



Practitioner Report

Gestalt Therapy Applied: A Case Study with an Inpatient Diagnosed with Substance Use and Bipolar Disorders

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Aim: The aim of the present paper is to open the discourse regarding the unmet needs of specific patients, especially those with substance use disorder and/or personality disorder where 'multimorbidities', and/or 'overdiagnosis' and/or 'diagnosis overlap' are frequent. An additional aim is to review the main therapeutic purpose and concepts of Gestalt therapy which might be appropriate in the treatment of these patients often characterized by their difficulties in being aware and in contact in the 'here and now'.

Methods: I first start with an overview of Gestalt therapy concepts. Then, I illustrate Gestalt's 'here and now' and awareness concepts applied during 18 sessions with an inpatient diagnosed with substance use and bipolar disorders. In addition, the patient had to face an open criminal charge, was regarded as having an antisocial personality disorder and argued suffering from post-traumatic stress disorder.

Results: After this two-month therapy period, the patient entered for the first time a daily rehabilitation program in the community, where he was doing well (this after a few prior hospitalizations). The awareness development in the 'here and now' through which different contact styles and cycles of experiences are experienced is a process that allowed the patient to start experiencing contact with himself, his true needs and his environment. This contributed to his well-being improvement, led and supported his rehabilitation and reinsertion within the society and decrease his relapses, either with drugs or criminal activities. Copyright © 2016 John Wiley & Sons, Ltd.

Key Practitioner Message:

- People with substance use disorder (where 'multimorbidities', 'overdiagnosis' or 'diagnosis overlap' are frequent), people with personality disorder(s) or people who have difficulties in defining what really disturbs them are the same people who could benefit of GT encouraging awareness and contact development in the 'here and now'.
- Gestalt therapy should not be regarded as a practitioner's toolbox but as a therapeutic process allowing awareness and I-boundaries development in the 'here and now' through authentic and genuine relationships.
- The therapist's awareness and contact with themselves and their environment are reflected in the therapist's relaxed but awake and aware state of mind as well as their wise, spontaneous and mindful approach.

Keywords: Gestalt Therapy, Awareness, Therapeutic Relationship, Substance Use Disorder SUD, Bipolar Disorder BP, Personality Disorder PD

INTRODUCTION

People with substance use disorder (SUD) are often suffering from comorbidity or even 'multimorbidities' that remain most of the time unattended. This makes the SUD a complex issue, with negative consequences, either

financial, social or relational. Meeting the clinical needs of the patients with SUD and/or 'multimorbidities' would have significant implications. The patients would benefit not only of a decrease in their drug use but also of an improvement in their quality of life. The society would benefit of a decrease in the high cost and harmful consequences engendered by any individual under drug influence either in terms of health, criminal activities or inter-personal problems within different entities (e.g., police forces, courts, families, schools, armies, studies).

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The current study aims to fill the void left by therapeutic interventions that do not approach the broad range of disorders affecting individuals with SUD.

There is a high bipolar disorder (BD) comorbidity rate among people with SUD (Baethge *et al.*, 2008; Cassidy, Ahearn, & Carroll, 2001; Chengappa, Levine, Gershon, & Kupfer, 2000). BD is often associated with a wide variety of other psychiatric disorders such as anxiety disorders, mood disorders, personality disorders (PDs), attention-deficit hyperactivity disorder and eating disorders (Krishnan, 2005; Mantere *et al.*, 2010; Mitchell, Brown, & Rush, 2007; van Emmerik-van Oortmerssen *et al.*, 2014). Recently, it was found that among people with SUD, BD might be overdiagnosed (Goldberg *et al.*, 2008; Stewart & El-Mallakh, 2007). The BD overdiagnosis might result from confounding symptoms with other disorders such as borderline personality disorder (BPD), attention-deficit hyperactivity disorder or SUD (Ghouse, Sanches, Zunta-Soares, Swann, & Soares, 2013). Other research have associated BD with mood and anxiety disorders (Mantere *et al.*, 2010) and substance use as a means to alleviate these symptoms. It was found that SUDs were moderately associated with manic symptoms, and eating disorders with depressive mood (Mantere *et al.*, 2010). Improving mood, relieving tension, alleviating boredom, achieving/maintaining euphoria and increasing energy were the main motives for drug use among people with SUD only or combined SUD/BD disorders (Bizzarri *et al.*, 2007).

Research indicates that comorbidity is not the exception but the rule among people with SUD such as anxiety, depression, psychosis, schizophrenia or PDs (George & Krystal, 2000; Grant, Stinson, Dawson, Chou, Ruan, *et al.*, 2004; Grant, Stinson, Dawson, Chou, Dufour, *et al.*, 2004; Rounsaville, 2007; Schuckit, 2006; Verheul & van den Brink, 2000; Volkow, 2009). Other studies debate on the high prevalence of maladaptive personality or PD in people with SUD (Ball, 2005; Grilo *et al.*, 1997; Rounsaville *et al.*, 1998). In some studies, it was emphasized that the most frequent PDs found among individuals with SUD were borderline, antisocial, avoidant and paranoid personality disorders (e.g., Chapman & Cellucci, 2007; Darke, Kaye, & Finlay-Jones, 1998; Verheul & van den Brink, 2000). Few studies had examined the relationships between PD comorbidity and other psychological symptoms in samples with SUD (Ball & Cecero, 2001; Hatzitaskos, Soldatos, Kokkevi, & Stefanis, 1999).

Disregarding the comorbidity disorder when treating people with SUD may explain the high rate of treatment dropout and/or relapse (van den Bosch & Verheul, 2007). In addition, comorbid psychiatric disorders (e.g.,

BPD, Schizophrenia, BD) in patients with SUD have a wide range of adverse consequences that include low quality of life¹ (Schaar & Öjehagen, 2003; Singh, Mattoo, Sharan, & Basu, 2005; Urbanoski, Cairney, Adlaf, & Rush, 2007), as well as involvement in criminal activities (Alden, Brennan, Hodgins, & Mednick, 2007; Fridell, Hesse, Jæger, & Köhlhorn, 2008; Fridell, Hesse, & Johnson, 2006; Hedden, Malcolm, & Latimer, 2009; Theriot & Segal, 2005). When BD is associated with a comorbid SUD, it has negative consequences in terms of suicide attempts (Dalton, Cate-Carter, Mundo, Parikh, & Kennedy, 2003), crimes (McDermott, Quanbeck, & Frye, 2007) and quality of life (Singh *et al.*, 2005). Improvement in psychiatric symptoms is associated with improvement in quality of life (Singh *et al.*, 2005) but despite this, there is a lack of systematic pragmatic clinical treatment of dual-diagnosis in population with SUD (Kienast & Foerster, 2008).

This case study has a twofold purpose: (1) reviewing Gestalt therapy's (GT) main therapeutic purpose and concepts and (2) describing the applicability of these GT concepts with an inpatient with 'multimorbidities' that I met twice a week during a two-month period. The awareness development in the 'here and now' through which different contact styles and cycles of experiences are experienced is a process that will allow the patient to experience contact with himself, his true needs and his environment. This will contribute to his well-being improvement, as well as lead and support his rehabilitation and reinsertion within the society and decrease his relapses, either with drugs or criminal activities. This process will slowly allow releasing energies that got stuck and impeded the fulfilment of smooth sequences of figure/background (F/BG) formations as well as experiencing new F/BG formations.

PART I — INTRODUCTION TO GESTALT THERAPY'S CONCEPTS

Awareness, Contact, Boundaries and GT

Awakening one's awareness is the main purpose of GT (Mackewn, 1997; Perls, Hefferline, & Goodman, 1951; Polster & Polster, 1974; Yontef, 1993; Zinker, 1978). According to Perls, raising awareness meant liberating people from *maya*, that is, from their world of concepts, ideals, fantasies and intellectual rehearsals they had to construct to live between their real selves and the real world. Perls said that the way for us to become free from *maya* was to '*lose our mind and come to our senses*', a famous phrase that became one of the symbols of GT at that time.

Based on existential and phenomenological approaches, the main GT awareness themes emphasize that (1) awareness is grounded in the present experience (whether the present experience refers to past, present or future events or thoughts that are relived in the present); (2)

¹Quality of life is a concept conceived and widely used by the World Health Organization (WHO), which covers four main domains in the individual life that are (1) physical health, (2) psychological, (3) social relationships, and (4) environment.

awareness is relevant when one is in contact with their environment (e.g., individuals such as close ones or strangers, culture, nature, animals and objects); (3) there is a need to adopt a non-judgmental and accepting stance towards one's and others' sensations, feelings/emotions, thoughts and behaviours; and (4) and there is a need to develop an ability to observe, describe and enquire about one's and others' sensations, feelings/emotions, thoughts and behaviours (Mackewn, 1997; Polster & Polster, 1974; Zinker, 1978, 1994). GT refers to emotions as one of the keys to awareness development and the understanding of behaviours and thoughts² (Perls *et al.*, 1951) and to cognition as one of the main integrative tools of personality³ (Perls *et al.*, 1951; Staemmler, 2009; Yontef, 1993). Once reached, awareness facilitates the emergence of wants and desires (Perls *et al.*, 1951; Polster & Polster, 1974; Zinker, 1978, 1994). Our sensory and motor functions are potentially the functions through which contact is made, and that contact extends into interaction with both inanimate and animate objects (Perls *et al.*, 1951; Polster & Polster, 1974). *'...What distinguishes contact from togetherness or joining is that contact occurs at a boundary where a sense of separateness is maintained so that union does not threaten to overwhelm the person...'* (Polster & Polster, 1974, p. 102). Now, we have two additional concepts: contact and boundaries.

Contact is the meeting between ourselves and that which is not ourselves (Perls *et al.*, 1951; Polster & Polster, 1974). *'Contact is a dynamic relationship occurring only at the boundaries of two compellingly attractive but clearly differentiated figures of interest.'* (Polster & Polster, 1974, p. 107). Contact occurs when two different entities encounter, a figure of interest appears for one or both of the entities involved, and whereas there is excitement around it, they are capable to create a bound (a 'we') around this figure. Once the figure of interest has been experienced and assimilated, we can say that the contact has facilitated

the entity growth and an expansion of his I-boundaries. These entities possess a sense of boundedness, and each has their own I-boundaries determined by the entire range of their experiences in life and their capacity to assimilate new experiences. Experiences at the I-boundary can be defined as body boundaries (sensations), value boundaries (automatic thoughts or beliefs or assumptions), expressive boundaries (behaviours) and exposure boundaries (the expression of one's I-boundaries in a genuine and non-judgmental way) (Polster & Polster, 1974). People need to become experts in sensing and creating environments in which movement outside their present I-boundaries can be supported or in leaving or altering environments where this seems impossible (Perls *et al.*, 1951; Polster & Polster, 1974). Hence, contact involves not only a sense of one's self but also the sense of whatever impinges at this boundary and whatever looms at the contact boundary and even emerges into it, and one is responsible for discerning and reacting to what emerges (Perls *et al.*, 1951; Polster & Polster, 1974).⁴ From this point of view, a therapeutic relationship might be regarded as a contact issue that requires awareness and knowledge of one's I-boundaries in any specific situation in the 'here and now'. When awareness develops in the 'here and now', it facilitates an I-Thou and a dialogical interaction where contact is established and the individual's boundaries expanded.

Diagnosis, Psychopathology/Health and GT

Diagnosis and psychopathology is an extensive subject beyond the scope of this paper. Nevertheless, I am going to refer to the main GT approach to diagnosis relevant to the present case. Perls defined psychopathology as the interruption of excitement at any stage in the sequence of figure-background (F/BG) formation, a pathology that he defined as a disturbance of the self functions (Perls *et al.*, 1951).⁵ The self is the system of present contacts and agent of growth, regarded as the boundary of an

²Emotion, considered as the organism's direct evaluative experience of the organism/environment field, is not mediated by thoughts and verbal judgments, but is immediate. As such it is a crucial regulator of action, for it not only furnishes the basis of awareness of what is important but it also energizes appropriate action, or, if it is not at once available, it energizes and directs the search for it' (Perls *et al.*, 1951, p. 95). 'It is only in the recognition (acknowledgement) of your emotions that you can be aware, as a biological organism, either of what you are up against in the environment or of what special opportunities are at the moment presented' (Perls *et al.*, 1951, pp. 98–99).

³In the integrated personality, thinking is a useful, active instrumentality in handling the complex relationships of aware need, imagined means of fulfillment, and the overt behavior which makes concrete what has been imagined.' (Perls *et al.*, 1951, p. 106). 'Every method ordinarily used in psychotherapy is, as single and isolated, relevant, but also inadequate. Since physical and social environment, body, emotion, thinking, speech all exist in a unitary functioning which is the total organism/environment process, to give attention to any one of these components is appropriate for promoting personality integration' (Perls *et al.*, 1951, p. 112).

⁴...Fundamentally, an organism lives in an environment by maintaining its differences and more importantly by assimilating the environment to its differences; and it is at the boundary that dangers are rejected, obstacles are overcome and the assimilable is selected and appropriated. Now (that) which is selected and assimilated is always novel; the organism persists by assimilating the novel, by change and growth...Primarily, contact is the awareness of, and behavior toward, the assimilable novelties; and the rejection of the unassimilable novelty. What is pervasive, always the same, or indifferent, is not an object of contact...All contact is creative adjustment of the organism and environment...Growth is the function of the contact-boundary in the organism/environment field; it is by means of creative adjustment, change, and growth that the complicated organic unities lives on in the larger unity of the field' (Perls *et al.*, 1951, p. 230).

⁵For example, '...anxiety is the interruption of creative adjustment...the various mechanisms and characters of neurotic behavior may be observed as the stages of creative adjustment at which the excitement is interrupted.' (Perls *et al.*, 1951, p. 448).

organism in contact with their environment.⁶ GT presents the self as a function of three structures that are the id, the ego and the personality, which are the major stages of creative adjustment. *'The id is the given background dissolving into possibilities, including organic excitations and past unfinished situations becoming aware, and the environment vaguely perceived, and the inchoate feelings connecting the organism and the environment. The ego is the progressive identification with and alienation of the possibilities, the limiting and heightening of the on-going contact, including behavior, aggressing, orientation and manipulation. The personality is the created figure that the self becomes and assimilates to the organism, uniting it with the results of previous growth.'* (Perls et al., 1951, p. 378). Psychosis is then defined as a disturbance of the id functions (loss of awareness and contact with the organism and the environment) and neurosis as a loss of ego functions (loss of the ability to see choices, opt for one of them and 'act' on it). These sequences of F/BG formations (or cycles of experience as it is often called in GT literature) in terms of id, ego and personality are illustrated in Annex #1 (Francesetti, Gecele, & Roubal, 2013; Perls et al., 1951; Zinker, 1978).

The energy disturbance, that is, the 'diagnosis', is reflected in one or more of the stages in the sequence of F/BG formation, also called the cycle of experience (refer to Annex #1), as well as in the different contact styles (Mackewn, 1997; Perls et al., 1951; Polster & Polster, 1974; Zinker, 1978) (refer to Annex #2), the individual unconsciously developed and assimilated as creative adjustments during the different life events they experienced. A patient's 'diagnosis' will orient the therapist by indicating on which stage of the cycle of experience and contact styles to focus. Once carried out, the intervention(s) must occur many times before any long-lasting changes occur (Melnick & March Nevis, 1997; Perls et al., 1951; Polster & Polster, 1974). This pattern of disturbance of the excitement in the F/BG dynamic is in contrast to healthy individuals' contacting, in which the energy moves smoothly along all stages of the cycle of experience.

The GT concepts of awareness, I-boundaries development, contact and cycles of experience become relevant face to Kazdin's (2015) recently published paper. Kazdin (2015) questioned the effectiveness of evidence-based practices (EBPs) over treatment as usuals (TAUs) and argued that TAUs were found as effective as EBPs. He added that whereas the TAU components are not always specified in research, maybe there would be factors worth clarifying either inherent to TAUs or common to TAUs

and EBPs, which would contribute to improvement. I would suggest that in specific cases, the contact between two entities and going through different F/BG formations would contribute to the individual growth. This might explain why sometimes people get better or worse without treatment, with TAUs or EBPs. The common factors we might find in different epistemologically oriented therapeutic approaches, TAU, EBP or no treatment at all, could be explained in Gestalt terminology and concepts. Therapeutic relationship involves the individual's genuineness and presence with their own awareness and I-boundaries, assisting the other in acknowledging and developing their own awareness and I-boundaries. This approach allows within the therapeutic relationship the cocreation of the fixed gestalt (pattern), its deconstruction and the appearance of the need for a new experience. The new experience creates a contact figure that is characterized by grace, harmony and brightness (Perls et al., 1951).

After this overview of GT's main purpose and concepts, in part II, I will report on an holistic case study referring to an inpatient presenting with 'multimorbidities' and without any real issue he wanted to address during our sessions.

PART II — A CLINICAL APPLICATION

A 'Multimorbidities' Case

Reasons Applying to Therapy and Past Experiences with Therapies

When I asked what he expected from the therapy and how I could help him, Ilan talked about what had happened in the past and how he was going to treat himself after his discharge from the psychiatric inpatient ward. He never brought up any issue that really disturbed him or that he wanted to treat 'here and now' during our sessions. He did think that he had to be hospitalized for at least 3 months according to the mandatory hospitalization court order. As he said, *'...I want to treat my mental illness... I am sick...I will focus on my mental illness...I am irresponsible because of my mental illness...'*. In addition, he argued that

⁶*'The self is the power that forms the Gestalt in the field; or better, the self is the figure/background process of contact-situations. The sense of this formative process, the dynamic relation of ground and figure, is excitement: excitement is the feeling of the forming of the figure-background in contact-situations, as the unfinished situation tends to its completion.'* (Perls et al., 1951, p. 374).

⁷PTSD is diagnosed when a person has been exposed to a traumatic event in which [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. The traumatic event is persistently re-experienced (e.g., recurrent distressing dreams of the event); persistent avoidance of stimuli associated with the trauma (e.g., efforts to avoid thoughts, feelings, or conversations associated with the trauma); persistent symptoms of increased arousal (e.g., difficulty falling or staying asleep).⁷ ASPD is characterized by a pervasive pattern of disregard for or violation of the rights of others occurring since the age of 15 years such as failure to conform to social norms with respect to lawful behaviors, deceitfulness or impulsivity, failure to plan ahead, or irritability and aggressiveness.

he suffered from post-traumatic stress disorder⁷ (PTSD) because he remembered that without drugs and medicine, he had nightmares. During this current hospitalization, Ilan was facing a serious criminal charge, which led the staff to think that there was perhaps a trade-off between his mental illness and his criminal charge. In addition, Ilan was regarded as having an anti-social personality disorder (ASPD)⁷.

Personal Background

Ilan was born in a well-established neighbourhood in Israel, where he grew up with his mother and sister after his parents divorced when he was about 6 years old. He remembers his mother as a lovely, strong and caring mother who worked hard and travelled a lot: '*...my mother cared about my studies...she paid private lessons for me...for my things I worked since I am 8 years old...I never asked either my mother or my father...*' he said. Ilan remembers his father as a cold person who liked to stay in the dark after he came home from work at night. His father remarried, and after a few years, the contact was cut off. As a child, Ilan suffered from emotional and physical neglect, learning disabilities and conduct disorder. He was expelled from two different schools due to conduct disorder. His mother found him a private school, from which he graduated. He was arrested for the first time for theft when he was 17 years old: '*...it was a big shock for me and my mother...but she never yelled at me...she was always on my side...*' he said. When he was 18 years old, Ilan enlisted in the army and recalled proudly that he learned new human values in the army. When he was still a soldier and started to feel that things could change positively for him, Ilan experienced the abandonment of two very important people in his life: his mother, who died from cancer (he was 19.5 years old), and one of his dear and valued commanders, who died in a terrorist attack. Once discharged from the army, Ilan worked hard as a heavy truck driver. He hardly slept. At the age of 28, he had a severe work accident that confined him to his home. He suffered from nightmares about the death of his commander and found that marijuana helped alleviate his suffering. He renewed his contacts with his childhood delinquent friends, started to use drugs (primarily cocaine, marijuana and LSD) and became involved in

criminal activities. At the age of 32, he was arrested for violent behaviour when in a psychotic state and for involvement in severe criminal activities. The charges against him were dismissed because Ilan was recognized as irresponsible due to his mental illness,⁸ BD.⁹ Ilan attempted suicide twice. Since then, Ilan lived a chaotic life trying to manage his depression, aggression, drug addiction, medication, hospitalizations, criminal records and the challenges of everyday life.

The Applied 'Here and Now' Gestalt Concept

When I asked Ilan, during our first session, about his personal experience from therapy and his expectations from this present therapy, Ilan answered, '*...I was not sincere with them...I lied to them...now I want to be sincere...I want to treat my illness...I gave you all the information...*' Ilan was authentic in telling that there was a part of him that wanted to really treat his illness and another part that was capable of destroying his therapeutic plans by lying, not being sincere, hiding and manipulating. My own experience was that Ilan chose to avoid being in the 'here and now', for example, by rejecting this present therapy occasion, as he said: '*...after my discharge from the hospital...I'll go to therapy and talk about my mother and my captain...they are things that I never talked about...*'.

My main therapy line was to assist Ilan in developing awareness, being present in the 'here and now'. In the following four sections, I illustrate the awareness development at different periods within the therapeutic encounter. This includes awareness of the different (mal-) adaptive contact styles (refer to annex #2) (un-)satisfyingly fulfilling the patient's inner needs when in contact with himself and/or his environment. This way, I explore a process and describe how looking for and seeing different options of behaviour guide the patient in his search to close gestalt, release energy and move to next Gestalten. This way, the patient learns to use his id and ego functions going through several F/BG formations or cycles of experience (refer to annex #1).

Discovering and Knowing Through Awareness in the 'Here and Now'

During the early phases of therapy, I spent most of the time bracketing (Yontef, 1993), mirroring and reflecting what Ilan said as well as amplifying Ilan's polarities about any subject he brought to the session. I would say that I

⁸According to the 1991 Israeli law and the Criminal Procedure Law 1982, 'Israeli legislation allows for the admission of an offender to an appropriate psychiatric hospital if a court considers that the offender is suffering from a mental disorder requiring treatment in hospital, or is not capable of standing trial because of illness, or if a court is satisfied that the offender was suffering at the time of the offense from a mental disorder and if he or she is still suffering at the time of the trial. In these circumstances the Israeli court must make a hospital order or an order for ambulatory treatment... Where mental illness is regarded by an Israeli court as present and of sufficient degree for a hospital order to be made, the offender is regarded as not criminally responsible' (Gordon, Kirchhoff, & Silfen, 1996).

⁹Bipolar disorder is a disorder characterized by two or more episodes in which the patient's mood and activity levels are significantly disturbed, this disturbance consisting on some occasions of an elevation of mood and increased energy and activity (hypomania or mania) and on others, of a lowering of mood and decreased energy and activity (depression).

was in a kind of conscious confluent contact style. This confluent state allowed the patient to develop his awareness and me to be touched by what was going to occur in the therapeutic encounter. This allows the diagnosis to be collaboratively constructed between the therapist and the patient, and it supports the development and building of the therapeutic relationship, which is a prerequisite with people who suffered from severe childhood trauma (Kepner, 1996) and currently suffering from substance use disorder (Miller & Moyers, 2014).

Ilan was compliant and polite in the department, promising to do the right things and respect the rules in the department, but when Ilan was found breaking the rules, he exploded in a defensive way. The sessions' focus was to help Ilan develop awareness about his way of being and his contact styles. The therapy experience at this stage, metaphorically speaking, was like being in the presence of an exploding multicoloured ball, which allowed us to discover the many colours that were closed inside and put them on paper. Now that I am writing these lines, a thought crosses my mind: 'It's a pity I couldn't share this metaphor with him'.

The Unspoken Issue 'Here and Now'

I initially thought that I would be unfaithful to the GT approach if I were the one that brought to the session the criminal charge issue. At the same time, I started to feel an uneasiness. I felt that something false began to install between me and Ilan, '*...an unspoken issue...*' that was relevant to his hospitalization—until one day, when Ilan was influenced by changes in the field, i.e., the department. His doctor talked with him about rehabilitation centres he should go to, otherwise the police would reopen the criminal charges against him. Ilan seemed confused and said that he did not understand what she said, adding that he did not want to hear about rehabilitation centres. I had read an article on the internet that described Ilan as the leader of a criminal activity. Although I knew that one day, but later, we would talk about it, I never referred to this article or brought it to our sessions in such an early stage of therapy. However, the subject came from the field, and I could no longer ignore it. I even felt released and pleased that it had arisen now. I had the opportunity to bring the article to the therapeutic field and treat my uneasiness and my fear that an abyss or a symbiosis could grow between me and Ilan regarding his criminal charges. I showed him the article, and I suggested we read it together. Ilan knew that a few years ago, there was an article on the web about him but he never read it. We slowly read it together. Ilan was shocked, devastated and stunned. He invested considerable energy in trying to explain to me that he was not responsible because of his mental illness and that the things and facts written were not what they seemed. After

the talk about the 'unspoken issue', I felt like the haze within the room faded away, and the air suddenly cleared. During the next session, Ilan was confident this time that all he had to do was to cooperate with the mental health system. He got the support of his attorney and his friends to treat his addiction, and he decided to focus on the treatment of his mental illness and his addiction. He showed interest in his therapy in an addiction rehabilitation centre and in increasing his current needs within the ward. After we finished talking about his current needs, a half hour remained. I asked him, '*...What subject you want to talk about?*' Ilan answered nearly without hesitation: '*My commander in the army...*'. Ilan began to tell the story about the death of his commander. I was pleasantly surprised by Ilan's ability to be present and bring to the 'here and now' of our sessions the events he thought he would talk about after his discharge from the hospital.

My own cycle of experience not only allowed the establishment of a contact between me and Ilan but also allowed Ilan to experience his own cycle of experience. After I started to be aware of my tension and uneasiness, I could feel energized by the opportunity to talk about the criminal charge. I mobilized energy, took the article and read it with Ilan. I established a contact with Ilan that later relieved my uneasiness. When Ilan was in contact with his anger, he became aware of his denial regarding his criminal charge (when I confronted him with the article we read together), which he assimilated and this way could move on to the next cycles that were accepting the rehabilitation opportunity and accepting to talk about his own trauma tied to the death of his commander.

Bringing 'Past', 'Current' and 'Future' Events in the 'Here and Now'

The pattern that reoccurred is that Ilan talked a lot about his past and about what he planned to do in the future but was never present in the 'here and now'. Based on my observation and my hypothesis, that the energy was in a first stage interrupted between the action and the contact phases of the cycle of experience, I started by being present in a non-judgmental way, being a mindful therapist (Zinker, 1978). Would this energy blockage explain why Ilan was sweating all the time and why sometimes he might have anger outbursts? In order to strengthen his ability to be aware and be present in an accepting and non-judgmental way, I asked questions such as '*...on what do you want to work on today?...*', I practiced with him mindfulness and breathing exercises or shared my own feelings.

During the 10th session, he said, '*...I do not want to be depressed anymore...*'. 'Depression' was the subject he chose to work on. Despite bringing the depression to the 'here and now', Ilan tended always to avoid to talk about his

'current depression' and instead talked about his 'past depression' and his 'future depression'. Ilan insisted that he was depressed and needed medication but according to clinical exams, there was no sign of any depressive symptom. I advised him to measure his depression in different situations and face to different people. We began by measuring his depression with me right now in the room. Ilan answered '...outside the room...not close...'. But very quickly he began to talk about his depression from past experiences. I recalled to myself his expressed need during our previous session, that is, his need to enlarge his life story before getting to the point. I restrained and bracketed my impatience and 'my need to focus', and stayed with his depression in his past experiences that were mixed with an anxiety component: '...I stayed at home in order not to cope with all this...I said to myself...this will sort out what happens within my head...but it did not...the depression came...' he said. Once he talked in-depth about these past experiences, I again suggested to Ilan to measure his depression and anxiety face to the different people he met during the weekend '...let's take 5 different situations...you will measure how far or close the anxiety or depression were close to you...let's start with R...'. Ilan's depression/anxiety with R. and with S. was manageable. With his father, Ilan did not feel any depression or anxiety, but more a concern for his father's health and it was energizing for him. With his sister, things were different. Ilan felt that depression was very close to him as he felt rejected during an intimate encounter with his sister's husband.

Hence, Ilan, who used to reject any contact with his depression and to look for medications and drugs as a way to get rid of it, did something new during this session. He was in contact with his depression, approaching and deconstructing it. In terms of contact styles, it was an experience for Ilan to move on the rejection-(destructuring)-introjection contact style axis (e.g., Mackewn, 1997; Polster & Polster, 1974) and in terms of cycle of experience to mobilize energy to move from the action stage to the contact stage (e.g., Zinker, 1978). During the next session, Ilan talked about his current 'fear of depression' as he accepted the fact that he was not depressed actually and continued to talk about his depression from the past.

The Contact in the 'Here and Now' — The Wall

Three sessions later, his fear of depression came again, and Ilan insisted he needed Edronax. Whereas I was apparently despaired and my impatience increased, I shared my thoughts with him, '...you are looking for chemicals to solve your problems...', but it just upset him more. Then, after a while, when I was in a relaxed but awake and aware state, Perls' remarks (through my supervisors' words), popped up, and I asked myself: '...where are you?...don't ask, make a statement...'; then, I

shared with Ilan what happened to me, saying, '...I'm trying to help you...and to understand what disturbs you but I am not able to do it...I can't do it...treating depression through therapy is possible...I try to help you...but I can't...'. Ilan interrupted me saying: '...and we withdraw...a wall comes from me...(I asked him if he felt this wall)...yes sure...yes sure...sure...I feel it...(I asked him if he wanted this wall to disappear)...sure, I want this wall to disappear...but as long as I have 800 mg (Seroquel)...(I asked him where he feels the wall and how does he build it)...it comes...it comes...at the moment people do not listen to me, it comes...I do not build it...it's not me...I have no intention to build it...it just comes...because there is no choice...it just happens...I do not want things happen this way (x2)...'. Ilan was vulnerable at this stage; he let me discover 'his wall...when nobody listens to him'. I shared with him that I felt this wall and that this was what prevented me from easily approaching him. When I showed my own vulnerability and helplessness, Ilan asked me '...how do we treat depression?', and we started together to question whether his everyday activities were a sign of depression. He also expressed his own desires and aspirations as signs of being alive and not depressed.

I had the opportunity to bring in the 'here and now' within the therapy session setting, Ilan's '...when people don't listen to me, I unintentionally build a wall...'. I said '...I do listen to you now...how do you think something could help you?...'. Astonished and confused he said '...I do not know...yes, I have a dilemma...no...I would decrease the Seroquel dose to 400mg and add an antidepressant...'. Once Ilan expressed his entitlement needs (which were opposed to the doctors' stance), Ilan was ready to listen to my suggestion: '...how do you treat depression?...how?...' he said. This was the end of the session, and I suggested homework to Ilan. Ilan showed interest in the subject and wrote down the tasks he had to do the next day. At the end of the session, his doctor entered the room and announced to him that he finally had an appointment for an interview in the rehabilitation centre. Ilan used his doctor's presence to enumerate all kinds of request. I was surprised that he did not bring up the main subject that had bothered him during our sessions, 'his need for medication to treat his depression', so I did it for him and asked his doctor all the questions that bothered him. Her answer was '...sure...after your discharge from hospital and within the rehabilitation center, the psychiatrist there could consider to lower the Seroquel dose...'. In the next session, Ilan seemed okay. Ilan said proudly, '...I did my homework...'. He paid his bills and went to the supermarket, driving alone for the first time in a long time. He had really made an effort to do his homework. Ilan said he paid attention to the fact that his fear of depression came mostly when he was alone in the afternoon or in the evening. We took one of the events he brought up, and we deconstructed it.

The energy was less stuck between the action and contact phases within the cycle of experience, the energy was flowing, and Ilan started to establish contact with himself and his environment. Two sessions later, we were able to make the first Gestalt experiential exercise where Ilan was in contact and dialogue with his commander in the battle field where he died in Ilan's hands. He said that what he took with him from this session was the sentence '*...what does he answer to you?...'*'. Ilan was also aware that what he wanted from his commander were two things: (1) '*...stop coming into my dreams...*' and (2) '*...I did not finish talking with you...*'. Ilan also expressed his love for his commander and suddenly saw a different picture '*...I see something else from him now...I see him smiling and laughing...*'. The recurring nightmare he suffered from took another shape, and a new figure and a new contact appeared, and Ilan had more agency over the situation (an important component in PTSD development, maintenance and cure).

Follow-up

Ilan was discharged from the inpatient department after the inter-committee allowed him to continue his rehabilitation program in the community. Ilan attended a TAU program in a daily rehabilitation centre where he participated in intensive group therapies, including an NA group once a week and optional groups, such as art or psychodrama group therapy. There, he experienced more cycles of experience moving on the different contact style axis.

I met Ilan 6 months after his discharge from the hospital in order to inform him about my intent to publish a case report and ask him to sign a consent form. At the time we met, he was doing quite well in the daily rehabilitation centre and was still facing his judicial procedure. During our meeting, he shared his own experience as an inpatient. For Ilan, it was clear that he did not want to either go back to 'this' hospital or be in contact with drugs anymore. He remembered that he had to ask me every time a permission to get a few hours or day(s) outside the ward and that the staff did not believe that he did not do what he was accused of. His anger increased when I reiterated that nobody really believed him, and he suddenly and proudly showed me his current psychiatrist assessment. I read the letter slowly and aloud, I expressed my satisfaction regarding the progress he did and the people he found to support him. Nevertheless, I reiterated that even if I believed that he did what he was accused of, I also believed in his ability to rehabilitate himself, and he proved it. Then he said '*...you know when you are under drugs...you are not the same person...you do things...you don't remember...*'. Whereas Ilan tended to

remember his negative experience from the ward, I recapitulated the pros and cons of being an inpatient as well as my own experience with Ilan. Then three subjects arose, the 'genuine relationship', 'the experiential exercise with his captain' and 'his criminal charge'. Being a therapist in an inpatient ward had pros and cons too. I faced pressure from Ilan (e.g., regarding his free time, his living within the ward, his relationships with the other patients and the staff, his medicines, etc.) and from the staff regarding the rehabilitation plans and options within and outside the hospital. I had also the chance to benefit of a quite good cooperation with the team in charge of Ilan, meaning the roles were more or less well defined. Working in an inpatient ward had a peculiar advantage, that is, I could easily learn about Ilan's phenomenology and contact styles with other patients, with the staff, with his friends and family members outside the ward, and even with me as part of the staff. All this influenced and contributed to Ilan's therapy development.

Discussion

Advantages, Limitations and Future Researches

Contrary to previous research that uses to show the effectiveness of therapeutic intervention in the treatment of one or two psychiatric disorders, this case study focuses on awareness development in the 'here and now' within an authentic and genuine therapeutic encounter. This is based on the assumption that suffering and psychopathology are reflected in the subjective and/or interpersonal relationship (Perls *et al.*, 1951) experienced at the contact boundaries (Francesetti & Gecele, 2009; Francesetti, Gecele, & Roubal, 2013; Perls *et al.*, 1951).

The latter may be more appropriate when patients are diagnosed with 'multimorbidities' and/or once in therapy they don't know exactly on what to focus on. This latter approach may also be appropriate when the 'multimorbidities' or the malaise felt by the patient have several repercussions on his life in terms of well-being, inter-personal and personal difficulties. It has also the advantage of allowing a therapeutic engagement of patients diagnosed as suffering from SUD where 'multimorbidities', 'overdiagnosis' or 'diagnosis overlap' are frequent. The present case study has also some limitations. This is a single case study and as such, bears the drawbacks inherent to single case study research. The findings cannot be generalized at a broader and larger level. The intervention effectiveness was not measured with any quantitative scale. In addition, in this specific case, the therapeutic intervention was confined and time-limited by the hospitalization, limiting an in-depth therapeutic work especially on Ilan's introjections (e.g.,

introjections that stood behind his feelings of rejection that often preceded his depression, anxiety, drug use and anti-social behaviours). Research based on multiple-case replication designs and embedded case studies allowing an extensive qualitative and quantitative analysis would add further insight into GT intervention process, outcomes and effectiveness. This intervention should also be replicated in different settings for inpatients/outpatients presenting with SUD, and/or PD(s) and/or 'multimorbidities'. The effectiveness could be measured in terms of well-being improvement, decrease in the number of rehospitalizations, decrease in the number of drug use relapses, decrease in the number of criminal activities and reinsertion in society.

Clinical Implications

Patients diagnosed with SUD and/or at least one PD are often suffering from one or more additional morbidities are recurrent users of the mental health system and/or are often involved in criminal activities. Once in therapy, these patients may also have difficulties in defining what really disturbs them, being aware in the 'here and now', being in an authentic and genuine contact, and identifying and making choices appropriate to their true needs. These are the same patients that could benefit of interventions based on GT concept of awareness development in the 'here and now' through a genuine and authentic therapeutic relationship (e.g., Kramer, 2015; Wickham, Williamson, Beard, Kobayashi, & Hirst, 2016). A therapist's own awareness and contact with themselves and their environment is a therapeutic approach used in a wise, appropriate and spontaneous way moving flexibly and mindfully on the impulsivity-spontaneity-egoism contact style axis. The therapist's own awareness, contact and genuineness are at the basis of awareness development allowing the individual to go through many cycles of experience or F/BG formations. This way, the individual increases their contact experiences, hopefully closing F/BG formations that were stuck and developing new and more adaptive ones.

Conclusion

Gestalt therapy's focus on awareness development in the 'here and now' is a process mirrored in the different contact styles and cycles of experiences (or figure/background formations) the individual is going through. The genuine and authentic therapeutic encounter is presented here as this process facilitator, allowing excitement to flow freely facilitating the opening and closure of Gestalten. GT refers to emotions as one of the main keys leading to awareness development, to cognitions as one of the main integration tools and to

the senses as one of the main contact tools. Patients presenting with SUD, PD(s) and/or 'multimorbidities' and/or diagnosis overlap or overdiagnosis and/or no real problem they could pinpoint at or have difficulties to be present in the 'here and now', are the same patients that could benefit of GT interventions based on awareness development in the 'here and now' through an authentic and genuine therapeutic relationship. A therapist's own awareness and contact with themselves and their environment is reflected in the therapist's relaxed but awake and aware state of mind as well as their wise, spontaneous and mindful approach.

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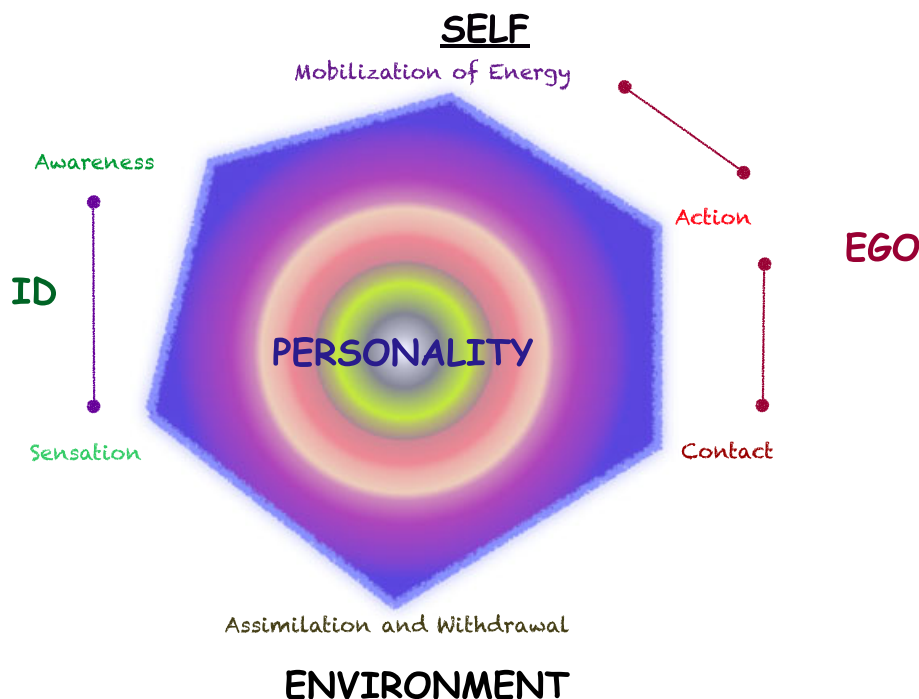
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APPENDIX

Annex #1 Sequences of figure/background formations, cycles of experience



Annex#2 GT contact style axes/polarities

Axes	Contact styles	Contact styles	Contact styles
#1*	Impulsivity	Spontaneity	Egotism
#2*	Isolation	Differentiation	Confluence
#3*	Rejecting	De-structuring	Introjection
#4	Literalness	Assumption	Projection
#5	Aggression	Expression	Retroflexion
#6	Super-sensitivity	Sensitivity	De-sensitization
#7	Bluntness/Directedness	Focus/Contact	Deflection

Impulsivity/spontaneity/egotism—Egotism is the slowing down of spontaneity by deliberate introspection and/or cautiousness. Normal egotism is indispensable in the process of any situation elaboration and long-term maturation. Normal egotism takes the form of diffidence, aloofness and slowness but is not non-committal. Neurotic egotism is characterized by an excessive self-control triggered by one's preoccupation with their own thoughts, feelings, behaviours and effect on others. Impulsivity is the absence of necessary self-reflexion and self-monitoring. Whereas in neurotic egotism, the individual seems trapped into his thinking, the impulsive individual seems unable to access his thinking but seems trapped in his feelings, emotions and impulses.

Isolation/differentiation/confluence—Confluence is the state in which two individuals or two entities tend to reduce differences in order to avoid any upsetting experience and to safeguard a peaceful unarticulated agreement. Any event that would be lived as a novelty, an otherness or a difference would be experienced as a breach of the

contract between these two entities who unconsciously 'agreed' and 'chose' to be part of this agreement. Once within a neurotic confluence, on the surface, the two entities would experience a kind of 'harmony' but underneath an uneasiness feeling will start to install together with overtly expressed or covert emotions such as guilt and/or resentment. This reflects a lack of good contact where the sense of the other with whom the contact is made would exist. This way, a good contact is not reflected in uninterrupted harmony but is punctuated occasionally with discord.

Rejecting/destructuring/introjection—Introjection is the primary mode of survival of the baby/child in any specific environment. They accept (introjects) without questioning or assimilating whatever they experience as 'needed' for their survival or spit out (rejects) what they experience as 'noxious' for their survival, either food, idea or personal treatment. This way, the growing child accumulates a bank of 'swallowed' introjects, part of them adaptive and others maladaptive to themselves and/or their environment as they did fit or did not fit their true needs accordingly. Discriminating between subjective beneficial and noxious introjects/rejections entering the individual means going through stages of destructuring and restructuring, seeing optional choices and incorporating personal values in the making-choice process. This way, the individual agency increases as they become aware of the introjects they accumulated, their personal values and the choices opening up to them.

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