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DIAGNOSING IN THE HERE AND NOW: THE EXPERIENCE CYCLE AND DSM-IV

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Editor's Note: This paper utilises the 'experience cycle' as the basis of a Gestalt therapy diagnostic system. First, diagnosis is defined and the Gestalt approach is differentiated from other theoretical orientations. Then, the Gestalt experience is described and specific DSM-IV formulations (borderline, specific phobia, histrionic, post-traumatic stress disorder) are analysed utilising the cycle as a template. Last, intervention strategies are suggested. This paper is adapted from a chapter in *Experiential Psychotherapy*, edited by Leslie Greenberg, Germain Lietaer, and Jeanne Watson, to be published by the Guilford Press, New York in 1998. It is published here by permission.

Key words: Gestalt therapy, diagnosis, assessment, experience cycle, borderline, phobia, histrionic, post-traumatic stress disorder

This paper explores formal diagnosis (DSM-IV) from the theoretical perspective of Gestalt therapy. The Gestalt therapy 'experience cycle' (Polster and Polster, 1973; Zinker, 1977) will be presented as the basis of a diagnostic system (see Figure 1.). Specific diagnostic formulations from DSM-IV (borderline, specific phobia, histrionic and post-traumatic stress syndrome) will be analysed and intervention strategies will be articulated.

What is Diagnosis?

Diagnosis is first and foremost a descriptive statement that articulates what is being noticed in the present. Yet it also means going beyond the present, implying a pattern as well as a prediction, no matter how minimal. In addition, diagnosis may or may not include a concept of causality. Thus, to diagnose is to attempt to enlarge the picture, to move from what is observable now to what is habitual. It includes a schema not only of what is to be observed, but also of *how* it is to be observed.

Gestalt theory does not imply a system of cause. Gestalt therapists believe in causation, but perceive it as inherently unknowable. Aligned with both a systems (Kraus, 1989; Huckabay, 1992) and field theory (Parlett, 1991; 1993) perspective, they are aware that the number of influences that impinge on any given system is so vast that a full and meaningful description of cause is improbable, if not impossible.

As indicated previously, Gestalt therapists believe that one constantly derives meaning after first organising unorganised experience. Gestaltists believe that this 'meaning making' is arbitrary, since it is selective and incorporates, along with the patient's behaviour, both the diagnostician and the environmental field.

Despite this strongly-held belief, there are several compelling reasons for diagnosing in a more formal, narrow and systematic manner. First, diagnosis gives one a map and describes possibilities of how a person can evolve. Therefore, the therapist benefits from a structure – that is, a compass to help organise the information and provide clues to a direction to navigate through the vast field of data.

Second, the process of diagnosing allows the therapist to control anxiety. By removing oneself from the data, the therapist may remain calm while waiting for a figure to emerge. Thus, the process of diagnosing is grounding and keeps the therapist from jumping precipitously into the infinite while waiting. Simply stated, it gives one something to do.

A third reason to diagnose in a more formal way is that it is economical. By linking Gestalt theory to other systems of diagnosis, a vast array of research and theory opens to the clinician. Furthermore, it is also efficient in that the therapist can make predictions without having to

wait each time for the data to emerge from immediate experience.

Fourth, Gestalt therapists in particular need to be grounded in a wider perspective that includes the future, and particularly the past. Although Gestalt therapists explore the patient's past, this exploration is of a different nature. 'We explore phenomenologically in order to understand, not believing that the past caused the present.' (Yontef, 1988).

Finally, diagnosing prevents the Gestalt therapist from becoming isolated from others with different theoretical orientations. Consequently, Gestalt theorists, even while debating issues concerning process versus structure, still use traditional diagnostic labels such as schizophrenia, narcissism and borderline (From, 1984; Tobin, 1985). Thus, although the use of diagnostic categories may not be totally congruent with our theory, we still employ them in communicating with others.

How Do Gestalt Therapists Diagnose?

Traditionally, Gestalt therapists have diagnosed by paying attention to the phenomenon in the moment. At some point, an aspect of behaviour becomes interesting, something stands out and a pattern emerges. This pattern might lead to a diagnostic statement such as 'The patient appears to be retroflecting' (constricting his or her emotions). The remaining therapeutic work in the session might be focused on that retroflection. This form of diagnosis is valuable for a number of reasons. First, the behaviour is readily observable. Second, the techniques outlining how to work with retroflections are clearly articulated and straightforward. And third, the diagnosis defines a piece of therapeutic work that can often be satisfactorily completed in one therapy session.

It should be pointed out that Gestalt therapists do not have a single way to deal with the phenomenon of someone who characteristically – that is, more often than is usual – retroflects energy when faced with stressful situations. Furthermore, we do not have a theory for predicting if the constant work on retroflections will result in some enduring change by affecting the ground of the individual. The ground consists of the traces of experience, history and physiology contained in larger, deeper grooves out of which lively figures spring forth. This ground must ultimately be affected if a person is to experience a more permanent change.

The Experience Cycle and Character

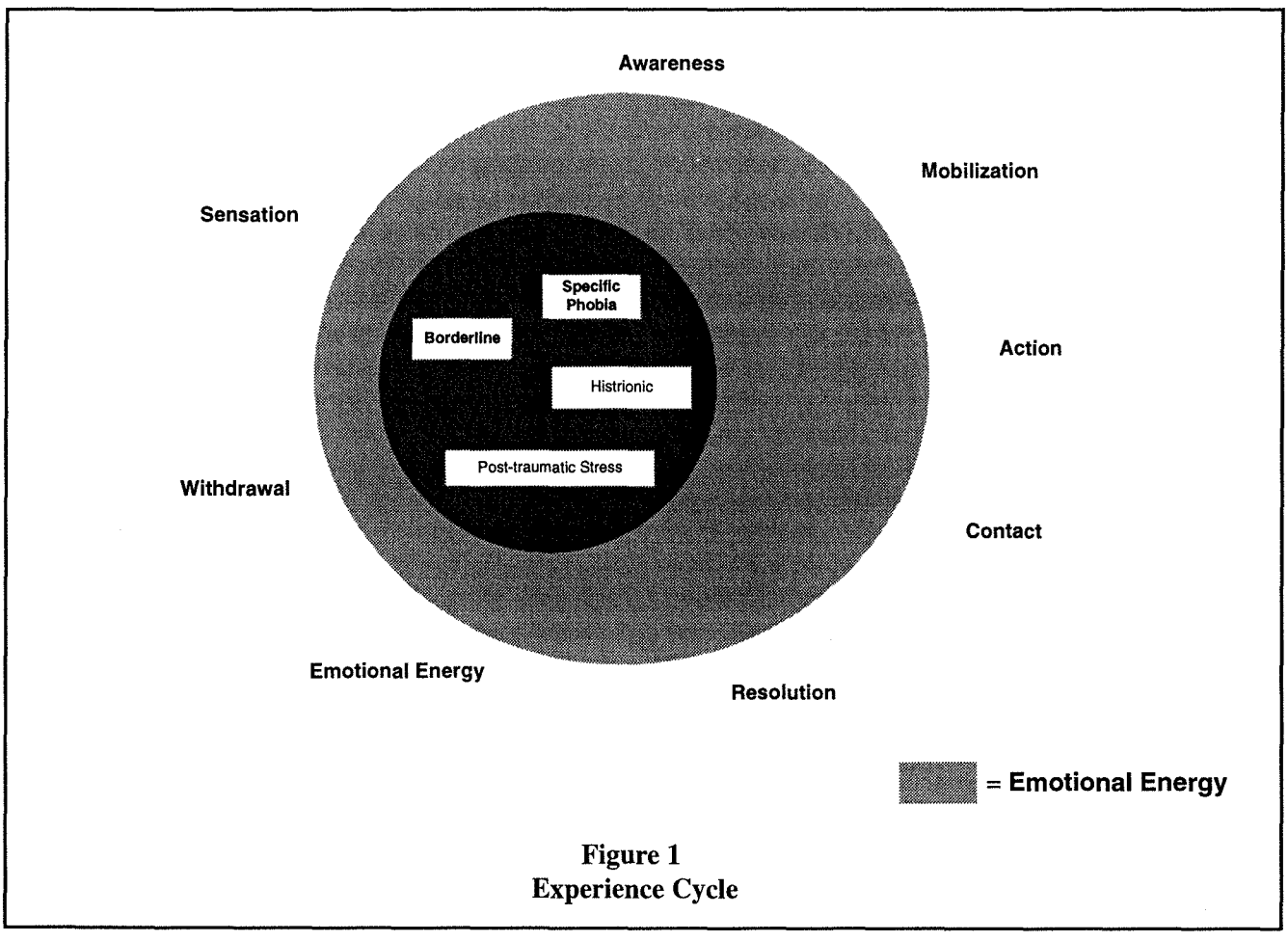

Figure 1
Experience Cycle

Healthy, organised functioning can be defined by breaking down figure formation and destruction into an 'experience cycle' (Zinker, 1977) which is illustrated in Figure 1.

The shaded portion represents emotional energy. Emotional energy builds from sensation to contact and then recedes through the withdrawal stage. Individual phases are placed around the outside of the outer circle and various disorders are placed along the inside of the inner circle. Their placement corresponds to the hypothesised original areas of blockage and distortion. It should be noted that the schema is a beginning attempt at integrating the cycle and DSM-IV diagnostic categories and rests on the following assumptions:

1. The stages of the experience cycle are in fact artificial demarcations of a continuous, flowing unit of experience; thus, the phases are overlapping.
2. Competence is directly related to the skills and abilities needed to articulate and complete each stage satisfactorily (Zinker and Nevis, 1981). Ultimately, being able to complete a cycle, to create and destroy a figure with clarity, defines healthy functioning (Wallen, 1957).
3. Although the cycle was originally intended to describe momentary experience, it can be extended to encompass larger periods of time.
4. The stages of the cycle reflect a developmental progression. The earlier in the cycle the disturbance occurs, the more the experience tends a) to consist of very old ingrained patterns; b) to be primarily physiologically (as opposed to behaviourally) influenced and c) to be less observable to others, and thus less amenable to therapeutic change.
5. A disturbance at one stage of the cycle will affect all remaining stages.
6. An understanding of the cycle is adequate to articulate therapeutic strategies and interventions. Utilising other theories to explain causality, although possibly useful, is not necessary.
7. Although one might intervene at later stages of the cycle with some success, character can be affected ultimately only by intervening at the phase where the disturbance originally occurred.
8. The intervention(s) must occur many times before any long-lasting changes occur.
9. When working as therapists, we are able to utilise direct observation to 'see' the patient move through the middle stages of the cycle where emotion is highest, that is, mobilisation, action and contact. Therefore, our understanding of the patient's experience during the other stages is usually inferred from self reports. Thus, most patient difficulties are originally noticed as an inability to mobilise emotion, move towards action or make contact. Much of therapeutic work involves pinpointing other phases that present difficulty and helping the patient develop skills and resources to move through and successfully complete these phases.
10. Although we recognise the difference between personality and neurotic disturbances, for purposes of illustration we are not distinguishing between them. This is in keeping with the DSM-IV. 'The coding of Personality Disorders should not be taken to imply that their pathogenesis or range of appropriate treatment is fundamentally different from that for the disorders coded on Axis 1.' (DSM-IV, p. 26)
11. For the purpose of this article we are ignoring relationship patterns as a primary vehicle for assessing blockage and distortion (see Evans, 1994). In fact, Gestalt therapy places much emphasis on here-and-now dialogue as well as the developing relationship between therapist and patient (see Melnick, 1997).

Sensation/Awareness Stage: Borderline Personality Disorder

Borderline Personality Disorder, as described in DSM-IV, is an example of blockage at the sensation/awareness level. Diagnostic criteria include:

A pervasive pattern of instability of interpersonal relationships, self-image, and affects and marked impulsivity beginning in early childhood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Frantic efforts to avoid real or imagined abandonment (does not include suicidal or self-mutilating behaviour covered in criterion 5).
2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge-eating). (Does not include suicidal or self-mutilating behaviour covered in criterion 5)
5. Recurrent suicidal behaviour, gestures, threats or self-mutilating behaviour.
6. Affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability or anxiety, usually lasting a few hours and only rarely more than a few days).
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms (p.654).

As one can surmise from the above diagnostic criteria, the borderline patient has little sensorial stability. These individuals cannot maintain a stable emotional response to input, whether internal or external. One result is high emotional lability and acontextual responses to stimulation. To use Gestalt terminology, the ground available to the borderline patient is non-supportive, resulting in an inability to tolerate more than minimal stimulation.

Whether it is caused by the distorted intake of sensations, the inability of an individual to code sensory stimuli into a manageable form, or the overloading of stimuli that interferes with figure formation, is of much theoretical debate. What is certain is that some individuals cannot easily tolerate, manage or translate these sensory stimuli into acceptable and manageable forms and figures.

It should be pointed out that sensations are difficult for all of us. Most of our sensory appetites are too large for what is organismically acceptable and thus we have to learn management techniques. However, most people do not have to deal with the variability, largeness and enormous distortion of sensation with which people who are characteristically bound in this phase must contend.

The therapeutic work with a borderline patient is to help with the management of sensations by lowering and limiting them at both an internal and external level. Once sensation is manageable, awareness can emerge and movement through the cycle can continue.

In psychotherapy, the task is to teach these patients to manage sensations by lowering input or, when this is impossible and stimulus overload occurs, by draining the mobilised energy through supportive and non-destructive forms of expression. The first task involves learning to slow down the input in order for the individual to run less of a risk of being flooded. Sensations need to be made smaller in order to form a figure that can be satisfactorily completed. This is accomplished by helping patients focus on and label accurately their experience.

Techniques that increase sensations, such as the use of the empty chair, are potentially dangerous (From, 1984), as are confrontational, behavioural and paradoxical interventions that tend to produce added or ambiguous sensory input. Another major therapeutic mistake would be to teach borderline patients management or repertoire expansion techniques that assume that their sensory mechanisms are working properly. The basic problem is not one of inadequate behavioural repertoires.

When flooding occurs, the therapeutic work involves teaching the patient to drain energy in a non-destructive way. Stimulus overload can be minimised in this instance by a therapeutic stance of 'soft, clean contact'. It is here that the concept of soothing is important. If the therapist becomes upset – for example, becomes mobilised or increases his or her sensations – it will add to the patient's already excessive stimulation. The therapist must learn to keep internal stimulation low by self-soothing and ultimately by teaching the patient soothing techniques. (It is interesting that this approach to the treatment of borderlines is consistent with that articulated by the self-theorists and outlined by Tobin (1982) and Yontef (1983). However, unlike self-theorists and as stated in assumption 5, Gestalt theorists do not believe it is necessary to hypothesise a cause, e.g. a specific form of inadequate mothering, in order to prescribe an intervention).

Mobilisation-Specific Phobia

The second phase of the experience cycle occurs with the generation of emotional energy around sensation. If the energy gets trapped in the body and there is no muscle release, anxiety occurs. The way that the individual deals with this trapped emotional energy has historically been labelled psychoneurosis and, more recently, anxiety disorder. DSM-IV lists within this category such disorders as obsessive-compulsive, panic disorder and various phobias such as agoraphobia and specific phobias. One can also add to these a vast array of psychosomatic problems that result from this chronic blocking of emotional energy.

To illustrate mobilisation dysfunction, Specific Phobia has been chosen. The characteristics include:

1. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g. flying, heights, animals, receiving an injection, seeing blood).
2. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response which may take the form of a situationally bound or situationally predisposed panic attack. Note: In children, the anxiety may be expressed by crying, tantrums, freezing or clinging.
3. The person recognises that the fear is excessive or unreasonable. Note: In children, this feature may be absent.
4. The phobic situation(s) is avoided or else is endured with intense anxiety or distress.
5. The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
6. In individuals under age 18 years, the duration is at least six months.
7. The anxiety, panic attacks, or phobic avoidance associated with the specific object or situation is not better accounted for by another mental disorder, such

as Obsessive-Compulsive Disorder (e.g. fear of dirt in someone with an obsession about contamination); Post-Traumatic Stress Disorder (e.g. avoidance of stimuli associated with a severe stressor); Separation Anxiety Disorder (e.g. avoidance of school); Social Phobia (e.g. avoidance of social situations because of fear of embarrassment); Panic Disorder with Agoraphobia, or Agoraphobia Without History of Panic Disorder (p.411).

Phobias involve either the investment of too much emotion around an apparently appropriate figure (a person will not visit certain countries because of a fear of poisonous snakes) or the mobilisation of emotion around an apparently inappropriate awareness (a person avoids all heights but has no experience with trauma connected with them). In the second case, the sensation is given the incorrect meaning because the individual's system cannot tolerate the correct labelling of earlier sensations. Labelling of a sensation is connected to meaning given, appropriate and inappropriate; to sensations in previous awareness. Phobia involves the avoidance of the accurate meaning that could lead to a completion of the cycle that is accurate to the sensation. Instead, a distorted (symbolic) or incorrect meaning is given to the sensation.

Phobias are maladaptive because they do not lead to satisfactory completion. They do, however, often serve to discharge or deflect emotion, thus temporarily controlling it so that the individual can tolerate it. For example, as stated above, one may label certain sensations (increased heartbeat, tightness in the chest, sweaty palms etc.) as 'fear of heights'. This incorrect attribution of meaning allows the individual to function in a relatively anxiety-free manner as long as heights are avoided. However, if therapy produces the understanding that these sensations are attached to an avoidance of intimacy, then the patient is faced with a conflicting duality. Now it is possible to move toward emotional closeness with another, but only with an awareness of the heightened tension that such intimacy may create.

The two major manifestations of phobias are a distorted or exaggerated response to an appropriate object to be feared (e.g., a poisonous snake) that is generalised well beyond the object and a distorted or exaggerated response to a metaphorical, symbolic or psychologically-linked object that has little or no correlation with the appropriate sensation. Treatment involves the symbolic or *in vivo* matching of the correct figure with the stimulus so that completion can occur. Since much of what we call psychotherapy deals with the above, it might be best to categorise the approaches briefly.

Certain techniques lead to diminution of anxiety so that the person can re-experience the situation and attach the correct meaning to the sensation. These include many desensitisation and cognitive approaches. Others, such as meditative and breathing techniques, help the individual to tolerate the sensations so that a less distorted meaning can emerge. Still other approaches provide support so that people do not have to bear their pain and anxiety alone, thus helping them to complete the cycle. The financial, psychological and ideological support that our society is beginning to provide for Vietnam veterans and victims of sexual and psychological abuse are examples of this support. It should be noted that if a specific meaning emerges, then the patient may be diagnosed as suffering from post-traumatic stress, which is described in the last section.

In summary, to move through the mobilisation stage of the cycle means to discharge the trapped emotional energy so that a contactful figure that may lead to completion can be created. As with other stages, the work must be done over and over again in order for the emotional energy to be available for the generation of appropriate and adequate contact. The Gestalt approach allows the therapist to draw from a wide range of techniques to craft a procedure which fits both the patient and the symptomatology (Melnick, 1980).

Contact Phase: Histrionic Personality Disorder

The fourth stage of the experience cycle occurs when awareness, supported by appropriate emotional energy, results in a flexible and meaningful meeting of the self and the environment, usually in the form of an other. To meet phenomenologically implies that not only do I see, but also I am seen; that not only do I speak in order to reach you, but also I am heard. In the moment, each notices that there is a 'we' that is different from either alone.

Disturbance of contact results in experiences that do not fit within the range of 'good enough', but rather are too little or too much for a specific environmental context. An example is a hug that either has too little energy or is not warm enough or is inappropriately passionate given the environmental situation. Either extreme is jarring and incompatible and does not result in a joining experience. Both extremes are contextual disturbances in that the evaluation of too little or too much is made in relation to the other, to the self, to the situation, to the total phenomenological field. The expression 'too little energy', which typically involves the pulling back from another, has been historically labelled as retroflection, whereas 'too much energy' has been traditionally called hysterical or histrionic.

It should be noted that disturbances of contact, rather than reflecting characterological issues, might instead be a function of inadequate behavioural repertoires. (Repertoire evaluation can also occur at the movement action phase, which was described previously).

Traditionally, inadequate repertoires have been analysed and increased by education, including behaviour modification. Furthermore, the increasing and refinement of repertoires had, until recently, generally not been considered as falling within the domain of psychotherapy. However, if the therapeutic dilemma is not one of inadequate but, instead, one of fixed repertoires that limit and narrow a person's ability to make contact with the environment, then the behaviours do fall within the diagnostic guidelines of disorders.

Histrionic Personality Disorder is an example of disturbance of the contact boundary, as described by DSM-IV. Diagnostic criteria include:

A pervasive pattern of excessive emotionality and attention-seeking, beginning in early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Is uncomfortable in situations in which he or she is not the centre of attention.
2. Interaction with others is often characterised by inappropriate sexually seductive or provocative behaviour.
3. Displays rapidly shifting and shallow expression of emotions.
4. Consistently uses physical appearance to draw attention to self.
5. Has a style of speech that is excessively impressionistic and lacking in detail.
6. Shows self-dramatisation, theatricality and exaggerated expression of emotion.
7. Is suggestible, i.e. easily influenced by others or circumstances.
8. Considers relationships to be more intimate than they actually are (p. 658).

The stereotypical model of histrionic functioning is that of the flamboyant actor. Unfortunately this stereotype is often true for the histrionic character who wishes to be seen, heard, appreciated and applauded and is not very interested in others in more deep, complex ways. Thus, if a therapist attempts prematurely to create for the patient a more contactful experience, the therapist may encounter indifference at best and difficulty at worst.

The emotional energy in histrionic patients is inner determined, undisciplined and exaggerated and does not keep in tune with the environmental field. They are perpetually in action without benefit of an accurate awareness. Thus, the existential work with histrionic people is to help them bear the truth of their overly large existence. They are fated to take up a lot of room, to say a lot and to do a lot. Even though they may suffer from an energy disturbance, it would be a mistake to attempt directly to teach them to be aware of or change their energy. Histrionic people are only minimally interested in awareness for it complicates life and makes it less exciting.

Thus the dilemma for the therapist is how to help these patients slow down as well as become interested in the environmental field. Experiments that deal directly with slowing down the action, such as reading a menu completely before ordering food or counting to ten before acting, may be utilised. Further, having the patient learn to go inward before acting heightens the probability that the forthcoming action may be truly contactful. Thus, directing the patient to notice tension, breathing and so on might ultimately lead to a slowing down of movement.

To help these patients trade in their wish for simplicity for a more complex orientation to the world is difficult at best. However, experiments that teach them to notice environmental contexts, including other people, are beneficial. Examples include having the patient ask the therapist questions as well as notice and articulate physical and psychological boundaries.

Demobilisation Phase: Post-Traumatic Stress Disorder

The last stage will be labelled demobilisation as it incorporates both the resolution/closure and withdrawal stages of the experience cycle previously discussed. The purpose of demobilisation is to allow for the absorption of an experience into the ground of the individual, principally by making meaning of it, so that it will not be elicited inappropriately.

As with other stages of the cycle, when there is a synergy between the experience of the individual and the individual's capacity to deal with it, demobilisation proceeds in a smooth and graceful manner. The person is able to disengage from the experience, to chew it over and absorb and digest it. Ultimately, the individual becomes somehow different and wiser in a subtle way. If the experience is too charged to be easily absorbed into the ground, then a form for expelling or using up the excess emotional energy must be initiated. If this is not done, then the old figure will not be properly integrated and will have a perpetually distorting and disproportionate effect on the current and future experience of the individual.

This need to demobilise is a complex process that has been largely ignored by Western society as well as by Gestalt therapists. Society supports a cultural bias against demobilisation by underestimating the amount of time needed to understand and integrate experiences. Among Gestalt therapists there is often a bias against 'talking about' experiences. Furthermore, as a culture we do not value aloneness and movement inward. When one mobilises, it is movement outside the skin toward contact. However, demobilisation involves a movement inward to a non-public place where one may be alone.

Gestalt therapists, too, have ignored and had difficulty in articulating the demobilisation process. In the past, it has been taught as a less significant part of the experience cycle than in fact it is. The difficulty in understanding this process is connected with its largely intrapsychic nature. As indicated previously, it is harder for others to see. Thus, like the sensation stage of the experience cycle, the process of the individual must often be inferred rather than actually observed.

Furthermore, demobilisation is often unpleasant. When the event is large and negative, the experience is a grief reaction. Thus, demobilisation is associated with death, illness, divorce and defeat. However, demobilisation is also a positive process, such as falling off to sleep, dreaming, fantasising and celebrating.

Hypothetically, demobilisation can be broken down into four sub-stages: *turning away*, *assimilation*, *encountering the void* and *acknowledgement*. By describing the experience cycle as reflecting larger experiences in the life of the individual, one expands beyond the original definition of the cycle as a description of present experiences. Hopefully, describing demobilisation in terms of sub-stages is useful, despite the distorting and stretching of the cycle experience.

The first sub-stage involves either a *turning away* from (e.g. stopping drinking) or a being turned away from a figure in which energy is still invested (e.g. death of a spouse). The need of parents in our society to diminish their interest in their children as the children grow older is a common experience of turning away. The relationship begins in confluence and progresses into the stage where the child introjects the parents' ideas and values. In some cultures, children may continue to introject for much of their lives, but in Western society, which values autonomy and independence, an increasing psychological separation between parent and child is preferred. For children to develop integrity – that is, to experience boundaries cleanly and clearly – they must detach from their parents and create other interests. As a child leaves, so must the parents distance themselves or they will be faced with one of two equally sad alternatives: either a hard rupturing of the child-adult boundary resulting in mutual trauma or a type of deadly confluence that restricts developmental maturation. One aspect of maturity is the capacity to move away from a boundary gently.

To turn away when one still has energy requires much support. It can come in many ways, in the form of either self-generated or external support. To be self-supportive, to rely only on one's own resources, is difficult and runs contrary to the natural inclination to move towards energised objects in the environment. Not only does self-support incorporate an intellectual and emotional introjection of values, it also includes an invoking of an internalised rhythm sadly absent for many in our society. For to have faith, to hold one's hand, to rock gently and talk softly to oneself, to soothe oneself, ultimately involves the introjection of good nourishing parenting.

The generation of external support often involves placing oneself within a structure that provides highly detailed procedures for leading one's life while in the process of turning away. Therefore choice, as well as temptation, is minimised. Examples of this type of structure are Alcoholics Anonymous and similar organisations that deal with addictive behaviours. These organisations articulate both the techniques for and the potential pitfalls in the turning-away process.

Another external option utilised in turning away involves the creation of a large and compelling figure to which to transfer unspent emotional energy. Love on the rebound and some born-again religious conversions are examples of this type of figure substitution. The problem with moving quickly toward something large and captivating is that it does not allow for the next sub-stage of the demobilisation process, assimilation, to occur. Consequently, little is ultimately learned and the person may be doomed to skip from one love or religious experience to another.

Assimilation involves a chewing-over of the experience in order to drain emotional energy. The process is difficult for many therapists in that the work may appear redundant and boring. Furthermore, because our society underestimates the amount of time necessary to chew over experience, patients may be faced not only with doing the hard work but also with having to deal with the embarrassment engendered by the intensity of feelings and the surprisingly long time that their interest remains. It is the therapist's task to normalise the experience and support the process. However, if a patient's restlessness with the duration and intensity of feelings is joined by the therapist's boredom, blockage may ensue.

The third sub-stage, *encountering the void*, can be terrifying. Our society does not value or provide much training for the experience of feeling emptied of interest, of caring, of figures. The void consists of a segment in time when nothing matters. Often we avoid it by creating artificial engagements such as self-talk and non-contactful activities. Ultimately, it is the fear of the unknown that keeps many locked into either painful or non-nourishing figures. And it is this inability to turn from the old, the painful and the non-nourishing to the unknown that is a precondition for many of the 'addictions' so prevalent in our society today, such as workaholism, love addiction and codependency.

The fourth sub-stage, *acknowledgement*, involves a soft, low-emotional energy and an owning of how the experience has changed the individual. It is during this time that individuals are able to articulate the learnings, both good and bad, from the experience as well as to

express and live out the changes in their lives. Thus the patients have gained a piece of wisdom and are able to interact with the environment in a fresh and more profound manner.

An example of an inability to demobilise can be found in Post-Traumatic Stress Disorder (PTSD). Criteria include:

A. The person has been exposed to a traumatic event in which both of the following were present:
1. The person experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury or a threat to the physical integrity of self or others.
2. The person's response involved intense fear, helplessness or horror. Note: In children, this may be expressed instead by disorganised or agitated behaviour.

B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
1. Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions. Note: In young children repetitive play may occur in which themes or aspects of the trauma are expressed.
2. Recurrent distressing dreams of the event, including images, thoughts or perceptions. Note: In children, there may be frightening dreams without recognisable content.
3. Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific re-enactment may occur.
4. Intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.
5. Physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.

C. Persistent *avoidance of stimuli associated with the trauma* and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
1. Efforts to avoid thoughts, feelings or conversations associated with the trauma.
2. Efforts to avoid activities, places or people that arouse recollection of the trauma.
3. Inability to recall an important aspect of the trauma.
4. Markedly diminished interest or participation in significant activities.
5. Feeling of detachment or estrangement from others.
6. Restricted range of affect (e.g. unable to have loving feelings).
7. Sense of foreshortened future (e.g. does not expect to have career, marriage, children or a normal life span).

D. Persistent symptoms of increased arousal (not present before a trauma) as indicated by two (or more) of the following:
1. Difficulty falling or staying asleep.
2. Irritability or outbursts of anger.
3. Difficulty concentrating.
4. Hypervigilance.
5. Exaggerated startle response.

E. Duration of the disturbance (symptoms in criteria B, C and D) is more than one month.

F. The disturbance causes clinically-significant distress or impairment in social, occupational or other important areas of functioning (p.427).

The first therapeutic task in the demobilisation of PTSD involves helping patients accept that a turning away must occur. Once this acknowledgement takes place, then the work of draining the interest can begin. However, since trauma can be mesmerising, we must help patients acknowledge both sides: that they both wish to lose interest and wish to stay interested in the traumatic event.

A second therapeutic task involves helping patients find forms through which they can express their feelings in a small way. These forms usually involve repetitive actions that cause no harm. Talking is the primary method utilised as a form of 'doing' without a large mobilisation. The patient must feel supported in the expression of a feeling without an external outcome or without an aim to change anything.

When demobilisation from powerful events associated with PTSD is dealt with, sadness is often elicited naturally as the seasons of the year and anniversaries trigger affect-laden memories and sensations. When the sadness is evoked, the task is then softly to talk through the events. However, the therapist may get stuck and experience difficulty in helping patients move beyond the traumatising event. There are several possible reasons for this. The first is pacing. Demobilisation is a slow process that must be supported. The therapist must struggle not to become impatient or judgmental regarding the redundancy and amount of time involved. Second, patients will sometimes become frightened by emotions that are engendered. It is the therapist's job to provide adequate support for the patient to tolerate the emotional arousal as well as to help keep the emotions at a level that can be absorbed into the individual's ground. Third, patients may have an inadequate repertoire with which to

drain the energy. To 'sing the blues', protest, light a candle or plant a flower are rituals that are socially sanctioned for dealing with trauma and can be used to expand patients' repertoire.

Lastly, the therapist must carefully monitor his or her own interest. One must learn to be interested just enough. Too little interest will not provide enough support and too much on the part of the therapist will generate energy that fuels the patient's attachment and prevents demobilisation. When demobilisation is being worked on, a real danger is created if the therapist is more interested than the patient.

It should be pointed out that we are describing an ideal, for one can never demobilise fully. If one is lucky, most figures will naturally be assimilated into background and the remaining energy will be used in a productive way.

The last sub-stage of demobilisation is an acknowledgement of the process. If patients have learned well, they will know something that they never knew before. If demobilisation has proceeded correctly, patients will be able to answer the question: 'How am I different?'.

In sum, the work dealing with problems in demobilisation is to help the individual create small experiences to reduce the level of emotional arousal. The danger is in creating a remobilisation experience. It should be pointed out that as with other stages of the cycle of experience, an inability to demobilise might be a function of a person's inability to experience or integrate sensations, to mobilise or to make contact. If this is the case, then the work must include dealing with these other aspects of the cycle.

Summary

In this article a basic human dilemma is posed: How is one to know and describe another? To answer that query, the issues faced by Gestalt therapists in attempting meaningfully to diagnose and assess patients and the Gestalt experience cycle and its utilisation for describing character have been discussed. Finally, an effort has been made to fit a few common DSM-IV diagnoses into the paradigm of the experience cycle as well as to prescribe appropriate methods of intervention.

Diagnosis is an art as well as a science, for its purpose, after all, is to provide a useful model of experience. As Gleick (1987) so aptly writes:

> The choice is always the same. You can make your model more complex and more faithful to reality, or you can make it simpler and easier to handle. Only the most naive scientist believes that the perfect model is the one that perfectly represents reality. Such a model would have the same drawbacks as a map as large and detailed as the city it represents, a map depicting every park, every street, every building, every tree, every pothole, every inhabitant and every map. Were such a map possible, its specificity would defeat its purpose: to generalise and abstract. Mapmakers highlight such features as their clients choose. Whatever their purpose, maps and models must simplify as much as they mimic the world. (p.279)

In retrospect, this attempt at mapmaking is but a rough beginning filled with contradictions and exceptions. But this is how it should be, for Gestalt therapy is phenomenologically-based theory grounded in the celebration of the uniqueness of the individual.

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