9 · Modifications to Contact

The Gestalt therapist believes that part of psychological health is having good contact with self and others. However, how we make contact will need to be modified according to the field conditions in each unique situation. As conditions or priorities change, we need to adjust or modify our behaviour to meet the new situation appropriately. For example, it is good to interrupt your impulse to cross a road without first stopping to check for traffic, but probably not good to interrupt your impulse to cry when you are at a funeral. In a sense, healthy living is itself a creative adjustment or continual modification to find the best way to meet our changing needs and priorities and also to find the best match between our needs and the needs of the other or the environment.

Ideally, this process of modification is ongoing and continually revised as field conditions change. It is easy to understand this if we consider the growing child. As a baby, the natural expression of the organism in distress is to cry out and wait for attention. At an older age, the creative adjustment may be to seek out a friend and ask for comfort, putting the distress into words. Where particular needs are ongoing and repeating, the child inevitably learns ways of meeting and managing the needs that are ‘successful enough’ and these become habitual responses. This is necessary and normal. However, problems arise when the habitual response is not updated for new or changed field conditions. This may be situation specific or it may become a general style of contact across a range of situations (usually out of awareness), which can pervade all aspects of the person’s way of making contact. The person is then not free to make new choices or adjustments and repeats the same response that was once useful (or at least seemed so at that time). This can be seen sometimes in an abused child who then avoids all intimate relationships as an adult or in people who always respond to stress by overeating or drinking to excess. Many of the reasons clients seek counselling are due to problems around creative adjustments that were once appropriate but have now become fixed gestalts.

From ‘interruptions’ to ‘modifications’ – a historical note

In the early days of Gestalt therapy, practitioners began to notice that there were certain common patterns of modifying contact. They were originally seen as avoidances or diversions which ‘interrupted’ the natural process of contact and
completion. Perls (1947) and Perls et al. (1989 [1951]) described the following patterns: Retroflexion, Confluence, Desensitization, Introsection, Projection, Egotism (Polster and Polster added Deflection in 1973).

These disturbances of contact became known as ‘interruptions’ and were originally seen as a hindrance to full contact and vitality. Much early Gestalt therapy became an attempt to destructure the interruptions to restore a state of optimal health. However, the understanding of interruptions to contact has changed radically in recent years (e.g. Swanson, 1988; Mackewn, 1997; Wheeler, 1991; Gestalt Journal 1988: 11 (2)). In field theoretical terms, no ‘interruption’ can be considered good or bad, helpful or unhelpful, other than in reference to the meaning and needs of each unique situation. ‘Modifications to contact’ are therefore a better way to describe a series of processes that are simply creative adjustments that may or may not be appropriate. A healthy person needs to be able to move along a continuum between completely avoided contact, modified contact and full contact, depending on each new situation. All these positions are potentially healthy and can only be judged in relation to the field conditions and the person himself.

We develop in the direction proposed by Mackewn (1997), mapping the seven commonly identified modifications as continua. We liken them to the variety of shades of colour in a paint colour chart. The seven traditional ‘interruptions’ represent one pole of a continuum. Each one has its opposite pole and a multitude of ‘shades’ in between. There would be times when each position on the continuum would be appropriate (for example, isolation during a spiritual retreat and confluence between a mother and baby). We will now describe these seven modalities of contact recognizing that every position on a continuum is potentially healthy and appropriate depending on the need and context of the situation.

We have arranged the modifications to contact in the following box. For each of the original modifications, we offer a suggestion of a polar opposite, which defines the continuum. For each continuum we then suggest ways of working with polarities that have become fixed gestalts. You may prefer to identify your own continua, or explore the unique polarity of the particular client.

| Retroflexion | ..................................... | Impulsiveness |
| Deflection | ..................................... | Reception |
| Desensitization | ..................................... | Sensitivity |
| Confluence | ..................................... | Withdrawal |
| Egotism | ..................................... | Spontaneity |
| Projection | ..................................... | Ownership |
| Introsection | ..................................... | Rejection |

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General therapeutic considerations

In many situations clients may have little awareness that they are modifying their contact in a particular way or that they have any other choice. Here the therapist's task is to raise the client's awareness and understanding of how they make contact. You may also need to consider what may be missing, what other positions are available on any continuum of polarities, what is in the ground of the client but not in his awareness. For example, the client may not realize that he deflects from any difficult emotion by changing the subject, or that he tensed his body every time he speaks of his father. He may be unaware of the options for self-expression that he is ignoring. You can offer a hypothesis for the client to consider or as something you have noticed and are curious about. 'I'm aware that you clench your fists every time you talk about your father, are you aware that you do this?' or, 'Have you ever considered expressing some of your anger to him?'.

It may help to conceptualize the modification as a way of avoiding pain or difficult feelings. Perhaps there was a time when it kept the person safe and helped them survive. Therefore, you may need sometimes to imagine or to empathize with the pain or difficulty of the original situation in order to make sense of the modification. You may also need to help the client find a new, more creative way to deal with the situation that was formerly managed by this particular fixed gestalt or modification. This may sometimes be a major focus of therapy as the person struggles to re-adjust their whole way of relating.

We will now examine each modification polarity separately. We will be focussing primarily on the times when modifications are used habitually and unhelpfully.

Retroflection... impulsiveness

A person is said to retroreflect when he holds back his impulse to take action (speech, expression of feeling, behaviour). The energetic flow is interrupted and this can have several outcomes. The withheld impulse may die naturally away. However, if the process is repeated frequently or if the impulse contains strong energy, suppressing it can lead to the energy being turned inwards toward the self. This can lead to bodily tensions, somatic illnesses, depression or even self-harm.

Intervention suggestions

- Explore what associated beliefs, introjects and early decisions accompany the retroflection. It is especially important to find out what the client believes will be the consequences only be 'undo enough support

Example

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Intervention su

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the consequences of letting out his energy into action. The retrofection should only be ‘undone’ when the client and counsellor are both sure that he has enough support and understanding to appropriately manage what is released.

**Example**

A client, Belanna, ignored her serious qualms about expressing her anger and over-rode her introject to stop herself retroreflecting. Choosing to tear a strip off the company director ensured that she had made the change in such a way as to bring about a bad outcome. She was demoted. This, of course, reinforced her decision to keep her feelings to herself and the retroflected style became even more fixed.

♦ As retrofection is commonly held in the body, it is useful to focus on body process when working to release it. Invite the client to be aware of where in his body he feels the held energy. You may also invite him to talk from that part of him, to give it a voice. In some circumstances, you may suggest the client breathe ‘into’ it and practise relaxing.

♦ Enact the retrofection in the consulting room. This is particularly useful when the client has identified the introject that is often at the heart of a retrofection (‘Don’t get angry’, for example). The client starts to focus on his body, exaggerating the tension and repeating the introject aloud. If and when he feels ready to do so, he can release the tension and direct his energy outwards in the support of the therapy room. (See Chapter Eight on experiments.)

The other pole of this continuum is impulsiveness or unrestrained expression – at its best it is the spontaneous vibrancy of action and contact. However, it can also be an inappropriate expression of feelings or of acting impulsively in a way that is dangerous to self or others, such as with self-harm or uncontrolled or violent outbursts.

**Example**

Leonard had very low frustration tolerance. In therapy, he recounted how at work he often became furious if his employees forgot to do something or if a telephone call could not go through. He would start by muttering and pacing up and down, then quickly escalate to punching the door (frequently hurting himself) or flinging the phone onto the floor.

**Intervention suggestions**

♦ If the client recognizes that he needs to learn to control his impulsiveness, it can be very useful to help him get into the habit of consciously becoming aware of the stages of the cycle of experience. He needs to pay attention to his sensations.
and feelings, take an interest in them, acknowledge and recognize them. He can consider what options he has for action, then choose one. By the time he has taken himself through these steps, he will have slowed himself down and got in touch with more appropriate action. The client may find this process very difficult and it will be necessary to experience it over and over again in the consulting room. It can also be modelled for him by the therapist, who frequently invites him to be aware of his sensations, name his feelings and allow full recognition.

- Grounding exercises and techniques described in earlier chapters can also be useful. Clients who are fixed in this pole, often experience being taken over by their feelings. They report things like ‘I am only my anger at that moment. I feel as though I will explode.’ Grounding and heightening awareness of body boundaries can be containing and calming.

**Deflection . . . reception**

Deflection means ignoring or turning away either an internal stimulus or one from the environment, in order to prevent full recognition or awareness. It is characterized either by blocking the stimulus itself or by turning oneself away and going off at a tangent. Clients often deflect from their feelings and impulses by endless talking, by laughing instead of taking themselves seriously or by always focussing on the needs of the other. Deflection of the impact of others can be seen in clients who change the subject repeatedly when a particular issue is raised, who appear not to hear or see something, who misunderstand or redefine what has been said or done. Deflection is an active process of avoiding awareness, which means that the client will tend to also push away your interventions when they touch the avoided material. The process can be extraordinarily subtle and frequently the only clue to it is when the counsellor finds that she is having a conversation about something and she has no idea how she got there!

**Intervention suggestions**

- Model persistence in keeping to one topic and offering hypotheses as to what might be difficult. ‘I guess you might find it hard to talk about being adopted, it would be easy to try to avoid even thinking about it’, or as in this example:

  **Couns:** Do you really think she ignored you deliberately?
  **Client:** Well, she just walked straight by me, just the same as she did last week. Her nose in her papers.
Couns: And do you think it was deliberate?
Client: It's easy enough to say 'Hello' to people isn't it? I only wanted an acknowledgement.
Couns: I'm noticing that you aren't answering my question about whether you think it was deliberate.
Client: [pauses and for a moment looks mutinous, then seems to relax] No . . . well . . . I guess probably not. I guess not. She probably just didn't notice me. She was thinking of something else and . . . but you know, if I stop feeling angry at her for being rude, it feels almost worse. She just didn't see me. That feels awful. As if I'm invisible.
Couns: What does invisible mean to you there?
Client: Am I so unimportant? Insignificant?
Couns: So if she doesn't notice you, that's something to do with you . . . with your worth?

At times you will need to gently but forcibly interrupt the deflective process, for example, 'I need to stop you for a moment . . .' before sharing your observation of what they have been doing or your own reaction to the deflection. 'I am aware that every time we talk about this particular topic you change the subject. Have you noticed this?' Or you could say, 'I notice that you haven't answered my question and I am wondering whether that's because you are not ready to talk about this.' This, in a sense, gives permission by acknowledging the right of the client to choose not to talk about something, while at the same time raising awareness and reassuring the 'silenced part' of them that it also is important.

We have called the other pole on this continuum 'reception'. Here, a person is available and open to experience the fullness of the world around him. This sounds like a very positive quality, but it too can create problems if used to excess. We are all bombarded by a myriad of stimuli, every day, while our inner and middle zones are a continuous source of sensations, thoughts and feelings. The overly receptive person receives too much, in contrast to the deflector, and has a tendency to pay too much attention to these stimuli. He finds it difficult to ignore them or to selectively choose what is relevant at any one time. He may be over-detailed in his speech and end up being indecisive as he struggles with all the apparently significant material. At worst, this condition can be found in people with psychotic process who feel so aware of all the stimuli they receive that they lose the ability to form meaningful gestals.
Intervention suggestions

- Help the client to be more in touch with his inner and middle zones of feelings and thoughts, to identify what his reactions mean and to name the actions he needs to take.

- Help the client to prioritize his experiences. For example, “What is most important to you now? How do you know that? What else is important?”

- Practise grounding exercises that enhance the client’s experience of embodiment.

- Explore introjects about adapting to others. Gently invite the client to explore what he imagines would happen if he ignored some things or people, missed some details and so on.

Desensitization . . . sensitivity

Desensitization is a process similar to that of deflection. It is another way of avoiding contact with the stimulus. However, while deflection is mainly concerned with preventing a stimulus reaching the middle zone of awareness, desensitization concerns a more profound form of shutting down – at the level of the inner zone. A clue for the therapist can often be found in her own phenomenology. Therapists often find themselves feeling sleepy and heavy in the presence of a desensitized client, while the response to a deflecting client is more energized (for example, irritation, frustration or agitation).

Examples

Keiko never notices when she is hungry or sits throughout the therapy session on the edge of her seat, oblivious to her stiffening limbs; Jean-Luc’s brother died and he said he felt nothing; Jennifer had been terribly abused but recounted the tale in a voice devoid of any emotion.

Intervention suggestions

- Encourage attention to breathing, bodily sensations, focussing on heightening body awareness, on what they are aware of and where their energy is held.

- Ask the client to imagine how they might feel about the situation or how someone else might react.

- Share your own reaction to the situation about which they have desensitized,
and offer possible reactions. Check to see how much resonance they have with your response.

- A technique described by Kepner (1995) may be useful. He suggests finding an area of the client’s body in which they have most sensation and starting to encourage a stronger connection with this part in order to show the client how to resensitize. Then, move gradually to nearby parts of the body, attempting to expand the field of sensitivity.

As the client resensitizes however, you may well find you move into the territory of other modifications to contact. This is especially true when the desensitized material is particularly traumatic. Having brought the out of awareness material into view, you need to pay careful attention to the client’s ability to self-support, otherwise he may then launch straight into the traumatic material without sufficient resources.

The person who experiences the other end of the polarity – sensitivity – is acutely aware of here-and-now stimuli. He is attuned to himself and to the world around him and this can sometimes mean a fine level of congruence and an exquisite ability to empathise. However, like the over-receiver, he can suffer from an overload of sensory stimuli that he is unable to ignore. This can appear as hypochondriasis, or at a more ordinary level, as an inability to evaluate the meaning or significance of a sensation. On the other hand, over-sensitivity can be found in a cognitive and emotional sense.

**Example**

Reg used deflection to avoid being aware of his feelings of shame at what he saw as his insignificance. When this was explored further, he revealed an extreme hypersensitivity to the real or imagined slights of others. Any chance remark or vague criticism felt unbearably humiliating to him and his resentment and blaming of others covered acute hurt, which he linked to his experiences with his distant and critical father.

Some people seem to hold both extremes of the continuum at the same time. The person who is hypochondriacal may be hyper-aware of his bodily sensations, for example, yet completely desensitized to his affective and emotional associations, thus noticing symptoms that he cannot explain.

**Intervention suggestions**

- In many ways, the suggestions are similar to the desensitized client. It is important that the work go very slowly, giving him time to connect with himself and what his sensations might mean.
Where the client is hypersensitive to real or imagined criticism, it can be useful to explore what happens to him in these situations. What does he feel? What does he believe about himself and the world? Learning to do some reality testing can be very important for a client who believes that if he is not perfect he is worse than nothing. It is especially important for the therapist to be willing to explore with the client when the process happens between them.

**Confluence . . . withdrawal**

The issue relating to this polarity is that of closeness and distance. The healthy person can move fluently and appropriately along the continuum between merger (say in a moment of loving sexuality) and withdrawal (in order to rest or meditate). A fixed position suggests some difficulty with either attachment or separateness. A person who fears that closeness to another person involves some threat (of loss, rejection, hurt or abandonment), solves the problem by either merging with the other or psychologically withdrawing.

**Example**

Naomi kept strong eye contact with the counsellor as she described her difficulties with her husband. Frequently she sighed and made somewhat enigmatic comments that left the counsellor guessing. At other times, she left her sentences hanging in the air for the counsellor to finish. As she talked, she nodded and smiled encouragingly at him.

*Naomi: We used to love being together, we did everything together. But now . . .*

[nodding a cue]

*Counsellor: Things have changed now?*

*Naomi: Yes – now we bicker and fight and well you know . . . we used to talk about things but . . . well, that side of things is unbearably . . .

*Counsellor: Do you mean you don’t discuss your differences any more?*

*Naomi: Yes. We never had differences about important things – well – or small things really until . . . you know . . .

*Counsellor: So. You mean there weren’t any differences to discuss.

*Naomi: Oh that’s absolutely right. I hadn’t thought of that.

(The counsellor began to feel that he was working very hard indeed. He wasn’t sure what was really happening in Naomi’s marriage, and yet the conversation had seemed to go quite smoothly. He began to wonder whether this was a parallel process (a relational dynamic that repeats in different situations) with Naomi’s relationships outside.)
A client who modifies contact through confluence, acts as if either he is a part of the other person in a relationship or that the other person is part of himself. Confluence is an inability to distinguish the interpersonal boundary. The feelings and wishes of another easily overwhelm the confluent client, who responds as if they were his own, also often becoming anxious when separation occurs or is threatened.

**Intervention suggestions**

- Encourage the person to make ‘I’ statements rather than ‘it’ or ‘we’. You can also model the process by being clear when you yourself say ‘I’. For example, you might say ‘I feel sad when I listen to you, how do you feel?’ or ‘I am sitting in this chair, you are sitting opposite, do you have any sense of what you want from me right now?’

- Look for and emphasize similarities and differences, ‘It sounds as if you agreed with/felt the same as . . . but you also didn’t agree with/feel the same as . . .’

- Explore and offer empathy for fears of separating, endings and loss.

- When there is a ‘clinical choice point’ in the therapeutic process, share your thinking with the client and offer options about the way forward. Which option does he feel drawn to, or does he have other suggestions? This underlines that there is not one but two people facing this problem!

The client whose habitual contact style is withdrawal does not often seek therapy. However, sometimes he will come saying that he sees other people having a better time than him and he thinks that he has ‘something missing’. He might use a metaphor about himself, such as feeling like an alien, or being trapped in a bubble or behind an invisible wall.

**Intervention suggestions**

- When working with this type of modification as a habitual style of contact, you might easily feel as if nothing is happening in therapy for months on end. Be content to spend a long time building a working alliance and offering a gentle dialogic approach.

- If he is withdrawn in the session, do not pursue him to tell you ‘what’s going on’. It is likely to increase his withdrawal. Adopt a position of creative indifference and wait with him in silence, taking care not to fall into a withdrawn non-contact yourself. Practise inclusion quietly yourself. Remain alert and interested. You
may choose to offer an invitation occasionally – such as ‘It looks as if you need to withdraw right now and I’m fine with waiting/being with you. I just wanted to say that if you would like to talk about what is going on, I would be very interested to hear.’

- If your client withdraws during an exchange with you, it is possible (likely!) that it may be a response to you. You could comment that you have noticed him withdraw and that you wonder if you said or did something from which he then wanted to move away. If he owns his withdrawal and tells you how you contributed to it, be ready to understand his experience and how he feels the need to protect himself. You might ask him what he would need to help him re-engage with you.

**Egotism . . . spontaneity**

Healthy egotism is the capacity for self-reflection. It could be called ‘self-consciousness’ in its best sense. Egotism as a habitual modification is characterized by an excessive preoccupation with one’s own thoughts, feelings, behaviours and effect on others. This preoccupation can be positive, admiring and self-congratulatory or critical and undermining; either way it is an avoidance of real relational contact. The task here is to encourage the client to move away from their self-monitoring and self-reflection into a more immediate contact with you and their environment.

**Example**

Kess frequently interrupted the story of her unhappy week to look intensely out of the window. When the counsellor enquired what was happening, she said that she was thinking how stupid she was, how silly she must sound, how he must be wondering why she hadn’t got her act together.

Intervention suggestions

- In the therapy room, notice how the client breaks contact with you in favour of his inner dialogue and invite him back into the here and now with *you*. Empathise with his present experience of worrying about himself, the impression he is making or with the need to be perfectly ‘right’.

- Encourage grounding techniques with a focus on body process and a deliberate attention to the external environment (‘lose your mind and come to your senses’).
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At the other polarity is spontaneity, which when appropriate is the hallmark of full,
vibrant living in the here and now. In some Western cultures, it is a rare exception
in an atmosphere of deliberation and retroflection. When unrestrained, however,
it is an absence of necessary reflection and self-monitoring. Ironically, it is often
the cause of inappropriate counsellor behaviour, of ill-considered interventions
and broken boundaries, unfortunately especially associated with some Gestalt
practitioners in the early years. It can be seen in impulse disorders, mania and anti-
social behaviour.

Example
Siete was a delightful, bouncy woman of thirty. At the assessment session, however,
she revealed a long history of putting herself in difficult or dangerous situations. She
bought tablets from strangers at parties and on one occasion, she had been robbed.
On another, she had found herself penniless after a spree in a foreign capital. She saw
no reason to think that she had contributed in any way to what had happened to her.

Intervention suggestions

- The overly impulsive client may well be using this modification in order to
  avoid more painful inner experiences. It is as if he escapes from his feelings into
  action. Offer the space for the client to tell his story, interrupting him if he
  turns it into an ‘exciting drama’. What sense has he made of events, what are his
  thoughts and opinions about them? Make sure he pauses to account for his
  feelings (both ‘then’ and those brought up by remembering).

- Help the client to think about what happens in those moments before feeling
  the urge to do something. Ask him what was happening, what he was feeling
  (e.g., boredom, fear, emptiness, neediness, sadness). Explore if there was a
  need to escape those feelings. If thinking about his experience produces agita-
  tion, focus on building self-support and appropriate environmental support.

Projection . . . ownership

There is sometimes confusion about the concept of projection. The difficulty
arises as the word is used in at least three different ways. Firstly, it is used to refer
to the ability we have to imagine what is not there, to anticipate a possible future,
to be creative. Artists project their vision onto the canvas, the novel and the film.
In this sense it is an essential component of human functioning (and an imagina-
tion which makes us uniquely human). Secondly, it is used in the sense of
transference, when the projected material is historical and inappropriate; for example, the client who treats the counsellor like a mother or father figure. Thirdly, projection refers to disowned or alienated parts of the self. When a client struggles with accepting a quality or aspect of his personality that is incompatible with his self-concept, he may effectively project it out of awareness onto another person. This is the sense in which we use it here.

**Example**
A hard-working client of ours told us a time when he returned home after a particularly taxing day. He met his wife at the door and said to her, ‘You look really tired’, to which his wife perceptively replied ‘You should lie down for a couple of hours’. When he woke up, his wife said to him ‘Do I look more rested now?’

**Intervention suggestions**

- Perls (1969: 72) believed that pathology was ‘partial projection’, and the process of reassimilation could start by encouraging the client to practise ‘total projection’. He suggested that the client first exaggerates the projection and then shifts to become as strongly as possible identified with the quality himself. The empty chair is an ideal technique to use for this sort of exploration.

- When a client sees you as critical or judgemental (when you are sure you are not), first explore the meaning and effect this has upon him. ‘How does it feel to be with someone whom you believe is always critical of you?’ Start to explore the possibility of them having the very same attribute. ‘Have you ever felt critical of me?’ Initially clients will often deny they could ever have that quality, ‘No, I never feel critical of you, you are always trying your best . . .’. You may need to start very gradually, for example, ‘If you were to feel critical of me, what would it be?’ We have sometimes suggested that clients look around the room to find objects, colours or shapes they did not like, to practise being critical of the belongings of the therapist. This can gradually be increased in intensity until they are encouraged to say things they did not like about how the therapist talked or acted towards them (surely a rich field of possibility!).

- Another approach is to investigate how the client came to believe their projection. What had you done or said that led them to believe you were critical? Projection is usually co-created. Look for the ‘grain of truth’ in your client’s view. It is very likely that you will have contributed in some way to their experience and being willing to own that can normalize both their experience and also the rejected attitude.

- Maintaining creative involvement is very important both in the therapy process. It involves both emotional and intellectual identification.

The polarity of ownership is the concept of accepting the client’s view, the concept of accepting what is not their own.

**Intervention suggestions**

- An empathic enquiry can start the process of self-discovery and identification.

- Engage the client in the process of identifying the possible and what is separating them from the actual.

**Introjection . . . rejection**

Introjection is a process of questioning taken in, not properly analysed, taken in and kept. In other fixed modifications of introjects are ‘Never do this to me’ ‘I only want to feel without the introject and feels to feel critical of me’. The introjects are taken as a part of functioning rules and to negotiate temporary strategies. For example, trainee may follow the introjec
• Maintaining creative indifference throughout an exploration like this can be very important both in normalizing the disowned quality and in avoiding shame reactions.

The polarity of ownership has always been a cornerstone of Gestalt practice. It is the concept of accepting responsibility for all aspects of yourself. However, taken too far, it involves the client accepting or owning what is not his responsibility or taking on what is not his. At the extreme, it manifests as self-blame or excessive guilt.

Intervention suggestions
• An empathic enquiry into the client’s feelings of responsibility and guilt can start the process of sorting out what belongs to him and what does not.
• Engage the client in a cognitive exploration of the situation, using his middle zone to sort out the facts. Question how he knows what things are his responsibility and what are not. This is particularly true for sexual abuse or sudden bereavement.

Introjection . . . rejection

Introjection is a process whereby an opinion, an attitude or an instruction is unquestioningly taken in from the environment as if it were true. An introject is not properly analysed, digested or assimilated and is effectively a foreign body taken in and kept. In our experience, an introject is usually at the heart of most other fixed modifications to contact. Clear examples of introjects can be seen in forceful instructions given to children which are absorbed often without understanding, ‘Don’t play near the river’ or ‘Come home before dark’. Other examples of introjects are ‘Never depend on others’ or ‘You will never succeed’. The person who is under the influence of an introject feels a strong pressure to conform with the introject and feels uncomfortable if he tries to go against it. Sometimes, if he pays attention to his middle zone, the client can hear the actual instruction and, if asked, can actually say who ‘gave’ it to him. However, introjects are also an essential part of functioning effectively, they allow us to internalize significant societal rules and to negotiate the education system. As therapists, they allow us to adopt temporary strategies based on the experience of others until we can find our own. For example, trainee therapists dealing with clients who have a history of violence, may follow the introject ‘Never see clients alone in a building late at night.’
**Suggestion:** Think back to your childhood, what messages or instructions were part of your family life? Were there particular rules around eating, ‘Don’t put your elbows on the table’, ‘Don’t eat with your mouth open’. What messages did you receive about your body, honesty, morality, culture? Now reflect on how many of these early instructions you still follow. Have you freely chosen all of them as an adult or are there some you just live by without question?

Many of the problems that the client brings to therapy will rest upon a belief or opinion that has been absorbed out of awareness and never questioned. It is the therapist’s job to help him bring such introjects into awareness so that he can make choices about whether or not he will keep them. The therapist should not normally try to have any influence on which beliefs are useful or not. It is the prerogative of the client to decide whether he keeps or rejects them.

**Intervention suggestions**

- Identify the full implications of the introject. You can carefully explore using the phenomenological method. This brings the introject or belief into awareness:

  ‘I notice you have a strong belief that you can never get it right’

  ‘How did you arrive at the conclusion that expressing your emotions is a sign of weakness?’

  ‘How did you come to believe that?’

  ‘Is it true then that you can never get anything right?’

  ‘Do you think that it is always wrong to express emotions?’

- Clients with enough support can be invited to exaggerate the introject in order to comprehend the extent of its limits in the present. ‘Tell me with as much energy and conviction that (for example) you will never let yourself become angry.’ You might ask the client to say the belief out loud, or even to shout it. ‘I will never show my anger under any circumstance.’ This in itself sometimes brings the introject to clear awareness. It can start to show the client how rigidly he has held this belief and how unquestioningly he applies it to all situations. The client may begin to become curious at this point and even genuinely puzzled as to why he believes this so strongly.

- Sometimes a role-play or enactment is necessary where the client is helped to go back to face the person or the situation where he took in the introject. He can then make a introject giver v

- Find a competi someone whom

- It is likely that a will introject act as it is rarely un opinions. Howe to recognize he stop and reflect

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client is helped to introject. He can then make a new decision, reject the message, modify it, or argue with the introject giver with all of his here-and-now resources and understanding.

• Find a competing introject. It can be quite powerful for a client to identify someone whom he respects and admires who would actually support a conflicting belief.

• It is likely that a client who uses introjection as a major modification to contact, will introject actively what you say. It is easy for a counsellor not to notice this, as it is rarely unpleasant to have someone agree so wholeheartedly with one’s opinions. However, it is important to monitor the process and invite the client to recognize how readily he swallows your suggestions. Encourage him to stop and reflect before he agrees.

The opposite pole to introjection is rejection. It is clearly healthy to reject an attitude, a belief (or indeed an intervention from a therapist) if it does not fit with the client’s values and integrity. However, sometimes a client may manifest rejection as a habitual style. For example, he may appear to disagree with or ‘spit out’ every intervention you make or he may reject anything in a particular area or related to a particular issue. Sometimes, the client rejects not only the opinions of others but anything he is given, including love and attention. Rejection can come across as mistrust, rebellion or excessive self-reliance.

Intervention suggestions

• Patterns of rejection can often be used by clients to define themselves. In the struggle to identify what is ‘me’ and what is ‘not me’, the client may find it easier to define what is ‘not me’ in terms of what he dislikes, disagrees with, etc. rather than identify what is ‘me’. It can be useful to help begin to find his sense of who he is by focussing on his inner zone and middle zone, recognizing the full range of his needs, feelings and sensations and putting them into words.

• Frequently, the rejecting attitude stems from a profound fear of being controlled or criticized. You will notice the client’s tendency to avoid answering questions or following suggestions. Here, your approach will need to be accepting and open, without making demands or even asking many questions. You may ‘sit alongside’ the client (both figuratively and literally), inviting him to speak about whatever he likes. Support him to talk about himself and his interests rather than question him, in order to avoid the impression of trying to ‘corner’ him. Once a good working relationship has been established, he may easily respond well to confrontations which are more playful and humorous.
The therapist’s modifications

Therapists, too, modify their contact sometimes in ways that are limiting to their therapeutic effectiveness and options. It is impossible for us to leave our own habitual patterns out of the consulting room and impossible to avoid being part of the co-created field of the client’s modifications. What we can ask of ourselves is to embrace a phenomenological and dialogic attitude as far as we can. This will reduce the likelihood either of imposing our own patterns on our clients or of colluding with theirs.

**Suggestion:** Think about your own patterns of contact. Which modification(s) do you most commonly use? How do they interfere with the contact you make? How do these modifications emerge in the consulting room? For example:

- If you commonly reflect you might hold back unnecessarily on sharing your own experience.
- If you project, whose face might you be likely to put on your client?
- If you are very expressive, you might have a tendency to self-disclose without exploring the meaning for the client of a situation.
- If you have a tendency to confluence, you might have difficulty in sitting with a client who disagrees with you, etc.

Now think of one of your clients and his common ways of modifying contact. How is that likely to interact with yours? What unhelpful or helpful relational patterns might you co-create?

**Conclusion**

One of the central tenets of Gestalt is that healthy functioning involves good contact with self and others. However, it is unrealistic to expect that we can make full contact with every emerging figure or need all the time, or would even want to. Every situation requires a unique response, usually some adjustment or modification of contact. Good contact needs to be appropriate and relational. We may help a fallen pedestrian as a result of an introject to be helpful, even though we are in a hurry and don’t want to stop. We may reflect a hostile comment that will get us into unnecessary difficulties, we join with our loved one in a moment of confluence, we use projection in order to be empathic, and we desensitize from a headache in order to get an important job done. We modify contact all the time. The important issue is to be able to do so fluidly and ‘choicefully’ so that we can employ the full range of contact options along new situations.
options along a continuum, continually updating our contact styles for each new situation.

**Recommended reading**