Renegotiating the life space

Neil Harris introduces and illustrates a Gestalt way of working with adolescents, while acknowledging commonalities with other approaches

Gestalt therapy is one of the humanistic group of therapies, now in its sixth decade of development. It grew out of an awareness that possibilities for change and growth in a person might best be supported by an 'experience-near' approach and is characterised by immediacy and attention to the present.

I do not have room here to do justice to the historical roots, changing emphases and continued evolution of Gestalt therapy theory, but I will try to introduce some key concepts and vocabulary, in order to communicate something of the particular flavour of Gestalt therapy as applied to work with adolescents. I will use some examples of therapeutic work that I hope will be generally recognisable and applicable in order to put some apparently abstract concepts into the real-world picture of the consulting room, the home, the school, the street – wherever we may need to go to engage with young people. What may come across is the commonality of therapeutic approaches that couch their theory in apparently different ways.

Basics

A flavour of the basic stance that Gestalt therapists take in working with adolescents is conveyed by the following quotes:

> *It is the sense that a true relationship is possible, that allows and motivates adolescents to examine their sense of the world and their behaviour.*[1]
>
> *To achieve contact, the therapist must be honest, congruent, respectful of the client's position, and above all begin where the client's interests are.*[2]

Three fundamental principles are those of:

- field theory
- phenomenology
- dialogue.

Adolescent development can be seen as a time of profound renegotiation of the 'life space' of the young person, the totality of their relating to themselves and to their world. The life space of the adolescent is increasing in complexity and expanse – and also in the sense of time, as past and future come more sharply into focus. Their life space is also becoming more differentiated, and a key element is the differentiation between the 'subjective' and the 'objectively real'. They make increasingly realistic assessments of elements of their world, and in particular of other people. They also increasingly differentiate aspects of their life space, and an example might be of how they can present very differently at school compared to at home, or when they are out with a group of friends. They begin to be able to make statements along the lines of: 'Here, I am like this, but when I'm there, then I'm more Y or less X.' This implies that there may be many places in their world where support for change may be necessary and possible; with them as an individual, in their school, in their peer group, their family, their interest groups – and at the societal level of support for adolescents as having particular needs, vulnerabilities, strengths and capacities.

Field theory

Briefly, field theory is a profoundly integrating description of this 'life space'. It undercuts the dualistic split of inner and outer. Symptoms are understood to be creative adjustments to the conditions of the field; that is to say, each person needs to be seen as making the best they can of their situation, given the totality of their genetic inheritance, their past experience and the level and quality of support that they have, or do not have, from their environment.

Phenomenology

Phenomenology – at least as it informs Gestalt therapy – is a practical philosophy and method of examining and experiencing the world, and in particular the here and now. Key elements of this stance are that we bracket previous assumptions and adopt a position of sustained enquiry. We track and are able to describe immediate experience, and we give equal potential to all elements of the field.

> *Young person*: I'm really bored at school and all the teachers don't know how to do their job. The only thing I get anything out of is tech, and that teacher's off sick at the moment.

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Therapist: As you talk, I'm listening to the tone of your voice and how quietly you are speaking. I'm also noticing how loud those birds are squawking outside the window.
Young person: Sounds like they are having a fight and one is saying to the other: 'How dare you?'
Therapist: Perhaps you might want to say 'How dare you?' to that teacher who you feel is letting you down.
Young person: Yeah, but what's the point?
Therapist: So somehow you sound like you give up and the energy goes out of you.

Dialogue

The word 'dialogue' is used by Gestalt therapists in a rather particular way. It stands for assumptions about the potential mutuality of meeting and relating; it conveys an expectation of communication that can foster the possibility of I-Thou relating (as Martin Buber describes it), of genuine meeting. However, we have to accept that the therapeutic situation is one in which the client or patient is not likely to be able or supported enough, at least initially, to meet in this way. It does not apply only to the verbal interchange, but to the whole of the experience of meeting, however that may be taking place.

In the dialogue, there is the potential for *contact*. This encapsulates the ways in which we meet with the environment, through our senses of taste, touch, sight, smell and hearing, and with our internal environment through our proprioceptive senses. During adolescence, this process of contacting matures, and, with that, come changes in capacity for awareness and relationship. All processes of connection – engaging, joining, separating, adjusting – undergo a process of differentiation and integration. As McConville[3] puts it: 'In a process that unfolds both recursively and progressively throughout adolescence, the field of the child's experience evolves from its pre-adolescent status of relative *embeddedness*, through a disembedding process of *differentiation*, toward a reorganised *integration* of the field.' The life space of each adolescent will support or block this process to different degrees and in different ways. Influences that are proximal and specific are the family and peers. More distal but no less powerful influences are the political and societal aspects of the field.

A case example: Alison

Alison, 16, was referred by her GP. She was the oldest of three, and her parents had split when the youngest was just a baby. She was low in mood and tearful. She presented herself on time, in her school uniform, on her own. She had been very clear in telling her GP that she did not want her parents to know that she had been referred to the Child and Adolescent Mental Health team. She was clever and used to doing well in her exams, but recently she had been struggling to concentrate, and was not managing to complete assignments on time.

In the second appointment, she said that she was cutting herself on her arms because she got some relief from her feelings of distress when she did so. She also talked about the demands her father was making, wanting to see her and often being mildly drunk when they met up, and sometimes failing to keep arrangements to meet. When she did visit him at his flat, she felt compelled to clean and wash for him, and vacuum the floor. She thought he would not look after himself at all if she did not help. She did not talk about herself at all with her mother, because if she did say anything, she found her mother worried a lot and Alison experienced this as intrusive and unwelcome.

Weekly therapeutic meetings initially focused on supporting her in describing her situation and in graded encouragement in staying with and expressing her feelings in a little more depth than she was used to. She hinted at deep anger and distress at the way her father insensitively introduced his new girlfriends to her, seeming to ignore her whenever he got involved in a new relationship. The self-harm seemed best understood as a retroflection of expression of this rage and an attempt to keep it under wraps for fear of its destructive potential.

Deterioration

Questions such as: 'What would you say to your father if he was here?' were ones that she found difficult to contemplate. Her low mood deepened, and she began to talk of suicide. One day, she said that she did not know if she would make it home safely from the appointment, and thought she might make some sort of impulsive attempt to kill herself on the way home. While there was a despairing

and hopeless element to this communication, it seemed also to contain a demand for some new engagement with one of the key elements in the field, her parents.

The therapist was mindful of Alison's statements to her GP that she didn't want her parents involved, but chose to state, with some emphasis, that he thought that the situation needed one of her parents at least to be aware of their daughter's distress. The dialogue was about managing risk, with support and respect. Alison nominated her mother as the one who could be contacted, and she did this with minor passing reluctance. The therapist made phone contact and Alison remained in the room while this happened. Her mother was shocked and upset at what she was hearing and agreed to come to the clinic to collect her daughter. Over the next week or two, Alison experienced her mother's concern as a mix of annoying and reassuring.

Interestingly, her mother made no further contact with the therapist despite an open invitation to do so if she wished. Alison's thoughts of suicide receded for a while, but she continued to self-harm on almost a daily basis. Then she was admitted to hospital following an overdose. As a result, another member of the team met her to make an assessment. After consultation with the therapist, both of Alison's parents were invited to the ward for a meeting.

Acknowledging feeling states

The therapy continued and the work centred around supporting Alison to become aware of and manage her different feeling states. As her awareness grew, a process of *disembedding* and *differentiation* began, in which she was more able to see her parents clearly for who they were, with their strengths and foibles.

She was able to negotiate with her mother so that she got more support, without the previous over-intrusive quality. She was able to speak to her head of year at school to clarify her difficulties there, and a plan that supported her work and rationalised the demands on her was developed. She struggled to develop a *differentiated* view of her father. It was difficult for her to become realistic, and to give up a hope of having the idealised relationship that she had desired. The work involved supporting her to express her disappointment and frustration, and this phase illustrates another key concept in Gestalt therapy, that of therapeutic *experiment*:

Alison: He said he'd pick me up and that we would go for lunch on Sunday, and he never called to say he was busy, but I saw him across the road in town in the afternoon, with his girlfriend and I went into a shop to avoid him.
Therapist: What I see – as you are saying that – is that you are clenching your hands tight, and speaking out through your teeth. I've got a suggestion. Would you be interested in trying something out, to see if it can make a difference?
Alison: What do you mean?
Therapist: My suggestion is that you take a slow deep breath, and then just say something that you would like your father to hear.
Alison: (slightly doubtfully) Well ... OK ... (breathes in and then out)...
Therapist: Maybe just say whatever it might be silently first?
Alison: (nods and breathes in again)
Therapist: Got it?
Alison: (nods)
Therapist: How about another breath and try saying it out loud?
Alison: (breathes in) I miss you and I want to shake you ... shake some sense into you.

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The experiment in which the therapist grades the new expressions, and focuses where necessary on what will support the new development, happens first in the here-and-now. It may lead to ideas of experiments that can take place between sessions. In this case, at this point, possible further experiments might be to suggest that Alison notices her breath when she is thinking of self-harm, and finds words that the breath supports. Or she might even find some words to say to her father about her disappointment and how let down by him she has felt.

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A case example: Luke

Luke is 13. He came to an appointment because his teachers and his parents were concerned about a change in his behaviour that had led to a short exclusion from school. His grandfather had died suddenly, four months previously. He had never been a model pupil, and always had a high profile in his class, but now he had been involved in several fights with older pupils, and had been swearing loudly at teachers whenever they reprimanded him. He was not going to be allowed back in to school until he had been assessed. He was difficult to engage. He was 'resistant' in the way that so many adolescents are, as part of their style of managing the transitions in relating and self-development that are going on for them. He made little eye contact, but remained seated, arms folded, rather stationary. An exploration of what needed to happen *in the moment* for him led to a mapping of who he rated as 'there' as a support in his life. He mentioned his grandfather as someone he looked up to.

> *Therapist*: Tell me more about your grandfather, describe him to me.
> *Luke*: Well, he was all right, he was old, he was kind.
> *Therapist*: What did he look like?
> *Luke*: He had a beard. He always wore an old jacket that smelt of his fags. (His face flushes a little at this point.)
> *Therapist*: You really remember him so well, don't you, as if he is still around somehow.
> *Luke*: Yeah, just stuff like when he would say, 'Let's walk down to the docks and see what's in.' (He brushes away a tear that has fallen from one eye onto his cheek, but does it gently.)

The work then was to support him in staying with this experience, not only to help him express the grief at the loss of his grandfather, but also to explore ways that his grandfather might have helped and advised him, so that he could integrate these realisations into his own repertoire of adaptive strategies.

Graded interventions and caveats

The Gestalt approach may seem to imply that experience-near interventions are central, and this has sometimes led to a reputation for 'whizz-bang techniques'. However, what is most important is that the grading of intervention is subtle, fluid, and led by the dialogue between therapist and client.

When working with adolescents, there are some caveats that apply. The phenomenological exploration of experience will often point to the embodied nature of our existence, but for adolescents in particular this can be uncomfortable and very often runs the edge of shame. We must be mindful of our clients' changing and uncertain physical experience of themselves, and, while we fail them if we shy away from this completely, we must be very attuned to what is possible and containable in terms of helping them develop a fully aware sense of themselves as embodied humans living in the physical world. Experiments have to be offered openly with genuine curiosity about possible outcomes, rather than as prescriptions. They may include widely used approaches such as drawing, using materials, stories, dreams, much that will be familiar to all therapists working with young people.

> *The therapist needs to know how to play with the child; if this quality of life is obscured or lost, the therapist herself must find a way to regain this joyful behaviour.*[2]

I hope that I have been able to introduce this way of working so that it is recognisable to Gestalt therapists, and intriguing and helpful to readers not familiar with the model. If you want to take your interest further, I would point you towards Mark McConville's book[3] in the first instance. The classic introduction to a Gestalt-based play therapy by Violet Oaklander, *Windows to our children*[4], is a resource of ideas for intervention with general application across the age range, and her latest book, *Hidden treasure*[2], contains a chapter dedicated to working with adolescents. One area I have not covered at all is the application of Gestalt therapy to work with groups and families. For those interested in a Gestalt family therapy approach, I would suggest Joseph Zinker's writing[5]. For a general introduction to Gestalt counselling, you might try Jennifer Mackewn's book, *Developing Gestalt counselling*[6]. ■

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