are you in the meadow?" The patient then commenced to describe his position and view of the meadow. The therapist then said, "where do you wish to go in your journey?" The reply started the fantasy journey and most of the therapist's interventions were as follows: "where do you want to go now?, "what do you see now?" "Can you get closer and describe in greater detail?"*

About 10 minutes later a pause occurred in the subject's adventure. The therapist asked if the patient could stop now and continue with his partner. The patient agreed and they both rejoined the circle.

The patients were then asked if the process was clear and were there any questions. Then the patients were instructed to select a new partner and decide who would be traveller and who would act as companion. The patients were given the starting image of a meadow. They were requested to describe their meadow as vividly as possible and to picture themselves in the meadow as well. They were told that anything could happen in a fantasy; and so one could be and do whatever one liked. They were also invited to allow an adventure to occur and to make sure they remained an active person in the adventure. This point was stressed - that the traveller was the active, living person, creating the fantasy, and that the fantasy itself was not the active component. The "companions" were told not to get involved with the fantasy aspect, but to be available for the physical body of the traveller. If the traveller were walking, then they were to encourage

* For a complete description of this technique, see Leurner (1969)
him to move his legs. If the traveller were climbing then the companion was to encourage the use of the arms. If swimming a river then encourage the use of the body in that way. Thus, the companion was to focus his attention on the physical body of the traveller and not be overly concerned with the fantasy itself. The companion was also requested to ask questions, as was instructed in the demonstration.

The patients were given 30 minutes each to travel in their fantasies. They were told that when this time ended, they should encourage the traveller to return to the room in the hospital via fantasy. When the adventure ended, the patients were instructed to discuss their fantasy in terms of how the issues in the daydream coincided with the issues in one’s life.

After the discussion, the traveller would change roles with his partner.

When all the patients concluded their journeys the group was asked to sit in a circle and share feedback about how their individual adventures progressed.

During one woman’s description, the therapist asked if she could go into greater detail about one specific image, a tree. After some description, the therapist asked if this tree reminded her of anyone that she knew. At that point the woman cried strongly and revealed that her husband had died several years ago but she could not accept his death. She said the tree was so much like her husband, and she could perhaps accept that her husband was now dead. This brought the group to emotionally share their feelings with one another and caused the group members to become closer through these feelings.

After considerable discussion and sharing, the therapist asked if the individuals felt strong enough to conclude the session. The patients responded that the experience was very intense but not at
all threatening or embarrassing. The session ended at that point.

In session 11, the same procedure was followed as in session 10. The only difference was that new partners were selected and a different starting image was given.

The second starting image was to begin in a meadow. The traveller would then look for a stream in his meadow and follow it either to its source or to the ocean. The adventure that followed would be entirely the traveller's own invention.

The patient acting as companion was asked to seek more detail from the traveller and to ask for increased physical expressions.

Each individual traveller was given between 45 minutes to 1 hour for his or her journey.

On conclusion of the first traveller's journey, the pair was asked to discuss how the journey related to their own life circumstances. When these discussions concluded, the partners were to change roles and start the second adventure.

On conclusion of all the partners travelling, the group was asked to rejoin the circle and feedback their adventures. This developed into a group discussion.

At the end of the session, the patients were told that the following sessions would consist more of individual work.

Critique of Phase IV

The purpose of working on imagery with the fantasy format is to engage communication between one who is travelling in his own phenomenological world and a companion or guide. By engaging the patients to speak of their inner pictures, the therapist accomplishes two important goals. Firstly, all the patients become involved in a form of intimate dialogue with their partner. They share key aspects
of their own personality without having to identify with the content of the images. One can argue that the patient is choosing to verbalise only censored aspects of his visual imagery. This may lead to false impressions of the patient's inner experience - yet this false impression still yields a patient willing to relate some of his inner experience to an outside observer.

The second goal is that each patient should become accustomed to thinking in the form of pictures. This is the particular ability to relate to scenarios instead of relating to words or implied meanings. By reinforcing a free dialogue pertaining to some form of intimate experience and developing the capacity to think in pictures, the next step of work, Gestalt dreamwork, will be more easily attained.

One caution still remains: the psychotic patient who is unable to differentiate and control his illusions should not be allowed to engage in this form of work.

**Phase V - Gestalt Dreamwork**

The main body of the work consisted in following the methods of Gestalt therapy as documented by Perls (1967). This was presented to the patients during the next 12 sessions of therapy. This phase of the therapeutic approach was introduced to the patients as a means of working on individual problems in a group setting. Towards the end of the programme, the work began to concentrate on group interaction and interpersonal relationships.

At the beginning of the sessions, the patients were told they could approach their individual work on three different levels. The first level could be to work on a specific problem bothering them currently in their life situations. The second level of work could deal with their problems in maintaining the "here and now" awareness
continuum as practiced in earlier sessions. The third level could deal with working through of dreams. The patients were informed that the level of dreamwork was by far the most effective means of self-discovery and therapeutic process. In this way, the patients were encouraged primarily to work with their night dreams and explore this mode of Gestalt therapy.

In the beginning of sessions 12, 13 and 14, a fourth alternative was also offered to the patients. If they wished, they could also explore their fantasy journeys and work on the issues that appeared important to them from these imaginary adventures.

Each session started with the "Now I am aware....." exercise to give every patient the opportunity to feed back anything they wished to say. This was done also to help the patients focus their attention on the present moment. After this the patients were given the opportunity to work on themselves by the therapist asking, "Would anyone like to work?" Those patients who were enthusiastic to explore their difficulties would usually volunteer to work on themselves in the group.

Those patients who chose to work on specific life situations were asked to describe when and where these difficulties occurred. Then the patient was asked to imagine that the situation was happening in the here and now and to re-create the scenario by describing the environment where the problem was taking place. Then the patient would be asked to describe the people he was with and also himself in terms of where he was in relation to others. The patient would then be asked to psycho-dramatise the situation and speak directly to the persons or difficulties in the situation. Now, the patient would be asked to role-play those persons in turn, and to have a back-and-forth dialogue between himself and the others (see Part I).
During this time the therapist would seek to discover where a possible top-dog/under-dog conflict was interfering with the patient satisfying his own needs. It is also possible that at this point one or all of the four neurotic mechanisms (see introjection, retroflection, projection and confluence) would have to be worked on with the patient. By applying skillful frustration at the appropriate moment, a possible reconciliation of needs might occur. If successful, the patient would be asked to reinforce this position of reconciliation by role-playing the position to the other members of the group. If it was impossible to find a reconciliation at this time, the patient would be asked to role-play his difficulty or weakness to several individual members of the group. The patient would also be told that this was where he was in his emotional development and urged to attempt to stay with these feelings for as long as possible.

The other group members would now be asked to feed back their experience to the individual patient in question by sharing whatever feelings the work revealed and opened to them. Then the patients would be asked if anyone else would like to work.

Those patients who chose to work on their "here-and-now- awareness continuum" were asked to begin stating their perceptions by using the format "Now I am aware......", and to state every perception, one at a time. The therapist then waited for the point where the patient either lost track of this awareness or avoided certain perceptions.

The work then focused on the missing aspects. The therapist accomplished this by encouraging the patient to focus his attention on a single perception and perhaps also to exaggerate an associated body movement. In doing this, the patient was led to explore fully the specific experience and behaviour. This was done in order to get the patient to take greater responsibility for his activity. Utilising
the awareness training often gave the patient insight into avoidance and chronic behaviour patterns.

When the work reached a closure, the therapist would ask the other patients to feed back their experience of the work.

Those patients who chose to work on dreams were asked first to tell their dream in the present tense. After this, they were asked to speak from the point of view of specific parts of the dream, i.e., "Speak from the point of view of the tree". The therapist chose to have the patients play the role of each significant image as it appeared in the dream sequence. Particular emphasis was placed on the images that had the most power and potential in the dream. These images were concentrated upon, in role-play fashion, until the patient could actually feel the strength and other aspects inherent in the image. For example, if a tiger were in the patient's dream the therapist would ask the patient to role-play until he could feel the power and behave as though he were a tiger. Then the therapist would attempt to locate the top-dog/under-dog conflict in the dream and ask the patient to exhibit the powerful image traits (in this case the tiger) in the under-dog position. This would lead to resolution by having the under-dog stand and support his own rights in the scenario. Often there would be blocks in this, then the therapist might have to work on one of the four neurotic mechanisms before resolution could be complete.

Should the patient voice any self-esteem expressions, then this would be reinforced by asking the patient to say these statements to several group members.

When a patient was unable to achieve resolution, the aspect that prevented the patient from supporting himself was reinforced by the same process. For example, a patient might be encouraged to say "At this point in my life, I am too frightened to tell you how angry I am". 
The material gathered from the fantasy journeys was also treated exactly like the dreams. In this case, the fantasy adventures were seen as a daydream.

Patients who would not volunteer to work, were involved by the therapist in a therapeutic encounter to stimulate motivation and discussion. Through gentle persuasion these patients were slowly taken through their dream material as well as other aspects of the therapy. The present writer found that after all the patients worked at least twice, the inhibited patients were more easily persuaded to invest their energy and work on their dreams.

When resistance was encountered during the fifth phase of therapy, the action of resistance itself became the only issue of work. In other words, the resistance or inhibition of the patient would be worked through by the patient. For example, the therapist would ask "what do you get by not working through your dream?" or "what do you achieve by refusing to express your anger?" or "what is good about resisting these issues?" In this way, the whole focus of attention would concern itself with the act of resistance and not with pushing the patient to say or do anything he did not wish to do.

During the fifth phase of work, many themes emerged from the individual work. For example, the issues of anger, love, sadness, relationships, responsibility to oneself and so on, were ultimately coloured with the morality of humanistic psychology. Thus, as every individual worked on a specific life issue, the therapist would comment on the Gestaltien, existential and phenomenological view of that life activity. This produced a value structure grounded in humanistic psychology ethics as an intermediate result of the work.

As the sessions progressed, the patients developed relationships with one another in the therapy setting. When individuals conflicted with one another, the therapist encouraged the following language changes to occur (see Linguistics).
The individuals would only be allowed to speak in the present tense. The patients were not permitted to use the words "it", "but", and "if". The plural "we" and "they" were also made taboo. The patients were then encouraged to argue for what they needed from the other persons. For example, the patients were instructed to demand "I need you to.....", or "I don't like you to.....", and so on. In this way, the patients were encouraged to demand their ground when in relationship with others.

The responding patient was directed to answer only the specific statements made to him and never to leave a question or demand unanswered. This is the method used when arguments and conflicts emerged during the therapy sessions. Following this format ensured that each patient during an interpersonal conflict neither played an over-powering top-dog role or a weak, ineffective under-dog role. Each patient was encouraged to compete for need satisfaction until both patients' needs were satisfied. (A detailed description of this method can be found in Gestalt-Experiential Family Therapy, W. Kempler, 1975).

**Critique of Phase V**

The methods of traditional Gestalt therapy were used for most of the therapeutic time. Individual dreamwork, awareness training and problem-solving through self-played psycho-dramatisations were the primary tools used. Relationship therapy was also implemented during the latter part of the therapy programme.

The last three sessions were reserved for Phase VI, termination of therapy. During these sessions individual plus group relation work continued, only the therapist kept reminding the patients that at a certain date the group as such would end. The therapist encouraged the patients to share their feelings concerning the theme of saying "goodbye" and to learn how to confront separation.
The patients were thus given exercises to be done both in pairs and in the whole group context. These exercises requested the patients to express appreciations, resentments, and regrets to individuals in the group. The patients were also directed to work on saying the above expressions in fantasy to dead loved ones, ended love affairs and lost possessions. The goal was to have the patients end all unfinished situations by saying "goodbye" to them.

The last session was spent entirely in discussion, concerning the feelings the patients had on leaving the group.
RESULTS

Personal Orientation Inventory

The calculations of the results of the POI for both the experimental and control groups and a comparison between the two can be found in Tables 2 and 3.

In Table 2, the POI profiles are graphically presented. In Table 3 a summary is presented of the difference-scores from the sample. The t-value and critical ratio significance levels between the experimental and control groups are also presented.

The most important result from the calculations is a rejection of the null-hypothesis for 10 of the 12 POI test categories; in other words, for 10 of the 12 test-categories our hypothesis has been retained.

The largest and most significant differences were found in the test-categories of Inner-Directedness (I), Self-Actualising Value (SAV), Feeling Reactivity (FR), Spontaneity (S) and Capacity for Intimate Contact (C).
TABLE 3

A Summary of the Difference Scores of the Samples on the 12 Test-Categories
and the t-value and Critical Ratio Significance Level between the
Experimental and the Control Group

<table>
<thead>
<tr>
<th>Scale</th>
<th>Difference Score Experimental Group</th>
<th>Difference Score Control Group</th>
<th>t-Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tc</td>
<td>+ 1.92</td>
<td>- 0.58</td>
<td>+ 1.928*</td>
</tr>
<tr>
<td>I</td>
<td>+ 17.16</td>
<td>- 3.50</td>
<td>+ 6.044 ****</td>
</tr>
<tr>
<td>SAV</td>
<td>+ 3.50</td>
<td>- 0.92</td>
<td>+ 4.041 ****</td>
</tr>
<tr>
<td>Ex</td>
<td>+ 3.33</td>
<td>- 1.58</td>
<td>+ 2.960 ****</td>
</tr>
<tr>
<td>Fr</td>
<td>+ 3.67</td>
<td>- 0.59</td>
<td>+ 4.173 ****</td>
</tr>
<tr>
<td>S</td>
<td>+ 4.00</td>
<td>+ 0.42</td>
<td>+ 3.955 ****</td>
</tr>
<tr>
<td>Sr</td>
<td>+ 2.92</td>
<td>- 0.08</td>
<td>+ 2.873 ****</td>
</tr>
<tr>
<td>Sa</td>
<td>+ 3.58</td>
<td>+ 1.33</td>
<td>+ 2.049*</td>
</tr>
<tr>
<td>Nc</td>
<td>+ 0.83</td>
<td>- 0.42</td>
<td>+ 1.461</td>
</tr>
<tr>
<td>Sy</td>
<td>+ 0.50</td>
<td>- 0.59</td>
<td>+ 1.537 **</td>
</tr>
<tr>
<td>A</td>
<td>+ 2.67</td>
<td>- 0.75</td>
<td>+ 2.480**</td>
</tr>
<tr>
<td>C</td>
<td>+ 4.91</td>
<td>-1.67</td>
<td>+ 5.282 ****</td>
</tr>
</tbody>
</table>

*= significant difference on .05 level
**= significant difference on .01 level
***= significant difference on .005 level
****= significant difference on .0005 level

If df = 22, then the t-values of one-tailed testing are:

\[ t_{.05} = 1.717; \ t_{.01} = 2.508; \ t_{.005} = 2.819, \text{ and} \]

\[ t_{.0005} = 3.792 \]

(For a more comprehensive reproduction of the results see Appendix D)
The most obvious explanation for the fact that these test-categories are showing a large and significant difference is in the basic departures that exist between the Gestalt approach and the psychoanalytic approach. Some important aspects are: (i) the first method is relatively more "here-and-now" oriented and more client-directed, whilst the second approach is more and more past-oriented and stresses establishing an "adjustment" to existing modes of behaviour and "reality"; (ii) the purpose of the Gestalt method is to initially help the patient to enlarge his awareness of his own blocked organismic expressions. The purpose of the analytic method is providing insight to the client. So the therapist tries to discover the "appropriate interpretation" of the client's problems which are discovered via "transference" from the client to the therapist. This forces the analytic therapist to hold himself in abeyance and not reveal his true identity to the patient in order for transference to occur; (iii) the Gestalt therapist is primarily a "facilitator" for the patient, while the analytic therapist is primarily an "explainer" to the patient, behaving in an intimate and sometimes evasive fashion.

Due to these differences, it seems plausible that these two different psychotherapeutic methods resulted in these different findings. In the case of Gestalt therapy, the client-therapist relationship is more personal and intensive. While in the case of the psychoanalytic therapist, the relationship is similar to a business transaction, with many formalities and a doctor/patient distinction.

The Time Competence/Time Incompetence (Tc/Ti) ratio score of the experimental group increased from 1.00 to 1.40. Even the last score is, according to Shostrom's findings, very low in comparison with a group of non-self-actualised persons (whose ratio score is about 3.00). This finding suggests that even after 6 months of psychotherapy, the level of self-actualisation on this test-category is low in the POI sense.
One explanation for this result could rest on the inter­
relationship the patient has with the hospital’s therapeutic community. Since the community philosophy is based on analytic viewpoints, the therapeutic advantage of being-in-the-now is seldom seen as important. Approximately 40 hours were spent each week in a therapeutic community enhancing recollections of the past, and only 3 hours per week were spent in training the patient to contact the present moment actuality.

The Self-Support (I/O) ratio scale of the experimental group can better stand a comparison with Shostrom’s findings. While the ratio score on this test-category is, according to Shostrom’s findings, about 3.00 for "self-actualised", 2.50 for "normal", and 1.30 for non-self-actualised groups, the ratio score of the experimental group had increased from 1.19 to 2.10. In other words, the pre-test ratio score on this category corresponds almost entirely to that of the non-self-actualised group. The post-test ratio score has moved considerably in the direction of the score of the "normal" group. This finding suggests that after 6 months of psychotherapy, the level of self-actualisation for the clients concerned has become nearly "normal" in the Self-Support POI sense.

The chance that this result is merely the consequence of accident is for two test categories (Tc and Sa) less than 5 per cent; for one test category (A) less than 1 per cent; for two test categories (Ei and Sr) less than 0.5 per cent, and for five test categories (I, SAV, FR, S and C) less than 0.05 per cent. (See Table 2).

By comparing the pre and post-test profiles of the control group in Table 1 and by the difference scores of the control group in Table 2, it can be seen that the scores of the control group decreased on 11 of the 12 test categories instead of increased, as might be expected. Although none of these 11 decreases taken separately is significant, the overall result of 11 decreases in 12 test categories proves to be
significant (the binomial probability of p of 11 variables going in one direction being $p = 0.00097$). The scores of the experimental group increased on all 12 test categories. This overall result also proves to be significant (the binomial probability $p = 0.00024$).

Further, we find that in 10 out of the 12 cases, the pre-test mean sum scores of the control group were higher than those of the experimental group (in two of these cases with a critical ratio significance level of .005), while in only two other cases ($Sr$ and $NC$) the opposite occurred.

The calculations also show that both ratio scores of the experimental group did increase - the $Tc/Ti$ ratio score increased from 1.00 to 1.40, and the $I/O$ ratio score increased from 1.19 to 2.10. Both ratio scores of the control group decreased again - from 1.16 to 1.04 and from 1.53 to 1.36 respectively. (See Appendix D). This suggests that the control group method produced a decrease in Time Competence and Inner Directiveness.

Repertory Grid Test Results

Out of the large amount of data available from the Repertory Grid Test, the investigator first sought to focus on what changes occurred in the several supplied constructs over time in relation to self-concept. The supplied constructs were Self as I am now; Self as I'd like to be; Self as I used to be; friendliness; openness; sexual approval; freedom to touch others, and spontaneity.

By asking the patients to rank-order on the constructs: "Who is the most like I am now"; "Who is the most like I'd like to be"; and "Who is the most like I used to be", to the given elements (Mother, Father, friend of same sex, friend of opposite sex, therapist, teacher you liked, teacher you disliked, lover or spouse, friend whom you have
fallen out with; employer) an opportunity to acquire objective evidence concerning present Self - Ideal-Self and Past-Self concepts is possible).

As Ryle (1975) points out, it is characteristic that patients who have a large discrepancy between Self concept and Ideal-Self concept experience greater dissatisfaction in terms of seeing oneself as having deficiencies. The greater the contrast of Self concept to Ideal-Self concept, the more likely a patient conceptualises himself as being inadequate. The stronger the correlation between Self concept and Ideal-Self concept, the more a desirable identification develops between one's Self and one's Ideal-Self.

By averaging the correlations between each grid test occasion within the experimental and within the control group populations separately, a mean matrix for the experimental group and a mean matrix for the control group is yielded. Analysing these results in terms of Self concept in relation to the specific given constructs yields a comparison between the two groups. The scores in Table 4 below are the averaged correlations between the combined group matrix in relation to the specific constructs in terms of similarity of use. These results should be treated only as scores for comparative purposes.

<table>
<thead>
<tr>
<th>TABLE 4</th>
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<tbody>
<tr>
<td>T₁ before treatment</td>
</tr>
<tr>
<td>E₁</td>
</tr>
<tr>
<td>Self as I am now to Ideal Self</td>
</tr>
<tr>
<td>Self as I am now to Past Self</td>
</tr>
<tr>
<td>Ideal Self to Past Self</td>
</tr>
</tbody>
</table>

Looking at T₁, we find both control and experimental groups
started roughly the same in terms of Self/Ideal Self values for coefficient convergence. The control group showed an initial closer convergence of Self/Past Self and Ideal/Past Self as compared to the experimental group. Examining the results in $T_2$ and the Degree of Change, we find the experimental group yielded a closer Self/Ideal Self convergence of .26, than the control group of .10. We can calculate that the experimental group Self/Ideal Self constructs are .16 closer to convergence than the control group. This shows a marginally closer Self/Ideal Self concept improvement for the experimental group than for the control group. This is in line with our second hypothesis.

The present Self/Past Self values for the coefficient of convergence have also increased by .17 in the experimental group, while $A_C$ for the control group decreased by .21. Here, the experimental group showed an overall increase over the control group of .38; showing a closer convergence between Present Self/Past Self constructs.

The Ideal Self/Past Self convergence for the experimental group also increased by .11. The control group decreased again by .07. This shows an overall increase over the control group of .18 for the experimental group.

These results demonstrate that the experimental group had found an increasing effect of change in Self/Ideal Self convergences over the control group. The control method appears to have effected change in the desirable direction for Self/Ideal Self concepts, but not as strongly as the experimental group. According to these results, the control group method appears to have a disunifying effect in terms of developing time continuity between present and past self-concepts as well as Ideal and Past Self concepts. It may be worthwhile noting again that both groups were less alike in terms of Ideal Self/Past Self and Present Self/Past Self constructs, but this discrepancy does not
negate the fact that the control procedure tended to split the Present Self concept from the Past Self concept, as well as the Ideal Self from the Past Self.

These results tend to show that both treatments produce favourable results in Self/Ideal Self concepts, but differing results for Past/Self/Ideal Self and Past Self/Present Self constructs.

Since standard reliability coefficients are not available for this form of grid test clear 'significance of difference' probability levels cannot be calculated. Nevertheless, direction and crude amount of change can be examined.

Friendliness:

The next elicited construct was friendliness. The investigator wanted to discover what effects the Gestalt procedure had on the construct of friendliness in comparison with the control method, since the Gestalt approach is seen as a method of developing more independent and self-supportive behaviour. The results of the friendliness construct in relation to Present, Past and Ideal Self constructs were as follows:

\[
\begin{array}{ccccccc}
 & T_1 & T_2 & A_c \\
\text{Friendliness construct} & E_b & C_b & E_A & C_A & E_{AC} & C_{AC} \\
\text{Correlations} & & & & & & \\
\text{Friendliness to Present Self} & .01 & .02 & .08 & .28 & +.07 & +.28 \\
\text{Friendliness to Ideal Self} & .34 & .24 & .27 & .25 & -.07 & +.01 \\
\text{Friendliness to Past Self} & .08 & .22 & .16 & -.08 & +.08 & -.30 \\
\end{array}
\]

Examining the Present Self construct in relation to friendliness we see that the experimental group and the control group start roughly at the same point. However, at \( T_2 \) we notice that the control group values for the coefficient of convergence jump to .28, an increase of
The experimental group increased by only .07. Here, the control group method appears to have produced an increase over the experimental group. We can thus assume that the patients saw themselves as becoming more friendly through the analytic method than with the combined method (or that the unstructured painting sessions generated a considerable amount of friendliness).

Examining the Friendliness construct in relation to Ideal Self in $T_1$, we see that the experimental group is higher in convergence (.34) than the control group (.24). In $T_2$ we see that the Ideal concept of friendliness decreases from .34 to .27. The control group increased from .24 to .25. Again, we can assume that the experimental procedure produced the effects of lessening the concept of an Ideal Self as friendly, whilst the control group method increased slightly (.01) the convergence of Ideal Self as friendly. Here again, the results point toward showing that the experimental procedure effected a trend toward less friendliness than the control group procedure.

Looking at $T_1$, the Past Self/Friendliness constructs, we see the control group as thinking of themselves as having been quite friendly in the past (.22) as compared to the experimental group (.08). But an interesting phenomenon occurs at $T_2$. The control group decreases from .22 to -.08, an amount of change that suggests seeing the Past Self now as unfriendly. The experimental group, however, increased from .08 to .16 in terms of seeing their Past Self as friendly. These findings tend to suggest that the analytic group method produces a decrease in identification with one's Past Self in terms of friendliness.

The combined experimental treatment tended to effect the patients toward decreasing their concept of friendliness, both in their Present Self and Ideal Self. This treatment did, however, increase the Past Self concept of friendliness.
The control group was successful in increasing the coefficient of convergence with the Present Self and Ideal Self as friendly, but shifted toward the view that the Past Self was friendly.

This could be attributed to the control group's method of attempting to alter their conception of past experiences by interpreting the past at a fundamentally cognitive level. By doing so, the past becomes thought of as an abstract issue in the distance. The problems of the present are then blamed on this abstracted past, and construed in perhaps a negative or disregarding fashion. The past is then thought of as a reason for the present problems. By intellectually abstracting these past problematic experiences into a category of cause and effect, the past experience is split into a dichotomy with the present. Thus, the present situation is viewed as more important and controllable than the past.

On the other hand, the experimental approach attempts to bring the patient toward a self-supportive position and to reject dependencies on others. This could account for the trend of friendliness diminishing in the Present and Ideal Self concepts. This decrease in convergence with Self as friendly may have both beneficial and detrimental effects. First, it could indicate that the issue of friendliness has become less important and less of a sought-after concern. Yet, secondly, it could develop into conceptualising separation and aloneness. The results do suggest a trend toward becoming less friendly to other people in terms of the patient's self-concept of friendliness, but this area could produce problems if excessive. However, according to the results above the degree of decreased friendliness in relation to Present and Ideal Self is small and not significant. Thus, the results could appear in accordance with the POI scale of becoming more self-supportive and independent.
Openness:

The next construct under examination is Openness. Here, the intent was to discover what comparative effects the two different approaches had on the patients' ability to talk openly about themselves. The "Group Grid" results for Self/Openness appear below:

<table>
<thead>
<tr>
<th>Openness</th>
<th>$T_1$</th>
<th>$T_2$</th>
<th>$A_{C}$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present Self to Open</td>
<td>-.04</td>
<td>.07</td>
<td>.15</td>
</tr>
<tr>
<td>Ideal Self to Open</td>
<td>.01</td>
<td>.09</td>
<td>.19</td>
</tr>
<tr>
<td>Past Self to Open</td>
<td>.02</td>
<td>.18</td>
<td>.30</td>
</tr>
</tbody>
</table>

By looking at $T_1$, we see the control group present as being relatively more open to talk about themselves than the experimental group. Present Self/Open correlations show $C_1$ increasing by .11 over $E_1$, and Past Self/Open constructs exhibit an increase of .16 over $E_1$. In $T_2$ we find both $E_2$ and $C_2$ at the same coefficient of .15. This represents a score increasing by .19 for the experimental treatment as compared to a score increasing .08 for the control treatment. Thus, both treatments produced the same amount of Present Self/Open convergence (.15), but the experimental treatment exceeded the comparative treatment in $A_{C}$ by .11.

In the Ideal Self/Open constructs, $E_2$ resulted in .19 as compared to $C_2$ at .08. This represents an overall $A_{C}$ of .18 as compared to a decrease in the $A_{C}$ of .01 for the control group.

Lastly, the Past Self/Open convergence in the experimental group showed an overall increase of .28 as compared to a decrease of .03 in the control group.

These figures indicate that the experimental procedure resulted in a relatively higher amount of convergence between Self and Openness than the control method.
Sexual approval:
The next supplied construct was Sexual Approval. Prior to the investigation, the researcher realised that an important issue in the analytic approach was the degree to which one can accept his or her sexuality. The results of this construct would determine if there are any differences between the two approaches on this issue.

**TABLE 7**

<table>
<thead>
<tr>
<th>Sexual Approval</th>
<th>(T_1)</th>
<th>(T_2)</th>
<th>(H_{AC}^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present Self toward Sexual Approval</td>
<td>(-.02)</td>
<td>(.01)</td>
<td>(.03)</td>
</tr>
<tr>
<td>Ideal Self Toward Sexual Approval</td>
<td>(+.05)</td>
<td>(-.16)</td>
<td>(.20)</td>
</tr>
<tr>
<td>Past Self Toward Sexual Approval</td>
<td>(-.13)</td>
<td>(-.08)</td>
<td>(.05)</td>
</tr>
</tbody>
</table>

In \(T_1\), we see \(E_1\) and \(C_1\) quite close at commencement of treatment. In \(T_2\) we notice that the control method shifts the degree of Present Self/Sexual Approval to \(+.14\), an increase over \(E_2\) of \(+.09\). Here, as might have been expected, the analytic treatment produced greater Present Self/Sexual Approval than the combined experimental method.

In the issue of Ideal Self/Sexual Approval, \(T_1\) shows a greater difference between the two groups. The experimental group only slightly approved of sex in terms of an Ideal \((+.15)\). The control group, on the other hand, was more against an approval of sex as an Ideal \((-1.16)\).

In \(T_2\) we see \(E_2\) increasing to \(.20\), whereas in \(C_2\) it increases to \(.05\). The experimental group's amount of change \((E_{AC})\) represents an increase of \(.25\) where the control group's amount of change \((C_{AC})\) is \(.21\). These figures indicate that although in \(T_2\) the experimental group had \(.20\) as compared with \(.05\) of the control group, the actual amount of change was quite close.
In the Past Self/Sexual Approval constructs, the $T_1$ of $E_1$ was -.13 and in $C_1$ was -.08. $T_2$ figures for this issue were precisely the same in both groups (.05). This indicates a greater shift for the $E_{AC}$ of .18 as compared with $C_{AC}$ of .13.

These figures show that the control group method has been as effective in shifting the amount of change in terms of the Sexual Approval construct as the experimental treatment.

Freedom to touch others:

This elicited construct was given as part of the grid test to discover what comparative changes occurred between the two treatments in terms of the freedom to touch others. In the experimental treatment, the act of touching others was a particular focus in the treatment. In the control group methods, this same issue was more or less ignored. The results of Self in relation to the freedom to touch others is as follows:

<table>
<thead>
<tr>
<th></th>
<th>$E_1$</th>
<th>$C_1$</th>
<th>$E_2$</th>
<th>$C_2$</th>
<th>$E_{AC}$</th>
<th>$C_{AC}$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present Self as free to touch others</td>
<td>.04</td>
<td>.23</td>
<td>.31</td>
<td>-.10</td>
<td>.27</td>
<td>-.33</td>
</tr>
<tr>
<td>Ideal Self as free to touch others</td>
<td>.09</td>
<td>.40</td>
<td>.25</td>
<td>.15</td>
<td>.16</td>
<td>-.25</td>
</tr>
<tr>
<td>Past Self as free to touch others</td>
<td>-.20</td>
<td>.23</td>
<td>.01</td>
<td>.15</td>
<td>.21</td>
<td>-.08</td>
</tr>
</tbody>
</table>

In $T_1$, the control group was far more free (conceptually) to touch others than the experimental group. Comparing these figures to $T_2$, we see that the experimental treatment managed to increase the amount of convergence for Self/Freedom to Touch Others in each Past, Ideal and Present Self concept. On the other hand, the control group procedure resulted in a decrease in the amount of convergence on each of the three self-concept scales.
Spontaneity:
The last supplied construct was spontaneity in the moment. The experimental treatment attempted to work on developing physical and emotional spontaneity as one goal of treatment. The following is a comparison of the change occurring between the two groups on the constructs Self/Spontaneity.

\[
\begin{array}{cccccc}
\text{Spontaneity} & T_1 & T_2 & h_{EC} \\
\text{Present Self as spontaneous} & E_1 & C_1 & E_2 & C_2 & E_{AC} & C_{AC} \\
\text{Ideal Self as spontaneous} & .13 & -.11 & .18 & .18 & +.05 & +.29 \\
\text{Past Self as spontaneous} & -.16 & .12 & .13 & .10 & +.29 & +.02
\end{array}
\]

The scores on \( T_1 \) show a similar starting point for Present Self as Spontaneous in both \( E_1 \) and \( C_1 \). In \( T_2 \) the control group had a closer convergence toward Present Self/Spontaneous \( (.20) \) than the experimental group \( (.08) \). This indicates that the control group procedure increased the Present Self concept as Spontaneous \( .18 \) over the experimental group of only \( .10 \). Thus, the control group conceptualised themselves as becoming more spontaneous than the experimental group.

In the Ideal Self as Spontaneous, the \( T_1 \) scores show a great discrepancy between the two starting groups. \( E_1 \) was \( .13 \) while \( C_1 \) was \(-.11\). The \( T_2 \) results show an identical shift to \( .18 \) for both groups. This indicates that the control group shifted Ideal Self as Spontaneous \( .29 \) over the experimental group increase of only \( .15 \). These figures demonstrate that the experimental method again had less effect to shift the constructs of Ideal Self as Spontaneous than the control method.

Looking at the Past Self as Spontaneous constructs, we find in \( T_1 \) that both \( E_1 \) \((-16\) and \( C_1 \) \(.12\) are unbalanced in terms of initial
level. The experimental group saw themselves as far less spontaneous in the past than the control group. Examining $T_2$ we find $F_2$ shifting to .13, an increase in convergence of .29. $C_2$ shifts in Past Self/Spontaneous constructs from .12 to .10, a decrease of .02. Here again, we see a characteristic pattern in the control method of shifting the Past Self concept towards a negative coefficient (except for the case of Sexual Approval).

These results are not in line with what one would expect from the experimental procedure. In both Present and Ideal Self concepts, the experimental group shifted less toward thinking of themselves as spontaneous than the control group. One explanation for this result could rest in the conceptualisation of the idea Spontaneity. In the combined experimental method, the issue of spontaneity was stressed upon as physical and emotional expressiveness. The experimental group patients were encouraged to be physically spontaneous and to allow their emotions free expression; whereas in the analytic method, the patients were encouraged to spontaneously "say" what they wished, but not to "act" these expressions through in the therapy situation.

The most notable features of the average construct relationship scores (both the initial correlations between constructs and the degree of change in construct relationships) is that both are very small. This may be due in part to the "cancelling out" effect which arises when individual grids are averaged. In individual grids subjects often have high positive and high negative relationships between constructs and when these are aggregated the resulting picture is misleadingly pale. It may be that the grid in the form used here is too "ideographic" for use in a group research of this kind and this possibility will again be examined at the end of the second study.
<table>
<thead>
<tr>
<th>Construct Correlations</th>
<th>T Before</th>
<th></th>
<th></th>
<th></th>
<th>T After</th>
<th></th>
<th></th>
<th></th>
<th>Amount of Change According to Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$E_1$</td>
<td>$C_1$</td>
<td>$E_2$</td>
<td>$C_2$</td>
<td>$E$</td>
<td>$C$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Self as I am Now to Ideal Self</td>
<td>-.06</td>
<td>-.04</td>
<td>.20</td>
<td>.06</td>
<td>+.26</td>
<td>+.10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Present Self in Relation to Past Self</td>
<td>.05</td>
<td>.18</td>
<td>.22</td>
<td>-.03</td>
<td>+.17</td>
<td>-.21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Ideal Self in Relation to Past Self</td>
<td>.02</td>
<td>.18</td>
<td>.13</td>
<td>.11</td>
<td>+.11</td>
<td>-.07</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Present Self as Friendly</td>
<td>.01</td>
<td>.02</td>
<td>.08</td>
<td>.28</td>
<td>+.07</td>
<td>+.26</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Ideal Self as Friendly</td>
<td>.34</td>
<td>.24</td>
<td>.27</td>
<td>.25</td>
<td>-.07</td>
<td>+.01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Past Self as Friendly</td>
<td>.08</td>
<td>.22</td>
<td>.16</td>
<td>-.08</td>
<td>+.08</td>
<td>-.30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Present Self to Open</td>
<td>-.04</td>
<td>.07</td>
<td>.15</td>
<td>.15</td>
<td>+.19</td>
<td>+.08</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Ideal Self to Open</td>
<td>.01</td>
<td>.09</td>
<td>.19</td>
<td>.08</td>
<td>+.18</td>
<td>-.01</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Past Self to Open</td>
<td>.02</td>
<td>.18</td>
<td>.30</td>
<td>.15</td>
<td>+.28</td>
<td>-.03</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Present Self toward Sexual Approval</td>
<td>-.02</td>
<td>.01</td>
<td>.03</td>
<td>.15</td>
<td>+.05</td>
<td>+.14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Ideal Self toward Sexual Approval</td>
<td>.05</td>
<td>-.16</td>
<td>.20</td>
<td>.05</td>
<td>+.15</td>
<td>+.21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Past Self toward Sexual Approval</td>
<td>-.13</td>
<td>-.08</td>
<td>.05</td>
<td>.05</td>
<td>+.18</td>
<td>+.13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Present Self as Free to Touch Others</td>
<td>.04</td>
<td>.23</td>
<td>.31</td>
<td>-.10</td>
<td>+.27</td>
<td>-.33</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Ideal Self as Free to Touch Others</td>
<td>.09</td>
<td>.40</td>
<td>.25</td>
<td>.15</td>
<td>+.16</td>
<td>-.25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Past Self as Free to Touch Others</td>
<td>-.20</td>
<td>.23</td>
<td>.01</td>
<td>.15</td>
<td>+.21</td>
<td>-.08</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Present Self as Spontaneous</td>
<td>-.02</td>
<td>.02</td>
<td>.08</td>
<td>.20</td>
<td>+.10</td>
<td>+.18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Ideal Self as Spontaneous</td>
<td>.13</td>
<td>-.11</td>
<td>.18</td>
<td>.18</td>
<td>+.05</td>
<td>+.29</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Past Self as Spontaneous</td>
<td>-.16</td>
<td>.12</td>
<td>.13</td>
<td>.10</td>
<td>+.29</td>
<td>-.02</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Examining Table 10 for the total number of movements in the positive direction we find the experimental group improving on seventeen scales as compared with the control group improving on only nine scales. The total instances of decreasing movements for the experimental group is one, while the total number for the control group is nine. Using Chi Squared Contingency for Table 10 we find:

<table>
<thead>
<tr>
<th>Experimental</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improvements</td>
<td>17</td>
</tr>
<tr>
<td>Decreases</td>
<td>1</td>
</tr>
</tbody>
</table>

(Chi^2 Contingency Table)

Computing for Chi^2 = 7.5385.
At one degree of freedom, this gives us a significant p < .01

Target Complaints Scale Results:

The Target Complaints Scale of Battle (1966) was used to compare the two groups of patients in terms of specific symptom change. The patients presented their specific individual symptom complaints and these complaints were rated on a self-rating scale in terms of severity of discomfort. Thus, the discomfort reduction of symptoms was used to determine therapeutic effectiveness.

According to the Target Complaint Scale, a mean improvement in both groups was reported; their improvement is statistically significant. The experimental group reported a highly significant mean overall improvement of .74 (p < .001)*, the control group showed a significant overall improvement of .20 (p < .05)*. Thus the experimental group reported a slightly higher improvement of .14. The degree of change between groups' probability level is p < .10**.

Summarising the reported symptom complaints, there are several descriptive categories frequently used when patients were asked to

* t-test for paired differences; ** t-test for uncorrelated means in samples of equal size (result not significant)
describe their target complaints.

In the order of frequency, these complaints were: sexual difficulties including the inability to give to others; fear of others, including fear of rejection and isolation; feeling inferior to others; lack of self-confidence; fearing delusions and uncontrollable fantasies; work difficulties; general anxiety and depression; creativity and achievement difficulties; poor concentration, focusing and coping difficulties; suicidal feelings and fear of death.

Comparing the symptom complaints with the self-rated results, we find the experimental group patients reporting more consistent improvement with the difficulties that take an interpersonal aspect. Thus sexuality, giving to others, fear of others, delusions, isolation, work difficulties, and feeling inferior to others, all appear to have improved with some consistency in the course of Gestalt treatment.

The control group appears to have had more consistent improvements with complaints of general depression, inability to cope, general anxiety and fear of death.

A category break-down of the Symptom Target Complaints can be made as follows: first, there were the complaints that dealt with both interpersonal and intrapsychic problems (i.e., symptoms of outer - inner world splitting). Second, the category of complaints dealing mainly with interpersonal problems only (i.e., outer-world alienation). A third category of complaints dealing solely with the wish to improve intrapsychic conditions (i.e., introjective self-identifications). A final category of complaints dealing with interpersonal plus intrapsychic problems, combined with physical discomfort (e.g., anxiety, depression, nerves, i.e., reflective behaviour).
Table 11 below summarises the results of the Target Symptoms Complaint Scale.

**TABLE 11**

<table>
<thead>
<tr>
<th></th>
<th>Splitting</th>
<th>Interpersonal Outer-world Only</th>
<th>Intrapsychic Inner World Only</th>
<th>&quot;Physical&quot; Discomforts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>E*</td>
<td>C*</td>
<td>E</td>
<td>C</td>
</tr>
<tr>
<td>Severity of Initial Discomfort</td>
<td>.77</td>
<td>.94</td>
<td>.50</td>
<td>.50</td>
</tr>
<tr>
<td>Severity of Discomfort after treatment</td>
<td>.35</td>
<td>.94</td>
<td>.42</td>
<td>.50</td>
</tr>
<tr>
<td>Degree of Improvement</td>
<td>.42</td>
<td>.00</td>
<td>.08</td>
<td>.00</td>
</tr>
<tr>
<td>Significance Level**</td>
<td>p .01</td>
<td>n.s.</td>
<td>n.s.</td>
<td>p .10</td>
</tr>
<tr>
<td>Number of Patients in which this kind of Improvement is Observed</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

- **E** = Experimental group
  - **C** = Control group
  - **t**-test for paired differences

Referring to Table 11 some trends seem to appear. With regard to the first category of splitting, it seems that the combined method is much more effective than the analytic method alone (a significant change of level p .01 versus no change). With regard to the second category of interpersonal problems only, both the combined methods and the analytic methods do not seem to result in significant changes, although the experimental group seemed to be somewhat more successful in this respect. With regard to the third category of intrapsychic problems only, both methods seemed to be effective, although the analytic method only resulted in a more significant change. With regard to the fourth category, the physical discomforts and retro-
fective behaviour, again both methods seemed to be effective, although the combined method results in a more significant change.

From the above, the most effective aspect of the combined method which included the Gestalt treatment seemed to relate to alleviating splitting symptoms and the physical discomforts in patients. This appears to be in line with the Gestalt approach which deals more explicitly with awareness of splits and awareness of bodily feelings.

The analytical method alone appears to be effective for individuals with intrapsychic problems. This appears to be in line with psychoanalytic theory.

The findings point only toward a trend. A more informative method could help to determine which patients would benefit most from the combined approach and which would not.

In the following discussion, there is a concrete procedure recommended that might determine which symptoms could be best treated with the combined approach.
DISCUSSION OF THE FIRST RESEARCH INQUIRY

Owing to an oversight the investigator failed to give a concluding MHQ to experimental and control group patients. This would have provided a symptom group classification assessment of the general effectiveness of the treatments.

One difficulty the investigator encountered was the mistrust and fear such research appears to engender in a therapeutic community staff. Collectively, staff showed scepticism and avoided involvement in the proposed research. On the other hand, the patient population showed more eagerness and good will to aid the research procedure. This investigator's experience suggests researchers in a therapeutic community need first to educate and assure the staff that the research outcome will in no way threaten their positions as workers.

A specific fear of community staff is that the research might determine who are the so-called "better therapists" and who are the so-called "poor therapists". There is a basic competitive feeling existing in a therapeutic community setting, and this is a source of rivalries, anxiety, envy, jealousy, and splitting. Thus, a researcher might well find obstacles and personal conflicts arising when planning and administering a research project.

To find adequate support and assistance for developing research plans, this investigator believes that a shared initial planning of the research procedure with the staff is advisable. This means that not only the needs or questions of the researcher are taken into account, but also the needs and questions of the staff of therapists. In this way, the research becomes a joint endeavour of the researcher and the entire staff.
For example, one might decide to share the workload and use an external "blind" supervisor to help determine the progress of patients. In the present research it was a short-coming that the therapist was also the researcher; this might have influenced the test data, thus lowering the reliability of the study. However, the investigator encouraged the patients to answer all test instruments as truthfully and accurately as possible. On most occasions the investigator was not present while the patients were filling in the POI test instruments and two other assistants helped in administering the Repertory Grid Test and Target Complaint Scale.

One difficulty in interpreting the results of the POI for the experimental group is that the POI Questionnaire has the same underlying philosophy as the experimental treatment. In other words, both questionnaire and therapy are based on humanistic psychology values. It has already been mentioned that one negative feature of the POI is its transparency and fake-ability for people who are familiar with the humanistic psychology values. In extreme terms, one might criticize this study by saying that the improvement of the POI scores in the experimental group does not reflect a therapeutic change but only a discovery of how to answer the POI in terms of what the therapist values.

This criticism, however, is not supported by the other experimental test results. For example, the Kelly "Repertory Grid" test results point in the same direction as the POI results in many aspects, notably between the Time Competence Scale on the POI and the Past, Present, Ideal-Self constructs on the Repertory Test in terms of past, present and ideal-self concept continuity. This
parallel also applies to the Openness and Freedom to touch others on the Repertory Test to the POI scale Capacity of Warm Interpersonal Relations (C) and Feeling Reactivity (FR).

Both tests support each other in their implied direction of change. It is worth noting that the Kelly Repertory Grid Test is less easy to fake in the direction of humanistic psychology values, because its theoretical base and presentation is completely different from the POI’s questionnaire format.

A more searching test of the values of a Gestalt approach would involve embedding it in a therapeutic community working with a totally "humanistic" approach. In this way, research could be initiated to determine what effects the self-actualising philosophy would have on patients and on the total psychiatric therapeutic community. For example, the findings of the Time Competence (TC) scale in the POI showed diminishing scores in terms of Time Competence in the control group who received a more traditional therapy. A specific "human potential approach" therapeutic community might yield worthwhile results in terms of time competence.

One drawback of this study is that the results were measured only once and immediately after the treatment. This means that we cannot draw conclusions on the longer lasting effects of this therapy. One way to assess how stable these changes are would be to measure the effects in a longitudinal study, that is, to repeat the test measurements with longer time intervals of say six months or a year.

The method of repeated measurements with relatively long time intervals will be used in the second part of this inquiry.

It is striking to find that in both the ratio scores of the POI and on 11 of the 12 test scales, the scores of the control group
decreased instead of increased, although nowhere was the amount of change on an individual scale significant. Yet the decrease on the 11 of the 12 scales is a significant decrease if the test is considered as a whole (binomial prob. p .00097). To seek an explanation of this decrease it may be wise to look at the way the POI is constructed. Opposite to the value judgements that are considered characteristic of self-actualised persons, we find value judgements that are characteristic of "normally adjusted" persons. The first value judgement is scored positive, the second is scored negative.

In other words, although the patients of the control group may have made progress according to psychoanalytic philosophy, this is not evaluated as "progress" in terms of the humanistic philosophy which underlies the POI.

With this in mind, the differences found in both groups would beckon us to perform a second similar study, using another personality questionnaire such as the M.N.P.I., and compare the scores on both questionnaires. However, in this case too it must be remembered that this can become a matter of values - POI values versus MMPI values.

In conclusion the economies of the study have meant that while it has provided data of interest it has not tested the issues of treatment by what method, by which therapist of what kind of patient. This is ultimately necessary if we are to understand the nature of the psychological processes involved in therapy.
PART III

THE SECOND RESEARCH INQUIRY

INTRODUCTION

The first research inquiry was concerned primarily with hospital patients and the feasibility of using Gestalt therapy in a psychiatric day hospital setting. The investigation explored the comparative effects of a combined treatment of Gestalt therapy with the existing psychoanalytic methods as used in two psychiatric day hospitals. This combined method was then compared in the hospital setting with the traditionally established object-relations psychoanalytic treatment method as used in these hospitals.

The results of this inquiry suggest that the differences which exist between these two psychotherapeutic methods also produces distinct differences in outcome for the patients concerned.

In order to investigate further the applicability and range of the Gestalt method, it was thought advisable to repeat the initial study in a completely different setting, culture and country, and with people who are not hospital patients. This might enable us to determine how the setting may have altered the effects of the therapy. As mentioned earlier the investigated therapeutic community, day hospital setting was essentially psychoanalytically oriented. This may have affected the particular results of the Gestalt method in a way which is not readily analysable.

Secondly, conducting the investigation in a different culture and country will help to determine whether Gestalt methods are specifically suited to one culture and language, or could be applicable to different cultures and languages.
Thirdly, by investigating the use of Gestalt methods with people who are not hospital patients, we can investigate whether such methods are of use to individuals who are not specifically psychologically handicapped and of potential value in non-hospital (e.g., educational) settings.

If we find similar results in both inquiries, we have a much firmer base for drawing conclusions about the applicability and effects of the Gestalt method.

The first study was based upon a before-and-after design conducted over a six-month period. The following study was concerned with monitoring any possible changes by using the method of repeated measurements within the total experimental period. This second study lasted one year and the measurements were repeated approximately every three months. This helped determine how the changes occurred during the longer time period.

The second inquiry focussed more on exploratory research. The subjects in this research were mostly psychologists, psychotherapists, and psychiatrists, and were directed to keep introspective diaries of the therapeutic work; in addition, open-ended interviews were held at the conclusion of the first year of work. These subjects were specifically trained in introspection prior to the experiment; thus, they provided insightful information concerning the nature, depth and effects of the experimental experience.

They were also asked to evaluate the therapy in terms of other therapeutic methods and to explore the issue of what types of setting and persons would benefit from the methods. The subjects were also asked to discuss where these methods might prove detrimental or inappropriate.
In this second inquiry, the therapist did not present the test tools to the subjects (in the first research, the investigator was also the therapist). Instead, the subjects themselves organised the administration of the test materials. This lowered the possibility that the test results would be influenced by the researcher therapist. An independent psychologist collected and scored several of the test instruments.

Another difference between the two inquiries is that in the first investigation, therapy was given weekly in two 1/2 hour sessions and in the second inquiry the therapy sessions were held for longer time periods, i.e., the weekend format of Friday evening to Sunday afternoon was conducted once per month. This provided approximately 15 hours of uninterrupted time (except for meals and sleeping), so that the methods might develop their full potential.

A final difference between the two studies lay in the use of several therapists in the second inquiry. Besides the author, Laura Perls, Albert Pesso and Ruth Runnell worked with this group. This provided an excellent opportunity to compare different effects of different Gestalt approaches. In this study, the subjects functioned as their own control.
1. **Topic of Study**

The following research inquiry was concerned with the effects and application of Gestalt-based therapy methods, as applied to the training of professional therapists and practitioners within the field of psychotherapy and mental health. The purpose of the study was to determine in greater detail the specific effects of the method produced and to acquire a firmer understanding of the range of possible applications these procedures could provide. The following is a longitudinal study covering a one-year period, measuring the effects of several therapists on 12 subjects who were candidates for training in Gestalt therapy.

2. **Hypothesis**

The following are a number of hypotheses based upon several retained notions developed directly from the results of the first experimental inquiry.

(i) Positive changes in Self-Actualisation scores as measured by the Personal Orientation Inventory (POI) in all scales: Time Competence (TC); Inner-Directiveness (I); Self-Actualising Values (SAV); Existentiality (EX); Feeling Reactivity (FR); Spontaneity (S); Self-Regard (SR); Self-Acceptance (SA); Nature of man as constructive (NC); Synergy (Sy); Acceptance of Aggression (A); Capacity for intimate contact (C).

(ii) A decrease in Self/Ideal-Self concept discrepancies as measured by the Repertory Grid Test (Rep Test) of George Kelly.

(iii) A decrease in Self/Past-Self concept discrepancies as measured by the Kelly 'Rep Test'.

(iv) Decrease in Past/Ideal-Self concept discrepancies as measured by the Kelly 'Rep Test'.

(v) A decrease in discrepancies between the Self/Ideal-Self concept as measured by the Semantic Differential (SD) of Osgood (1957).

(vi) A decrease in discrepancies between the concepts of thinking and feeling as measured by the Semantic Differential.

(vii) A decrease in neurotic symptoms as measured by the Middlesex Hospital Questionnaire (MHQ).

3. Design and Procedure

The research inquiry was based on a longitudinal repeated measurement design. The design of this longitudinal study aimed to determine: (1) at what point in time does the experimental treatment produce the greatest amount of therapeutic change? (2) what is the optimum amount of time needed to apply the Gestalt procedure effectively? (3) what are the effects after long, repeated exposure to the Gestalt method, Gestalt techniques and Gestalt life philosophy?

To answer these questions the inquiry took the following form:

\[ H_1 \quad T_1 \quad H_2 \quad T_2 \quad H_3 \quad T_3 \quad H_4 \]


\[ H = \text{Measurement occasions} \]

\[ T = \text{Treatment methods} \]

\[ H_1 \] represents the initial testing of the experimental group of 12 subjects (the sample will be discussed in Section 5). \[ T_1 \] represents the treatment implemented by the first therapist who is the present writer (This will be discussed in greater detail in Section 7). \[ H_2 \] is the testing of the effects of the author's therapeutic interventions and procedures. \[ T_2 \] represents the combined treatments of A. Pesso, L. Perls and H.unnell. (To be discussed in detail in Section ). \[ H_3 \] is the measurement of the combined effects of the three 'visiting' therapists' procedures and interventions and some longer range effects.
of the therapeutic work in phase $T_1$. $T_3$ represents the present
writer's application of the therapeutic treatment in the last phase,
while $M_4$ is the last measurement of the effects of the total combined
treatment.

4. Measures

The instruments used in this study were the Personal Orientation
Inventory of Shostron, the Kelly Rank-Order Repertory Grid Test, The
Semantic Differential of Osgood (1957) and the Middlesex Hospital
Questionnaire (MHQ).

The Personal Orientation Inventory (POI) Although recognised by
the author as a fairly transparent instrument, the POI still offers
the research an excellent opportunity to gauge the process toward
self-actualising attitudes, values and behaviour. A detailed description
of this instrument has already been given.

The Kelly Rank-Order Repertory Grid Test In the first inquiry,
the Grid Test proved useful in providing detailed measures of self-
concept relationships. In this second study, the Grid Test was re­
modelled to explore specific questions related to the Gestalt approach.

This new form of the Grid Test was constructed as follows: First,
the original 10 elements were retained as in the first inquiry. These
elements were: (1) Mother; (2) Father; (3) Friend of same sex;
(4) Friend of opposite sex; (5) Therapist; (6) Teacher you liked.
(7) Teacher you disliked; (8) Lover or spouse; (9) Friend with whom
you have fallen out; (10) Employer/Supervisor. Second, the number of
supplied constructs was diminished to seven in number and the constructs
were reformulated to relate more specifically to results aimed for in
the Gestalt approach.
The given constructs were:

1. Like I am now
2. Aware of feelings versus thoughts
3. Able to concentrate versus unable to concentrate
4. Like I would like to be (ideal)
5. Free and open in relations with others versus defensive
6. Like I used to be
7. Lives in the present versus lives in the past or future

The number of elicited constructs was limited to three. The procedure to elicit these first three constructs was to first select the elements of mother, lover, (or spouse) and friend whom you have fallen out with, and to then ask the subjects: "How are two of these people alike and the third one different?"

The answer to this question was formulated into a bi-polar construct. This same procedure was repeated with the elements father, friend of opposite sex, and teacher you liked. The last elicited construct was elicited with elements friend of same sex, employer and teacher you disliked.

As in the first inquiry, the subjects were again asked to rank-order the elements in terms of the constructs present. The results produced a grid form which was gathered four times during the year-long inquiry.

The Semantic Differential The Semantic Differential (SD) is an instrument designed to measure an individual's connotative meaning or attitude toward certain specific issues or concepts. Developed by Osgood, Suci and Tannenbaum (1957), and Osgood (1962), the SD takes the form of a series of seven-point rating scales (bi-polar adjectives). Bi-polar terms such as good versus bad, strong versus weak, beautiful versus ugly and so on, are placed separately on a seven-point rating
scale, where common, everyday meanings can be expressed, i.e., deciding whether a person is considered to be beautiful rather than ugly.

The series of 15 bi-polar adjectives used in this study was selected from the most widely used in previous studies, and reflect items most pertinent to the concepts in question. Using factor-analytic procedures, Osgood and Suci (1955) discovered that three general factors of meaning were measured by the SD. These factors are evaluation, potency and activity. According to their studies, Osgood and Suci found the evaluative factor the most prominent of the three, and determined that specific bi-polar adjectives referred to each of the three orthogonal factors.

The bi-polar adjectives selected for the evaluation factor are good-bad; beautiful-ugly; clean-dirty; valuable-worthless; pleasant-unpleasant; happy-sad; relaxed-tense; and clear-hazy.

Those selected for the potency factor are strong-weak; hard-soft; and powerful-powerless.

Those selected for the activity factor are fast-slow; sharp-dull; and active-passive.

A new bi-polar adjective was also included as it is concerned with specific aspects of the research. This bi-polar adjective was fluid-rigid. A copy of the SB question sheet can be found in Appendix F.

The specific concepts rated in this study were: Myself as I am; Myself as I'd like to be; My thoughts are; My feelings are. Each concept was placed separately at the head of a page above the bi-polar scales, in the box provided.

The subjects were asked to place mark in the position indicating both the direction and intensity of their feelings about the concept

* Marked adjectives were presented in reversed order to avoid fixed response tendencies.
in question in terms of each scale. Four SD rating sheets were
administered during each test occasion for the four specific concepts.

A large number of studies have used the SD. The study by Thigpen
and Checkly (1954) utilised the SD to demonstrate the existence of
multiple personalities with the psychotherapy patient "Eve". Using
the SD as an independent measure, Osgood and Luria (1954) were able
to make a blind analysis of the data, distinguishing the "three distinct
personalities", as well as providing insight into the behaviours in each
personality and predicting correctly some of the results of psychotherapy.

The SD has also been used in many other fields of research. These
include the field of developmental psychology, where the agreement of
meaning of objects from first grade to college level (Donahoe and
Osgood, 1957, p. 289) was studied and found to be a function of age.

A number of learning theory studies by Osgood (1957) examined the
response time in learning and habit formation using the SD. Experiments
in classical conditioning (Staats and Staats, 1957) utilised the SD
to demonstrate conditioning in a stimulus-response framework. Lastly,
many public attitudes studies are available, measuring social issues,
minority groups and commercial products using the SD scales.

Examining reliability of the SD, Osgood, Suci and Tannenbaum (1957)
reported test-retest reliability ranging from .83 to .91. Jenkins,
Russell and Suci (1957) reported an average test-retest reliability of
.97 for N = 30. Validity studies presented by Osgood (1957) show
correlations with the Thurston's scales, ranging from .74 to .82.

The present investigator administered the SD in order to provide
an additional criterion of "meaning" changes other than the Rep Test.
When comparing the construction and format of the SB with the Rep Test,
we find the former far simpler and more transparent than the latter.
The SD perhaps more effectively measures connotative aspects of meaning.
A discussion of Rep Test/SD similarities and differences is available in Bannister and Hair (1968).

**Middlesex Hospital Questionnaire (MHQ)** The use of a short, self-rating scale of psychoneurotic symptoms and traits provided a criterion of improvement in this second inquiry. The Middlesex Hospital Questionnaire (MHQ) was developed by Crown and Crisp (1966) to provide a simple and convenient method to assess psychoneurotic symptoms and traits into diagnostic categories. The MHQ consists of 48 questions divided into six sub-tests designed to measure free-floating anxiety, phobic anxiety, obsessive-compulsive traits and symptoms, somatic symptoms, depressive symptoms and hysterical traits and symptoms.

After a preliminary study a final form of the MHQ was constructed and administered to 62 unselected patients and 109 normal subjects. Validity results with the Mann-Whitney U-test showed that each sub-test scale differentiated between normal subjects and the patients at a highly significant level (all greater than .001). The relationship of each of the six sub-scales was also compared with clinical ratings for 50 patients by several examining clinicians. Using clinical judgement as criterion and the Mann-Whitney U-test as a method of statistical analysis, the results showed that the sub-scales measuring free-floating anxiety, phobic, somatic, depressive and hysterical symptoms and traits had been significantly differentiated by the MHQ. The sub-scales measuring obsessional traits and symptoms showed the same trend, but did not reach a statistically acceptable level (p = 0.12).

Reliability coefficients were calculated by the split-half method separately for 62 patients and 43 controls (nurses). Internal reliabilities were considered adequate for all the sub-test categories except for the obsessive and somatic sub-scales (p levels not provided).
These results reveal that the MHQ may not be so highly reliable as some of the other instruments used in this present study, but the instrument does provide a clinical criterion to assess psychoneurotic conditions and complaints. For this reason, the MHQ was included in this second research inquiry.

The MHQ was administered along with the three other test instruments, for the four test occasions.

5. The Sample

The subjects who took part in the inquiry were all Belgians from the Dutch-speaking sector. They were professionals in the fields of psychiatry, psychology, mental health and in organizational development. The subjects were all psychotherapists interested in acquiring skills in the methods of Gestalt therapy. They were chosen because they were undertaking advanced education in prior post-graduate training in the "helping" professions and prior psychotherapy training. An additional requirement was that each was presently working as a practicing psychotherapist or group worker.

The sample group of 12 subjects consisted of the following professionals:

One male psychiatrist, age 31, currently working in a psychiatric hospital and in a private clinic as a therapist.

There were a total of seven practicing psychologists in various disciplines, including: one male, aged 27, working with mentally retarded children, families and psychiatric patients. One male, age 39, working as a director of a school counselling service as well as having an individual psychotherapy practice. Two males, ages 34 and 35, working in organisational development on the corporation level as well as conducting therapy groups and individual psychotherapy. One female
psychologist, age 43, currently training medical doctors in psychological observation and diagnosis. One male educational psychologist, age 27, working in the field of diagnostic education. One female supervising psychologist, age 30, working as an individual and group psychotherapist, graduate nurse lecturer and team-work supervisor.

The four remaining subjects comprised one male sociologist, age 30, working in counselling with the Rogerian approach, including individual and family counselling as well as training staff counsellors and administrators in several youth centres. There was one female social worker, age 27, working in the organisational development and personal development programme of a human potential training institute. There was one female physiotherapist, age 25, working in a psychiatric hospital in non-verbal therapeutic methods. Lastly, one male Ph.D candidate, age 27, working in the field of organisational behaviour and development.

The above sample comprised eight males and four females. The average age of the sample was 31.2 years. All subjects were fluent in the English language.

6. The Setting

The subjects who participated in the inquiry lived within the Dutch-speaking sector of Belgium. They were all trainees accepted for a three-year training programme in methods of Gestalt therapy. The subjects were told that the first year of work would consist strictly of personal therapy under the Gestalt approach with no theoretical work presented during this period.

The subjects were informed that theoretical study would be presented during the second year of training, while supervised work would be dealt with during the third and final year.
The therapy period was one weekend per month for a year. In addition to this, a five-day workshop was held in July. All subjects were required to arrive at the residential conference centre on Friday evening by 8:00 p.m. and expected to stay the two evenings until 3:00 p.m. on Sunday afternoon.

The work consisted of five 3-hour sessions per weekend. The first session began on Friday from 8-11:00 p.m. The second session on Saturday morning from 9:30 a.m. to 12:30 p.m. The third session was from 2:30 to 5:30 p.m. on Saturday afternoon. The fourth session on Saturday evening from 8:00 p.m. to 11:00 p.m. The fifth session on Sunday morning from 9:30 a.m. to 12:30 p.m. The last hour or two after lunch was used in finishing the weekend and to discuss general matters with the group.

The above format was strictly adhered to during the entire experimental inquiry. The subjects were given individual sleeping accommodation and it was a common occurrence that all participants socialised in the drinking lounge after the evening session.

7. The Treatment

The treatment administered to the subjects of the inquiry was the same as described in the first research. Although not as systematically presented as in the first inquiry, the treatment followed very closely the procedure outlined. For example, Phase I to IV were implemented during the first four consecutive weekends. The Gestalt therapy dreamwork method was introduced after the second weekend and remained as a primary tool during the whole of the year-long inquiry.

Between the months of June and September (omitting August for holidays), three visiting therapists administered their forms of treatment to the group of twelve subjects. These therapists were Albert Pesso, Laura Perls, Ph.D., and Ruth Runnell, Ph.D.
Albert Pesso worked with the subjects during the five-day workshop in July. Here, he implemented his form of treatment called Psychomotor therapy (1973, 1974). His methods are based firmly within the Gestalt procedure, except for several important considerations:

First, Pesso used what he calls negative and positive accommodators. These are individuals in the group role-playing the part of "good parent" and "bad parent". Second, Pesso introduced physical expression and contact with these role-played parents, in an attempt to discharge negative feelings toward one's parents, and at the same time to develop harmonious physical contact with the role-played "good parents" (called Archetypal good parents).

Third, Pesso has a specific fantasy-like scenario which is followed during his treatment. He takes one single patient at a time by observing the patient's here-and-now physical behaviour, and leads the patient into a symbolic world with the goal of discharge of unresolved emotions, by way of a role-played "bad parent". The patient then receives a harmonious physical contact with the role-played "good parent". In this way a physical relaxation occurs as well as a psychological resolution of a problematic child-parent relationship episode.

Pesso's work deals mainly with attempting to fulfil hitherto unfulfilled expectations and desires which were either disregarded or abused by one's "unloving" parents. This is done by replacing the experience of pain and accompanying discouragement with warm physical contact and the fantasy of having a totally fulfilling relationship with one's mother and father.

This focus on parental relationship produces a unique and particular therapeutic access in the realm of mother-father-child cohesiveness and wholeness. This work attempts to complete and dissolve early parental influences which were either inadequate or toxic.
The second visiting therapist was Laura Perls, Ph.D, who administered her form of Gestalt therapy to the 12 subjects during a weekend workshop in June. Perls, who is the co-originator of Gestalt therapy with her husband Frederick Perls, used a more traditional approach with individual dreamwork and confrontative here-and-now awareness continuum work.

The third guest therapist in the programme was Ruth Runnell, Ph.D, who is also a Gestalt therapist working in collaboration with Laura Perls. Her work was carried out during a weekend workshop in September, and is of the same traditional spirit of Gestalt therapy as L. Perls. The work of Runnell dealt mainly with the group process in terms of a Gestalt model.

The final three workshops of October to December were administered by the present author. The treatment carried out during this time was similar to that which was outlined in Phases III, IV and V of the first experimental inquiry.

The data were so collected that the three guest therapists would have the test occasion number three as a monitor of their particular influence on the whole therapeutic process.

8. Results

Middlesex Hospital Questionnaire (MHQ) Results:

The results of the MHQ can be found below in Table 12. These results are statistically significant. The figures demonstrate a total decrease in neurotic symptoms as compared with the first test occasion (A) to the last test occasion (D). A steady decrease in diagnostic symptom categories is shown in obsessive-compulsive traits and symptoms and in hysterics symptoms for the total time of the treatment programme. The four other symptom categories fluctuate as follows during the period of treatment.
Examining test occasion B, we find an increase in neurotic symptoms occurring only in the phobic anxiety category, while the other symptom categories decrease in symptomology scores.

When we examine test occasion C, we notice an unexpected increase (not significant) in symptomatic scores on the scales measuring phobic anxiety, somatic symptoms and depressive symptoms, but find an expected decrease in free-floating anxiety, obsessive-compulsive traits and symptoms and in hysteria. Therefore, test occasion C shows us the greatest unexpected variation in mixed results for the treatment programme. This may be due to a greater awareness of feelings and symptoms.

When we examine test occasion D, the final test occasion, we find five of the six symptom categories decreasing in symptomology scores, the exception being the free-floating anxiety score. We see an increase in anxiety as compared with the previous test occasion, C.

These results show a fluctuation of improvement as measured by the MHQ. Examining the total results of the treatments, we find a numerical decrease in the averaged diagnostic symptom scores for all test categories. Each of the test occasions are measuring against the initial measurement. The binomial probability of six variables going in one direction is $p = .01562$. This overall result is significant.

Examining the results of treatment II (monitored by test occasion C) we find a numerical decrease in the scores measuring free-floating anxiety, obsessive-compulsive traits and symptoms and hysteria, yet also find an increase in the scores measuring phobic anxiety, somatic symptoms and depressive symptoms.

This points in the direction of mixed beneficial and detrimental results occurring from treatment II, the visiting therapists' phase of the programme.
Looking at test occasion D, the final treatment results, we find a decrease in all diagnostic scores as compared with treatment II, except for the scale measuring free-floating anxiety. Here, we see the free-floating anxiety scores increasing over the previous test occasion C, but still remaining below test occasions B and A.

**TABLE 12**

<table>
<thead>
<tr>
<th>Test occasion</th>
<th>Free-floating Anxiety</th>
<th>Phobic Anxiety</th>
<th>Obsessive-compulsive traits and symptoms</th>
<th>Somatic symptoms</th>
<th>Depressive symptoms</th>
<th>Hysteria</th>
<th>Mean (M) scores for the six Diagnostic Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb. 1976 A</td>
<td>4.66</td>
<td>3.16</td>
<td>5.75</td>
<td>5.00</td>
<td>4.00</td>
<td>8.41</td>
<td>K = 30.58</td>
</tr>
<tr>
<td>May 1976 B</td>
<td>4.09</td>
<td>3.18</td>
<td>5.09</td>
<td>4.68</td>
<td>3.00</td>
<td>7.09</td>
<td>K = 23.63</td>
</tr>
<tr>
<td>Sept. 1976 C</td>
<td>3.33</td>
<td>3.41</td>
<td>4.83</td>
<td>4.83</td>
<td>3.41</td>
<td>6.58</td>
<td>K = 22.00</td>
</tr>
<tr>
<td>Dec. 1976 D</td>
<td>4.08</td>
<td>2.58</td>
<td>3.58</td>
<td>3.25</td>
<td>2.25</td>
<td>6.00</td>
<td>K = 16.16</td>
</tr>
<tr>
<td>t-Value*</td>
<td>.39</td>
<td>.76</td>
<td>2.55</td>
<td>1.86</td>
<td>2.46</td>
<td>2.14</td>
<td>2.01</td>
</tr>
<tr>
<td>Significance level</td>
<td>n.s.</td>
<td>n.s.</td>
<td>p .05</td>
<td>p .05</td>
<td>p .05</td>
<td>p .05</td>
<td>p .05</td>
</tr>
</tbody>
</table>

* t-test for period differences over the data for the first and the last measurement

One possible explanation for this variation in the free-floating anxiety scale, as well as phobic anxiety, somatic symptoms and depressive symptoms at the moment of the third measurement, may be found in the different treatment in the period just before the third measurement. In this period, the subjects received treatments by Pesso, Perls and Gunnell, e.g., the Psychomotor work of Pesso focusses much on the
somatic aspects of the person, and this may have led to a greater awareness of symptoms. This may be reflected in the somewhat higher score of somatic symptoms as well as the increase in depressive symptoms and phobic anxiety. This is in line with the data reported from the open-ended interviews with the group members concerning the results of Pessoa's work upon them.

The increase on the free-floating anxiety scale for the last test occasion is puzzling. One possible explanation might be due to the season of year. The time of test occasion C occurred just after the long summer holidays (a time of low psychiatric day hospital attendance), which might account for the drop in free-floating anxiety levels as compared with test occasion D, the time of year just before Christmas. This explanation can be supported by the amount of change occurring between test occasions A and B, which shows a decrease in anxiety levels.

The total mean scores for the six diagnostic symptom categories are: (H) = 30.58 for test occasion A; (M) = 23.63 for test occasion B; (M) = 22.00 for test occasion C, and (M) = 16.16 for test occasion D.

Hypothesis number seven is supported by a significant decrease in neurotic symptoms as measured by the MMQ.

**Semantic Differential Results:**

Referring to hypothesis number three, we predicted a decrease in discrepancies between the Self/Ideal-Self concept as measured by the Semantic Differential of Osgood (1957). In hypothesis number four, we predicted a decrease in discrepancies between the concepts of thinking and feeling as measured by the same instrument.
These two hypotheses were tested in the following way: First, as mentioned in Section 6 concerning the construction of the Semantic Differential, the instrument consists of several scales which can be grouped together into three categories: the evaluation factor; the activity factor, and the potency factor.

We included in our instrument eight scales that were specifically identified by Osgood et al. (1957) as evaluative scales, three scales as specifically activity scales, three scales as specifically potency scales, and one new scale.

Osgood et al. urges us to factor analyse the scales in each new study, so as to be certain of the factor composition for the total set of scales used. For our data, we performed a factor analysis using the principal components method.

The results of the factor analysis showed two main emerging factors:

**FACTOR 1 (After Varimax Rotation)**

<table>
<thead>
<tr>
<th>Item</th>
<th>Scale</th>
<th>Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>8 Valuable - Worthless</td>
<td>.7757</td>
</tr>
<tr>
<td>2.</td>
<td>1 Good - Bad</td>
<td>.7227</td>
</tr>
<tr>
<td>3.</td>
<td>12 Relaxed - Tense</td>
<td>.7136</td>
</tr>
<tr>
<td>4.</td>
<td>2 Strong - Weak</td>
<td>.7106</td>
</tr>
<tr>
<td>5.</td>
<td>3 Beautiful - Ugly</td>
<td>.6760</td>
</tr>
<tr>
<td>6.</td>
<td>9 Pleasant - Unpleasant</td>
<td>.6595</td>
</tr>
<tr>
<td>7.</td>
<td>13 Clear - Hazy</td>
<td>.6399</td>
</tr>
<tr>
<td>8.</td>
<td>6 Powerful - Powerless</td>
<td>.5682</td>
</tr>
<tr>
<td>9.</td>
<td>11 Sad - Happy</td>
<td>-.5401</td>
</tr>
<tr>
<td>10.</td>
<td>15 Rigid - Fluid</td>
<td>-.5094</td>
</tr>
<tr>
<td>11.</td>
<td>10 Sharp - Dull</td>
<td>.4912</td>
</tr>
</tbody>
</table>
FACTOR 2 (After Varimax Rotation)

<table>
<thead>
<tr>
<th>Item</th>
<th>Scale</th>
<th>Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>14</td>
<td>Passive - Active</td>
</tr>
<tr>
<td>2.</td>
<td>7</td>
<td>Slow - Fast</td>
</tr>
<tr>
<td>3.</td>
<td>6</td>
<td>Powerful - Powerless</td>
</tr>
</tbody>
</table>

The results of the factor analysis showed an extracted variance of .3805 for Factor 1, .0667 for Factor 2, and .0409 for Factor 3. The total extracted variance is .9802, or the common variance equals about 48%. The remaining 52% is attributed to specific variance and error variance.

To enable a clearer analysis, the factors have been rotated using Varimax Rotation. Using the principle component method of factor analysis after Varimax Rotation, we now find Factor 1 accounting for .3127 of the total common variance, Factor 2 accounting for .1138 of the total common variance and Factor 3 accounting for .0615 of the total common variance (still equalling about 48%).

As the first two factors emerged with the largest amount of common variance, we have decided to concentrate on only these first two factors. Factor 1 now accounts for .3127 of the total common variance and Factor 2 accounts for .1138 of the total common variance; a total of .4265 for all the variance of all the variables is accounted for by the first two factors.

By dividing the combined common variance of Factor 1 and Factor 2 into the variance accounted for by Factor 1, we have 3127 ÷ 4265 = 73.31. Dividing the combined common variance of Factor 1 and Factor 2 into the variance accounted for by Factor 2 we find 1138 ÷ 4265 = 26.69.

Thus Factor 1 covers 73.31 per cent of the total common variance accounted for by the factors 1 and 2.
The second factor covers 26.69 per cent of the total common variances accounted for by the factors. Note that only the loadings higher than .40 are included in this second table. The underlined adjectives indicate the direction of sign of the loadings.

Interpretation of the composition of Factor 1 showed that the content of this factor follows closely what Osgood et al called the Evaluation Factor. So this is the name we will apply to the data based on this first factor.

Interpretation of the composition of Factor 2 showed that the content of this second factor follows closely what Osgood et al called the Activity Factor. This is the name we shall apply to the data based on this second factor.

The Regression method of factor analysis was employed to derive factor scores. This method allowed the computer to print-out the regression weights and also to transform the factor scores from between 0 and 105 (each specific scale numbered seven, times the total number of 15 scales), to a new distribution score with a mean of 500 and a standard deviation (sigma) of 100.

On the basis of this factor analysis, factor scores were computed for each individual (12 subjects); for each concept (four concepts); and for each occasion of measurement (four times). This resulted in 192 factor scores based on the Evaluation Factor, and 192 factor scores based on the Activity Factor. The Potency Factor did not emerge in this study.

The factor scores obtained were also converted into discrepancy scores as follows: a particular factor score on the Self concept minus the corresponding factor score on the Ideal-Self concept gave the discrepancy factor score Self/Ideal Self.

We used the same procedure to compute the discrepancy factor
score between the concepts of Thoughts and Feelings by taking the difference between a particular factor score on the concept of Thoughts and the corresponding factor scores on Feelings.

This resulted in two sets of discrepancy factor scores for Self/Ideal Self, one set of scores being based on the Evaluation Factor and the other set on the Activity Factor. We also computed two sets of discrepancy factor scores between the concept of Thoughts and the concept of Feelings (one on the Evaluation Factor and one on the Activity Factor).

The following results are based on these four sets of discrepancy factor scores.

The data regarding hypothesis three, Self/Ideal Self, is presented below. Table number 13 provides the results of the whole group mean scores for Self/Ideal-Self discrepancy scores for the Evaluation Factor.

**TABLE 13**

**SUMMARY OF DATA ON FACTOR SCORES I (EVALUATION FACTOR)**

<table>
<thead>
<tr>
<th>Month</th>
<th>Mean Score Self</th>
<th>Mean Score Ideal Self</th>
<th>Diff (Mean Self - Mean Ideal Self)</th>
<th>t-value</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb. 1976</td>
<td>557.85</td>
<td>437.38</td>
<td>120.46</td>
<td>2.08</td>
<td>.05</td>
</tr>
<tr>
<td>May 1976</td>
<td>526.83</td>
<td>428.50</td>
<td>98.33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oct. 1976</td>
<td>518.23</td>
<td>455.38</td>
<td>62.85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec. 1976</td>
<td>474.77</td>
<td>428.46</td>
<td>46.31</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 1 is the graphical representation of Self/Ideal-Self discrepancies on the Evaluation Factor.
Table number 14 (below) provides the results of the whole group mean scores for Self/Ideal-Self discrepancy scores for the Activity Factor.

**TABLE 14**

**SUMMARY DATA ON THE FACTOR SCORES 2 (ACTIVITY FACTOR) FOR THE SELF/IDEAL-SELF CONCEPTS**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Score Self</td>
<td>518.23</td>
<td>545.92</td>
<td>512.77</td>
<td>492.31</td>
</tr>
<tr>
<td>Mean Score Ideal Self</td>
<td>460.62</td>
<td>451.00</td>
<td>463.31</td>
<td>466.31</td>
</tr>
<tr>
<td>Diff. (Mean Self - Mean Ideal Self)</td>
<td>57.61</td>
<td>94.29</td>
<td>49.46</td>
<td>26.00</td>
</tr>
</tbody>
</table>

\[ t\text{-value} = 1.88 \]
\[ p \leq .05 \]
Figure 2 is the graphical representation of Self/Ideal-Self discrepancies on the Evaluation Factor:

According to the above results, hypothesis number three is supported by this data.

The data regarding hypothesis number four is as follows: Table 15 (below) provides the results of the whole group mean scores for Thoughts/Feelings discrepancy scores on the Evaluation Factor:
### Table 15

**Summary of Data on Factor Scores (Evaluation Factor)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean Score Thoughts</strong></td>
<td>567.23</td>
<td>559.83</td>
<td>519.08</td>
<td>489.85</td>
</tr>
<tr>
<td><strong>Mean Score Feelings</strong></td>
<td>523.69</td>
<td>550.50</td>
<td>504.31</td>
<td>463.31</td>
</tr>
<tr>
<td><strong>Dif. (Mean Thoughts - Mean Feelings)</strong></td>
<td>43.54</td>
<td>9.33</td>
<td>14.77</td>
<td>26.54</td>
</tr>
</tbody>
</table>

\[ t\text{-value} = 3.90 \]
\[ p < .005 \]

Figure 3 is the graphical representation of discrepancies on the Evaluation Factor:

![Figure 3: Patterns of Mean Factor Scores on the Concepts of Thoughts and Feelings over Four Occasions on the Evaluation Factor of the Semantic Differential (data are over the whole group)](image-url)
Table 16 (below) provides the results of the whole group mean scores for the Thoughts/Feelings discrepancy scores on the Activity Factor:

**TABLE 16**

**SUMMARY OF DATA ON FACTOR SCORE 2 (ACTIVITY FACTOR)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Score Thoughts</td>
<td>498.62</td>
<td>447.58</td>
<td>487.46</td>
<td>490.20</td>
</tr>
<tr>
<td>Mean Score Feelings</td>
<td>546.69</td>
<td>556.25</td>
<td>531.92</td>
<td>530.77</td>
</tr>
<tr>
<td>Diff. (Mean Thoughts - Mean Feelings)</td>
<td>-48.07</td>
<td>-108.67</td>
<td>-44.46</td>
<td>-40.54</td>
</tr>
</tbody>
</table>

Worse  better  better

t-value = 3.40

p < .005

Figure 4 is the graphical representation of Self/Ideal self discrepancies on the Activity Factor:

Figure 4: Pattern of Mean Factor Scores on the Concepts of Thoughts and Feelings over Four Occasions of the Activity Factor of the Semantic Differential (data are over the whole group).
Conclusion from the above data strongly supports hypothesis number four. Thus, thoughts and feelings became closer associated with one another due to the treatments offered over time.

In order to get a clearer picture of how these changes occurred in the course of treatment, during the several time intervals, we also computed the means of the absolute differences between Self and Ideal-Self concepts (absolute differences means the observed differences regardless of direction, i.e., regardless of sign).

These results are shown below. Table 17 shows Self/Ideal-Self absolute differences for the Evaluation Factor:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (Diff.) Self/Ideal Self</td>
<td>120.16</td>
<td>100.17</td>
<td>81.92</td>
<td>49.22</td>
</tr>
</tbody>
</table>

Figure 5 (overleaf) shows graphically the Self/Ideal-Self Evaluation Factor (regardless of sign).
Table 18 (below) shows Self/Ideal-Self absolute differences for the Activity Factor:

**Table 18**

**ABSOLUTE DIFFERENCES (REGARDLESS OF SIGN)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (Diff.) Self/Ideal Self</td>
<td>93.46</td>
<td>112.08</td>
<td>89.46</td>
<td>53.08</td>
</tr>
<tr>
<td></td>
<td>worse</td>
<td>better</td>
<td>better</td>
<td>Overall Much Better</td>
</tr>
</tbody>
</table>
Figure 6 (below) shows graphically the Self/Ideal-Self Activity Factor (regardless of sign).

The above results show that in the beginning of treatment the subjects became worse with respect to an increase in discrepancies between Self and Ideal Self. Then, by the third or fourth test occasion, got better in the sense of a decrease in discrepancies between Self and Ideal Self.
We used the same procedure with regard to discrepancies between Thoughts and Feelings; here, also, we computed the means of the absolute differences between the concepts of Thoughts and Feelings.

The results are shown below. Table 19 (below) shows Thoughts-Feelings absolute differences for the Evaluation Factor:

**TABLE 19**

**ABSOLUTE DIFFERENCES (REGARDLESS OF SIGN)**

**FOR FACTOR 1 (EVALUATION FACTOR)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (Diff.) (Thoughts-Feelings)</td>
<td>76.15</td>
<td>114.50</td>
<td>62.77</td>
</tr>
<tr>
<td>worse</td>
<td>better</td>
<td>better</td>
<td>better</td>
</tr>
</tbody>
</table>

Figure 7 (below) shows graphically the Thoughts-Feelings Evaluation Factor (regardless of sign):
Table 20 (below) shows Thoughts/Feelings absolute differences for the Activity Factor:

**TABLE 10**

**ABSOLUTE DIFFERENCES (REGARDLESS OF SIGN)**

**FOR FACTOR 2 (ACTIVITY FACTOR)**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean (Diff.)</td>
<td>90.85</td>
<td>142.83</td>
<td>111.54</td>
<td>59.15</td>
</tr>
<tr>
<td>(Thoughts-Feelings)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>worse</td>
<td>better</td>
<td>better</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Overall Much Better

Figure 8 (below) shows graphically the Thoughts-Feelings Activity Factor (regardless of sign):

![Graph showing activity factor trends](chart.png)

Figure 8: Discrepancies Between Thoughts and Feelings over Four Occasions in the Activity Factor of the Semantic Differential (data over the whole group)

(Absolute discrepancies - regardless of sign)

Here we see the same picture of deterioration first and then improvement later.
The Personal Orientation Inventory (POI) Results

A summary of the results of the POI appears below in Table 21 and Table 22. These results indicate an improvement on all 12 test categories of the instrument for the before-and-after test comparison (see test occasions 1 and 4). This overall change is significant (the binomial probability being p = .00097). These results of the POI support our first hypothesis concerning the enhancement of self-actualisation attitudes as measured by the POI instrument.

It is interesting to note that on examination of the data, we find one fluctuation occurring in the opposite direction for test occasion 4, the last test occasion. Here, we see the Existentiality and the synergy scale scores drop slightly instead of increasing, as we would expect. One explanation of this could be that the POI has a psychological "ceiling" above which the level of self-actualisation as measured by the instrument cannot accurately register.
**SUMMARY OF RESULTS FOR THE PERSONAL ORIENTATION INVENTORY**

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>S&lt;sub&gt;d&lt;/sub&gt;</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1  2  3  4</td>
<td>2-1 3-1 4-1</td>
<td>2-1 3-1 4-1</td>
<td>2-1 3-1 4-1</td>
</tr>
<tr>
<td>T&lt;sub&gt;1&lt;/sub&gt;</td>
<td>6.30 4.50</td>
<td>2.90 2.40</td>
<td>2.166 2.176 1.342</td>
<td>0.427 0.237</td>
</tr>
<tr>
<td>T&lt;sub&gt;c&lt;/sub&gt;</td>
<td>16.50 18.50</td>
<td>20.10 20.60</td>
<td>1.256 1.347 1.418</td>
<td>1.418 1.477</td>
</tr>
<tr>
<td>O</td>
<td>36.70 24.70</td>
<td>21.30 19.90</td>
<td>5.617 6.992 7.123</td>
<td>1.945 2.126 2.203</td>
</tr>
<tr>
<td>I</td>
<td>88.70 03.30</td>
<td>105.50 107.10</td>
<td>6.065 7.328 7.856</td>
<td>2.165 2.175 2.821</td>
</tr>
<tr>
<td>SAV</td>
<td>22.80 23.70</td>
<td>24.00 24.40</td>
<td>1.690 2.145 1.979</td>
<td>0.423 0.317</td>
</tr>
<tr>
<td>Ex</td>
<td>22.50 26.80</td>
<td>27.90 27.30</td>
<td>2.385 2.392 2.797</td>
<td>1.236 1.881</td>
</tr>
<tr>
<td>Fr</td>
<td>16.70 19.30</td>
<td>20.30 19.30</td>
<td>1.049 1.356 1.267</td>
<td>0.562 0.699</td>
</tr>
<tr>
<td>S</td>
<td>13.50 15.30</td>
<td>15.80 16.40</td>
<td>1.336 1.356 1.656</td>
<td>0.410 0.526</td>
</tr>
<tr>
<td>Sr</td>
<td>11.50 13.00</td>
<td>14.40 14.90</td>
<td>1.249 1.426 1.275</td>
<td>0.427 0.407</td>
</tr>
<tr>
<td>Sa</td>
<td>15.70 18.80</td>
<td>20.80 21.00</td>
<td>0.690 0.888 0.967</td>
<td>0.730 0.948</td>
</tr>
<tr>
<td>N&lt;sub&gt;c&lt;/sub&gt;</td>
<td>11.10 12.70</td>
<td>12.80 13.20</td>
<td>0.945 1.342 1.197</td>
<td>0.640 0.671</td>
</tr>
<tr>
<td>S&lt;sub&gt;y&lt;/sub&gt;</td>
<td>7.20 8.20</td>
<td>8.40 8.30</td>
<td>0.650 0.762</td>
<td>0.841 0.389 0.433</td>
</tr>
<tr>
<td>A</td>
<td>16.40 18.20</td>
<td>19.10 19.50</td>
<td>1.245 1.146</td>
<td>1.012 0.623 0.967</td>
</tr>
<tr>
<td>C</td>
<td>19.02 21.30</td>
<td>22.60 24.20</td>
<td>1.777 1.641</td>
<td>1.844 0.547 1.116</td>
</tr>
</tbody>
</table>

*M* = Mean  
*S*<sub>d</sub> = Standard deviation  
*t* = t-value  
*P* = Level of significance of differences

**t-values for one-tailed testing**
TABLE 22

SUMMARY OF RESULTS

<table>
<thead>
<tr>
<th>TIME</th>
<th>OTHER DIRECTED</th>
<th>Values of self-actualizing people</th>
<th>Rigid in application of values</th>
<th>Inept in own needs and feelings</th>
<th>Fearful of expressing feelings</th>
<th>Has low self-worth</th>
<th>Unable to accept self with weaknesses</th>
<th>Sees man as essentially evil</th>
<th>Sees opposites of life as antagonistic</th>
<th>Denies feelings of anger or aggression</th>
<th>CAPACITY FOR INTIMATE CONTACT</th>
<th>Has warm interpersonal relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tc</td>
<td>1</td>
<td>SAV</td>
<td>Ex</td>
<td>Fr</td>
<td>S</td>
<td>Sr</td>
<td>Sa</td>
<td>Nc</td>
<td>Sy</td>
<td>A</td>
<td>C</td>
<td></td>
</tr>
</tbody>
</table>

ADULT NORMS

<table>
<thead>
<tr>
<th>TIME</th>
<th>OTHER DIRECTED</th>
<th>Values of self-actualizing people</th>
<th>Rigid in application of values</th>
<th>Inept in own needs and feelings</th>
<th>Fearful of expressing feelings</th>
<th>Has low self-worth</th>
<th>Unable to accept self with weaknesses</th>
<th>Sees man as essentially evil</th>
<th>Sees opposites of life as antagonistic</th>
<th>Denies feelings of anger or aggression</th>
<th>CAPACITY FOR INTIMATE CONTACT</th>
<th>Has warm interpersonal relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tc</td>
<td>1</td>
<td>SAV</td>
<td>Ex</td>
<td>Fr</td>
<td>S</td>
<td>Sr</td>
<td>Sa</td>
<td>Nc</td>
<td>Sy</td>
<td>A</td>
<td>C</td>
<td></td>
</tr>
</tbody>
</table>
Kelly Repertory Grid Test

The results of the "Rep" test can be found in Summary Table 23.

<table>
<thead>
<tr>
<th></th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>Significance of Degree of Change between 1st and 4th Test Occasion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present Self/Ideal Self</td>
<td>.35</td>
<td>.31</td>
<td>.43</td>
<td>.03</td>
<td>N.S.</td>
</tr>
<tr>
<td>Present Self/Past Self</td>
<td>.12</td>
<td>.14</td>
<td>-.01</td>
<td>.02</td>
<td>N.S.</td>
</tr>
<tr>
<td>Present Self/Live in Present</td>
<td>.20</td>
<td>.24</td>
<td>.41</td>
<td>.21</td>
<td>N.S.</td>
</tr>
<tr>
<td>Present Self/Able to Concentrate</td>
<td>.20</td>
<td>.29</td>
<td>.31</td>
<td>.32</td>
<td>N.S.</td>
</tr>
<tr>
<td>Present Self/Feelings</td>
<td>.13</td>
<td>.10</td>
<td>.19</td>
<td>.17</td>
<td>N.S.</td>
</tr>
<tr>
<td>Present Self/Open</td>
<td>.33</td>
<td>.29</td>
<td>.27</td>
<td>.30</td>
<td>N.S.</td>
</tr>
<tr>
<td>Past Self/Ideal Self</td>
<td>.06</td>
<td>-.02</td>
<td>.04</td>
<td>-.01</td>
<td>N.S.</td>
</tr>
<tr>
<td>Past Self/Live in Present</td>
<td>.07</td>
<td>.39</td>
<td>.14</td>
<td>.08</td>
<td>N.S.</td>
</tr>
<tr>
<td>Past Self/Able to Concentrate</td>
<td>.15</td>
<td>.28</td>
<td>-.24</td>
<td>.18</td>
<td>N.S.</td>
</tr>
<tr>
<td>Past Self/Feelings</td>
<td>.18</td>
<td>.38</td>
<td>.22</td>
<td>.09</td>
<td>N.S.</td>
</tr>
<tr>
<td>Past Self/Open</td>
<td>.25</td>
<td>.11</td>
<td>-.10</td>
<td>.13</td>
<td>N.S.</td>
</tr>
<tr>
<td>Ideal Self/Live in Present</td>
<td>.23</td>
<td>.39</td>
<td>.33</td>
<td>.45</td>
<td>N.S.</td>
</tr>
<tr>
<td>Ideal Self/Concentration</td>
<td>.26</td>
<td>.16</td>
<td>.24</td>
<td>.23</td>
<td>N.S.</td>
</tr>
<tr>
<td>Ideal Self/Feelings</td>
<td>.07</td>
<td>.18</td>
<td>.21</td>
<td>.19</td>
<td>N.S.</td>
</tr>
<tr>
<td>Ideal Self/Open</td>
<td>.34</td>
<td>.19</td>
<td>.35</td>
<td>.16</td>
<td>N.S.</td>
</tr>
</tbody>
</table>
These results fluctuate and no invariable pattern develops in terms of directions of change. We find improvements on several of the construct relationships in the beginning of treatment, but then notice a reversal of these improvements as the time of treatment progresses.

These results are so variable that we find no improvement reaching a customary level of acceptable significance. Referring to our second hypothesis, we find the Self/Ideal-Self concept discrepancies improving in the desirable direction, but falling off on the last occasion.

All we can argue from this data is that there is a general tendency for an upward trend in the direction of the hypothesis.

The complex variations between subjects in the ways in which the self-ideal self constructs have moved suggests that the grid is measuring subtleties of individual change which cannot be readily aggregated in a group study of this kind. As indicated in the first study, it may be that this form of repertory grid is too ideographic for the purposes of this study. This seems more likely when we consider that change is clearly shown on "group" instruments such as the POI but not on the repertory grid. The author found that while data on the elicited constructs were of clinical interest there was no way in which they could be brought into the general "progress of the group under treatment" argument. This is a further indication of the ideographic limitations of the repertory grid test in the form in which it was used in this study.

In Table 24, we have examined the Spearman rho between the self/ideal constructs for each individual subject. Calculated in this way, we find a statistically significant shift at the 5% level \( t = 2.343 \). However, this shift shows that the self/ideal self constructs are moving further apart.
By examining the individual construct grids to determine the direction of movement, we find that seven of the subjects show the self construct moving away from ideal-self construct by shifting closer to more positive attributes. These seven subjects show the self construct as central to all other correlations in their repertory "space". In the remaining five subjects, we see the ideal-self construct shifting further away from the self construct. Three of the subjects show the ideal-self shifting away from the positive correlations toward passivity, inactivity, and further afield from central construct clusters. In two of the subjects, we find the ideal-self construct disconnected from the remaining construct clusters.

TABLE 24

SPEARMAN RHO BETWEEN CONSTRUCTS 1 & 4

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<thead>
<tr>
<th>Subject</th>
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<td>.3212</td>
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<td>-</td>
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<td>.1636</td>
<td>.1878</td>
<td>-.4122</td>
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Mean difference                                  = -.37375
Standard error of the mean difference              = .1595

\( t = 2.343 \)

This \( t \) is significant at the 5% level
Personal Diary Results

Some aspects of the personal diaries are noted below. These comments have been organised into five categories: (1) Personal changes; (2) Interpersonal changes; (3) Independent observations; (4) Other possible applications of Gestalt methods, and (5) the nature of Gestalt methods.

For ease of presentation, the relevant comments are reproduced as written from the individual summaries.

Personal changes: "I have developed a feeling of weight-body sense. I re-discovered weight; I've learned how to dance (before this year I never danced)"

"I feel much more a person with a body; I listen to what my body tells me and I'm glad at the signals it points me to".

"I perceive better; I'm more aware of what is going on inside of me".

"I now feel free from the past. This is important to me because I had the idea that the past determined my whole life and future. In my relationship with my husband I found that he wasn't the source of my problems, because I discovered I had the same problems with others and that he wasn't the guilty person. I found out that blaming others destroyed communication".

"I am giving up objectivity in favour of a reliance on subjective experience".

"I never dreamed before. Now I dream a great deal".

"Before I felt as though I was a powerless person. I discovered from the work that I have a lot of power, a lot of energy, and that I use my energy now to directly do things outside of myself".
Interpersonal changes: "I feel closer to people, and feel more tender".

"Dreamwork was extremely relevant and useful to me. The work this past year made clear to me I can relate to people in an undefensive, open way".

"Formerly I only paid attention to the verbal aspects of the therapy situation. Now I pay attention to the non-verbal. I am now able to interrelate with the client more as a whole person. The Language of the body has more significance for me".

"I know and express my own needs in a clearer way. I have become clearer, more transparent for the client, and I notice the client feels safer to express his needs. I have become more fluent and easier to understand to the client".

"I notice I work better with married couples and families. I am able to function better and take larger numbers of clients. I live in an intenser way, enjoying nature, people, my work and my own body".

"I accept criticism and punishment easier now. I feel more freedom in relationship with my father and mother. I see the positive and negative aspects in which I am the same or different from them".

"I see a great growth in my relationship with my husband. It has given us the opportunity to choose to adopt children".

Independent observations: "People have noticed an ease in talking with them. There are fewer unsolvable conflicts. I am easier to live and work with".

"Now you can stand open to people, even when you express negative feelings toward them".

"You have become much more creative".
"People in groups experience me as warm and open and trust me. (In the past, more as hard and at a distance. I feel at ease in groups now!).

"People commented I became more open and talked more freely about important and difficult things. This wouldn't be possible for me a year ago. I've changed some of the friends I had, and now I feel more satisfied and pleasant with the relations I have".

"People comment I am less tense and more relaxed".

Other possible applications of the Gestalt method: "I see opportunity to use Gestalt work with young, normal children and families".

"I think the most important task as a (Gestalt) therapist is to make sure that the other person no longer needs me; that he or she is able to take care of him or herself".

"I use the Gestalt approach in my work to explain the different ways people are denying their perceptions and their body signals".

"I find the Gestalt approach useful in individual, family and group therapies. It is also perfectly useful in organisational development especially when we are dealing with ways people are not co-operating - either competing, withdrawing or resisting. The basic questions I ask in organisational work are: what are we doing in this organisation to have the results we have? How do we behave to keep our problems intact? what are we doing to not solve this problem? Or, what are we not doing to solve this problem? I find the use of language - verbal and body - most important".

"Gestalt work uses a lot of non-specific factors that accomplish positive therapeutic evolution: Suggestion, stressing the aspect of feeling the therapeutic relationship, catharsis, informal learning (modelling and feedback), digesting opposite experiences, and manipulating rewards".
"I believe Gestalt methods would be useful for strongly inhibited persons, depressives, disturbances in relations and psychosomatic complaints. I think it would not be beneficial for euphoric clients, uninhibited clients, character-disturbed people (lack of self-reflection, empathy, weak super-ego). In borderlines and psychotic persons, the question is dependent on the play of the therapist. I see this would require stressing structured experiences and less confronting".

"I don't think one needs to be highly effective with verbalising to achieve benefits from the Gestalt work".

On the nature of the Gestalt methods: "Gestalt works with the whole person - his body, emotions and mind".

"I'm very enthusiastic about the possibilities Gestalt offers to work with dreams and, although I do not totally follow the theoretical concepts of Gestalt Dream theory, I found the Gestalt practice a worthful vehicle to work with dreams".

"Gestalt means for me wholeness and unity (with each moment different faces). Being and keeping in touch with two entities in one - wholeness: i.e., me and my situation. Therefore, I use: (i) my perceptions to face the situation outside myself; and (ii) my awareness to feel my body sensations and body signals".

"For me, Gestalt is focussing energy. Work is no longer an island where one isolates oneself for eight hours a day".

"Gestalt is a new way of teaching and being taught. It differs from other ways of learning because one does not learn from cognitive means (i.e., reading, films, tapes, seminars) but by experiencing one's feelings, senses and fantasies - this is more real because one learns this for oneself, not by someone else telling the information".

"To me, Gestalt is not only a form of very effective therapy: in my eyes it is a way of life. And maybe it is life. By focussing on what
happens here and now paradoxically life becomes broader and intenser. There are no fixed rules or behaviours, feelings, or whatsoever; there are alternatives to anything I do. And everything flows, nothing remains. Gestalt teaches me to take responsibility for myself. And it also shows me the unique union between body and mind: what I feel within my body is the way I feel and how I am. Gestalt makes me stand on the ground with my two feet, and gives me an opportunity to come in touch with who I am and what I am”.

**Individual Interview Results**

The following is a summary of the individual interviews conducted at the end of the year-long study. All test data results were presented to each individual subject and they were asked to comment on and evaluate these results. Those comments relevant to the present study were summarised and are now presented below.

"The results of the POI in all probability indicate a cognitive change in learned norms rather than a behavioural change in these norms".

"The results of the first Grid showed me connections to the Self-as-I-Am component. The last Grid results show a strong central theme of Self as I Am, with strong connections with freedom to be open in relationships, ability to concentrate, and Ideal Self. The SD results show Self/Ideal-Self concepts coming very close together at the end of treatment".

One individual commented that the giving of test instruments during the therapeutic process might interfere with the personal growth process.

The results of the SD indicated in one woman's opinion that her Evaluation Factor of Self was higher than the Activity Factor. This indicated to her that she could do more than she is actually doing at this moment.
Another woman commented that her personal self-acceptance was actually not so high as suggested by the POI measurement. The results of the Grid Test, however, were more consistent. These results showed that she was running away from her feelings in the beginning of treatment, but came to accept these feelings toward the end of treatment.

One man did not totally believe that the results suggested by the POI. He did comment that a few points in the POI results were evident in his life. These were existentiality, presentness, synergy, and improved contact in relationships. He also commented that a chronic physical tension in his abdominal area disappeared about 10 months through the treatment.

"Thinking and feeling were two separate things for me when I started the therapy. Now they are close together and equally important for me. Also, as suggested by the Grid Test, the negative aggression aspect was the only concept connected to self at the beginning of treatment. Now, concentration as well as a positive relation to aggression are strongly related to self. These seem accurate for me, because I no longer use tricks or manipulate others to express my aggression. The POI results also show a higher acceptance of aggression at the end of treatment than when I started. I am also living more intensely in the present now. In the beginning of treatment, I had a very high independence score on the POI. Now, at the end of treatment, it is lower and I feel myself that I have become more sociable and in stronger contact with others."
"The first two test occasions indicate a self disconnected from all other constructs. The last two test occasions show the self in the middle of my construct system. The self now has the most connections. Before, the self was not even part of the other Grid concepts. Now, concentration has a positive correlation with awareness (before it was negative). I am more aware of movements in my body. This is concentration. I am aware of what is in me and my concentration with others. Open and free in relation to others was my ideal in the first Grid results. Now, my Ideal Self is strongly connected with Present Self, concentration and awareness. The results of the SD show a trend of becoming more passive. This is the way I want to be. I am acting with my feelings more now than with my thoughts. Presently, I am pessimistic with people. This is reflected in the POI results."
DISCUSSION

Patterson (1973, p. 375) comments that Gestalt therapy has never been adequately evaluated in terms of whether the methods and techniques are useful for clients from populations other than those demonstrated via film and transcript by Perls and his associates. The purpose of this research was to pursue the question of whether a Gestalt framework might offer some important contributions to clinical psychology as well as to explore the difficulties of therapy assessment as a field of research.

By testing the several stated hypotheses presented earlier, using quantitative methods of data collection, we have come to the point where we can make the following statements:

For hypothesis 1, we have found positive changes (p .00097) in self-actualisation scores as measured by the Personal Orientation Inventory (similar results were also found in our first research inquiry). This demonstrates that we can retain our first hypothesis insofar as Gestalt method enhances self-actualising traits and values, as measured by the Personal Orientation Inventory.

Hypothesis 2 predicted that we would find a decrease in Self/Ideal-Self concept discrepancies, as measured by the Kelly Repertory Grid Test. The results of this method of measurement showed an increase in the Self/Ideal-Self concept discrepancy, though as a group effect, these results proved statistically non-significant. However, the Grid Test permits us to view each individual subject separately. Thus, we found that 7 of the 12 subjects shifted the Self concept to the centre of their construct space. Three subjects shifted Ideal-Self away from Self concept toward greater inactivity, while two subjects shifted the Ideal Self out of their central construct space.
Hypothesis 3 predicted a decrease in discrepancies between Self/Ideal-Self concepts as measured by the Semantic Differential. The results of this instrument showed a significant change in the predicted direction ($p < .05$). The results on these scales indicate that the ideal-self concept remains relatively constant throughout the therapy. The self-concept, however, shifts closer and closer toward the ideal-self concept, suggesting that the subjects see themselves getting better and improving in the direction of a stable, ideal-self picture.

Hypothesis 4 predicted a decrease in discrepancies between the concepts of thinking and feeling, as measured by the Semantic Differential. The results of this measure showed a significant level of predicted change ($p < .005$), enabling us to retain this hypothesis. The results on these scales indicate the subjects see themselves becoming more and more active; that thoughts have improved and become more active over feelings and that feelings have improved over thoughts, however, not substantially.

Hypothesis 5 predicted a decrease in neurotic symptoms, as measured by the Middlesex Hospital Questionnaire. The results of this instrument showed significant improvements for obsessive-compulsive traits ($p < .05$), somatic symptoms ($p < .05$), depressive symptoms ($p < .05$) and hysteria ($p < .05$), and a therapeutically favourable direction of change (though not significant) for free-floating anxiety ($t = .39$) and phobic anxiety ($t = .79$).

What can explain these results which are broadly consistent in both a psychiatric hospital population and a group of normals from a different culture. The most likely explanation of these results is two-fold in terms of Gestalt theory.
First, the basic response reinforced during all of the entire therapy programme has been the consistent development of a "present-oriented time competence". In other words, positive reinforcement was offered to those actively attending to present-moment experience. The author admits that the use of behaviour modification-related methods was employed in relation to developing time competence. This was accomplished by offering positive reinforcement in the form of interest, praise and encouragement for those attending the ongoing "now" process, while any other time orientation was either ignored, teased or frustrated (negative reinforcement).

Linking time-competence to Gestalt psychology, we must argue that the way to develop strong, clear, "good gestaltung" is by helping the patient to attend to his quality of perceptual contact with the actual external world stimuli, as well as to his body sensation stimuli in the present moment.

This offers us the opportunity to work on the patient's clarity of perceptions in order to develop a clear dynamic field (Lewins' field theory) via the laws of form (Gestalt psychology). This produces an ever-increasing "whole" experience (some might call this the feeling of health and vigour), which is more than the sum of individual experiential parts.

Kohler writes:

"In my case, which may be taken as representative of many others, that naive picture consists, at this moment, of a blue lake with dark forests around it, a big, grey rock, hard and cool, which I have chosen as a seat, a paper on which I write, a faint noise of the wind which hardly moves the tree, and a faint odour characteristic of boats and fishing. But there is more in this world: somehow I now behold, though it does not become fused with the blue lake of the present, another lake of a milder blue, at which I found myself some years ago, looking from its shore in Illinois. I am perfectly accustomed to beholding thousands of views of this kind which arise when I am alone. And there is still more in this world: for instance my hand and fingers as they lightly move across the paper."
Now, when I stop writing and look around again, there also is a feeling of health and vigour. But in the next moment I feel something like a dark pressure somewhere in my interior which tends to develop into a feeling of being hunted - I have promised to have this manuscript ready within a few months."

The second most important contention that could explain how we can effect positive changes in the direction of greater integration (as measured by the POI, SD and Kelly Rep Test) might be that Gestalt therapy technique resolves polarised forces. It may be central that throughout therapy patients were repeatedly required to role-play and act-through each of their polarised positions until some form of resolution was achieved. This was the main method used to help resolve all the different forms of Self/Ideal-Self conflicts, environmental conflict, intrapsychic conflicts, thought/feeling conflicts, and so on. This same technique was employed over one thousand times during the year-long inquiry. The technique of developing awareness (acceptance) of polarised forces has also been traced to the writings of Jung, and can be seen as facilitating the development of time competence. The less one is investing interest in polarised issues, the more one can attend to the ongoing gestaltung formation process.

Thus, these two basic techniques were employed with other supportive techniques, in order to promote the type of results described earlier. As Kohler made clear, the problem of learning is secondary to the problem of perception; for the key to learning is the discovery of the right response, which is dependent upon the "structuring of the field" or Gestalt formation.

The present writer is deliberately, if tentatively, linking Gestalt methodology to learning theory. The reason for this is that behaviour therapists, despite theoretical schisms can be argued to be the practitioners who come closest to using the methods of Gestalt
therapy. The successful effects of operant conditioning when limited to singular behaviour disorders have shown empirically the possibility of extinguishing problematic behaviour 'here and now' learning new behaviours.

The Gestalt position de-emphasises historical antecedents, causes, disease concepts and the like. Instead, it is concerned with the functional behaviour on the perception level, where behaviour modification social learning such as imitation and identification, counter-conditioning, cognitive learning, reward and punishment, persuasion in the form of warmth and empathy, can be utilised to elicit permissiveness and free behaviour instead of manipulating and controlling the responses of the patient. Its main difference from behaviour modification methods is that the latter are symptom-oriented treatments, whereas Gestalt methods are more of an integral process guiding the patient towards clarity and comfort within his own world conception.

One point commonly accepted concerning behaviour modification procedure is that the patient can expect a decrease in the problematic area, but will not necessarily find any personality changes ensuing from treatment. On the other hand, more "dynamic psychotherapies" claim that there is a change in the individual personality. These two approaches appear to be polarised in both theory, practice and results.

The present author argues that by applying the several simple Gestalt principles, such as time-competence and the method of resolving polarised forces with learning theory practices, a clear and precise method of re-learning healthy behaviour can be developed for use with a large majority of psychiatric patients, the primary exception being psychotics.
The results demonstrate that the present author, applying the methods of Gestalt therapy upon a cross-section of psychiatric day hospital patients as well as on a sample of non-patient volunteers, found benefits in the terms previously described.

When examining the results with individual subjects, we find several patterns of response developing within the Gestalt method of therapy. First, we notice that those individuals who were capable of clearly expressing their experience in an "extrovert" fashion were able to benefit most from the therapeutic methods. These individuals could be characterised as having a willingness to examine their problems and negative behaviours in a forthright fashion.

This optimum patient may be one who is fairly fluid in construct formation, willing to communicate his experience verbally and having a certain degree of self-actualising potential. As well as these above characteristics, this "ideal" patient would also be fairly responsive in an interactive dialogue and capable of trusting the therapeutic setting.

The results with this type of patient showed a considerable drop in all six of the MMPI symptom categories, an across-the-board increase in the level of self-actualisation traits and values as measured by the POI, the development of a centralised position of the self in relation to all other constructs, as measured by the Kelly "Rep Test", a narrowing discrepancy of thoughts and feelings and a narrowing of Self/Ideal-Self discrepancies, as measured by the Semantic Differential.

The idea of an ideal patient for psychotherapy had also been researched by Nash (1965). He found significantly different outcomes favouring the more attractive patients, e.g., "YAVIS" - Young, Attractive, Verbal, Intelligent and Successful. The only difference
here is that we of the Gestalt position are concerned with individuals who can communicate their experience as well as work experimentally with their perceptions and modes of behaviour.

The patients who benefitted less can be characterised as follows: First, these individuals tended to be more introverted and frequently "absent-minded" or "drifting" off into thoughts which were not related to the present situation. They also had a tendency to be devious or untruthful about their feelings and perceptions. An element which would constantly prevent any benefit from the Gestalt approach would be mistrust of the therapeutic setting and a refusal to explore one's problems. This "defensive" individual would most likely block interventions, rendering the approach ineffective, unexplorative and wasteful.

Individuals who have developed fixed construct systems would also find initial difficulties with the approach. It was felt clinically that those individuals who had fixed illusions concerning their world perception were resistant to the Gestalt treatment.

The results of those individuals described above showed a characteristic marginal shift on the Kelly "Hept Test", as well as slight shifting on the Semantic differential. Improvements on the MHQ occurred only on the hysterical and obsessive-compulsive scales for this instrument. The POI results showed improvements on only some of the several scales with a characteristic low self-esteem rating.

Referring to the study by Green and Cowley conducted at the Maudsley Hospital over a 4-6 year follow-up investigation, we find several facts of interest. These findings showed that patients who suffered with depression, hysteria and anxiety reactions, had the most favourable outcomes, while those with obsessive-compulsive or hypocondriatic symptoms had poor outcomes.
Yet we find with the more difficult patients some benefits in the area of obsessive-compulsive traits and symptoms and in somatic symptoms with the Gestalt treatment. The reason for this may be that the key issues of living through problematic experience, as well as adequately directing one's perceptions to body feelings, may have some beneficial results when used as a single method of therapy.

Clearly an ideal research design into the effects of therapy outcome, would require access to a very large number of subjects. This can only be accomplished on the institutional level. One would require a team of practitioners, a team of researchers, and a vast number of available subjects from which to select.

Unfortunately, it is not within the confines of a single-investigator inquiry to carry out such an ideal study. The main obstacle is in establishing the needed three additional control groups which, in itself, offers seven matching problems.

The first control group would have to consist of ordinary people who are not clinically defined. This is necessary in order to establish base lines and to check for score changes that might occur simply as a function of time.

The second control group would be a group receiving a contrasting form of therapy. This would allow us to compare one form of therapy with the contrasting form of therapy. In our first research investigation this second type of control group existed only in the form of a combined Gestalt treatment and traditional method of object-relation psychoanalytic therapy.

The third control group would consist of individuals who are similar in psychiatric definition to the experimental group, but who would have to be left untreated over the same period of time. This immediately raises ethical implications in terms of leaving a
population of needy psychiatric patients alone and unattended.

The experimental group plus all three control groups are needed in order to perform an ideal experiment. This requirement confronts the researcher with major problems in matching variables such as psychiatric condition, age, social class, intelligence and a number of other variables which might be argued to be relevant.

Within the limits of the much more confined experimental design used here it has been possible to show two things: Firstly, that Gestalt therapy appears to benefit its receivers at least clearly enough to justify further evaluation in more extensive research designs.

Secondly, the inquiry has indicated that there may be several psychological process variables which could be involved in the course of therapy, which have previously been unexplored and might possibly open new directions in therapeutic research. Thus, the purpose of the research has been two-fold: to indicate to some degree whether or not the therapy is helpful, and additionally, to explore reasons why it might be helpful. These have been described above, as well as suggested in the introduction.

In order to secure a control group for the second inquiry, the present investigator attempted to locate a comparable number of professional people who were similar in background to the experimental group. Such a group was located - they were undergoing a programme of Yoga training. Unfortunately, the second group's motivation to answer and complete all questionnaires and grid tests was disappointingly low. The number of completed tests from this second group was too few to act as a control.

However, the results of the second inquiry are parallel and highly similar in direction of change to the results in the experimental group of the first investigation. It is highly unlikely
that the direction of change occurring in the second inquiry was purely due to chance and re-testing, because the results proved significant in three out of four test instruments. Furthermore, the control group in our first investigation had several distinct differences in the direction of change when compared with the experimental group in the first investigation. These similarities of significant shifts in the direction of change that occurred in both investigations support one another in both of the investigations.

Lastly, further investigations along the following lines would be of interest. We might try to isolate specific theoretical and technological aspects of the therapy and then apply them singularly through a behaviour modification programme. We need to find how many principles and under what range of possibilities could we apply these methods in terms of learning theory. For example, it might be possible to isolate the theoretical issue of here-and-now presentness (or, for that matter, the technique of resolving polarised forces), then apply the technique through reinforcement procedures and test the results on different psychological dimensions and measures.

One possibility might be to teach patients figure/ground perception. A set programme could be developed to reinforce figure/ground perception training. For example, one could teach figure/ground visual appreciation through the use of paintings, photographs or training films. This could offer alternative methods to be used alongside other therapeutic treatments. This same procedure could be applied to music appreciation, taste and food appreciation, dance, movement and sensory awareness. Research programmes gauging the results of these procedures could also be applied to monitor what psychological changes, if any, occur.
A further series of possibilities arises if we are able to confine a psychiatric community to the philosophy and methods of the Gestalt approach. Researching the results through various psychological measures and methods, we could acquire further indications of the applicability and range of the effects that this approach might offer.
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<td>T&lt;sub&gt;1&lt;/sub&gt;/T&lt;sub&gt;C&lt;/sub&gt;</td>
<td>TIME RATIO Time Incompetence/Time Competence - measures whether or not use of time is efficient</td>
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<td>127 (2)</td>
<td>O/I</td>
<td>SUPPORT RATIO Other/Inner - measures whether reactivity orientation is basically toward others or self</td>
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<tr>
<td>II. Sub-Scales (10)</td>
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<tr>
<td>26 (1)</td>
<td>SAV</td>
<td>SELF-ACTUALIZING VALUE Measures affirmation of a primary value of self-actualizing people</td>
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<tr>
<td>32 (2)</td>
<td>Ex</td>
<td>EXISTENTIALITY Measures ability to situationally or existentially react without rigid adherence to principles</td>
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<tr>
<td>23 (3)</td>
<td>Fr</td>
<td>FEELING REACTIVITY Measures sensitivity of responsiveness to one's own needs and feelings</td>
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<tr>
<td>17 (4)</td>
<td>S</td>
<td>SPONTANEITY Measures freedom to react spontaneously or to be oneself</td>
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<tr>
<td>16 (5)</td>
<td>Sr</td>
<td>SELF REGARD Measures affirmation of self because of worth or strength</td>
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<tr>
<td>26 (6)</td>
<td>Sa</td>
<td>SELF ACCEPTANCE Measures affirmation or acceptance of self in spite of weaknesses or deficiencies</td>
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<tr>
<td>16 (7)</td>
<td>Nc</td>
<td>NATURE OF MAN Measures degree of the constructive view of the nature of man, masculinity, femininity</td>
</tr>
<tr>
<td>9 (8)</td>
<td>Sy</td>
<td>SYNERGY Measures ability to be synergistic, to transcend dichotomies</td>
</tr>
<tr>
<td>25 (9)</td>
<td>A</td>
<td>ACCEPTANCE OF AGGRESSION Measures ability to accept one's natural aggressiveness as opposed to defensiveness, denial, and repression of aggression</td>
</tr>
<tr>
<td>28 (10)</td>
<td>C</td>
<td>CAPACITY FOR INTIMATE CONTACT Measures ability to develop contactful intimate relationships with other human beings, unencumbered by expectations and obligations</td>
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PERSONAL ORIENTATION INVENTORY

EVERETT L. SHOSTROM, Ph.D.

DIRECTIONS

This inventory consists of pairs of numbered statements. Read each statement and decide which of the two paired statements most consistently applies to you.

You are to mark your answers on the answer sheet you have. Look at the example of the answer sheet shown at the right. If the first statement of the pair is TRUE or MOSTLY TRUE as applied to you, blacken between the lines in the column headed "a". (See Example Item 1 at right.) If the second statement of the pair is TRUE or MOSTLY TRUE as applied to you, blacken between the lines in the column headed "b". (See Example Item 2 at right.) If neither statement applies to you, or if they refer to something you don't know about, make no answer on the answer sheet. Remember to give YOUR OWN opinion of yourself and do not leave any blank spaces if you can avoid it.

In marking your answers on the answer sheet, be sure that the number of the statement agrees with the number on the answer sheet. Make your marks heavy and black. Erase completely any answer you wish to change. Do not make any marks in this booklet.

Remember, try to make some answer to every statement.

Before you begin the inventory, be sure you put your name, your sex, your age, and the other information called for in the space provided on the answer sheet.

NOW OPEN THE BOOKLET AND START WITH QUESTION 1.
I am bound by the principle of fairness.
I am not absolutely bound by the principle of fairness.

When a friend does me a favor, I feel that I must return it.
When a friend does me a favor, I do not feel that I must return it.

I feel I must always tell the truth.
I do not always tell the truth.

No matter how hard I try, my feelings are often hurt.

If I manage the situation right, I can avoid being hurt.

I feel that I must strive for perfection in everything that I undertake.
I do not feel that I must strive for perfection in everything that I undertake.

I often make my decisions spontaneously.
I seldom make my decisions spontaneously.

I am afraid to be myself.
I am not afraid to be myself.

a. I feel obligated when a stranger does me a favor.
b. I do not feel obligated when a stranger does me a favor.
a. I feel that I have a right to expect others to do what I want of them.
b. I do not feel that I have a right to expect others to do what I want of them.
a. I live by values which are in agreement with others.
b. I live by values which are primarily based on my own feelings.
a. I am concerned with self-improvement at all times.
b. I am not concerned with self-improvement at all times.

12. a. I feel guilty when I am selfish.
b. I don't feel guilty when I am selfish.
13. a. I have no objection to getting angry.
b. Anger is something I try to avoid.
14. a. For me, anything is possible if I believe in myself.
b. I have a lot of natural limitations even though I believe in myself.
15. a. I put others' interests before my own.
b. I do not put others' interests before my own.
16. a. I sometimes feel embarrassed by compliments.
b. I am not embarrassed by compliments.
17. a. I believe it is important to accept others as they are.
b. I believe it is important to understand why others are as they are.
18. a. I can put off until tomorrow what I ought to do today.
b. I don't put off until tomorrow what I ought to do today.
19. a. I can give without requiring the other person to appreciate what I give.
b. I have a right to expect the other person to appreciate what I give.
20. a. My moral values are dictated by society.
b. My moral values are self-determined.
21. a. I do what others expect of me.
b. I feel free to not do what others expect of me.
22. a. I accept my weaknesses.
b. I don't accept my weaknesses.
23. a. In order to grow emotionally, it is necessary to know why I act as I do.
b. In order to grow emotionally, it is not necessary to know why I act as I do.
24. a. Sometimes I am cross when I am not feeling well.
b. I am hardly ever cross.

GO ON TO THE NEXT PAGE
a. It is necessary that others approve of what I do.
b. It is not always necessary that others approve of what I do.

a. I am afraid of making mistakes.
b. I am not afraid of making mistakes.

a. I trust the decisions I make spontaneously.
b. I do not trust the decisions I make spontaneously.

My feelings of self-worth depend on how much I accomplish.
b. My feelings of self-worth do not depend on how much I accomplish.

a. I fear failure.
b. I don't fear failure.

My moral values are determined, for the most part, by the thoughts, feelings and decisions of others.
b. My moral values are not determined, for the most part, by the thoughts, feelings and decisions of others.

a. It is possible to live life in terms of what I want to do.
b. It is not possible to live life in terms of what I want to do.

a. I can cope with the ups and downs of life.
b. I cannot cope with the ups and downs of life.

a. I believe in saying what I feel in dealing with others.
b. I do not believe in saying what I feel in dealing with others.

Children should realize that they do not have the same rights and privileges as adults.
b. It is not important to make an issue of rights and privileges.

I can "stick my neck out" in my relations with others.
b. I avoid "sticking my neck out" in my relations with others.

36. a. I believe the pursuit of self-interest is opposed to interest in others.
b. I believe the pursuit of self-interest is not opposed to interest in others.

37. a. I find that I have rejected many of the moral values I was taught.
b. I have not rejected any of the moral values I was taught.

38. a. I live in terms of my wants, likes, dislikes and values.
b. I do not live in terms of my wants, likes, dislikes and values.

39. a. I trust my ability to size up a situation.
b. I do not trust my ability to size up a situation.

40. a. I believe I have an innate capacity to cope with life.
b. I do not believe I have an innate capacity to cope with life.

41. a. I must justify my actions in the pursuit of my own interests.
b. I need not justify my actions in the pursuit of my own interests.

42. a. I am bothered by fears of being inadequate.
b. I am not bothered by fears of being inadequate.

43. a. I believe that man is essentially good and can be trusted.
b. I believe that man is essentially evil and cannot be trusted.

44. a. I live by the rules and standards of society.
b. I do not always need to live by the rules and standards of society.

45. a. I am bound by my duties and obligations to others.
b. I am not bound by my duties and obligations to others.

46. a. Reasons are needed to justify my feelings.
b. Reasons are not needed to justify my feelings.

GO ON TO THE NEXT PAGE
There are times when just being silent is the best way I can express my feelings.
I find it difficult to express my feelings by just being silent.

I often feel it necessary to defend my past actions.
I do not feel it necessary to defend my past actions.

I like everyone I know.
I do not like everyone I know.

Criticism threatens my self-esteem.
Criticism does not threaten my self-esteem.

I believe that knowledge of what is right makes people act right.
I do not believe that knowledge of what is right necessarily makes people act right.

I am afraid to be angry at those I love.
I feel free to be angry at those I love.

My basic responsibility is to be aware of my own needs.
My basic responsibility is to be aware of others' needs.

Impressing others is most important.
Expressing myself is most important.

To feel right, I need always to please others.
I can feel right without always having to please others.

I will risk a friendship in order to say or do what I believe is right.
I will not risk a friendship just to say or do what is right.

I feel bound to keep the promises I make.
I do not always feel bound to keep the promises I make.

I must avoid sorrow at all costs.
It is not necessary for me to avoid sorrow.

59. a. I strive always to predict what will happen in the future.
   b. I do not feel it necessary always to predict what will happen in the future.

60. a. It is important that others accept my point of view.
   b. It is not necessary for others to accept my point of view.

61. a. I only feel free to express warm feelings to my friends.
   b. I feel free to express both warm and hostile feelings to my friends.

62. a. There are many times when it is more important to express feelings than to carefully evaluate the situation.
   b. There are very few times when it is more important to express feelings than to carefully evaluate the situation.

63. a. I welcome criticism as an opportunity for growth.
   b. I do not welcome criticism as an opportunity for growth.

64. a. Appearances are all-important.
   b. Appearances are not terribly important.

65. a. I hardly ever gossip.
   b. I gossip a little at times.

66. a. I feel free to reveal my weaknesses among friends.
   b. I do not feel free to reveal my weaknesses among friends.

67. a. I should always assume responsibility for other people's feelings.
   b. I need not always assume responsibility for other people's feelings.

68. a. I feel free to be myself and bear the consequences.
   b. I do not feel free to be myself and bear the consequences.

GO ON TO THE NEXT PAGE
a. I already know all I need to know about my feelings.
b. As life goes on, I continue to know more and more about my feelings.

a. I hesitate to show my weaknesses among strangers.
b. I do not hesitate to show my weaknesses among strangers.

a. I will continue to grow only by setting my sights on a high-level, socially approved goal.
b. I will continue to grow best by being myself.

a. I accept inconsistencies within myself.
b. I cannot accept inconsistencies within myself.

a. Man is naturally cooperative.
b. Man is naturally antagonistic.

a. I don't mind laughing at a dirty joke.
b. I hardly ever laugh at a dirty joke.

a. Happiness is a by-product in human relationships.
b. Happiness is an end in human relationships.

a. I only feel free to show friendly feelings to strangers.
b. I feel free to show both friendly and unfriendly feelings to strangers.

a. I try to be sincere but I sometimes fail.
b. I try to be sincere and I am sincere.

a. Self-interest is natural.
b. Self-interest is unnatural.

a. A neutral party can measure a happy relationship by observation.
b. A neutral party cannot measure a happy relationship by observation.

a. For me, work and play are the same.
b. For me, work and play are opposites.

81. a. Two people will get along best if each concentrates on pleasing the other.
b. Two people can get along best if each person feels free to express himself.

82. a. I have feelings of resentment about things that are past.
b. I do not have feelings of resentment about things that are past.

83. a. I like only masculine men and feminine women.
b. I like men and women who show masculinity as well as femininity.

84. a. I actively attempt to avoid embarrassment whenever I can.
b. I do not actively attempt to avoid embarrassment.

85. a. I blame my parents for a lot of my troubles.
b. I do not blame my parents for my troubles.

86. a. I feel that a person should be silly only at the right time and place.
b. I can be silly when I feel like it.

87. a. People should always repent their wrongdoings.
b. People need not always repent their wrongdoings.

88. a. I worry about the future.
b. I do not worry about the future.

89. a. Kindness and ruthlessness must be opposites.
b. Kindness and ruthlessness need not be opposites.

90. a. I prefer to save good things for future use.
b. I prefer to use good things now.

91. a. People should always control their anger.
b. People should express honestly-felt anger.

GO ON TO THE NEXT PAGE
a. The truly spiritual man is sometimes sensual.
b. The truly spiritual man is never sensual.
a. I am able to express my feelings even when they sometimes result in undesirable consequences.
b. I am unable to express my feelings if they are likely to result in undesirable consequences.
a. I am often ashamed of some of the emotions that I feel bubbling up within me.
b. I do not feel ashamed of my emotions.
a. I have had mysterious or ecstatic experiences.
b. I have never had mysterious or ecstatic experiences.
a. I am orthodoxly religious.
b. I am not orthodoxly religious.
a. I am completely free of guilt.
b. I am not free of guilt.
a. I have a problem in fusing sex and love.
b. I have no problem in fusing sex and love.
a. I enjoy detachment and privacy.
b. I do not enjoy detachment and privacy.
a. I feel dedicated to my work.
b. I do not feel dedicated to my work.
a. I can express affection regardless of whether it is returned.
b. I cannot express affection unless I am sure it will be returned.

Living for the future is as important as living for the moment.
Only living for the moment is important.
It is better to be yourself.
It is better to be popular.
Wishing and imagining can be bad.
Wishing and imagining are always good.

105. a. I spend more time preparing to live.
b. I spend more time actually living.

106. a. I am loved because I give love.
b. I am loved because I am lovable.

107. a. When I really love myself, everybody will love me.
b. When I really love myself, there will still be those who won't love me.

108. a. I can let other people control me.
b. I can let other people control me if I am sure they will not continue to control me.

109. a. As they are, people sometimes annoy me.
b. As they are, people do not annoy me.

110. a. Living for the future gives my life its primary meaning.
b. Only when living for the future ties into living for the present does my life have meaning.

111. a. I follow diligently the motto, "Don't waste your time."
b. I do not feel bound by the motto, "Don't waste your time."

112. a. What I have been in the past dictates the kind of person I will be.
b. What I have been in the past does not necessarily dictate the kind of person I will be.

113. a. It is important to me how I live in the here and now.
b. It is of little importance to me how I live in the here and now.

114. a. I have had an experience where life seemed just perfect.
b. I have never had an experience where life seemed just perfect.

115. a. Evil is the result of frustration in trying to be good.
b. Evil is an intrinsic part of human nature which fights good.

GO ON TO THE NEXT PAGE
a. A person can completely change his essential nature.
b. A person can never change his essential nature.

a. I am afraid to be tender.
b. I am not afraid to be tender.

a. I am assertive and affirming.
b. I am not assertive and affirming.

a. Women should be trusting and yielding.
b. Women should not be trusting and yielding.

a. I see myself as others see me.
b. I do not see myself as others see me.

a. It is a good idea to think about your greatest potential.
b. A person who thinks about his greatest potential gets conceited.

a. Men should be assertive and affirming.
b. Men should not be assertive and affirming.

a. I am able to risk being myself.
b. I am not able to risk being myself.

a. I feel the need to be doing something significant all of the time.
b. I do not feel the need to be doing something significant all of the time.

a. I suffer from memories.
b. I do not suffer from memories.

a. Men and women must be both yielding and assertive.
b. Men and women must not be both yielding and assertive.

a. I like to participate actively in intense discussions.
b. I do not like to participate actively in intense discussions.

a. I am self-sufficient.
b. I am not self-sufficient.

a. I like to withdraw from others for extended periods of time.
b. I do not like to withdraw from others for extended periods of time.

a. I always play fair.
b. Sometimes I cheat a little.

a. Sometimes I feel so angry I want to destroy or hurt others.
b. I never feel so angry that I want to destroy or hurt others.

a. I feel certain and secure in my relationships with others.
b. I feel uncertain and insecure in my relationships with others.

a. I like to withdraw temporarily from others.
b. I do not like to withdraw temporarily from others.

a. I can accept my mistakes.
b. I cannot accept my mistakes.

a. I find some people who are stupid and uninteresting.
b. I never find any people who are stupid and uninteresting.

a. I regret my past.
b. I do not regret my past.

a. Being myself is helpful to others.
b. Just being myself is not helpful to others.

a. I have had moments of intense happiness when I felt like I was experiencing a kind of ecstasy or bliss.
b. I have not had moments of intense happiness when I felt like I was experiencing a kind of bliss.
a. People have an instinct for evil.
b. People do not have an instinct for evil.

a. For me, the future usually seems hopeful.
b. For me, the future often seems hopeless.

a. People are both good and evil.
b. People are not both good and evil.

a. My past is a stepping stone for the future.
b. My past is a handicap to my future.

a. "Killing time" is a problem for me.
b. "Killing time" is not a problem for me.

a. For me, past, present and future is in meaningful continuity.
b. For me, the present is an island, unrelated to the past and future.

a. My hope for the future depends on having friends.
b. My hope for the future does not depend on having friends.

146. a. I can like people without having to approve of them.
b. I cannot like people unless I also approve of them.

147. a. People are basically good.
b. People are not basically good.

148. a. Honesty is always the best policy.
b. There are times when honesty is not the best policy.

149. a. I can feel comfortable with less than a perfect performance.
b. I feel uncomfortable with anything less than a perfect performance.

150. a. I can overcome any obstacles as long as I believe in myself.
b. I cannot overcome every obstacle even if I believe in myself.
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**INCOMPETENT**

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**REPRODUCTION OF THIS FORM BY ANY MEANS STRICTLY PROHIBITED**
BRIEF DESCRIPTION OF WHAT THE POI MEASURES

Your profile on the Personal Orientation Inventory (POI) shows the degree to which your attitudes and values compare with those of self-actualizing people. A self-actualizing person is one who is more fully functioning and who lives a more enriched life than does the average person. Such a person is developing and utilizing his unique talents to the fullest extent. It is generally agreed that a self-actualizing person might be seen as the desired result of the process of counseling or psychotherapy.

The interpretation of your scores falls into two general categories, the ratio scores and the profile scores. If your ratio scores are close to the scores that self-actualizing persons make, you may consider your values and attitudes, as measured by the POI, to be similar to these people. Your profile scores will further help you to compare yourself with self-actualizing people.

RATIO SCORES

Interpretation of the $T_I - T_C$ Ratio

In order to understand the Time Incompetent - Time Competent ($T_I - T_C$) ratio, it is of help to consider time in its three basic components — Past, Present, and Future.

The $T_I$ (Time Incompetent) person is one who lives primarily in the Past, with guilt, regret, and resentments, and/or in the future, with idealized goals, plans, expectations, predictions, and fears.

In contrast to the $T_I$ person, the $T_C$ (Time Competent) person lives primarily in the Present with full awareness, contact, and full feeling reactivity. Because it is known that the self-actualizing person is not perfect, he is understood to be partly $T_I$ and partly $T_C$. His $T_I - T_C$ ratio is, on the average, 1 to 8. His ratio shows that he therefore lives primarily in the Present and only secondarily in the Past or Future.

If your score is significantly lower than 1 to 8, for example 1 to 3, this suggests that you are more time incompetent than the self-actualizing person. If your score is above 1 to 8, for example 1 to 10, this suggests that you are excessively time competent and this may perhaps reflect a need to appear more self-actualized than you really are.

Interpretation of the $O - I$ Ratio

In order to understand your score on the Support (Other - Inner) ratio, one should first understand that the self-actualizing person is both "other-directed" in that he is dependent upon and supported by other persons' views, and he is also "inner-directed" in that he is independent and self-supportive. The degree to which he is each of these can be expressed in a ratio. The $O - I$ ratio of a self-actualizing person is, on the average, 1 to 3, which means that he depends primarily on his own feelings and secondarily on the feelings of others in his life decisions.

If your score is significantly higher than 1 to 3, that is 1 to 4 or above, it may be that this indicates an exaggerated independence and reflects a need to appear "too self-actualized" in responding to the POI. On the other hand, if your score is lower than 1 to 3, for example 1 to 1, it would suggest that you are in the dilemma of finding it difficult to trust either your own or others' feelings in making important decisions.

PROFILE SCORES

On the Profile Sheet, short descriptions of each of the sub-scales are shown which describe high and low scores. In general, scores above the average on these scales, that is, above the mid-line shown by a standard score of 50, but below a standard score of 60 are considered to be most characteristic of self-actualizing adults. The closer your scores are to this range, the more similar are your responses to the POI responses given by self-actualizing people. The further below the score 50 your scores are, the more they represent areas in which your responses are not like those of self-actualizing people. If most of your scores on the profile are considerably above 60, you may be presenting a picture of yourself which is "too" healthy or which overemphasizes your freedom and self-actualization. Your counselor can discuss the psychological rationale of each scale in greater detail with you.

The ratings from this inventory should not be viewed as fixed or conclusive. Instead they should be viewed as merely suggestive and to be considered in the light of all other information. The Personal Orientation Inventory is intended to stimulate thought and discussion of your particular attitudes and values. Your profile will provide a starting point for further consideration of how you can achieve greater personal development.
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- -95
- -100
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- -110
- -115
- -120
- -125

**TIME INCOMPETENT**
- LIVES IN THE PAST OR FUTURE

**OTHER DIRECTED**
- DEPENDENT, SEeks SUPPORT OF OTHERS' VIEWS

**REJECTS VALUES OF SELF-ACTUALIZING PEOPLE**
- RIGID IN APPLICATION OF VALUES

**INSENSITIVE TO OWN NEEDS AND FEELINGS**
- FEARFUL OF EXPRESSING FEELINGS BEHAVIORALLY

**HAS LOW SELF-WORTH**
- UNABLE TO ACCEPT SELF WITH WEAKNESSES

**SEES MAN AS ESSENTIALLY EVIL**
- SEES OPPOSITES OF LIFE AS ANTAGONISTIC

**DENIES FEELINGS OF ANGER OR AGGRESSION**
- HAS DIFFICULTY WITH WARM INTERPERSONAL RELATIONS

---

**T<sub>C</sub> - T<sub>C</sub> (Time) Ratio:**
- SELF-ACTUALIZING AVERAGE: T<sub>C</sub> / T<sub>C</sub> = 1:8
- Your Ratio: T<sub>C</sub> / T<sub>C</sub> = 1:4

**O - I (Support) Ratio:**
- SELF-ACTUALIZING AVERAGE: O : I = 1:3
- Your Ratio: O : I = 1:1
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### TIME COMPETENCE

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<th>$\sigma$</th>
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**SPONTANEITY**

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<td>- 2.834**</td>
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**SELF-REGARD**

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<td>$D(M_2 - M_1)$</td>
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### Nature of Man

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<td>+2.037</td>
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### Synergy

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<td>10.17</td>
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### Acceptance of Aggression

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<td>Pre-test</td>
<td>13.33</td>
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<td>-2.84</td>
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### Pre-test

<table>
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<tr>
<td><strong>Pre-test</strong></td>
<td>14.92</td>
<td>4.37</td>
<td>19.75</td>
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<td>- 4.83</td>
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<td>19.83</td>
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### Ratio Score $T_c/T_i$

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### Ratio Score I/O

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<td>2.10</td>
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**Remarks:**

The experimental group consisted of 12 subjects treated by psycho-analytic and Gestalt therapeutic methods.

The control group consisted of 12 subjects treated by psycho-analytic methods only.

If $df = 22$, then are the $t$-values of one-tailed testing: $t_{.05} = 1.717$; $t_{.01} = 2.508$; $t_{.005} = 2.819$; and $t_{.0005} = 3.792$.

If $df = 11$, then are the $t$-values of one-tailed testing: $t_{.06} = 1.796$; $t_{.01} = 2.718$; $t_{.005} = 3.106$; and $t_{.0005} = 4.427$.

The meaning of the symbols used above:

- $M_e$ = the mean of the sum-scores of the experimental subjects
- $M_c$ = the mean of the sum-scores of the control-subjects
- $D_e$ = difference-score
- $t$ = $t$-value of the difference-score
- $M_2$ = the mean of the sum-scores at the pre-test
- $M_1$ = the mean of the sum-scores at the post-test

**Critical Ratio Significance Levels:**

- $* * *$ = .05
- $* *$ = .01
- $* * *$ = .005
- $* * * *$ = .0005
Problem or complaint ...........................................................
...........................................................................................
...........................................................................................

In general, how much does this problem or complaint bother you?

- Couldn't be worse
- Very much
- Pretty much
- A little
- Not at all

Patient's name .................................................................  Date ........................................

Reason .................................................................  Occasion .................................
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