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This Journal, which is owned and supported by GANZ (Gestalt Australia and New Zealand, Inc), an association of Gestalt practitioners, presents the written exploration of Gestalt concepts within psychotherapy practice, training and supervision. It publishes articles, book reviews and case studies that focus on the discussion of current practices, research, organisational development and dynamics, community development, social and political domains and everyday life. The Journal offers an opportunity to writers to express their passion for and understanding of the Gestalt paradigm. The Journal also invites writing that explores (or even challenges) the use of Gestalt principles within other theories and disciplines. Through theoretical, methodological, practical and experiential approaches, with the rigour of a professional peer reviewed publication, the Journal encourages and fosters the growth and creativity of writers and provides a resource for anyone interested in discovering more about themselves and others through this rich perspective.

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Contributions
We welcome articles, case studies, literature reviews, critiques of theory and methodology, research, senior Gestalt trainee's projects and assignments. All contributions will be peer reviewed twice and will reflect or add to an understanding of Gestalt theory and methodology or practice. *Guidelines for Contributors* can be found in the back pages of the Journal. Further enquiries may be made directly to the Editors. The views and comments expressed by the writers in this journal are their own and do not necessarily reflect those of the Editors, the Editorial Board or the GANZ council, nor is responsibility taken for the accuracy of statements made by contributors.

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Editorial: A deeper field.

Alan Meara

As I look out my window onto a hilly urbanised environment with a variety of trees illuminated by a setting sun, there are many points my attention could be attracted to – a particular leaf, a telephone pole and so on. Figures, and each time, the ground fades. I could also view the panorama, a relatively wide field, yet somewhat flat as if a high definition, wide screen photograph. If I relax my eyes, the world emerges in terms of depth – trees, houses, fluttering birds, roads, hills, and the horizon. This experience is different and bodily engaging. According to Steinbock (1987, p. 336), "Depth, Merleau-Ponty writes, is 'the most existential dimension,' `the dimension of dimensions'; it is the `sine qua non' of the world and being." He also notes that depth was essential for pursuing and expressing a novel, radical ontology. In the terms of that ontology, sometimes called "flesh", the world I see is also seeing me. I invite readers to consider how each article might be a leaf, the whole Journal a panorama, and relax into sensing an underlying landscape of themes, a deeper field.

Dominic Hosemans begins by drawing parallels between the principles of existential dialog and a Japanese philosophical concept 'internal and external relations' with particular relevance to 'inclusion' and the 'in-between'. Hosemans argues that these principles are insufficient to lead to 'I-thou' He then proposes 'living through' is necessary, reviewing the recent work of Richard Grossman a relational psychoanalytic psychotherapist, who advocates 'companioning the client', especially where a client struggles with verbal expression. He offers a thoughtful and reflective extensive case study concerning a child who had experienced complex relational trauma to illustrate this approach.

Steffi Bednarek engages with a wide field, stimulated by concerns regarding societal responses to climate change, and the role of psychotherapy in contributing to those responses. This is a topical issue, which she notes, acknowledging that there have been some initiatives within the Gestalt movement, but calls for examination of unconscious biases in our theory and practice. Bednarek addresses these in relation to anthropocentrism, individuality, materiality, privatisation, growth, progress and a lack of a cosmological perspective. She also examines concepts of mental health and extending 'the other' beyond individuals to the 'more than human' world.

Barry Laing provides a thorough and respectful review of the literature on indigenous health care, particularly policies and principles related to the

Social and Emotional Wellbeing (SEWB) framework in Australia. He also examine literature to support the proposition that Gestalt therapy could become an ally in providing more collaborative culturally appropriate health services that is less focussed on the individual in isolation. He argues that Gestalt therapy's dialogical and phenomenological approach is identified as an ethical and political stance that may contribute to radical inclusion and social change via social activism. Public discussions during the recent National Reconciliation Week would seem to support much of his critical analysis.

Barbara Suess explores the literature on differences between bereavement and grief and how attitudes to bereavement in particular and therapeutic practices and theories have changed over time. She also describes the variety of cultural views on bereavement, and the history of what death means, which become more pertinent in our contemporary multicultural society. In particular Suess challenges a generic 'letting go' stages approach as opposed to a more Gestalt oriented support for the bereaved engaging in present experiences in an ongoing relationship, without the therapist's alignment to any particular culture, religion, or philosophy.

Suess' second paper in this issue, reports on a project that aimed to test some of the findings in her literature review. She presents an analysis of a small set of interviews with bereaved people from different or mixed cultural backgrounds. Suess found that the actual felt experiences of the interviewees seemed more similar rather than being diversely affected by cultural backgrounds. She acknowledges limitations of the study and includes reflections on her own experience.

The experimental Gathering/Hui that has been promoted in the Journal in recent editions has had quite a positive response from participants, as expressed by in an expression of gratitude from the President of GANZ. Many action groups were formed and an overarching statement of the heart produced.

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Extending Dialogical Existential Theory: 'Living through' as underlying I-Thou

Dominic Hosemans

Abstract

Dialogical Existentialism is one of the pillars of relational gestalt therapy. Dialogical existentialism rests upon the ideas of inclusion, presence, confirmation, as well as surrendering to the inter-subjective space. The current article extends the idea of dialogical existentialism through a Japanese philosophical lens of internal and external relations. Within this context, it is discussed that dialogical existentialism is a necessary but not sufficient condition for the experience of an I-thou moment. Additionally, it is discussed that 'living through' an experience with a client is the outcome of developing the conditions underlying dialogue. Therefore, it is argued that 'living through' an experience with the client in psychotherapy is the sufficient condition in order to experience an I-thou moment. Finally, the idea of 'living through' an experience with the client in the therapeutic situation is highlighted through an extensive case study with a young girl who had experienced complex relational trauma.

Key words: relational gestalt therapy, dialogical existentialism, inclusion, living through an experience, internal and external relations.

Beyond Dialogical Existentialism: 'Living through' as underlying I-Thou

Dialogical existentialism, as defined by Mackewn (2013, p. 81) is an "interaction between two people when there is a desire to genuinely meet the other person". Dialogic relating does not necessarily need to occur through the exchange of words, but can also occur through play, laugher, and silence. Essentially, dialogical existentialism refers to being present to another's human-ness in whatever way that expresses itself in the moment. In this way, as indicated by Sabar (2013), dialogic existentialism is situated within the field of the client.

Yontef (2002) described four conditions necessary within dialogical existentialism, which include inclusion, confirmation, presence, and surrendering to the 'in-between'. Although not discussed at any length by theorists on dialogic existentialism, inclusion is potentially in a hierarchical

relationship with the other three conditions. Inclusion entails being able to sense the client's phenomenological experience without losing a sense of one's own phenomenology in the process. Without having a sense of oneself within the therapeutic situation, there is no center of gravity from which to confirm the other, be present to their experience, or to be available to the inter-subjective space.

Internal Relations

Inclusion can also be further explored through an understanding of the Japanese philosophy of external and internal relations (Kasulis, 2019). Both internal and external relations refer to different ways of relating between physical entities, ideas, social structures, or people. External relations refer to a potentially third object or idea that connects the initial two. Within internal relations, the relating force is not external but overlapping, interrelating the two. In the context of psychotherapy, external relations sees the client and therapist relate through dialogue in terms of an abstract concept, removed from their embodied and phenomenological experience of being-in-the-world. On the other hand, within internal relations, the two are interrelating by virtue of how they overlap, or rather through their shared humanness and existentially lived experience within the world.

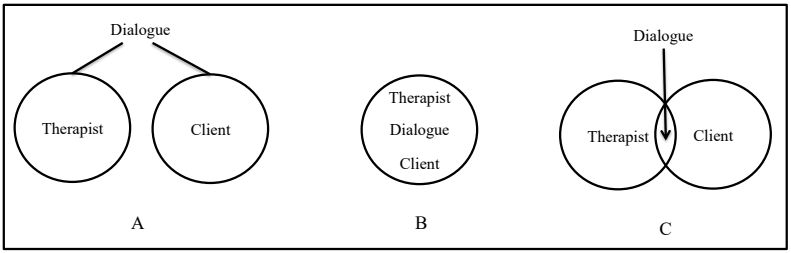

Figure 1. Internal and external relations in the context of psychotherapy. Adapted from "Japanese Philosophy," by T. Kasulis, 2019, Stanford Encyclopaedia of Philosophy. Copyright 2019 by Stanford University.

The idea of internal and external relations is made clearer through an illustration. As indicated in Figure 1A, through external relating, the client and therapist relate through dialogue that is essentially abstracted from one's phenomenological experience, something more akin to cognitive therapies. Next Figure 1B illustrates empathy, where through dialogue, the therapist experiences the client's phenomenological experience to the detriment of

their own internal experience; in other words, feeling the client's experience without being impacted due to losing the integrity of their own psychic boundaries. In such a situation, there is no opportunity for confirmation, presence, or surrendering to the in-between, due to the therapist ultimately surrendering his or her own experience in exchange for the client's. Each of the conditions underlying dialogical existentialism requires a strong center of gravity within oneself that can be perpetuated outwards.

Internal relations, as indicated in Figure 1C, demonstrates the idea of inclusion, both therapist and client retain the integrity of their phenomenological experience whilst sharing their inter-related humanness through dialogue. Only through retaining the integrity of one's psychic boundaries is it possible for the therapist to be present and confirm the other as well as surrender to the inter-subjective space. The meeting at the contact boundary, where both client and therapist overlap in their human experience of being-in-the-world, is what Buber (2010) potentially means through the notion of I-thou.

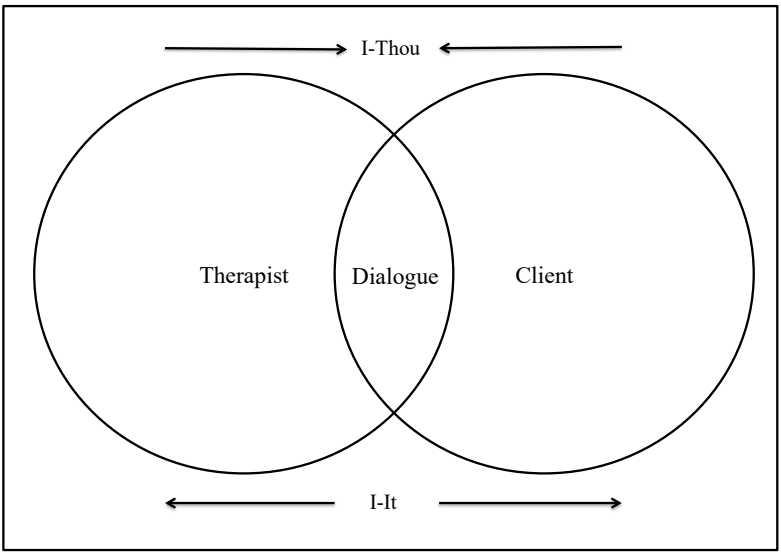

Figure 2. I-Thou as internal relations through dialogical existentialism

Thus, the conditions of inclusion, presence, confirmation, and surrendering to the inter-subjective space are necessary but not sufficient to experience an I-thou moment. These same conditions are necessary for 'living through' an experience with the client, which in itself is a necessary and sufficient condition for experiencing an I-thou moment. As indicated in

Figure 2, the idea of internal relations provides theoretical insight into how the conditions underlying dialogical existentialism are necessary for 'living through' an experience with the client; which in turn is a necessary and sufficient condition for experiencing an I-thou moment. As also illustrated in Figure 2, the therapist osculates between I-it and I-thou, as the former is the foundation in which the latter can arise. I-it facilitates in establishing the center of gravity within oneself, as only through such can the conditions of I-thou arise.

Implications for change in Psychotherapy

Within the context of therapy, Mackewn (2013) indicates that change does not arise within either the client or therapist, but within the inter-subjective space between both individuals. As the inter-subjective space changes over time, those attending to the co-constructed space internalise the change. In order for this change to be internalised by both the client and therapist, both must 'live through' the change of the inter-subjective space together.

The idea of change as being a function of the inter-subjective space, which is then internalised by both client and therapist, indicates the importance of the paradoxical theory of change (Beisser, 1970). The desire to move the client out of the phenomenological space at any given moment implicitly assumes that change occurs within the client alone, and therefore acts to reject the inter-subjective nature of contact. The object of therapy, then, is not to pursue change in the client, but rather to 'live through' an experience together in the therapeutic situation. Change within both the client and therapist is a secondary outcome of this experience of togetherness or rather relationality. Therapy then can be understood as a 'living through' of the relationship together.

The Meaning of 'Living Through' an Experience

Robert Grossmark has written a revolutionary book "*The Unobtrusive Relational Analyst*" that reconceptualises and further develops ideas enhancing Gestalt theory and practice, such as the notion of 'being-with', the therapeutic space between, and relationality. Although written to an audience of psychoanalytic psychotherapists in mind, the ideas postulated by Grossmark are just as relevant to Relational Gestalt therapists, as described below.

Grossmark (2018) indicates that therapeutic healing occurs by 'living through' the client's phenomenological experience. The 'living through' is important as the more damaged self-stated of an individual cannot

be verbally expressed and therefore can only be experienced together rather than through dialogue. For this reason, he argues that the focus within the therapeutic situation needs to move away from the content expressed by the client. The focus, rather, needs to be on the therapeutic relationship and how the client is using the therapist in relation to what is being experienced. When too much focus is placed on the content, the 'what' as opposed to the 'how' (process), such focus tends to exclude the non-verbalised and less organised parts of the client that do not have the capacity to relate through dialogue.

Thus, therapeutic healing does necessarily occur through dialogue, but rather through living an experience together within the therapeutic relationship. Grossmark (2018) uses the phrase 'companioning the client' in order to describe a process of living through the client's disorganised self-states and surviving with the client, rather than 'doing' anything in particular to the client. In this way, healing and growth occurs neither through relatedness nor separateness, but through companioning the client into their own darkness, the more unformed and regressed states of their being, self-states that do not necessarily lend themselves to words. Therapy is not necessarily about helping the client to organise or make sense of their inner world, of 'doing' anything to the client, but to companion them into such states of their own self.

Grossmark (2018) argues that relationality, rather than primary to the therapeutic work, is actually an outcome. It is only through living an experience together do both the client and therapist cultivate a greater sense of relatedness. The focus within the therapeutic space needs to be on companioning the client into the dark recesses of the client's psyche, into the disintegrated and unformulated self-states, as opposed to engaging the organised and verbalisable self-states through relationality and dialogue. Similarly, Jung had reflected that, "one does not become enlightened by imagining figures of light, but by making the darkness conscious" (Jung, 1945, p. 335). In fact, Grossmark makes the point that if the therapist was to focus solely on the aspects of the client that the client is able to bring into relationship then the 'wholeness' of the client is not being respected within the therapeutic space. Additionally, in order to create the space where the client's 'whole' self is invited to be present, the therapist needs to reflect his or her own capacity to be a 'whole person'. The therapist needs to bring into the therapeutic space their own subjectivity and experiential process in relation to the client.

Coinciding with the relational gestalt therapy emphasis on inviting the 'whole' person into the therapeutic space, Grossmark indicates that there are many 'self-states' of an individual that contain "earlier underdeveloped,

empty, unspeakable, and profoundly non-related parts of themselves that find no expression in language" (2018, p. 3). He argues that rather than engaging the individual into conversation and therefore out of these regressed states, the work of therapy is to allow the full expression of such states in its own unfolding regression and enactment. In terms of the latter, when a particular relational experience is unthinkable or consciously unknowable, the client will enact this within the therapeutic 'in-between' space of how the client is 'with' the therapist.

In a metaphysical sense, and in line with the ideas postulated by Buber (2010), Grossmark indicates that when the therapist surrenders to the flow of the 'in-between' space, the space between "takes on a transformative and generative quality of its own" (2018, p. 97). Words across the therapeutic narrative are no longer arising within either the client's or therapist's mind, but rather through the field that holds the two 'whole' persons. The field then allows the emerging of unformulated ideas and meanings that cannot be expressed in words, but are lived through together by both the therapist and client.

All narrative occurs within relationship. Grossmark claims that it, "takes two people and an emergent field to tell a story" (2018, p. 79). Thus, only by living through an experience together, with such 'living through' only possible in relationship, can psychological pain arising from a traumatic experience become thinkable. Where there is a witness to one's psychological pain, with the witness able to hold and tolerate being in relationship with the individual's pain, does it become possible to know, feel, and think about the pain. Essentially, one must be able to tolerate something within one's mind in order to begin to think about it.

Relational Gestalt Therapy with Complex Trauma: A Case Study

Background

Lucy was eight-years old when I first met her and was initially referred to me in my private practice due to expressing a number of very complex behaviours, of most concerning to her temporary carers was sexualised self-soothing. This behaviour is not uncommon for children who had experienced sexual abuse. She resided with a temporary carer provided by the Department of Human Services subsequent to being removed, along with her younger brother, from her mother's care two years ago. Her mother had substance abuse issues and has been found, on a number of occasions, to have carelessly placed Lucy in harm's way. Lucy's father is currently in prison for perpetrating domestic violence against both Lucy and her mother. Subsequent to his incarceration, Lucy's mother entered into a string of

relationships, which were marked by similar violence. Lucy at that point had been placed with a number of foster carers, however, due to Lucy's complex behaviours and pervasive mutism, such arrangements did not last very long.

When I first made contact with Lucy in my waiting room, she looked at me with a blank stare, as if she just saw straight past me. Her way of dissociating is something that we both came to bear together over time, with it being a very common occurrence over the proceeding months. Her matted hair showed how much she disliked contact, as she was reported to scream and her mind seemed to disintegrate when her current carer attempted to care for her in any meaningful way. Recent intelligence testing, which was conducted as part of a thorough assessment by psychologists within the Children's courts in association with the Children's hospital, indicated that her cognitive capacity was well below average. Nonetheless, it is important to consider the effect of trauma on such seemingly objective testing (van der Kolk, 2015). As a result of significant trauma, the child's defenses against experiencing the thoughts of such trauma take up a substantial amount of their cognitive capacity. What may look like a cognitive deficit can often be masking unprocessed traumatic experiences.

In discussing with her current carer, who had been looking after her just over six months at that time, she barely spoke, with words only expressing her extreme aversion of any form of relationality. Instead, the only modes of contacting the other were through pushing them away when they were on the fringes of the contact boundary through screaming, biting, scratching, or hitting. I initially introduced myself to Lucy and stated what the session would look like, as per her expected way of contacting, she screamed at me. I was able to contain this scream within myself, reflecting back to her that she has decided she does not want a session today but welcomed her back next week if that was something she wanted. As a result of this reflection, the week after, when she again was in my waiting room, she said 'no' quite calmly with a sense that in this space her own agency and capacity to decide was respected.

Upon our third meeting, it appeared that she was able to build a minimal degree of trust, allowing herself to venture into my therapy room. I was totally not prepared for what would happen next. In her own silence, she went straight for the neatly organised shelves and pulled all the contents off, throwing them all across the room – everything appeared to become disintegrated. Regardless of me setting limits on such behaviour with her, she completely emptied the shelves, with chaos ensuring across the room. Ultimately, it appeared that she was attempting to project into the room her own internal world, which was experienced as completely disorganised

and chaotic.

Process

Following her process in the here and now, and helping her to make sense of this process by reflecting back her experience as well as my experience of her experience, I stated in this instance that, "everything feels so chaotic, nothing is where it should be". Contrary to a direct gestalt approach with children, as elsewhere discussed by Blom (2004) and Oaklander (2007), I worked with Lucy in a very organic way, allowing her to play in an unstructured way. Although one could argue that structure is what such a traumatised child needed, I felt it was important to follow her process and her needs rather than a preconceived idea of her needs based on previous similar presentations. In a sense, I was attempting to live through her experience of herself at that time.

In the beginning, these sessions with Lucy were very difficult to stay present with, which was potentially a parallel process with Lucy's blank stares. In a sense, she was giving me her experience of being unable to tolerate the present moment and it was our work going forward to 'live through' this experience together. I remained in a state of 'unknowing', whereby I would be open and receptive to how the client presented herself without attempting to change her behavioural expressions in any way. Such behaviour was seen not as coming from an inconsiderate and disruptive child, as she was presented by her temporary carer and teachers, but as symptoms reflecting her current contacting style.

Based on the chaos that ensured within these initial sessions, it appeared that Lucy's style of contact incorporated a need to feel contained within relationship. She was constantly pushing against boundaries in the therapeutic space, potentially in order to elicit a reaction thereby noting where the boundaries existed. I also understood this as testing the therapeutic relationship – she wanted to know if she could express how she was feeling without having to worry about how I would react. I remained calm and asked her to help me clean up, which she would often put in some effort to do so. It was almost as if a sigh of relief came over her when I developed, after a few sessions of similar chaos and with some of her input, a few rules within the space. But this did not guarantee that she would follow them in the next few sessions, especially when she was overcome with anger.

I dreaded these initial session with Lucy, as much of the time was spent containing the space and ensuring that she did not harm herself in the process of destroying the room. I did notice however, that prior to her fits of rage, she would stare straight through me as if I were not even there. Even

saying her name and waving my hand, elicited absolutely no reaction from her, she continued to stare. On the few occasions that she did talk to me in these first sessions, her words were often jumbled and confused. However, it appeared to me that these were actually her attempts at connecting with me, as I had realised after connecting some dots, that she was repeating some partly remembered phrases from cartoons that she watched earlier that morning.

Within a number sessions together, it was clear that Lucy was becoming more comfortable, quite liking the power she had in the room, which was missing within her own life. As if it were hers, she would often pull up a chair next to the easel and canvas. In these sessions, she would just use dollops or splashes of paint in a very indiscriminate way. It was as if the disintegration of her mind did not allow her to hold any particular idea within mind across space and time. However, at approximately the twentieth session mark, with previously repeating the same process, she instead on this occasion painted a rudimentary self-portrait. Essentially, this had marked the beginning of perceiving herself as a 'whole person' (Segal, 1982), if not embodied, but at least on a conceptual level. This cognitive development, or rather claiming back disintegrated parts of her thinking mind, allowed her to hold in mind other conceptual ideas throughout space and time – no longer living only in the present through a constant survival mode. Her awareness of the current phenomenological field was beginning to expand, with a large part of this developing awareness a resurfacing of her self-supports.

According to Quinn (2010) and Welsh (2013) the phenomenological method of enquiry is especially appropriate in the context of counselling children. The relational space with children involves the continuous reinterpretation of phenomena as well as understanding their process of contact, which is quite often only communicated through means of metaphor. However, as existence is always an unfolding process, the therapist's understanding is always multi-layered (Quinn, 2010), whereby the same phenomena is continuously reinterpreted according to the context in which it arises. One particularly rich way to engage children to communicate their view of relationship is through the use of sandplay.

Sandplay is a projective therapeutic technique that was originally developed by Kalff (2003) and is very consistent with relational gestalt phenomenological inquiry. Sandplay involves the use of a small tray approximately 30cm by 60cm wide and 40cm deep. The bottom of the tray is painted blue in order to represent water, which is covered by a layer of sand at least one inch thick. The child then projects their internal world onto a number of miniature figurines that are placed in the sandtray representing an imagined scene. Once the child feels that they have finished a sandtray

by arranging a number of figures in relationship to one another, the therapist explores with the child what some of the prominent figures are experiencing – What do the figures feel? What are the figures doing? How do the figures feel about other prominent figures in the sandtray?

Although limited in her capacity to express herself, in using these techniques, I had learned that Lucy's view of relationship involved a constant sense of not feeling safe. In one particular session, she had placed two horses in the center of the sandtray and then surrounded them with plastic trees. As she buried the horses in the sand, she said that the horses needed to be protected. The second horse I presumed represented her younger brother. In this moment, she had internalised the feeling of being protected, but equated it with being covered with sand. She then asked me if she could sit inside the sandtray. After agreeing, she began to lift handfuls of sand above her head and released her fists slowly, allowing it to rain down over her. This behaviour reiterated the need for her to feel contained, as the sandtray is considerably small, thereby acting to contain the therapeutic space.

Much research (See: Cochran, Nordling, & Cochran, 2010; Landreth, 2012; Wilson & Ryan, 2005) has indicated that children project their thoughts and feelings within non-directive play so as to develop an understanding of and organise their internal world. The lack of direction, then, allowed me to come as close as possible to her internal process of how she derives meaning from her experience. The focus of the sessions were on the 'here and now' of her experience, with myself reflecting what was happening and helping her to develop an understanding of what was occurring just outside the horizon of her awareness.

For example, a significant process occurred within a marble game that she developed. She would divide marbles between us, but always giving herself many times over what I had. I understood this as trying to make me feel like the impoverished one, so she did not have to carry that internal sense of herself. Clients, especially children, project an intolerable feeling within the inter-subjective space in order for the therapist to make sense of the feeling and give it back in a way that is digestible. The point of the marble game, as she indicated, was to roll the marbles across the room, coming close to a chosen object. The person with most marbles landing within the designated area, as she described, would win. However, regardless of the rules and obstacles that she had stipulated, these would often change according to what was happening within the game. My sense was she was expressing to me how powerless she felt within her world and that constantly the rules would change and there was nothing she could do about it. Rather than telling me how she felt, she was making me feel it through the inter-

subjective space between us.

For many weeks, I played along with these rules, reflecting on how powerless I was rendered and how I had no control and she had all the power. Although it felt like nothing was happening but the same game every session for quite a number of weeks, something began to eventually shift. The rules began to entail that that we both roll the marble at the same time, landing in the designated at the same time, therefore ensuring that both of us won. My sense was that we were now in this together; she was reflecting to me that I was with her and that I understood.

The sense of 'together with' was further accompanied by more work in the sandtray, in which she would place her hands upon the sand and have me slowing sprinkle the sand over her hands until they were covered. With a look of delight, she would uncover her hands, and allow the sand to just fall away. I envisioned this process as one in which she was beginning to conceptualise the idea, even in a rudimentary form, that what is lost can be found again, the lost-ness she experienced was temporary and that it was possible to make sense of her disintegration.

The development of her capacity for contact, by around one year of weekly sessions, was becoming generalised to others beyond our sessions through more complex relational behaviours. Within each session during this phase in her therapy, she would come into my office, pick up the phone and start dialing random numbers and let it ring. Sometimes the call would go straight through to reception, in which she would pursue a conversation about a cartoon she recently saw or something she liked such as her new shoes. She was more often sitting on the edge of her contact boundary, welcoming the possibility of relationality.

It was around this time that her blank stare began to fade, she was coming towards the contact boundary more often than receding back into herself, where she was essentially protected from all forms of contact. Words and ideas were much easier to form compared to when we first commenced therapy. She was able to mentalise, or hold within her mind, greater parts of the phenomenological field. Through reflecting on her process in the here and now, she essentially began to internalise my reflections of her internal world, and therefore having a way to structure her experience in a coherent way. The disintegration that had occurred in order to tolerate the mental repercussions of intense relational trauma was starting to find a way to wholeness.

Over time, her teachers had reported that she had improved significantly at school. Moreover, her carer indicated that she was using words more often, with the creative adjustment of violently pushing people

away something of the past. By this time, I had quite a substantial waitlist and had been seeing Lucy on a weekly basis for almost two years. She had made significant progress over this time, and as all children start to do when they are beginning to entertain the idea of terminating counselling is to indicate to the therapist that they would rather be somewhere else. This somewhere else for Lucy was in school with her friends. She was much more focused on her school work, had developed the capacity to make and maintain friendships, and her temporary carer was making the appropriate arrangements to take her on a permanent basis in order to offer her the consistency she so desires.

Although we had discussed that our final session would be coming up for a number of months at that point, our last session came too quickly. Even in this final session, as we were drawing to a close for the final time, as per usual she had indicated to me her plans for the next session. Although knowing that we had mutually decided to end therapy, she indicated that she could not bear the loss of this relationship. As she drew on a piece of paper, she wrote down on the same piece of paper that she could not end counselling "because I love being here! I love seeing you! It is just me and you! "LOVE"!" I still keep this piece of paper, which I later laminated, to remind me of these sessions – in true therapy, the therapist is just as affected by the client, as the therapeutic work occurs in the space 'in-between', which is internalised by both individuals.

Reflection

The phenomenological experience of being in relational gestalt therapy, of being in the presence of someone that has an unwavering attention to your process and the way in which you make sense and meaning of this process, is experienced as love (See: Hosemans, 2019). Lucy barely spoke, especially at the beginning of therapy, within the process of our work together she had taught me that words are not necessary for therapy to take place. Therapy is more about a sense of 'living through' rather than the words spoken in the co-constructed space. Words can facilitate the process by signifying togetherness, but can never be in the stead of.

Over the period of Lucy's therapy, I never made mention of any problematic behaviour which instigated the referral. Instead, we were working with the cause of such symptoms – the mental disintegration that occurs as a result of not being able to tolerate particular traumatic experiences. It seems to me that a lot of mental effort was used to sustain such disintegration in order to help carry the trauma more effectively. As a relational gestalt therapist, one stands beside the other as they carry their own 'stuff' with no wish to make them free of their 'stuff' or no desire to

carry their 'stuff' for them. Rather, by tolerating what the client finds difficult to tolerate within himself or herself reflects to the client that it is possible to tolerate such feelings and thus increases their capacity, as they no longer feel alone within their struggle. It is within this context that healing takes place by 'living through' the client's pain with them.

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Biography

Dr. Dominic Hosemans is a counselling psychologist in private practice, predominately with children. Dominic has completed extensive clinical training in play therapy and is a clinical member of Australian Play Therapy Association. His Ph.D. thesis looked at the phenomenological experience of equanimity within meditation. Prior to commencing studies in psychology, he studied philosophy for five years, where he was introduced to philosophical ideas underlying relational gestalt therapy. He is now currently completing official training in relational gestalt therapy with Gestalt Therapy Australia

How wide is the field? Gestalt therapy, capitalism and the natural world

Steffi Bednarek

Abstract

A recent UN report has warned that we are heading for an unprecedented global crisis if we don't radically change our ways. Climate change is no longer a hypothetical argument but a reality that threatens the existence of human and other than human life on the planet. With that information in mind, can we afford to keep practicing psychotherapy with a focus on the individual and their personal needs, or do we need to radically question the role of psychotherapy in its lack of relationship to the more than human world? This article investigates where aspects of Gestalt Psychotherapy may be too closely aligned with the capitalist paradigm, that risks costing us the Earth. I argue that we need to widen our notion of what is part of the field. I reflect on our theory in relation to anthropocentrism, individuality, materiality, privatisation, growth, progress and the lack of a cosmological perspective. This is by no means an exhaustive overview but an attempt to open the conversation.

Key words: capitalism, complex systems, 'more-than-human world', anthropocentrism, individuality, materialism, systemic change, mythology, cosmology.

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Preface

I am a white European woman. I carry the horrors of Auschwitz, industrialisation and the Empire in my bones. The traces of the

Berlin Wall run through my body like an invisible chain. The raping of women and the raping of the Earth has scarred the texture of my femininity. My voice is silenced by patriarchy. Plastic in the oceans clogs my veins. Refugees washed up on the shores of our rich countries make me blind and numb. My body retches in an attempt to rid itself of my bingeing on accumulated privilege.

In order to survive, I anaesthetise my human experience. I have forgotten how to connect with the land underneath my feet. I have killed off any notion that the Earth may be alive. I have banished God and the idea of the sacred. What I believe in is my individuality and the value of owning things. Matter is dead. I feel lost and empty. I live in a world and in a body that I no longer know how to inhabit. I have settled in this no-man's-land, but I am not alone. It is densely populated here.

Sometimes in certain precious moments, my body remembers that I am made of the Earth. What I call 'I' is made up of more micro-organisms than human cells (Clark, 2012). 'I' is not an entity but a multiplicity, a reciprocal relationship between the human and the more-than-human world. I am made up of stardust, oxygen, carbon dioxide, hydrogen, nitrogen, calcium and phosphorus, just like the world around me. I am not separate from it, I am made of it. In those moments I feel a sense of wonder.

In October this year, the UN Intergovernmental Panel on Climate Change published a report calling for urgent and unprecedented changes over the next twelve years in order to limit the catastrophic effects climate change will have on life as we know it (Watts, 2018). Previously, the Capital Institute itself made a direct link between the capitalist worldview and climate change and called for broader, more holistically oriented approaches to global problems (Confino, 2015). We may ask what this has got to do with psychotherapy and how we can, as a discipline, begin to determine our role in wider world issues.

The systems theorist Fritjof Capra (1982) points out that the dysfunction of

complex systems on the world stage is primarily a crisis of perception. He believes that our seemingly innocent collective everyday beliefs contribute to the stuckness of much larger, complex systems. Our assumptions often serve as the connective tissue that holds things in their rigid place. Our Western culture seems to destroy with a sense of superiority the very basis on which our existence rests, whilst psychotherapy continues to focus on our individual and inner worlds. In line with Capra's argument, I believe that it is time for us to ask if there are areas in which our profession may reinforce unconscious biases that risk costing us the Earth. Are there aspects of our theories that inadvertently contribute to the larger problem?

It is the business of Gestalt psychotherapists to bring awareness to fixed, dysfunctional and repetitive patterns. Our theoretical view is holistic and encompasses all that is part of the field. Field theory and our notion of self as being formed at the contact boundary emphasises our embeddedness in the world and our reciprocal interdependence with this world. So how come that we are still relatively ill prepared to include the state of the world and our relationship with it in what we do in our consulting rooms? I argue here, that despite our wide-ranging theory, figure formation often operates within an invisible confine of an individualised and privatised psychology. In this article, I investigate aspects of Gestalt therapy in terms of their alignment with the dominant capitalist paradigm in its emphasis on anthropocentrism, progress, privatisation, domestication and materialism. I suggest that this lens has become so familiar that we can hardly see outside of it. My main focus is on the relationship our discipline has with what cultural ecologist David Abram (1997) calls the 'more-than-human world', meaning the natural, living world that humans participate in. I also reflect on existing aspects of Gestalt theory that already offer the possibility of a wider notion of the field and allow for something new to emerge on the fringe.

My intention is not to deliver a definitive statement, but to widen the conversation. I believe that Gestalt therapy has got something to contribute to the bigger picture but will not deliver '*the*' answer and neither will psychotherapy as a whole. No single discipline can do this.

The philosopher Zygmunt Bauman (2000) writes about our Western culture as being in a state of 'liquid modernity' – a state that is characterised by chaotic, ungovernable situations, where change in one area of the system has ramifications throughout in unpredictable ways (Bednarek, 2017). Complex problems cannot be solved in old, familiar ways anymore; they require trans-disciplinarity. We have to think outside of the confines of the known, look beyond the boundaries of our defined schools of thought and widen the perspective, just as Perls, Hefferline and Goodman (1951/1994) once did. Fritjof Capra (Capra and Luisi, 2014) tells us that in order to encourage change within a system, we do not have to throw out all that we know. He suggests that change emerges from something dynamic within the old system. He advises us to pay close attention to emergence on the fringes. We can do this with our attention on large or small complex systems.

I suggest that we urgently need to widen our theories, open up dialogue and create new visions for where we are heading – but we need to stay clear of the old patriarchal ways of generating these visions, i.e where a few powerful, often white, often Western, often upper-class, often male individuals are in charge of the narrative. The celebration of the lone heroic thinker who presents '*the*' answer denies co-created wisdom and is in itself a symptom of a patriarchal worldview that seems to be letting us down.

Response-ability in the Therapy Room

I started my study of Psychology and Social Policy in Germany in the 1990s. At the time I was a research assistant for a community psychology project in a deprived area of a German University town. The project was based on Gestalt principles and the thinking of Paul Goodman. Psychotherapists worked with individual clients but took systemic issues that arose in therapy out into the world. Therapists convened large community meetings, and educated and empowered the neighbourhood to tackle matters regarding housing, infrastructure, education, employment and mental health with the local Government. Working with the whole was considered more

empowering than a focus on the sum of the parts. This project fundamentally changed the structure and landscape of the community through its systemic, ecological approach. It was my first encounter with Gestalt therapy and it deeply moved and inspired me.

When I finally studied Gestalt Psychotherapy, my four-year training focused entirely on the dyadic relationship. Sociopolitical issues were not part of what was deemed to be a relevant focus for the aspiring psychotherapist. They were understood to be part of the field but this part was hardly ever made figural. Whilst I became more and more focused on understanding inner processes, attachment patterns and the private needs of my clients, the state of the Earth deteriorated.

At the UKAGP/BGJ joint conference in 2017, one of the main focal points was the question: '*How does our political field influence our response-ability in the therapy room and beyond?*'. I hope it is fair to summarise that there was overall agreement that we face a global ecological crisis. Delegates expressed strong desires to impact positively on the wider society through their work. When it came to how we do this, we found that some of us have started to leave the therapy room. We work in the natural environment, with communities, corporations and larger systems. Some delegates had published contributions to larger world issues (Melnick, in Melnick and Nevis, 2013; Parlett, 2015). But on the whole there seemed to be a pervasive sense of insecurity in knowing how best to respond to global challenges.

There is a widely held belief in our profession that all psychotherapy is a political act (Melnick, 2017). This opinion was voiced by many delegates at the conference named above. The hope was that a person who is aware of themselves and the choices they make will contribute positively to a healthier society (Melnick, 2017). Personally, I believe this to be too optimistic. We are all steeped in the same culture, which risks making us blind to that which we take for granted. Therapists are subject to unconscious bias as much as clients (Fishbane, 2016). The title of Hillman and Ventura's (1992) well-known book 'We've Had a Hundred Years of Psychotherapy and the World's Getting Worse', highlights the problem with the assumption that

more psychotherapy will automatically lead to a better world. Hillman criticises our profession for its focus on the individual at the expense of the wider world. And indeed, in comparison to other subjects, there seems to be little focus on the political and ecological field in our training institutes, our journals and our conferences.

I would argue that before we can even begin to explore where our response-ability in the therapy room and beyond could lie, we need to understand where we may be aligned with the cultural values of the patriarchal and capitalist paradigm that is said to be at the heart of causing major problems (Confino, 2015).

Mental Health – a Cultural Construct

In a report, titled Regenerative Capitalism, the Capital Institute stresses a link between the capitalist worldview and global challenges such as climate change and political instability (Confino, 2015). According to this report, we need a move away from capitalist values towards a new systems-based mindset, which recognises that the functioning of complex wholes cannot be understood without paying attention to the dynamic relationships that give rise to greater wholes. This recommendation comes from a conservative institution at the heart of capitalism itself. The shift would not only revolutionise our political, economical or corporate worlds, but would also have far-reaching consequences for mental health professions. Capitalism has become hegemonic in Western culture and permeates the mental health field too.

Psychotherapy itself has grown up in a capitalist, patriarchal Western culture that has inevitably left its imprint on it. We are all a product of its influence. Our Western notion of mental health is far from being neutral. What we have come to expect as 'healthy' human behaviour in a capitalist society is intrinsically linked to the dominant norms and values that govern our everyday lives (Rosenthal, 2008). Capitalism has led to an individualising attitude to social issues and a marketisation of health care. In a capitalist society we value individualism over community, ownership over an idea of

the commons, and private property over stewardship. We invest in growth models and operate in a competitive climate that tells us that we are masters of our own destiny if we only try hard enough.

The capitalist system requires a certain type of disposition in the general public in order to function (Adams, 2016; James, 2007). For example, the Industrial Revolution has torn us from our contexts. Individuals embedded in a close community and a rich network of reciprocity with the more-than-human world were no longer useful in the machinery of capitalist growth and expansion. Rapid urbanisation processes needed more and more people willing to leave the rural communities they were woven into in exchange for wage labour in cities.

We are all expected to serve the capitalist model, to be motivated to contribute to the economy, to gain satisfaction and identity through a reward system that is removed from primary human needs.

A dictionary definition (Macmillan, 1986) names the following characterisation to describe capitalism:

> Accumulation of capital, production for profit and accumulation of capital as the implicit purpose of production; constriction or elimination of production formerly carried out on a common social or private household basis, focus on maximising value, private ownership, wage labour, investment in order to make profit and freedom of capitalists to act in their self-interest. (p. 54)

These culturally promoted characteristics have repercussions on our notion of expected behaviour and therefore also on what we perceive as deviations from the norm. Psychotherapists are not outside of cultural socialisation. We therefore have to reflect on the values that we perpetuate (consciously or unconsciously) and investigate where our understanding of health may inadvertently contribute to values that risk alienating us even more from each other and our participation with the world. In the following, I outline aspects of Gestalt therapy that in my opinion need deeper exploration in their uncomfortably close relationship to the dominant capitalist paradigm.

Anthropocentric Worldview

In the dominant Western culture we mostly see the world from a perspective that places our species on top of the pile and all else beneath. Our major psychological theories seem to suggest that we are shaped by human relationships alone whilst the more-than-human world is considered irrelevant. But what if we have anthropocentricised our understanding of human development in the absence of our sense of belonging in the world? The story is not that different in Gestalt Psychotherapy despite its holistic perspective. Our therapeutic discourse focuses almost entirely on human-to-human relationships. We do not include the absence of relationship with the living world into our diagnostic thinking of developmental trauma, attachment patterns, personality adaptations and mental health problems. Equally, our notion of community, relationship and kinship usually stops at the threshold of our social network or our own species. It rarely includes our relationship to trees, rivers, mountains, salmon, bees, or water flowing through our bodies. When we talk about loss and bereavement we mostly focus on the loss of people. Rarely does a personal loss include the catastrophic loss of attachment to nature itself, the loss of endangered species, the loss of living in a functioning community, the loss of meaningful rituals or the loss of connection to a place – even though these are losses so deep that they change who we believe we are.

We seem to have become so inflated with our sense of ourselves as a species that we cannot see our actual dependence on that which we are destroying. The cultural historian Thomas Berry (1988) says that we have become autistic to the world. And indeed, our focus on our-selves makes it easy to forget that we do not live in a vacuum.

Perls acknowledges that we have split off from the world and forgotten how to experience our reciprocity with it when he says:

> We use a lot of our energy in strategies of either defence against the world by separating ourselves from it or attacking the world by forcing our own will upon it. We have lost the ability of being in communion with it and hence we lessen our ability to act

> spontaneously in a participatory way. (Perls et al., 1951/1974, p. 449)

For most Westerners, the world around us is experienced as 'other' to such an extent that we have become blind to the devastating cost that this tear from a state of interconnected participation may present to us on a collective basis. The split has become 'normal' and therefore does not feature in our therapeutic theories or assessments. The idea that we may share a collective trauma is mainly unexplored. We have paid very little attention to the cultural and personal impoverishment that may ensue from our loss of reciprocal relationships with the more-than-human world.

If our Western society was a client in our consulting room, it would most likely present as a white, middle-class man. As therapists, we would probably view his self-centred, individualistic perspective and his righteous belief in his superiority as dysfunctional and deluded. We would note his lack of empathy, his exploitative relationships and his impoverished materialistic outlook despite his polite and politically correct manner. We would apply the spectrum of our diagnostic criteria to describe his stuck patterns of addiction to consumption, his annihilation of the basis of his own existence, and his ardent pursuit of an idea of happiness he feels he deserves.

The psychotherapist Francis Weller (2015) suggests that many of us carry a deep, but silent grief for our diminished sense of community with a world that we see as alive. We grieve for "what it is we expected and did not receive" (2015, p. 54). And in the absence of connection with a wild, reciprocal world, we seek what we long for in our next of kin. For instance, we look to our parents to provide unconditional love and belonging and many therapy sessions focus on the shortcomings of this expectation. By doing this, we keep the idea alive that this longing can and should be met by our birthparents. The Earth is no longer experienced as Gaia (mother). Instead we look to our actual mothers, or to psychotherapists as the new mothers, to provide the magnitude that may be beyond human beings to provide. We have become literal about our need to be mothered whilst we have killed off and de-sanctified the much bigger feminine principle in our

culture. We are looking for something in individual human relationships that may be unattainable whilst we have cut off from a reciprocal relationship with something outside of us.

We have lost access to the ways of weaving ourselves into the 'web of life' (Capra, 1996) and we lack humility in relation to other life forms. For most of us, our engagement with the more-than-human world has become an 'I-It' relationship (Buber, 1958). And what we do not relate to, we are free to use, manipulate and destroy. In principle, field theory and our holistic approach stress our interdependence with the field. This field can include anything, but in practice much of our focus in the Gestalt community does not operate outside of this dominant anthropocentric focus. There is a split between the breadth of our theory and how we chose to frame it.

I believe that we need to critically examine our anthropocentric assumptions in relation to our theories and our notion of reciprocity and relationality. What would it be like to include the quality of our relationship to the natural world in our assessments and our notions of trauma, attachment and fixed gestalts? What is our profession's contribution to transforming the deep intergenerational disconnection from the other-than-human world? How do we un-learn our addiction to consumption? These and other questions need to be taken up in more depth.

Boundary Between 'Me' and 'Not me'

The question where the 'me' is located, and where the 'other' begins and ends, is at the core of psychological thinking. Where we see the boundary in our community with things determines the way we relate to the world. Most commonly we located this 'me' within and saw the boundary in our physical skin. Postmodernism has deconstructed this rather simplistic idea of a coherent linear self. In Gestalt therapy we acknowledge this and define self as a process at the contact boundary. The 'I' is influenced and shaped by its contact with the world. It is wherever my focus is at any particular time. I can, for example, be so dissociated that my body feels fragmented and 'other'. Or I can be so confluent with someone that it is hard for me to

distinguish a sense of self at all. At one point I can focus on my skin and define it as 'me' and a minute later that boundary may extend all the way to the starry sky. As Gestaltists, we know that we do not have a separate self-identity from the world. There is no clearly defined personal phenomenal field that meets a clearly defined phenomenal field of another. We know that we cannot exist without the presence and health of the interconnecting circles of earthly rhythms. It is impossible to imagine a self that does not include the warming light of the sun, the wind, or animal and plant life. Our theory of self acknowledges this when Perls writes:

> Now the 'self' cannot be understood other than through the field, just like day cannot be understood other than by contrast with night. … So, the 'self' is to be found in the contrast with the otherness. There is a boundary between the self and the other, and this boundary is the essence of psychology. … Now this contact boundary, to be sure, is nothing rigid. It is something that is always, always moving. There is always something either coming into the foreground or receding. But we always meet. Whether I look at you and my eyes meet a 'picture' that I can't see beyond, whether I hear, whether I feel and touch, always, where I meet the other there is the boundary. There is awareness. There is experience. (Perls, 1978)

Philippson (2009) describes the permeability of this boundary:

> In my image, which comes from Gestalt Therapy, the boundary is a process that separates two areas (using spatial language for what is not just a spatial process) so that the activity on one side is qualitatively different to that on the other side. The boundary both maintains the separation, and allows interchange between the two processes (which are therefore really only one process). The boundary thus *creates* the regions, rather than, like [a] wall, marking pre-existing regions. (p.19, original italics)

The Jungian analyst James Hillman says that:

> … since the cut between self and natural world is arbitrary, we can make it at the skin or we can take it as far out as we like – to

> the deep oceans and distant stars. But the cut is far less important than the recognition of uncertainty about making the cut at all. This uncertainty opens the mind to wonder again, allowing fresh considerations to enter the therapeutic equation. (Hillman, 1995, p. 9)

Alan Boldon (2008) describes the absurdity of the way we think about the environment as 'other' in the attempt to try to decide at which point an apple we eat stops being part of the environment and becomes part of me, or at which point a raindrop that finds its way into the water I drink and then my body, and then out again, is the environment.

The early Gestalt theorists, Kohler and Koffka, went far, even by today's perceptions, when they located emotions in the field. Therefore a place or landscape could be sad by its expressive formal gestalt and not because feelings were projected on to it (Hillman, 1995, p. 11). Our theory acknowledges complexity and in principle already reaches beyond the anthropocentric paradigm. This is implicit, but not explicitly explored in our theory and our practice. The 'emergent self' (Philippson, 2009) is likely to stay a concept applied only to human-to-human interaction until we develop ways to explicitly work with what the Buddhist master Thich Nhat Hanh (1998) calls 'interbeing' – the essential interconnectedness and interdependence that binds us ever more deeply into the thick of the world. This would imply that changes in the external world may be as therapeutic as changes in what we perceive to be our internal landscape, or that working on a client's feelings is not more or less therapeutic than working on cleaning a local riverbank.

Hillman suggests that:

> … perhaps killing weeds on my lawn with herbicides may be as repressive as what I am doing with my childhood memories. Perhaps the abuses I have unconsciously suffered in my deep interior subjectivity pale in comparison with the abuses going on around me every minute in my ecological surroundings, abuses that I myself commit or comply with. … The 'bad' place I am 'in' may refer not only to a depressed mood or an anxious state

> of mind; it may refer to a sealed-up office tower where I work. (1995, p. 19)

Hillman (1995) suggests that the most radical intervention in psychotherapy would be a theory that replaces the individual with the world and that sees treatment of the inner requiring attention to be placed on the outer. This would be a departure from anthropocentrism and a decisive move towards a polycentrist view of life. Bill Plotkin (2013) suggests that an 'ecocentric' life means that all other memberships, such as primary partnerships, family, social groups, neighbourhood, workplace, profession, ethnic or gender identity group, state or nation become secondary or derivative of the inherent participation in the greater web of life. Our belonging in this web, and the wellbeing and care for this web, become the primary concern and command the greatest loyalty.

I believe that as Gestalt therapists, we already have a wide-ranging theory that allows us to widen our perspective of how self and other intertwine. How does the practical application of this widest aspect of our theory of self impact on our interventions and our response-ability in the work with clients? How may our theory of self inform other parts of the larger system in useful ways?

Privatisation and Ownership

We are big on ownership in our culture and are taught to find comfort and identity in what we possess and consume. Even the natural world has become a commodity ready to be used for our benefit. Land is property, real estate, capital, recreation ground or natural resource. We try to possess everything as private property, including ideas, feelings, dreams or what goes on in our own psyches.

As psychotherapists we encourage this sense of ownership by asking clients to 'own' their feelings, thoughts or ideas and talking about them as residing clearly within the client. In doing so our language has a norm of acquisition that separates us from the field context in which a particular feeling emerged. Once we own an idea, we can then extract the maximum potential

from it, as if we were eternally hungry for something. 'What do you take from our session today?' 'What can I take from this dream?' We focus on what we think we want and convince ourselves that our needs deserve to be met. But maybe life calls us to serve something larger than our own individual needs. What we are missing is the quality of intimacy where the focus does not always lie on 'me' but on serving something outside of me and appreciating my participation in a bigger whole. We have forgotten to think as a village or a commons. We do not know anymore how to relativise the self in service of community. Our hegemonic ideology has isolated us out of our sense of belonging to a greater, more meaningful entity than our individual existence. We are so conditioned to the individualistic mindset that we often do not even have ways of imagining a different way of being. And yet, I believe that a communal bond is indigenous to our human nature. We are wired for it.

As therapists our focus on the individualistic paradigm makes us less experienced in allowing something to unfold of what *it* wants to become. An alternative approach would be to put our own lives in a relative position of service, allowing ourselves to surrender to *it*, serving *its* needs and being curious about what *it* wants from us rather than the other way around. From this perspective we would ask what the dream, the crisis or the relationship asks of the client not how *it* can be beneficial to them. 'What does this situation or problem require of you in order for *you* to do justice to *it*?' 'How can you be of service to the idea that presented itself to you in your dream?' Can we find in us the willingness to be of service to the things in life that are bigger than our own concerns, our own lifespan or the lifespan of the people we love? And how would we learn to love the land around us as deeply as we love our partners?

We may not be able to learn this from humans but only from a deep engagement with the land itself, an immersion in its rhythms. We do this with our sensual bodies, smelling, sensing, touching and tasting the world. We may need to take our sorrows, dreams and insecurities out into a place we learn to love and see if we come back changed. This would be an aesthetic engagement, which invites participation in something bigger than

our individuality. The question we need to address as therapists is how best to facilitate an I-Thou relationship with the world that offers itself to us.
A few examples of psychotherapists working to reconnect clients with the undomesticated natural world can be found in Joanna Macy's work (Macy and Brown, 2014), Nick Totton's *Wild Therapy* (2011), in the ecotherapy movement (Roszak et al., 1995; Rust and Totton, 2012) or Bill Plotkin's Animas Valley Institute (2003). Whilst these are currently still voices from the fringes of our profession, I believe that there is some urgency in Gestalt therapy raising its profile and finding its distinctive voice in the growing chorus.

Individuality

When asked about the role of the more-than-human world in the shaping of humanity, the human biologist Paul Shepard said: 'The grief and sense of loss, that we often interpret as a failure in our personality, is actually a feeling of emptiness where a beautiful and strange otherness should have been encountered' (Shepard, 1994, p. 214). In Shepard's opinion we have lost the continuity of connection to this beautiful and strange otherness to domestication. What follows is an emptiness. We typically blame ourselves for this feeling of emptiness and psychotherapy often colludes with this. Shepard asks us to consider that this emptiness may be the absence of our encounter with the other than human world, in which case the feeling is not a personal shortcoming, privately owned, but a healthy reminder of something essential that we have lost. In a personalised psychology, based on individualism and ownership, we ascribe our feelings of emptiness to a failure in our own personality. The problem becomes interior and we try to fix or eradicate that which is calling out to us from beyond the confines of our individual lives. As we may look in the wrong place, what we are left with is a chronic feeling of emptiness that walks with us wherever we go and that we get so used to that we hardly feel it anymore. And as we often do not even have words for this sense of loss, we learn to anaesthetise our longing.

The psychotherapist Francis Weller (2015) believes that what we are longing for are primary satisfactions, satisfactions that evolved over thousands of years and that our brains are wired for, such as: gathering around communal life, around story, mythology, meaningful relationships, ritual, gathering around fire, around slowly evolving local connections, sharing and preparing food, spending time in nature, being fully embodied, etc. For the most part we have abandoned these primary satisfactions and are now surrounding ourselves with what he calls secondary satisfactions, like individual power, rank, prestige, wealth, status, material goods, stimulants, etc. These are all things that no matter how much we get of them, it will never be enough. We always want more in order to temporarily fill this permeating sense of emptiness that has already depleted the world of its resources. If, on the other hand, this emotional hunger is truly met, we become receptive to reciprocity and gratitude. If we experiment with offering ourselves to the world we may be astonished at what we receive in return. So how do we support clients in daring to reconnect to what truly nourishes them in a culture that sells them the opposite?

The individualistic perspective tells us that we shape our own lives and that it is within our grasp to be content, unique and accomplished if we only try hard enough. This heroic ideal separates us from community and leaves us wide open to a sense of individual failure when life events do not work out for us. As therapists we risk reinforcing this, by over-attending to a client's self-interests whilst neglecting a humble attitude of serving something greater than ourselves. It does not have to be an either/or, but the weight lies heavily on one end of the spectrum.

What if our primary human need is not to attend meticulously to our emotional wounds or to eradicate any signs of so called mental health '*conditions*', but rather to live our flawed and imperfect human wholeness in a participatory way and to embody our fallible existence in deep connection with all that we encounter in the world?

Addiction to Progress, Growth and Self-improvement

In a capitalist society we subscribe to the idea that everything has to progress to something bigger and better. We like things rising – stock markets, profit margins, house prices, whilst we are fearful of depression in the economy or in individuals. We are focused on trying to improve, fix and rectify in our relentless pursuit of happiness. In line with the patriarchal heroic ideal we turn everything into a problem to be overcome, even death.

Aspects of our fallible human experience such as collapse, decay, loss, regression and stillness are often approached with a notion of repair. It is therefore maybe not surprising that many clients come to us trying to create a self that is approvable to the world. This agenda is often based on self-hatred and a wish to eradicate the parts in them that stand in the way of the idea of progress and perfection. In our attempts to domesticate that which frightens us, we risk pathologising the aspects in life that refuse to move anywhere or lead us downwards (Weller 2015). This is the problematic aspect in our notion of healing as opposed to an aesthetic approach that finds beauty in broken places.

The cultural obsession with things rising is often mirrored in psychotherapy when we collude with the idea of perpetual self-improvement or overemphasise the experience of lack and proclaim that there has not been enough parenting, unconditional love, attachment, etc. In the hunger thus created lies the risk that both therapist and client are continually looking for what we can grab to fill up the emptiness (Weller 2015). From this place, we devour the world without ever being nourished. The focus on our inner longings seems to make us blind to the holes we tear into the fabric of the outer landscape.

Most mythologies tell us that the price for initiation and wisdom has to be paid in the currency of suffering. Our experiences of abandonment, loss, death and betrayal are part of life and what has bound us together over centuries. In many myths all over the world the question is not whether or not our hearts will get broken, the question is what meaning we ascribe to a broken heart. Do we follow the culturally dominant path of hunting

for personal happiness or do we educate our hearts and allow them to be broken, so that the world can flow into us? In order to take in the enormity of devastation that we have caused in the world, we need to know how to allow our hearts to break. In mythology an educated heart often comes through the gateway of rupture, as a certain level of pain and our ability to bear it is the vehicle that allows us to cross threshold moments. How can we facilitate this process in our clients when we are steeped in a grief-phobic culture?

Materialism

I remember a Gestalt therapy session many years ago in which I expressed deep grief over a desolate landscape that I had visited that day. I expressed disgust at what we are doing to ourselves and the land we live on. After an exploration of where I felt this in my body, my experience was explored as a projection on to the world. This is a worthwhile avenue to take but it is a much trodden path. The phenomenological exploration of my experience as perception or a dialogic encounter with place is extremely rare. This avenue would open up questions about the way we see the world. Is what is out there dead matter or in some way able to communicate and reciprocate? Is the fact that we do not hear anything when we contact the world proof that there is no other consciousness than human consciousness or a sign that we have forgotten how to listen to a different language?

The existence of non-human subjectivity is what indigenous cultures have lived by for millennia, but which ours has eradicated a long time ago. However, the question about matter holding consciousness is no longer a concern of freaks and New Age hippies. It is at the cutting edge of the current scientific debate (Koch, 2004). In philosophy, the concept of panpsychism, for instance, holds the view that consciousness is a universal feature of all things (Bruntrup and Jaskolla, 2017). The paradigm shift that we may be faced with may not be an either/or, but seems to ask for a wider road that can hold a bigger section of the polarity. We may continue to view subjectivity as only residing in human nature or we may expand our view

of the field and consider the possibility of a subjectivity in animals, plants, waterways, trees, rocks. We are still a long way away from this, but do we, as Gestalt therapists, have anything to say about this?

Lack of a Mythological and Cosmological Dimension

Descartes made the world dead. Everything has become solid matter. As opposed to our ancestors we no longer feel at home with the mystical, divine or the numinous. We seem to have replaced our human need for mythology and transcendence with materialism, which means that most Westerners can no longer take their sorrows to a bigger entity. Cosmology and mythology traditionally place the human experience in a wider context, but with the loss of connection to our mythological and cosmological ground we have become self-referential. It all becomes about our own personalised and exceptional life. Our focus seems to fall only on us. This risks creating a culture of literalness that becomes blind to that which is not tangible and dismisses meaning that is outside of our cognitive realm of reason. There are few exceptions in psychotherapy that break with this norm, but they are often looked down upon. In Jungian psychology the ideas of soul, archetypes and the collective unconscious transcend the merely human realm and ascribe agency to forces and presences outside of human control. Hillman (1995) suggests that if we want to live soulful lives we have to look outside of ourselves and engage with the '*anima mundi*', the soul of the world. For him, the *anima mundi* is an entity in its own right that acts upon us and asks us to participate in its dance. As Gestalt therapists we may agree or disagree with the Jungian perspective, but it puts forward a view of the world that transcends the material and individualised perspective of the Western mind.

In Gestalt therapy the notion of a dialogic relationship is based on the work of Martin Buber (1958), who sees the premise of existence as encounter (Buber, 1947/2002). Buber's work was based on religious consciousness. He argued that an I-Thou relationship with anything or anyone connects us in some way with the eternal relation to God. In order to experience

an I-Thou relationship with God, we have to be open to it, as opposed to pursuing it (which would turn it into an I-It relationship). Buber claims that if we are open, God will eventually come to us and respond to our openness. It seems to me that we have largely taken Buber's thinking and left God out of our notion of the dialogic encounter. We don't talk much about God in Gestalt psychotherapy.

Equally, our theory is influenced by Zen Buddhism and yet the transpersonal aspect of Buddhist philosophy is not explicit in much of our work. There are a few exceptions, but the discourse is discordant. Some writers consider a concept of transcendence being part of the field (Brownell, 2010; Naranjo, 1978), whilst others believe that Gestalt therapy and spirituality are two separate concepts (Au, 1991). The lack of a more coherent exploration of what lies in the space between the 'me' and the 'not me' seems to suggest that many therapists do not share the same ground. We leave it up to individuals to decide whether or not they put a third entity in between. As in the wider culture, it has become a matter of personal taste and opinion.

This lack of a cosmological and transpersonal perspective opens us up to the risk of practising a wild mix and match of individualised preferences. In our insatiable hunger we often appropriate other cultures' cosmologies and risk ending up like consumers; taking whatever fills our longing for now and discarding what we do not like. We try Buddhism, shamanism, yoga, Sufism, etc., in the knowledge that we do not have to commit to any of it. We feel entitled to decontextualise that which is sacred to others. Only a few people are willing to surrender to something bigger. In the absence of a transpersonal perspective, how do we learn to approach the world with a sense of wonder? What rituals guide us? How can we elicit a sense of what is sacred to clients and where does our moral compass come from? Whom or what do we serve if there is nothing that deserves our humility?

Conclusion

In this article I outlined how anthropocentrism as well as the capitalist values of individualism, materialism, privatisation, ownership, progress,

and growth are reflected in our notion of mental health and the practice of psychotherapy in general, including Gestalt therapy. I highlighted that psychotherapists risk reinforcing a culturally endemic I-It relationship to the world. I argue that Gestalt theory already lends itself to widen our notion of the field, but in order to build on the strengths of Gestalt theory and practice we have to make our voices explicit, rise beyond the individualistic paradigm and widen our theory and practice.

When it comes to transitioning out of the deep rupture we have torn between us and the world, there are no rules, no maps and hardly any elders to look to. We need to decide where to steer the boat, and so it is up to us to step out of our comfort zones and act in service of something that is greater than us. When alarm bells are repeatedly ignored, the only way to wake up is through crisis. Is that where we are heading? Some people suggest that we are at the beginning of a major paradigm shift – a time of transition between the world as we have known it and a new world that we cannot know yet. In such a time it is easy to feel disheartened and to dismiss what we have to contribute.

Clarissa Pinkola Estes, a teacher of mine, reminds us that:

> Ours is not the task of fixing the entire world all at once, but of stretching out to mend the part of the world that is within our reach … It is not given to us to know which acts or by whom, will cause the critical mass to tip toward an enduring good. What is needed for dramatic change is an accumulation of acts, adding, adding to, adding more … When a great ship is in harbour and moored, it is safe, there can be no doubt. But that is not what great ships are built for. (n.d)

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Biography

Steffi Bednarek is a Gestalt psychotherapist, supervisor and trainer. Apart from being passionate about Gestalt therapy, Steffi also trained with Clarissa Pinkola Estes, Francis Weller, the Animas Valley Institute, and the 8 shields model of nature connection. Steffi works in private practice in Brighton and in a small woodland outside of Brighton. She has been a Head of Counselling and Mental Health in Higher Education for many years, and managed counselling and mental health services for the charitable sector. She has worked as an international consultant and trainer for several government ministries, worked in the Human Rights sector for the Council of Europe and set up and managed a National Violence Prevention Project for the Ministry of Education in Luxembourg. She has delivered mental health projects for the World Health Organisation, the Red Cross and the British Council. She is a regular consultant to mental health organisations on issues of clinical governance.

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Indigenous Australian Peoples' Social and Emotional Wellbeing (SEWB): Gestalt Therapy as a Potential Ally

Barry Laing

This article is adapted from a Literature Review submitted in 2018 as part of requirements for a Master of Gestalt Therapy degree at Gestalt Therapy Brisbane.

I acknowledge the Bundjalung people as traditional owners and custodians of the land on which I work and live and pay my respects to Elders past, present & emerging.

Working psychotherapeutically with Indigenous Australian peoples (see Note before References) poses many challenges, including challenges to its applicability. Western psychology and psychotherapy have been instrumental in the history of colonisation that has disempowered and disadvantaged Australia's First Nations peoples (Calma, Dudgeon, & Bray, 2017; Dudgeon, Rickwood, Garvey, & Gridley, 2014a; Riley, 2014). Indigenous psychology research proposes an alternative, holistic framework for working with Aboriginal and Torres Strait Islander peoples that addresses individual, family and community social and emotional wellbeing (SEWB) (Dudgeon, Milroy, & Walker, 2014). My awareness of disparity in the lived experience of Indigenous and non-Indigenous people in Australia began in childhood. I witnessed Indigenous students' struggles with racism, bullying and institutional discrimination with anger, sadness and a sense of injustice. This felt sense has stayed with me. In educational and professional contexts, I became aware of the limitations of my cultural awareness and understanding of Indigenous peoples' experience. Contemporary Indigenous psychology research and associated discourses posit that psychotherapists and other practitioners working with Australia's First Nations peoples must proceed from a deeply reflexive practice grounded in an understanding of Indigenous history and an acknowledgement of Aboriginal and Torres Strait Islander peoples' right to self-determination, including of their own social and emotional wellbeing (Calma et al., 2017; Dudgeon, Bray, D'Costa, & Walker, 2017; Dudgeon & Kelly, 2014). I undertake this research in support of this imperative. As a non-Indigenous person, Gestalt therapist and educator, I wish to contribute to decolonising my profession and become

an ally to Indigenous Australian peoples' SEWB. Contemporary Gestalt therapy's relational field and dialogical perspectives and practices (Wheeler & Axelsson, 2015) are potential ground for such an alliance.

This literature review is organised in three parts. In part one, SEWB is firstly defined and described. Colonisation, racism, transgenerational trauma and the social determinants of health and wellbeing are then examined. In part two, Australia's First Nations peoples' self-determination and human rights are identified as central to SEWB that emphasises Indigenous knowledge, cultural strengths and resilience. Holistic and collectivist Indigenous healing concepts, processes and programs are considered in this context. Part three reviews relevant Gestalt therapy literature. It begins with description and definition of contemporary Gestalt therapy's relational field model. Psychopathology and trauma are then considered through the lens of this relational and situational theory and practice. Finally, Gestalt therapy's dialogical and phenomenological approach is identified as an ethical and political stance that may contribute to radical inclusion and social change via social activism. A final section summarises key themes and findings in each body of literature and cautiously proposes points of congruence that may support future research and collaborative practice with Gestalt therapy positioned as an ally to Indigenous Australian SEWB.

Social and Emotional Wellbeing (SEWB) Guiding Principles: A Social Determinants Approach

Indigenous SEWB is a term that has evolved over more than 30 years as a strategic policy and practice framework for working with Indigenous Australian peoples' health and wellbeing. SEWB can be defined as:

> a multidimensional concept of health that includes mental health, but which also encompasses domains of health and wellbeing such as connection to land or 'country', culture, spirituality, ancestry, family, and community (…) [and which] places Aboriginal and Torres Strait Islander world views and culture as central. (Gee, Dudgeon, Schultz, Hart, & Kelly, 2014, p.55)

Numerous contributors to SEWB literature affirm the evidence base for the specificity and centrality of culture to Australia's First Nations peoples' wellbeing (Calma et al., 2017; Dudgeon et al., 2017; Dudgeon, Wright, Paradies, Garvey, & Walker, 2014c). Phenomenologically, SEWB represents "a physically healthy, culturally intact and spiritually connected person" (Sheehan, Martin, Krysinska, & Kilroy, 2009, p. 4). As such, key proponents

of SEWB (Dudgeon, 2017; Garvey, 2008; Gee et al., 2014) argue that mental health, and/or mental ill-health or disturbance, are inadequate terms and concepts if isolated from other domains of SEWB.

Aboriginal and Torres Strait Islander peoples' SEWB is framed in terms of nine principles and seven domains (Department of the Prime Minister and Cabinet, 2017). The nine principles comprise a holistic view of health that accommodates mental, physical, cultural and spiritual health as interconnected and inseparable from wellbeing. Ill-health derives from disruptions to these connections. Culturally appropriate praxis and self-determination of the provision of health services are asserted. Recognition of human rights is linked to mental health, and trauma stemming from colonisation and persistent racism is tied to ill-health. Family and kinship systems must be understood as central to Indigenous Australian peoples' SEWB, and the diversity of Aboriginal and Torres Strait Islander peoples appreciated in the context of resilience and cultural strengths (Department of the Prime Minister and Cabinet, 2017. See Appendix 1, *Figure 2,* for comprehensive details of these nine principles). The nine principles inform a widely accepted model in SEWB literature showing seven intersecting and overlapping domains of wellbeing. According to this model, an Indigenous Australian conception of self and wellbeing clearly emerges from a holistic, culturally specific and collectivist experience of self embedded in and inseparable from historical, social, political and cultural determinants (Calma, 2009; Dudgeon et al., 2017; Gee et al., 2014):

Figure 1. A model of Social and Emotional Wellbeing. Reprinted from *National strategic framework for Aboriginal and Torres Strait Islander Peoples' mental health and social and emotional wellbeing 2017-2023.* (p. 6), by Department of the Prime Minister and Cabinet, 2017, (https://healthinfonet.ecu.edu.au/key-resources/publications/?lid=33834). In the public domain.

This approach to SEWB is informed by, and informs, an understanding of colonialism, racism and transgenerational trauma.

The SEWB model of self is starkly distinct from an individualist self which is centred within hegemonic Western discourses that have shaped and continue to determine the provision of broadly reductionist and atomised health services in Australia (Dudgeon et al., 2017; Dudgeon, 2017). Individualism is identified as pervasively at odds with, and harmful to, Aboriginal and Torres Strait Islander peoples' wellbeing in the context of psychology, psychotherapy and associated discourses and practices that are predominantly culturally unresponsive (Dudgeon & Kelly, 2014; Dudgeon & Walker, 2015; Riley, 2014). In such contexts, it cannot be assumed that individual revelation or sharing of self is desired, useful or culturally safe for individual First Nations people requiring therapeutic support (Dudgeon, Garvey, & Pickett, 2000; Gee et al., 2014). More than cautionary, this is a prohibitive perspective on the use of non-Indigenous or un-adapted Western

psychotherapeutic practices when working with Aboriginal and Torres Strait Islander peoples. The principles of self-determination and recognition of human rights inform this perspective.

Colonisation and racism are destructive historical and contemporary forces in the lived experience of Australia's First Nations peoples. Extreme disruption to cultural wellbeing from dislocation, dispossession, forced removal of children and consequent profound loss and grief have resulted in individual, familial and cultural trauma for Aboriginal and Torres Strait Islander peoples (Atkinson, Nelson, Brooks, Atkinson, & Ryan, 2014; Dudgeon et al., 2014c; Sheehan et al., 2009). Such trauma persists over the life-span and through and across generations. Transgenerational trauma stemming from colonisation may be understood as both cause and effect of the suffering of contemporary Indigenous Australians (Atkinson et al., 2014; Charles, 2015; Sheehan, Dunleavy, Cohen, & Mitchell, 2010). It can be defined as "the subjective experiencing and remembering of events in the mind of an individual or the life of a community, passed from adults to children in cyclic processes" (Atkinson et al., 2014, p. 294) that cause emotional and psychological damage to the collective. When physical, emotional, mental and behavioural issues follow from such damage, profound ethical injustice and re-injury is done to Indigenous Australians in treating such symptoms a-historically and individually as deficits in mental health (Charles, 2015; Sheehan et al., 2009). A social determinants approach to health and wellbeing is needed to redress this injustice in theory and practice (Calma et al., 2017; Dudgeon et al., 2017; Gee et al., 2014). Furthermore, colonialism and racism also harm Indigenous *and* non-Indigenous Australians (Charles, 2015; Sheehan et al., 2010; Sheehan, 2012). Contemporary Australian society as a whole cannot be considered socially and emotionally well as long as neo-colonialism and racism continue to disadvantage and traumatise Aboriginal and Torres Strait Islander peoples (Charles, 2014; Sheehan 2012; Sheehan et al., 2009). This is an incisive perspective on social and cultural wellbeing that requires understanding of the social determinants of health and a remodelling of the provision of health services, bi-cultural literacies and understanding (Dudgeon, 2017), and Indigenous and non-Indigenous collaboration in keeping with SEWB principles.

The social determinants of inequity in health flow from economic and social advantage or disadvantage. Colonisation, racism and their impacts cannot be excluded from the determinants of disadvantage for Australia's First Nations peoples (Zubrick et al., 2014). Social determinants of Indigenous disadvantage stemming from this history extend today to inequity in access

to income and employment, education, housing, and control over resources (Dudgeon et al., 2017; Zubrick et al., 2014). These are all domains of influence conventionally understood to be beyond the reach of the health sector. Furthermore, racism is an ongoing stressor explicitly linked to many of these domains systemically, and poor mental health and wellbeing individually (Sheehan, 2012; Sheehan et al., 2009; Zubrick et al., 2014). In a health and wellbeing context, a social determinants approach depathologises individuals, whole groups and cultures because it situates individuals in a complex set of social, cultural, economic and political relationships in full acknowledgement of the impacts of colonisation (Charles, 2015; Sherwood, 2013). In this way, it provides a decolonising framework for working with Indigenous Australians' loss, grief, and trauma and associated presenting issues (Dudgeon, 2017; Dudgeon et al., 2017; Dudgeon & Walker, 2015). This framework emerges as an ethical, social, political, and economic whole-of-sector imperative that posits a safe cultural space in which health and wellbeing supports can be provided (Dudgeon et al., 2017; Muller, 2014; Taylor & Guerin, 2014). A trauma-informed approach is fundamental (Calma et al., 2017; Dudgeon & Kelly, 2014). Consequently, given the political dimension of the social determinants of health and wellbeing (Dudgeon & Kelly, 2014), Western psychotherapies undertaken with individuals must cede ground to Indigenous Australian peoples' self-determination of the theories, processes and practices of their own SEWB (Calma et al., 2017; Dudgeon et al., 2017; Dudgeon & Kelly, 2014). A human rights perspective is prominent in underpinning this framework.

Human Rights, Cultural Strengths and Healing

A human rights approach to SEWB prioritises self-determination, and self-determination centres Indigenous Australian peoples in control and leadership of their own affairs. Article 3 of the *United Nations Declaration on the Rights of Indigenous Peoples* (2007) links this principle of Indigenous peoples' empowerment to self-determination of political, economic, social and cultural development. Articles 24.1 and 24.2 enshrine Indigenous peoples' right to their own health practices and knowledge, and equity of access to the "highest attainable standards of physical and mental health" (p. 4). Article 34 asserts the right to the maintenance of unique customs, traditions and cultural practices. As a framework proposed as a whole-of-sector imperative, SEWB is based on respect for these human rights in concert, and a call for their fulfilment (Dudgeon & Walker, 2015; Gooda, 2011). Australia has been a signatory to this declaration since 2009.

Without specific transformation of health and mental health services according to Indigenous SEWB principles at systemic, organisational and individual levels, closing the gap on Indigenous Australian peoples' health remains elusive (Calma et al., 2017; Dudgeon, Calma, Brideson, & Holland, 2016; Gooda, 2011). In respect of this gap, and of human rights pertaining to cultural difference in the domain of mainstream service provision, cultural competence and cultural safety figure significantly (Walker, Schultz, & Sonn, 2014). Cultural competence is predicated on a deeply reflexive process and practice of cultural awareness and sensitivity for all practitioners, and particularly non-Indigenous Australians, working with Australia's First Nations peoples in health and wellbeing contexts (Ranzijn, McConnochie, & Nolan, 2009; Secretariat of National Aboriginal and Islander Child Care [SNAICC], 2012; Taylor & Guerin, 2014). However, cultural safety can only be verified in experience by an Indigenous Australian client of health and mental health services (Walker et al., 2014). Unsafe cultural practice can be more easily defined as "any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual" (Clear as cited in Parker & Milroy, 2014, p. 114). Therefore, for Western, predominantly dyadic therapies to be practised safely with Aboriginal and Torres Strait Islander peoples they must adapt to Indigenous SEWB principles concerning culturally attuned service provision, self-determination and recognition and respect of human rights (Dudgeon et al., 2014a; Dudgeon & Kelly, 2014). Failure to do so "constitutes continuous disruption to mental health" (Department of the Prime Minister and Cabinet, 2017, p. 3). In practice, this applies particularly to empowerment of the client in any consultation via collaboration with Indigenous health and mental health workers, family members and/or significant community members including cultural healers (Dudgeon et al., 2016; Dudgeon et al., 2000; Dudgeon & Ugle, 2014). Within the protective supports of these relationships and cultural protocols, working together with non-Indigenous practitioners and clinical practices, the client themselves is understood to possess the cultural resilience necessary to contribute to their own SEWB (Calma et al., 2017; Sheehan, 2012; SNAICC, 2012). Recognition of human rights and self-determination is critical to strengthening culture and cultural resilience to this end.

Indigenous Australian culture itself, in all of its diversity in urban, rural and remote contexts (Dudgeon & Ugle, 2014), is identified as a protective factor for Aboriginal and Torres Strait Islander SEWB (Calma, 2009; Dockery, 2010; Sheehan, 2009). Opposed to the often deficits-based, conventional approaches of the mainstream Australian health system, SEWB gives recognition to and fosters Indigenous cultural strengths (Calma et al.,

2017; Sheehan, 2012). Such strengths inhere in kinship systems, family and community relationships, connection to land/country, Indigenous knowledge and law, and Indigenous languages. There are many cultural practices that sustain these strengths such as ceremony, song, dance, art and storytelling (Gee et al., 2014; SNAICC, 2012; Taylor & Guerin, 2014). It is the fundamentally relational nature of Aboriginal and Torres Strait Islander culture that is identified as its key strength and resilience marker (Sheehan et al., 2009). Cultural strengths may be framed in terms of knowledge/awareness, caring/appreciation, sharing/aspiration and respect/autonomy and organised for application in SEWB contexts according to four domains: mental, spiritual, ancestral and emotional (Sheehan, 2012). In this model, Indigenous culture and SEWB (both framework and outcome), are positioned as preventative of ill-health by building on and practising cultural strengths and resilience to enhance and realise SEWB holistically (Sheehan et al., 2009). There is an increasing evidence base for Indigenous-led SEWB healing programs (Dudgeon et al., 2014; McKendrick, Brooks, Hudson, Thorpe, & Bennett, 2014), guided by SEWB principles including human rights and self-determination, which demonstrates the efficacy of this approach.

For Australia's First Nations peoples, trauma stemming from colonisation, racism and their ongoing effects requires healing. Moreover, cultural trauma requires cultural healing (SNAICC, 2012). "Fundamental wounds" to the soul in historical and transgenerational trauma demand restoration of the social and cultural fabric of Indigenous society (Milroy, Dudgeon & Walker, 2014, p. 421). Healing in this context is understood holistically as simultaneously of the individual and the collective, and as a process of empowerment or agency emergent of self-determination by Indigenous communities (Dudgeon et al., 2014b; Sheehan, 2012). Healing is also a spiritual process across time that requires structured initiatives to facilitate recovery from trauma and reconnection to family, community and culture (Dudgeon et al., 2014b). Experiences of powerlessness and loss of control, loss, grief, disconnection, and helplessness are identified as key themes of trauma. These are met with three strategic pathways to healing and recovery: self-determination and community governance, reconnection to community life, and restoration of culture and community resilience (Milroy et al., 2014. See Appendix 2, *Figure 3*). Such restoration is a precondition for healing and for addressing specific contemporary health issues, including mental health, within a SEWB framework (Calma, 2009; Day & Francisco, 2013; Dudgeon et al., 2014b). Self-determination, reconnection to community life and restoration of culture are protective and preventative factors in support

of SEWB and are essential to healing trauma.

It is beyond the scope of this review to detail particular Indigenous healing programs. However, common factors have been identified that determine the success of healing programs. These factors include: local community-identified need and support; local Indigenous leadership; a well-developed theoretical and evidence base; a combination of traditional cultural healing and aspects of Western therapeutic methodologies; design, implementation and impacts that reach beyond individuals to families and community in capacity-building and knowledge and skills acquisition (McKendrick et al., 2014). Furthermore, Indigenous ownership and evaluation are essential to the centring of Indigenous Australian peoples' world views in all programs. Such programs should be holistic, sensitively informed by the unique historical story of each location within the history of colonisation and its impacts, and focussed on familial, community and cultural interconnectedness (Day & Francisco, 2013; N, Tujague, personal communication, June 9, 2019). A comprehensive decolonising process is required upstream from conventional therapeutic work with individuals and families in order to enhance Aboriginal and Torres Strait Islander peoples' SEWB (Dudgeon et al., 2014b). Centring Indigenous leadership in this process is essential.

The *Gayaa Dhuwi (Proud Spirit) Declaration* calls for embedding Indigenous leadership in all aspects of the health and mental health system (Dudgeon et al., 2016). A best-of-both-worlds approach to SEWB, mental health and healing requires access to culturally informed healing methods and Indigenous cultural healers, as well as Western clinical approaches, to achieve the highest attainable standard of health for Aboriginal and Torres Strait Islander peoples (Dudgeon et al., 2016). This integrated or blended healing approach is pragmatic, inscribed in the Indigenous SEWB framework and constitutes part of a reform agenda of the Australian Government (Department of the Prime Minister and Cabinet, 2017). In respect of Western therapeutic practice, the framework calls for "structured therapies including cognitive behavioural therapy (CBT), dialectical behavioural therapy, mindfulness, and other evidence based therapeutic approaches as appropriate" (Department of the Prime Minister and Cabinet, 2017, p. 14). Narrative therapy has also been identified as acceptable to Aboriginal and Torres Strait Islander peoples because of its perceived harmony with Indigenous storytelling (McKendrick et al., 2014; Sheehan, 2012; SNAIC, 2012). However, research processes and outcomes that may indicate CBT's applicability and efficacy with Indigenous peoples have been criticised as culturally biased and technically flawed (Dudgeon & Kelly, 2014; Pomerville, Burrage, & Gone, 2016). Furthermore,

given a holistic, social determinants and human rights approach to SEWB, CBT and other Western therapies should not be practised with individual Indigenous people in isolation as a stand-alone response to Indigenous SEWB, mental health and healing (Dudgeon & Kelly, 2014; Dudgeon et al. 2014b; Peeters, Hamann & Kelly, 2014). Therapeutic practice should be undertaken by Indigenous therapists where possible, partnered with non-Indigenous practitioners if required and where appropriate (Peeters et al., 2014). Group therapy may be more acceptable to and suitable for Indigenous clients because of its perceived potential to be more collectivist than individualist in its approaches and methodologies (Pomerville et al., 2016). It is also structurally more amenable to partnership and collaboration in both group leadership and group participation.

Indigenous Australian dialogue, storytelling and yarning practices precede any pragmatic, blended approaches to SEWB and healing necessitated by the existing structures of the contemporary Australian health system. Awareness of *how* one is in relation with one's self, with others and the environment is a site of control and agency for Indigenous Australian peoples (Bales, 2016). This forms the basis of an articulate and structured yarning process. In Indigenous yarning circles, a simple discipline of everyone seated facing each other, speaking in turn, uninterrupted, with no-one silenced creates a culturally safe space where difficult issues and new ways of dealing with them may emerge (Sheehan, 2012). This approach develops "cultural literacy" and situated understandings in Indigenous groups and may also be used in non-Indigenous groups to engender "social literacy concerning equity" (Sheehan, 2012, p. 94). *Dadirri*, or deep listening, is a culturally informed practice of listening and understanding, which hears what is spoken in relationship to respect and deference to Elders, and protocols connected with kinship systems, gender, Country and numerous other factors (Muller, 2014). There is a culturally safe, collective hermeneutic at work in the dialogue. Respect, genuine caring, sharing stories from experience, and demonstrating awareness and knowledge are guiding principles embodied in Indigenous yarning circles in service of the whole group and wider community (Sheehan, 2012). Such principles, enacted in culturally safe spaces, may form the basis of healing for both cultures (non-Indigenous society also being harmed by its colonialism and endemic racism), and between Indigenous and non-Indigenous people (Muller, 2014; Sheehan, 2012; Sheehan et al., 2010). Indigenous yarning circle practices underpin healing processes and provide a framework for dialogue and partnership between Indigenous and non-Indigenous people.

Contemporary Gestalt Therapy

While Gestalt therapy literature does not address Australia's First Nations peoples' SEWB, Gestalt therapy has the potential to participate in partnerships as an ally in support of Indigenous SEWB due to the consonance and protective factors of its dialogical and relational praxis. Gestalt therapy has multiplicitous sources. It has roots in psychoanalysis, humanist psychotherapy, existentialism, phenomenology, holism and some Eastern spiritual practices such as Buddhism (Crocker, 2005; Wheeler & Axelsson, 2015). Founded in the United States of America (USA) in the 1940s and 1950s, Gestalt therapy was influenced by the Gestalt psychologists in Germany of the 1930s, and particularly by Kurt Lewin's field theory (Wheeler & Axelsson, 2015). Contemporary Gestalt therapy can be broadly identified and described as a relational psychotherapy underpinned by field theory, phenomenology and hermeneutics, and practised via dialogical and experimental methodologies (Fairfield, 2009; Staemmler, 2016; Yontef, 2002). Gestalt therapy's relational approach is grounded in the leading edge of field theory which understands individuals as always and already located, or situated, in complex phenomenal environments (Schulz, 2013; Wheeler & Axelsson, 2015; Wollants, 2012). Gestalt therapy's hermeneutic phenomenology has been described as a "willingness to be uncertain" (Staemmler, 2009, p. 93) in therapeutic dialogue that tracks closely and enquires into the client's and therapist's awareness of present or emerging phenomena. Such phenomenological practice suspends or holds lightly the therapist's preconceived assumptions and interpretations of clients' presenting phenomena and affirms the client in their experience (Brownell, 2010; Crocker, 2009). Dialogue in Gestalt therapy is an aspirational ideal of a particular kind of embodied exchange of two human beings facing each other *as others* (Bloom, 2011; Jacobs, 2009; Robine, 2011). It requires an open disposition as a way of being with another and attending to how one is in relationship with others. Values of "compassion, kindness, wisdom, equanimity, and humility" are made explicit as the ethical ground of such dialogue (Yontef, 2002, p. 25). Awareness is one of Gestalt therapy's primary methods and aims (Yontef, 2007). Phenomenologically focussed dialogue is undertaken in support of clients' awareness and of their capacity for the experience of novelty, spontaneity and, consequently, change within the phenomenal/psychological field (Spagnuolo Lobb, 2013; Wheeler & Axelsson, 2015). Furthermore, awareness is a dialogical, sensorial awareness of the whole situation that is embodied, exchanged and given form in relationships from which situation-specific meanings emerge (Wollants, 2012). Dialogical, relational, phenomenological and situational theory and

practice are central to contemporary Gestalt therapy.

This review of Gestalt therapy literature focusses primarily on exponents of contemporary Gestalt therapy that address social, political and cultural considerations in working therapeutically in dyads and as extensions of Gestalt therapy in groups, organisations, communities and specific social situations (Bar-Yoseph, 2005; Klaren, Levi, & Vidaković, 2015; Melnick & Nevis, 2012). Cultural considerations in Gestalt therapy addressing ethnicity and race are framed in terms of dialogue, the necessity for reflexive awareness, the complexities of white shame and guilt, and descriptions of cultural sensitivity (Jacobs, 2016; 2005; 2014; McConville, 2005). From a Gestalt therapy perspective, cultural competency in practice emerges as a model based on awareness, behaviour, culture and data (Plummer, 1997). Awareness of one's own cultural position as well as direct and indirect experience and knowledge of other cultures are fundamental requirements. These discussions are centred on and limited by the social and cultural contexts of the USA. There is scant Gestalt literature that addresses Indigenous peoples specifically. A recent exception applies a Gestalt organisational development model to work with a US Native American Health Centre (Melnick, 2017). A strengths based social change methodology is described in which Gestalt therapy process-oriented principles and practices of awareness and dialogue are emphasised (Melnick, 2017, p. 23). Social and cultural awareness are essential to a Gestalt therapy social change process applied in specific situations.

One book chapter and two articles explicitly address social and cultural issues in regard to Aboriginal and Torres Strait Islander peoples (Fernbacher, 2005; Hunt, 2014; Plummer & Fernbacher, 2016). Gestalt therapy's principles of awareness and attention to figure/ground formation (Yontef & Jacobs, 2014) are directed to therapists of a dominant culture in working cross-culturally (Fernbacher, 2005). Field theory, phenomenological practice and dialogue as method are highlighted as felicitous in working cross-culturally in therapeutic settings (Fernbacher, 2015). Racial identity resolution and the concept of therapists' use of self are discussed (Plummer & Fernbacher, 2016). A focus on cultural humility and seeing the client as teacher are consistent with Gestalt therapy's dialogical ethics and method (Bloom, 2011; Jacobs, 2009; Jacobs, 2016). Field theory is used to point to important situational factors in the wake of colonisation impacting on Indigenous people's phenomenal/psychological fields in Central Australia (Hunt, 2014). Cultural issues are opened up to scrutiny of social and political contexts understood as determinants of Indigenous Australian peoples' health and wellbeing.

In a revision and critique of Gestalt therapy's field-theoretical approach, the word field is replaced with *situation* (Wollants, 2012). This is axiomatic of existential phenomenology. A situational perspective offers a bridge between dyadic Gestalt therapy and work in groups. It also further opens Gestalt theory and practice to explicit social action in myriad settings. The situation is defined dynamically as the "phenomenal, experienced field of a person and his [*sic*] world over a given interval of time" (Wollants, 2012, p. 3). This definition simplifies and cuts across many ambiguities in use, understanding and application of field theory in Gestalt therapy (Robine, 2011; Wollants, 2012; Staemmler, 2006). The addition of the dimension of time facilitates consideration of social, cultural and political factors in individuals' phenomenal fields, including the therapist's, beyond the therapy room (Staemmler, 2002). In this way, Gestalt therapy is directed towards "the whole situation" (Wollants, 2012, p. 51). Within this framework, individual suffering is seen as a field phenomenon (Francesetti, 2015a & 2015b; Francesetti & Gecele, 2009; Spagnoulo Lobb, 2013). The *situation* can also be considered to be suffering or unwell. Therefore, pathology and illness cannot be simply reduced to and localised in an individual client (Francesetti, 2015b). Consequently, dyadic therapy treatment and diagnoses must be addressed to "impairing situations" (Wollants, 2012, p. 35). Such situations invite certain kinds of contact or have environmental "requirements" (Wollants, 2012, p. 53). Contemporary Gestalt therapy addresses itself to such requirements in specific relationships which constitute contact within the total situation.

Relational trauma is an impairing situation. Gestalt therapy has been identified as highly applicable to working with traumatised clients (Pfluger, 2013). Gestalt therapy's capacity to address the complexity of figure/ground processes in the relationships between parts and wholes is valued (Pfluger, 2013). It provides support for building ground for careful, staged dialogical experience which is appropriate and safe for the characteristic subjective splitting of trauma sufferers (Francesetti & Gecele, 2009; Kepner, 2003; Taylor, 2014). Integration of the experience of alternative, detraumatising phenomenal/psychological fields modelled in dialogue *constitutes* the therapy of the safe container of the therapeutic relationship (Bloom, 2011; Pfluger, 2013; Taylor, 2014). Neurobiological insights into the severely restricted agency or choice of those suffering recursive trauma experience caution against experimental integrative processes without sustained support and graded experiments (Pfluger, 2013; Taylor, 2014). A situational perspective also opens Gestalt therapy's trauma contributions up to cultural considerations.

Gestalt therapy literature does not explicitly address cultural and transgenerational trauma. However, a therapist cannot imagine themselves free of their *social and cultural location* in the total situation which may be impairing, including in and of the therapeutic relationship (Jacobs, 2005, 2014 & 2016; Plummer, 1997; Plummer & Fernbacher, 2016). Where suffering and psychological pain are concerned, situational impairments are of a field which is not symmetric in terms of social, cultural and political relationships of power (Francesetti, 2015b; Jacobs, 2016). Support is understood as already in play in the prevailing conditions of the situation *and* as a therapeutic strategy/action that can be addressed to *any part of the situation* as well as to the client (Robine, 2011; Wollants, 2012). Francesetti & Gecele (2009, p. 8) contend that "one way of preventing and curing harm *at the social level* [emphasis added] is to provide support for pain". A relational situational perspective provides an important nexus between a relational field approach in dyadic Gestalt therapy and more explicit, preventative engagement and participation in specific social situations such as activism in groups, communities and between cultures.

Gestalt activism at systemic levels, in its preventative intentions, moves beyond therapy. Prevention of the relational conditions that constitute ill-health and expressions of relational suffering, such as trauma and depression, is emphasised (Fairfield, 2013; Francesetti & Gecele, 2009; Knijff, 2015). Supported by comprehensive theoretical elaborations and revisions, Gestalt therapy principles and practices have been extended from dyadic therapy into group work (Fairfield, 2009; 2013; 2004; Fairfield & O'Shea, 2008). Dialogical practice informed by hermeneutic phenomenology with groups is the foundation of this approach (Fairfield, 2009 & 2004). A "demonstration project" (Fairfield, 2013, p. 28) called The Relational Centre is a public education, training and consulting model that attempts to explicitly structure and embody group relationships in multiple projects and settings that are *contrary to prevailing field conditions* in social, cultural and economic terms (Fairfield, 2013). These conditions exclude minorities (Evans, 2015; Fairfield, 2009; Jacobs, 2016). The co-creation of new and alternative meanings and experiences in the therapeutic relationship in dyadic or group Gestalt therapy does not emerge against an equitable ground. The truth of the suffering of the disempowered and disadvantaged in the total situation holds greater weight and must be allowed to emerge fully in the therapeutic field (Francesetti, 2015b). Contemporary Gestalt therapy is an inclusive approach that supports interventions that reorganise relationships to allow for complexity and destabilisation of dominant social and cultural determinants

of health, for some, and ill-health for others.

Some of these social and cultural themes are addressed in four edited collections of Gestalt therapy articles concerned with cross-cultural dialogue, clinical practice, human rights and social change (Bar-Yoseph, 2005; Francesetti, Gecele, & Roubal, 2013; Klaren, Levi, & Vidakovic, 2015; Melnick & Nevis, 2012). Wheeler's (2005a) contribution to the collection on cross-cultural dialogue emphasises and develops the significance of culture in relational field Gestalt therapy. However, his constructivist approach (McNamee, 2002; Wheeler, 2000) falls back upon constructs existing within the individual, by means of which phenomenal reality is constructed (Robine, 2011). This can be defined as "weak relationality" (Staemmler, 2016, p. 14). Contemporary Gestalt therapy is still permeated with a "residual individualistic bias" in which the individual remains the "primary entity that only secondarily enters relationships and is then influenced by them" (Staemmler, 2016, p. 14). Many others support this assessment (McNamee, 2002; Robine, 2011; Wollants, 2012). In practice, this dilemma poses the risk of potentially contributing to the "psychopathology of an isolated entity" despite a relational stance (Robine, 2011, p. 39). An alternative theoretical position is social constructionism. Fundamental relationality is posited as the very conditions in which the phenomenal/psychological realities of *subjects in relationship* are always already constructed (McNamee, 2002). Staemmler (2016, p. 14) describes this as "strong relationality". Here, the field is multiplicitous and constraining/enabling of the possibilities of individual selfhood which emerge in relationship (Robine, 2011). Individual selves are subject of and to the field. Meaning making is then a relational process that encompasses and is encompassed by complex contexts such as culture and history (McNamee, 2004). Culture constitutes, relies upon and reproduces *shared* meanings in this regard (Staemmler, 2005; Wheeler, 2005b). Strong relationality underpins support for interventions in specific social situations where field conditions compromise individuals' wellbeing, including transgressions of their human rights.

A human rights perspective is consistent with Gestalt therapy's humanist-existential foundations. Important insight is provided into how tensions between independence (of individual selves) and interdependence, understood as belonging, might co-exist creatively and therapeutically in Gestalt therapy training groups (Spagnuolo Lobb, 2015). A reading of contemporary social and cultural conditions as impairing and isolating, and the assertion of the necessity for belonging, is framed as a human rights issue (Spagnuolo Lobb, 2015). Gestalt therapy dialogical theory and figure/ground

formations are used to explore immigration in Europe as a way of framing meeting and being with others in their difference (Gecele, 2015). Gestalt therapists must be keenly aware of their own cultural position, particularly in respect of relationships of power, and need to "become trained in *holding the complexity of background* [emphasis added]" (Gecele, 2015, p. 111). In these terms, the specificities of exclusion, marginalisation, disadvantage and oppression may be contextualised as "structures of ground" (Wheeler, 1998, p. 117). Structures of ground is a highly contested construct in Gestalt therapy (Kenofer, 2018; Kjønstad, 2016). However, the idea that figures emerging in any phenomenal/psychological field do so in cultural processes riven by history and power captures something of its significance here (Gecele, 2015). Processes that move extremely slowly (or ostensible structures) in person/environment relationships form, constrain or enable particular configurations of those relationships (Kjønstad, 2016). Opportunities for action or choice-making for individuals are therefore variously constrained or enabled in any field. Social, cultural, political and economic disparities in power/disempowerment, advantage/disadvantage and centring-belonging/marginalisation are organising conditions of the social relational field that may contravene human rights. Contemporary Gestalt therapy understands these contexts as fundamental to particular relational experiences of individuals in groups, communities and between cultures.

Conclusion

The SEWB model is a coherent body of literature grounded in research developed over decades. Aboriginal and Torres Strait Islander people have provided organisations, agencies, and State and Federal governments with detailed, strategic frameworks for policy and practice in support of their SEWB. SEWB is sound theoretically and based on solid and developing evidence. Indispensable to the model are self-determination and centring of Australia's First Nations peoples' worldviews or cultural knowledge in any and all matters concerning their own SEWB. This is a human rights issue. It is the social and political dimensions of this requirement that are problematic for, and refused by, governments and Australian society at large. Racism continues to contribute to Indigenous Australians' ill-health. A social determinants approach to Indigenous Australian SEWB is depathologising and decolonising of diverse Aboriginal and Torres Strait Islander peoples and their culture. Such an approach is also a bridge to addressing the

social, political, cultural and economic advantage/disadvantage, power/disempowerment and inclusion/marginalisation polarities that divide non-Indigenous and Indigenous Australian social and cultural groups. To become an ally to Indigenous SEWB, non-Indigenous people working in the health and wellbeing field must engage substantially with Indigenous Australian people, SEWB literature and research. Moreover, a comprehensive and ongoing reflexive process concerning one's own social, cultural, political and economic position is required.

Contemporary Gestalt therapy has strengths and weaknesses in respect of its potential for becoming an ally to Indigenous Australian SEWB. There is congruence in the sense of harmony, though not parity, between Indigenous Australian collective cultural relationality and contemporary Gestalt therapy's relational field theory and practice. Gestalt therapy's situational stance is accommodating of a social determinants approach to health and is, in concert with SEWB, likewise depathologising. Aboriginal and Torres Strait Islander peoples' dialogue and yarning practices and Gestalt therapy's dialogical ethics and methodology are potentially consonant and ripe for mutual learning. Collaborations at the group level seem more suitable for explicitly therapeutic work with Indigenous people. This is because Gestalt therapy's individualist bias or weak relationality are a potential risk for Indigenous SEWB and must be addressed critically and more fully in Gestalt therapy training and literature. Beyond therapy, Gestalt dialogical theory and practice may support partnerships, led by Indigenous people, that are crucial in undertaking the upstream work in political, institutional and organisational settings that is required to realise the best possible outcomes for Indigenous Australian peoples' SEWB. A trauma informed approach is critical to any partnerships, whether delivering therapeutic services, or working at systemic levels. Gestalt therapy is a suitable approach for working with traumatised individuals, given protective factors in its figure/ground practice and hermeneutic phenomenological methodology. However, Gestalt therapy needs development in research and practice in terms of cultural and transgenerational trauma. Future research in Gestalt therapy might usefully develop the construct of structures of ground in a specifically Australian context. This would contribute to Gestalt therapy's literature and training in cultural awareness and competence, informed by disparities in power and advantage that are oppressive for Australia's First Nations peoples. Jacobs (2015, p. 148) observes that "we do not talk much about power in Gestalt therapy". It is imperative for Gestalt therapy to give attention to power and culture as constraining/enabling field conditions, and for whom, as they may relate to individuals, groups or cultures. Further elaboration of a human

rights perspective and development of Gestalt therapy's strong relationality are both integral to supporting Indigenous Australian SEWB as an ally.

Note: With respect for and appreciation of the cultural diversity and sovereignty of Indigenous Australian peoples, the terms Australia's First Nations peoples, Aboriginal and Torres Strait Islander peoples, and Indigenous peoples are used variously and interchangeably with Indigenous Australian peoples throughout this review.

Appendix 1

The Nine Guiding Principles of SEWB

1. Aboriginal and Torres Strait Islander health is viewed in a holistic context, that encompasses mental health and physical, cultural and spiritual health. Land is central to wellbeing. Crucially, it must be understood that when the harmony of these interrelations is disrupted, Aboriginal and Torres Strait Islander ill health will persist.
2. Self-determination is central to the provision of Aboriginal and Torres Strait Islander health services.
3. Culturally valid understandings must shape the provision of services and must guide assessment, care and management of Aboriginal and Torres Strait Islander people's health problems generally, and mental health problems, in particular.
4. It must be recognised that the experiences of trauma and loss, present since European invasion, are a direct outcome of the disruption to cultural wellbeing. Trauma and loss of this magnitude continues to have inter-generational effects.
5. The human rights of Aboriginal and Torres Strait Islander people must be recognised and respected. Failure to respect these human rights constitutes continuous disruption to mental health. Human rights relevant to mental illness must be specifically addressed.
6. Racism, stigma, environmental adversity and social disadvantage constitute ongoing stressors and have negative impacts on Aboriginal and Torres Strait Islander peoples' mental health and wellbeing.
7. The centrality of Aboriginal and Torres Strait Islander family and kinship must be recognised as well as the broader concepts of family and the bonds of reciprocal affection, responsibility and sharing.
8. There is no single Aboriginal or Torres Strait Islander culture or group, but numerous groupings, languages, kinships, and tribes, as well as ways of living. Furthermore, Aboriginal and Torres Strait Islander people may currently live in urban, rural or remote settings, in traditional or other lifestyles, and frequently move between these ways of living.
9. It must be recognised that Aboriginal and Torres Strait Islander people have great strengths, creativity and endurance and a deep understanding of the relationships between human beings and their environment.

Figure 2. Nine guiding principles of SEWB. Reprinted from *National strategic framework for Aboriginal and Torres Strait Islander peoples' mental health and social and emotional wellbeing 2017-2023.* (p. 7), by Department of the Prime Minister and Cabinet, 2017, (https://healthinfonet.ecu.edu.au/key-resources/publications/?lid=33834). In the public domain.

Appendix 2

Pathways to Recovery from Transgenerational Trauma

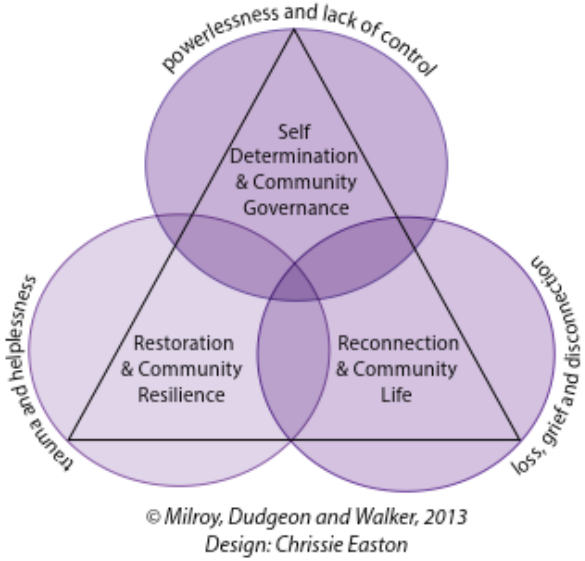

Figure 3. A model of pathways to recovery from transgenerational trauma. Reprinted from Milroy, H., Dudgeon, P., & Walker, R. (2014). Community life and development programs: Pathways to healing. In P. Dudgeon, H. Milroy, & R. Walker (Eds.), Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice (2nd ed.) (p. 424). (http://e-doc.me/working2/working2/assets/common/downloads/publication.pdf).
In the public domain.

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Biography

Barry Laing, M Gest Therapy; PhD; BA Hons, lives in Northern NSW and completed his training in Gestalt therapy in 2018. He currently works in the School of Arts & Social Sciences and Centre for Teaching & Learning at Southern Cross University. Barry has extensive experience as a performance maker and educator in Australia, the United Kingdom and Europe over many years. His work with actors, dancers, musicians, and visual, sound and performance artists has included work with disadvantaged young people, Indigenous Australian people, homeless people, post-release prisoners, and people perceived to have disabilities. As a Gestalt therapist and educator, he is concerned to develop dialogue with and support for people that affirms them in their experience and fosters agency and change.

Bereavement – An Evolution

Barbara Suess

This article is adapted from a Literature Review submitted in 2018 as part of requirements for a Master of Gestalt Therapy degree at Gestalt Therapy Brisbane.

This literature review focuses on bereavement and how attitudes and therefore therapy for grief and bereavement have evolved and changed. My interest in the subject began when my daughter lost her 11-month-old baby to a rare genetic condition. I became acutely aware of my inadequacy to help her in her bereavement. I was familiar with assisting and supporting my children through a variety of life's trials and challenges, however, in this situation I felt uninformed and unqualified. I was experiencing my own grief and powerless to help my daughter. Eventually, my daughter and her husband focused their grief into creating a charity to support others. A year ago, my mother, the matriarch of a very large extended family, passed away. My extended family encompasses a variety of ethnic backgrounds. There were as many attitudes and coping mechanisms to loss within my family, as there are family members. These variations to loss, cultivated my interest in the subject of bereavement; how it is experienced across various cultures and religions, and what changes have taken place in therapeutic processes. The desire to know more and support the bereaved in a meaningful way, led me to the methodology that Gestalt Therapy offers.

This literature review is presented in three parts. The first section defines and describes grief and bereavement and explores the literature, presenting both classic and contemporary theories on how grief and bereavement are experienced in society. The second section reviews the literature that defines what culture is, the influence of culture on attitude to death, the impact of western culture, noting Australian views, and how they are changing. This will encompass common traits among all cultures, introduce the concept of acculturalism and explore the role of religion. The third section defines how Gestalt therapy supports the bereaved, noting recent developments in the neurosciences. An exploration of Gestalt literature demonstrates how the Gestalt methodology of phenomenology, dialogue, field theory, the paradoxical theory of change, and the cycle of experience are well suited to supporting the bereaved.

Grief and Bereavement – Definitions and Theories

Grief in response to the death of a loved one is a natural, expectable, and health-producing process that aids the individual in adjusting to the absence of a loved one (Pomeroy and Garcia, 2009). Grief is often described as an individual's unique response to loss; it is shaped and moulded by the social context in which an individual resides. These contextual factors influence; how loss and grief are viewed; expectations about how grief is expressed; the support systems available to the bereaved (Worden, 2015). Grief is a broad term used to describe the natural reaction to loss and encompasses the thoughts, feelings, behaviours, and physical symptoms, commonly experienced after a significant loss (Pomeroy & Garcia, 2009). Grief responses, include physical, emotional, cognitive, behavioural and spiritual manifestations (Harris & Winouker, 2016). Grief reaction refers to the grief experienced by loss other than death. Bereavement specifically refers to the loss of a loved one to death and the term mourning refers to the different cultural and religious practices through which bereavement is expressed (Pomeroy & Garcia, 2009). Disenfranchised grief is the term given to a significant loss that is not openly acknowledged or socially supported, such as death through suicide. Disenfranchised grief amplifies the fact that societies have norms, that dictate who, when, where, how, how long, and for whom people should grieve (Doka, 2002). Cumulative grief results when a person suffers several losses over a period of time. Cumulative losses can result in an accumulation of stress, which may lead to mental health issues such as anxiety and depression (Roos, 2002). The experience of trauma associated with a death is referred to as complicated bereavement. The trauma can occur due to the nature of the death or to the loss of security the relationship brought (Cohen & Mannarino, 2004). Often, those who experience high levels of distress after a death exhibited high levels of personal dependency prior to the death. A lack of expectation or psychological preparation for the loss, as occurs in unexpected death, also contributes to distress (Bonanno, 2009). Everyone experiences grief and a sense of loss following the death of a loved one and there is no one grief theory that applies to everyone (Benatar, 2016).

Theory provides a conceptual base for understanding grief and loss as a process involving common characteristics and phases (Leming & Dickinson, 2011). Many theorists outline a model to be followed, that tracks patterns of behaviour, to reach that place where the bereaved can live with the loss (Hedtke & Winslade, 2016). Classical grief theory suggests that recovery from grief involves letting go of the deceased, while recent practice focuses on maintaining a sense of continuity through memory or

a representation of the person (Machin, 2009). Freud, an early theorist, recommended that individuals detach themselves from the relationship they had with the deceased, and refocus their lives on other things and other people. Freud's view was that if the bereaved failed to engage with or complete their grief work, the grief process would become complicated, increase the risk of mental and physical illness, and compromise recovery (Freud, 1957). The grief process reflects the disruption of attachment bonds, resulting in behaviours, designed to regain the connection (Pomeroy & Garcia, 2009). Attachment theory explores the nature of the connection between humans, and the consequences of separation (Bowlby, 1980). Bowlby hypothesised that individuals do not progress through grief in a linear, structured, and universal way and it could take months, or years, with people tending to vacillate throughout the process (Machin, 2009). Kübler-Ross (1969) is well known for writing about five stages of grief associated with certain emotional or behavioural characteristics. This model, developed to enhance understanding of grief experiences of terminally ill patients, has been applied to the bereaved. The implication was that failure to complete any of these stages would result in a variety of complications (Pomeroy & Garcia, 2009). Rando's theoretical framework, built on Kübler-Ross' work, proposed three phases. These incorporate avoidance, where the reality of the loss must be acknowledged; confrontation, where the person responds to the loss by experiencing many grief reactions; and accommodation which involves readjusting to a world without the deceased (Rando, 1993). Set stages bring order to chaos and offer predictability to the uncertainty of grieving, however, the early stage theories of grief were considered to be too rigid (Anderson, 2009). Later grief models emphasize maintaining the memories and connection with the deceased and recognise the individuality of the grief experience (Strobe, 2011).

Contemporary approaches focus on adjustment and integrating a loss, rather than recovery or resolution. In place of fixed stages, the grieving process presents a person with a series of tasks, which may differ in importance from person to person and may present in any order (McLeod & McLeod, 2011). These models endeavour to understand the grieving process and suggest active ways to work through grief, offering frameworks that guide interventions and enhance the client's self-awareness (Harris & Winokuer, 2016). Worden's task model (2009) was based on Bowlby's attachment theory, with an emphasis is on the continuum of bereavement, as moving from the pain of separation to the adjustment of a new relationship (Pomeroy & Garcia, 2009). Four tasks are involved in the process. The first is acknowledging the reality of the loss. Next is processing the pain of grief, followed by learning to adjust to a world without the deceased. The

final task is to find a way of connecting with the deceased, whilst creating a new life, acknowledging that a full awareness of the loss may take some time to comprehend (Worden, 2009). The dual process model of grief, another contemporary model, describes the grief experience as a process of oscillation between two states of functioning; loss orientation and restoration orientation, whereby the grieving individual sometimes confronts, and at other times avoids, the different tasks of grieving (Stroebe, Schut, & Boerner, 2010). In loss-orientation, individuals are immersed in grief work, the pain of separation, and coming to terms with the loss. In restoration orientation, the bereaved engages with more problem-focused coping, attending to the many life demands following a loss and making appropriate adjustments (Hall, 2011). The emotions of the mourner oscillate with varying degrees of strength and force and this model uses the differences in coping, to account for the diversity in the grief experience evidenced across individuals (Stroebe & Schut, 2001). There are no fixed and predictable patterns of coping with loss, because there are major differences between people, how severely they are affected, how long they grieve and whether they go through set stages (Wilson, 2014). While stage theories bring a sense of order to a complex process and offer recovery and closure, they do not capture the complexity, diversity and personal quality of the grieving experience, nor do they address the physical, psychological, social and spiritual needs experienced by the bereaved (Downe-Wamboldt & Tamlyn, 1997). Feelings associated with bereavement may change normal behaviours, including a loss of interest in all relationships (Stroebe, Abakoumkin , Stroebe & Schut, 2012; Worden, 2015).

Relationships, their meaning, and consequences for one's perception of self are central to the nature of the grief response (Machin, 2009). Bereavement challenges a person's beliefs about their world and most bereaved engage in the process of meaning making (Winokuer & Harris, 2012; Neimeyer, 2002). The reconstruction of one's inner world, involves a relearning of both the self and the outer world (Attig, 2000). This is facilitated through transforming losses into continuing bonds in spiritual connections, memories, and stories (Neimeyer, 2002). Meaning-making is an interactive process and the significance of a loss can be affirmed or disconfirmed, and supported or contested within families and cultural groups (Kuehn, 2013). How the person was connected, the security of the attachment, ambivalence in the relationship or conflict with the deceased, may influence how a person grieves (Leming & Dickinson, 2011). Traumatic or untimely losses, such as the death of a child, involve making sense of the loss and entwining the loss into a new identity and future life (Konigsberg, 2011; Walsh, 2007). The expression of grief is typically congruent with an individual's existing personality and temperament. Individuals will most likely experience

bereavement in a way that is similar to dealing with other stresses, using strategies such as resilience, denial, or extreme emotion (Lawton & Lawton, 2012; Winokuer & Harris, 2012). A previous history of mental health issues such as depression or anxiety may also influence the process (Worden, 2009).

Models of bereavement therapy originating in the psychological literature view grief as an intrapsychic, individual experience, based on measuring levels of distress, problematic coping and screening for mental disorders (Lovibond & Lovibond, 1995). The works of Freud, Bowlby, and Kübler-Ross were significant in constructing the meaning of grief as an individual, symptomatized, private, inner experience (Hedtke & Winslade, 2016). These models encourage completion of unfinished business, letting go of the relationship, and moving forward without the deceased (Neimeyer, 2014). Any proposed treatment to support the bereaved was also directed at the individual level, emphasising detachment from the deceased as a way to promote recovery (Daniel, Roysircar, Abeles, & Boyd, 2004). Society had a similar attitude. Expectations such as; one should get over the loss and move on; a person should not talk about grief in social situations; something is wrong with a person who cannot mask emotional response to loss; there are stages of emotions that everyone should follow; and grief should be a time-limited experience with a definite endpoint, may play a role in the mourner's attempts to cope with loss (Pomeroy & Garcia, 2009). These expectations may cause difficulty for those who do not grieve in the socially expected way. Rather than risk isolation or rejection, a grieving individual may conform to expectations, which do not reflect their inner experience (Worden, 2009). The trend that saw successful grieving as letting go, has shifted. An alternate approach is offered, where bonds with the deceased do not have to be severed, and it is considered potentially healthy to maintain continuing bonds after death (Klass, Silverman & Nickman, 1996).

Influential Factors Affecting Bereavement

Concepts evolving over the last two decades, recognise that death ends a life, not necessarily a relationship. There exists the possibility of the deceased being both present and absent (Klass, Silverman & Nickman, 1996). Bereavement can mean post-traumatic growth as one integrates loss with the acknowledgement that grief may always be present (Winokuer & Harris, 2012). Attention has shifted from a focus on emotional consequences, to one that also considers cognitive, social, spiritual and cultural dimensions (Klass, 2003). Culture is the interplay of beliefs, values, behaviours, traditions, and rituals, shared by members of a particular group. Cultural identity is an interwoven and integral aspect of personality (Hardy-Bougere, 2008).

Response to death as seen through a cultural lens is influenced by beliefs, customs, and rituals (Hooyman & Kramer, 2006). The perception of death, subsequent response, and meaning made of that death, varies depending on one's culture (Anderson, 2010; Rosenblatt, 1997). Each culture has a unique approach to bereavement and the cultural beliefs, values, expressions, expectations, ceremonies, and rituals give meaning to the loss in different ways (Anderson, 2010; Hooyman & Kramer, 2006). Cultural perspective impacts what type of loss is perceived as traumatic, influences how a person and a community interprets the loss, and how grief is expressed. It creates a context through which people form their ideas of how to respond and defines pathways to life after a loss (Doka, 2002; Walsh, 2012). The concept of normal also varies across cultures. In some, it is expected that mourners will wail loudly or wear black for a year. In others, mourners are expected to remain stoic, internalise their emotions and move on (Despelder & Strickland, 2015). The social messages held by a person's cultural group, influence self-perception, how the experiences of that individual will be interpreted, and whether they are validated or invalidated (Harju, 2015). Experiences that cause one to feel isolated or disconnected from a social group, disrupt the sense of safety and security and increase anxiety, which is motivation to align with socially acceptable values. The values in most Western societies focus on productivity, efficiency, and the economy (Parlett, 2015). Western values shape grief with an emphasis on stoicism, with limited leave after a loss, and emotional expression kept private (Boss, 2006, Harris, 2010).

Death and bereavement are topics western societies struggle to make sense of. The scientific assumption of grief as an expression of human nature, rather than a culturally modulated experience, has led to the western model of grief being accepted as universally valid with little attention given to cultural variation (Bonnano, 2009; Mellor, 1993). The grief endured by one culture is thought to be the same as the grief in every other cultural context. This assumption infers that one person's experience is the same as the next and removes cultural responses to death and bereavement (Hedtke & Winslade, 2016). Australia glorifies youth, beauty, and health, thereby denying the reality of death and grief and providing little support for the bereaved. Direct expression of grief is discouraged and even the language used is designed to make the pain less intense (Babacan & Obst, 1998). Euphemisms such as one loses someone, they pass away or expire, reduce the sense of loss and emotional response of mourning (Taylor & Box, 1999). Experiencing grief beyond the first acute phase represents a failure to adjust. Independence and individualism are highly regarded, weakness is frowned upon, and emotional subjects are discouraged. Death directly conflicts with

the belief that people are in control of their lives. It is a reminder of the uncertainty of one's existence (Hooyman & Kramer, 2006). Bereavement is not just about death; it is also about missing a future with that person. Death interrupts the experience of time and leads a person into a different awareness, where time speeds up or slows down (Berger, 2009). During this process, where the experience of time is altered, the bereaved construct a narrative of the deceased's life, in the past, present and future. At this point, people defer to cultural patterns (Baumgartner & Williams, 2014). The narrative concept enables the bereaved to take comfort from the sense of continuity of life, within their familiar culture and /or religion and to have access to new relationship possibilities with the deceased (Baumgartner & Williams, 2014). When faced with death, religious practices, rituals, and beliefs may resume an important place (Babacan & Obst, 1998).

The role of religion is important because answers to religious questions form the view of life, death and meaning (Benatar, 2016). Australian residents represent many cultures and religions, with differences among groups across all aspects of life (Australian Bureau of Statistics, 2018). These differences are emphasised at vulnerable times like death (Cowles, 1996). The 2016 Census shows that 49% of Australians where either born overseas, or have one or both parents born overseas (ABS, 2018). The data also highlights Australia's religious diversity, with Christianity the most commonly reported religion, Islamic the second largest, closely followed by Buddhism (ABS, 2018). Cultures typically have a dominant religion used to give meaning and validity to their rites and rituals (Parkes & Prigerson, 2010). Religion gives death a special meaning and purpose. It provides a future and the possibility of immortality, which helps reduce the impact of a physical death (Babacan & Obst, 1998). The dying process can be a profound and life-altering experience. For some, their faith is a source of comfort, to find solace and to make sense of their loss. Their faith serves as an internal anchor, grounding their thoughts and emotions and providing some stability when they feel out of control. It is an affirmation that validates and strengthens their beliefs (Benatar, 2016). For others, their faith is inadequate in alleviating pain. This provokes a disruption in their entire faith system resulting in disillusionment, rejection of their existing beliefs, and a subsequent spiritual crisis. For another group, the experience stimulates a search for life's meaning and an exploration of spirituality (Benatar, 2016). Many people do not know their position on religion until they experience a loss, and then their religious faith and beliefs are formed or challenged (A memory tree.co.nz, 2017).

The infrastructure that supports a society must be responsive to all members of a culturally diverse population at all the stages of life, including

death and bereavement (Hardy-Bougere, 2008). Economic globalization and immigration has resulted in many societies experiencing the intermingling of cultures, their many different traditions, beliefs, and social norms, often resulting in acculturation: "Acculturation refers to the process that occurs when groups of individuals of different cultures come into continuous first-hand contact, which changes the original culture patterns of either or both groups" (Rothe, Tzuang, & Pumariega, 2010, p. 681).

Individuals are influenced not just by their larger societal culture, but by smaller subcultures as well. A person's family, friends, school, community and religion all contribute to creating a unique grief response. Acculturation can cause individuals, families, and communities to move away from their cultural heritage, become homogenized into the popular majority culture, and lose those clearly defined customs for responding to the bereaved (Rothe et al, 2010). There are many for whom religion in the context of their life in Australia does not have as significant a role as it may have in their country of origin (Babacan & Obst, 1998). Furthermore, it cannot be assumed that all people within a particular religion practice the same rituals or have the same beliefs (Konigsberg, 2011). In many cultures, spirituality or religiosity is so intertwined with the culture that it becomes difficult to separate the two, though spirituality can have different meanings. It may mean a personal expansion of meaning or self-boundaries, a feeling of being at one with nature, an experience of a radically different consciousness, or a connection with a higher presence (Joyce & Sills, 2014). Despite the significant differences in ways of thinking about religion, spirituality, and traditions between various cultures, there are some general features that all cultures tend to share (Parkes, 1997).

There are three overarching themes of how societies respond to death (Attig, 1996). The first is death-defying; the refusal to believe that death would take anything away and the belief that it could be overcome. An example is the early Egyptians who built pyramids for the Pharaoh which included money and possessions, ready for the world after death (Green, 2008). The second theme is death-accepting; viewing death as an inevitable and natural part of the life cycle. Behaviours and events associated with the dying process are integrated into everyday life, and rituals include relaxed discussions about death (Broome, 2004). The third commonality is death-denying; refusal to confront death, believing that death is antithetical to living and not a natural part of human existence. This characterizes the response of most western cultures, where there are few rituals associated with bereavement and people work individually on coping with grief (Rando, 1999). Suggested reasons for the western attitude begin with urbanization. Living in cities, people are removed from nature and the natural life and

death cycle (Lifton, 1968). Western society excludes the aged and those in palliative care. They are removed from general society, so their death is hidden (Taylor & Box, 1999). With the advent of the nuclear family there is less opportunity to see aged relatives die and to experience death as natural part of the life cycle (Balk & Corr, 2010). Advances in medical technology have given the illusion of control over life and death. Death has become less frequent and is perceived as a failure for healthcare providers or an inadequacy of patients unable to heal themselves (Dollinger, Rosenbaum & Cable, 1998). Mass deaths through war or terrorist attacks also have an impact. Sensitivities have become dulled to individual death and it takes larger numbers of deaths to gain attention (Rando, 1984). When therapists work with the bereaved, it is important to understand a person's cultural heritage and what they recognised to be religious or spiritual; as core beliefs about self are affected by the social norms that are an inherent part of an individual (Joyce & Sills, 2014).

Gestalt Therapy and Bereavement

Gestalt therapy has much to offer the bereaved, combining an eastern focus on awareness and being in the here and now, with the western attitude on action and doing (Toman & Woldt 2005). Distinctive in a Gestalt therapy approach to bereavement, are the ways in which the principles of phenomenology, dialogue and field theory are applied, with an emphasis on process and a clearly articulated relational focus (Hycner, 1995; Yontef, 2005). These methodologies, along with the paradoxical theory of change and the cycle of experience all play a role in support of the bereaved in areas such as facilitating "letting go of hoped for things and possibilities lost" (O'Shea, 2005, p.35). Such letting go can be initially inhibited by pragmatic concerns as Roos (1991) points out: "The immediacy of care, crucial decision-making, planning, and the stress of many competing needs usually do not allow time or space within which to openly grieve" (p. 298).

Gestalt methodology is evolving in the areas of neuroscience and interpersonal neurobiology, expanding the understanding of the healing effects of relational therapy and how to support and enhance those effects (Siegel, 2012). With the social media revolution, the distances between global issues, local events, and personal lives are shrinking, and relations between people are changing. A neighbour could live on the same street or on another continent, and friends on-line are dispersed globally (Parlett, 2015). People seeking meaning and connection, and to be part of a community, have found that the structures of society, which previously provided familiarity and basic support, have been eroded (Parlett, 2015). Gestalt theorists are

meeting the challenge of keeping with the core principle of here and now in a changing global, social environment (Spanuolo-Lobb, 2018). Psychotherapy leans toward pathologizing and labelling as mentally ill, a person whose grief response does not fit the set stages or tasks generally accepted (Reed, 2016). Mental Health is defined as a state of well-being in which people rely on their own potential to cope with the stresses of normal life (WHO, 2011). The increasing knowledge of nervous system activation, relational processes, effects at a nervous system level, and healing from trauma, inform the application of this information based on a relational field (Wheeler & Axelsson, 2015). Applying the methodology of Gestalt therapy, mental health can be understood as the unfolding process of fulfilment or suffering at the contact boundary (Francesetti & Gecele, 2009). Gestalt therapy, works at the contact boundary with the client, and experiments with ways of making contact in the here and now. This allows awareness; the ability to be fully present with the other at the contact boundary, to be the guiding principle (Parlett, 2015). Awareness, assists the bereaved to understand their particular grief symptoms, and allows them to adjust to their loss in their own time (Sabar, 2000). "Saying goodbye to the dreamed-for, expected, and now forever lost self or other does not happen all at once. "In a lifetime of chronic sorrow there are multitudes of closures, multitudes of disruptions, and multitudes of goodbyes" (Roos, 1991, p. 299).

Awareness includes knowing the environment, knowing oneself, accepting oneself, and being able to make contact (Brownell, 2010). Awareness is process in action. Process is the unfolding sequence of moments of contact between a person and the other, defined by the situation of the meeting, and the conditions which exist in that moment (Wheeler, 2009). A basic tenet of Gestalt therapy is that individuals have the capacity to self-regulate, when they are aware of what is happening in and around them, particularly the meaning of their physical symptoms and the way emotions affect their ways of relating (Sabar, 2000, p. 159).

Therapy provides the setting and opportunity for that awareness to be supported (Brownell, 2010). The therapist responds to changes in the phenomenological field, by being with a person, deepening their awareness, and the relational process (Spanuolo-Lobb, 2018). Phenomenology can be defined as the description of data available to the senses, evident in any immediate experience (Bloom, 2009). A phenomenological perspective requires that the therapist attends to what the client is actually experiencing, rather than assuming what a person is experiencing and suspending judgements about this experience. The therapist's attention is on *being with* the client, rather than interpreting or changing the client's experience (Hycner & Jacobs, 1995). Meeting the other authentically requires the therapist's

willingness to be uncertain, support ethical creativity, mutual respect and presence, through the recognition that meaning and understanding are in a state of constant change (Staemmler, 2012). The willingness to be uncertain supports the therapist in not making assumptions about a correct way, or the right order of stages to grieve, and supports the bereaved in maintaining a similar attitude (Hedtke, 2012b). Gestalt therapy does not treat a person's thinking as if it were diseased and needing to be changed, so allows the bereaved to honour their grief with the support they need (Brownell, 2010). Gestalt therapy's focus on process, acknowledges that the bereaved are in an ongoing process that requires adapting, reviewing and integration of the person they've become after the loss (Hedtke & Winslade, 2016). Phenomenology supports clients in the articulation of their experience, in the presence of a therapist who has developed a relationship with the client and values this expression (Fairfield, 2004). A defining principle of Gestalt Therapy is this dialogical and relational approach, which can be applied in conversations with the bereaved that includes the deceased rather than excluding them (Hedtke & Winslade, 2004; Wheeler & Axelson, 2015).

Grounded in the ideas of Buber (1970), the fundamental premise of relational practice is that the relationship between therapist and client is in and of itself transformative (Yontef, 2009). Grief is a relational experience, so how a person makes sense of a loss will be determined by what that particular loss means for them. This highlights the importance of exploring the experience from the perspective of the bereaved, and stresses a relational approach (Mackewn, 2011). A relational experience happens when two people meet and respond to each other in a real encounter and dialogue is key to this contact (Brownell, 2010; Hycner & Jacobs, 1995). Dialogue is not just about words but also what is happening between people in nonverbal ways (Yontef, 2005). Dialogue provides the framework for understanding how the therapist and client can meet one another with empathy and presence (Cole & Reese, 2018). Generating meaning about the deceased begins with awareness of the relationship between the deceased and bereaved before the death, noting little moments that can become part of the bereaved's present and future identity (Brownell, 2010). These moments grow into a collection of memories that give shape to a narrative, through which a posthumous relationship becomes feasible (Wollants, 2012). Gestalt therapy supports this approach, by the intentional remembering of the deceased, and the nurturing of relational connections, both in life and in death. The paradoxical challenge is to support clients in creating full and future oriented lives, while supporting their awareness of their present bereavement (Cole and Reese, 2018).

The Paradoxical Theory of Change (Beisser, 1970), recognising what is, through raising awareness of the here and now, is significant when

working with the bereaved (Yontef, 1993). An adjustment to a person's environment, according to their needs is referred to as creative adjustment or organismic self-regulation (Parlett, 2015). Adjustments made in childhood can become maladaptive in adulthood, as modes of perception and behaviour that function out of awareness, structure our experience. When people refuse to, or are unable to grieve, the loss becomes unfinished business, or a fixed Gestalt; an experience avoided, rather than being faced (Sabar, 2000). Unfinished business remains in the background, and may disturb a person's effective functioning, resulting in a range of psychopathology (Seligman, 2006). Gestalt therapy assists in identifying what may become unhelpful or unhealthy, thus preventing fixed Gestalts (Yontef, 2005). The Cycle of Experience, working with fixed Gestalts, can be usefully applied to grief work. It describes a range of processes a person might move through, in a few moments, or over the length of the therapeutic journey (Zinker, 1980). It provides a framework through which to track moment-to-moment processes, and gives an understanding of how thoughts can become stuck, and how the therapist can be supportive in their unfolding (Clarkson 1989). At the same time, an individual must be viewed in the context of their whole field as all human functioning is happening in an environmental field (Perls, Hefferline & Goodman, 1994).

Gestalt Therapy's holistic perspective focuses on the whole system, the dynamics of how the system functions and how the parts relate to each other to create an overall field (Yontef, 1993). The therapist stays in contact with and awareness of the whole field, recognising that the self is always a part of the situation, not an isolated entity, and person's behaviour is in response to the interpreted understanding of the situation at the time. The larger field is conditioning and constraining options in thinking and behaving (Wollants, 2012). The influence of field theory and the dialogic method have established a more connecting, communal and ecological emphasis on therapy (Finlay, 2011). Field theory offers a basis for working with broader social, economic and family issues as they arise in a bereaved person (Cole & Reese, 2018). People are not passive receptors of stimuli from the outside world; humans seek meaning and connection to others and connection to the greater whole (Fairfield, 2014). Through a relationship based on nonjudgmental, nonauthoritarian, non-corrective respect for the client's experience and meaning making, Gestalt therapy aims to connect. The bereaved finds potential through environmental responsiveness offered by the therapist, which leads to self-support (Lichtenberg, 2007; Wheeler & Axelsson, 2015). In an ever-changing society, the ritual of coming to a Gestalt therapist offers the bereaved an environment where vulnerabilities can be shared, meaning searched for and authentic connections made (Reed, 2016).

Conclusion

The field of grief and bereavement has undergone transformational change in terms of how the human experience of loss is understood and how the goals and outcomes of grief therapy are conceptualised (Machin, 2009). After decades of implied consensus about the nature of grief work and its therapeutic facilitation, a great deal of current research is challenging traditional conclusions and supporting a range of new models and methods (Neimeyer, 2014). There has been a shift away from the views that construe grief as the navigation of a predictable emotional trajectory, leading from distress to recovery (Strumpfel & Goldman, 2002). The literature, supported by contemporary research into neuroscience and neurobiology, fails to maintain the idea that bereavement, associated with a complex process of working through stages or tasks, is critical to recovery, or that recovery itself is a desired outcome (Reed, 2016). The idea that successful grieving requires letting go of the deceased, has moved towards a recognition of the potentially healthy role of maintaining continued bonds with the deceased (Klass, 2003). Current research has expanded understanding of the distinctive symptoms, risk factors, psychological processes and outcomes of bereavement, which has contributed to more appropriate interventions for the bereaved, where no one model or approach is justifiable (Beder,2004). Therapy, tailored to the uniqueness of the relationship and circumstances that characterise a client at a particular point in time has healthier outcomes. (Beder, 2004). The story is changing, resonating more with a sense of relational continuity (Valentine, 2006).

Gestalt therapy emphasizes the living process necessary to continue growth throughout life. The desired outcome of Gestalt therapy is the healthy functioning of the client, integrating the capacity for ongoing growth and the capacity to create new patterns of experience, action, and understanding (Wheeler & Axelsson, 2015). Society is changing rapidly and with it, human experience (Parlett, 2015). Gestalt therapy has much to offer the bereaved, as it accommodates the actual social conditions in which people live, engaging directly with people's fields of experience, and how they shape their reality. As demonstrated throughout the literature, Gestalt methodology and therapy emphasizes the living process needed and used to continue growth through both life and death (Cole & Reese, 2018). The Gestalt approach to grief and bereavement does not align with any particular culture, religion, or philosophy, nor adhere to the concept of bereavement stages or tasks. Gestalt therapy supports the needs of the individual offering the opportunity of being what and where they are (Sabar, 2000). Gestalt methodology is well suited to working through the mourning process, as each person is acknowledged

as reacting to loss in their own individual here and now, and given the space to tell their story, while receiving empathy and support from the relationship built with the Gestalt therapist (Cole & Reese, 2018). Gestalt is uniquely, theoretically and practically, capable of addressing the new shifts that are occurring (Parlett,2015).

This literature review has demonstrated that attitudes to grief and bereavement are changing and that Gestalt therapy is and will continue to be, a force in that change and in supporting the bereaved.

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Biography

Barbara Suess, M Gest Therapy, Bachelor of Business (Marketing/ Event Management), Certificate of General Nursing, Certificate of Midwifery, Diploma of Counselling. Barbara lives in Brisbane and completed her training in Gestalt Therapy in 2018. She has always been interested in the welfare of her fellow man.Her focus beyond her Gestalt training is in the support of others in the field of grief and bereavement. She is currently working towards further developing her skills in this area, though volunteer work.

Good Grief

Barbara Suess

This article is a report on a project as part of the requirements for gaining a Master's degree at Gestalt Therapy Brisbane, and which aims to extend the learnings of final year students through a form of proposed or actual engagement in the wider community. In this case, the project follows from a Literature Review (this edition) to test out the relationship between culture and bereavement processes that was explored through the literature.

Description of the Project

This project falls under the category of written work, potentially for a journal article. Face to face interviews were conducted with a variety of subjects, asking the participants to describe their experience of bereavement as it is now. Seven individuals (subjects) were asked questions that aimed to elicit their experience of bereavement. The subjects have all lost a close family member. Notes were made of the interviews and the results were collated. The intended audience was any person interested understanding how to respond to bereaved persons of varying cultures ages and social backgrounds. The subjects were interviewed over a period of 6 weeks, from mid-June to end July 2018. The written component was compiled in August 2018.

The Aims of the Project

These were to determine:

1. whether persons from different cultural backgrounds responded differently to grief and bereavement;

2. if and how the age and nature of the death had an impact on the bereavement process

3. if and how their culture had an impact on their attitude toward bereavement.

4. to raise awareness within the individual of how they mourn and what influences them in terms of cultural expectations.

5. to observe the impact of a Gestalt Therapy framework when interviewing the subjects.

The title of my literature review was "Bereavement – An Evolution". It describes what the Western attitude to death and bereavement is and then described differences in cultural attitudes. This included that people grieve differently, depending on the relationship between the persons involved and the deceased and expectations of themselves, based on cultural, spiritual, and religious beliefs. The literature review also traced the changes in attitude and therapy towards the bereaved. The literature review then established how Gestalt Therapy sees beyond these factors when working with the bereaved. The interviews are designed to demonstrate these factors in a practical medium.

Context, Procedure and Summary of Data

What is grief and what is good for the bereaved person? This project looks at the experiences of people with one thing in common – the loss of a loved one. Grief and bereavement differ somewhat. Grief is a broad term used to describe the natural reaction to loss and encompasses the thoughts, feelings, behaviours, and physical symptoms, commonly experienced after a significant loss (Pomeroy & Garcia, 2009). Grief responses include physical, emotional, cognitive, behavioural and spiritual manifestations (Harris & Winouker, 2016). Grief reaction refers to the grief experienced by loss other than death. Bereavement specifically refers to the loss of a loved one to death and the term mourning refers to the different cultural and religious practices through which bereavement is expressed (Pomeroy & Garcia, 2009).
Seven persons (subjects) were asked to share their story of bereavement with me. I wanted to know; beyond all the books, and the speculation, and the tasks, and the stages; what people really went through during bereavement and what they did to cope. Moreover, what is it that the bereaved need from others to support them.

The questions asked of the subjects were framed from a Gestalt perspective, with the intention of eliciting the true here and now feelings of the person.

The questions were designed to ensure the subjects felt safe and also to encourage the subject to become aware of their thoughts and feelings in the present and give responses that reflect this. The subjects varied in age, cultural background, the relationship with the loved one, and coping mechanisms. The one thing they had in common was the loss of a loved one. However, once we began talking, common threads began to emerge. Every one of them felt societal pressure to act, react and cope a certain way. While not all were influenced by the same rules, each commented on some form of expectation from outside themself.

Subject 1: 60 y.o. male, Japanese, lost his brother 5 years ago to bowel cancer. His cultural heritage is Japanese.

The Japanese are expected to adhere to an order of bereavement events that carry on for 12 months. This subject, having lived in Australia for 15 years, was lost and confused with what he felt was acceptable. He felt the rituals of his culture of origin was too much, while the lack of acknowledgement in his adopted culture left him bereft of any ongoing support. This is still how he views his bereavement today.

Subject 2: 21 y.o. female, lost her mother to breast cancer when aged 4. Her mother was American.

She found that many, many people expect that she doesn't remember her mother because she was so young when she died, and therefore doesn't feel it much. In reality she missed the future events a mother is generally part of, more than her presence at 4 years of age. Events such as her first bra, how to apply make-up and shopping for her formal dress. The truth of her experience is that she wanted a mother so badly, that she created a being in her mind, based on photographs, videos and stories she's seen and heard. This mother is as real for her as if she were physically present. Her friends and family are not aware of this as she fears their reaction – they might think she needs therapy or medication.

Subject3 : Father of subject 2, raised his children as a single parent after his wife died.

Has never re-partnered. He has devoted his life to the care of his 2 daughters. He states that he contained his grief for the sake of his children and would face it when the time was right. Now that they have both grown up, he is just beginning to acknowledge the fact that his wife is gone and he is alone.

Subjects 4 & 5: 31 y.o. female & 34 y.o. male lost their baby aged 11 months, to a rare genetic condition, 4 years ago.

This couple spent 4 months in hospital with their daughter, while friends and family looked after their other children, brought them meals and organised financial support. After their daughter died, their supports dwindled to a very small number. They found people stopped calling or visiting and generally avoided them. Eventually gave birth to another child and were appalled at the amount of people that viewed this child as a 'replacement', complete with the expectation that they would no longer grieve their lost child. They turned their grief into action and established a charity that supports parents of critically ill children with meals, mementos

and counselling. Both attend counselling themselves regularly four years on.

Subject 6: 20 y.o. female, lost her father to Parkinson's disease when aged 16.

Felt very isolated. Her father was diagnosed with Parkinson's Disease when she was 5 and she feels she grew up without a father, despite his physical presence for many years. She was still in high school when her father died. As none of her friends had lost anyone close to them, she felt there was no support for her at all. The general attitude of those around her was 'at least you still have your mother' and her grief was dismissed. This subject became depressed and eventually sought help in the form of Gestalt Therapy. She was able to acknowledge the anger she felt, guilt at feeling angry and states she ' is now in a much better frame of mind' and can now cope.

Subject 7: 70 y.o. female, lost her friend of 65 years to cancer. Her background is German.

This woman felt that, as it was a friend, not a family member, she missed a lot of support. She wanted to be with her friend's family, but didn't feel it was her right. They included her in their grieving initially, but she didn't want to force herself on them. She really felt there was a gulf between what was allowed as a family member and what was acceptable as a friend. She was relieved to have someone to talk to about her friend when she was interviewed.

Results

The results of this project were not what I expected.

What emerged from these interviews were more commonalities than differences. It seemed to matter little what the religious, cultural or social backgrounds were – they all responded in a similar fashion.

My intention was to draw conclusions based on the research of my literature review. I expected to find cultural differences. The differences I found were of the practical kind – how, where and when the individual cultures acknowledged a death. Once I started asking the question about how each of them experienced bereavement inside their own skins, these differences fell away. The core raw emotions were very similar across all the subjects.

I was also interested in the men, in terms of emotional experience.

While they were more reticent to display their emotion to the outside world, their partners saw the real grief reaction. It was the same response as the women displayed. All three men stated their social circle did not allow for an outward display of emotions beyond the first few months.

Another very strong common theme was that each of the subjects felt unsupported by those around them who said they know how the bereaved felt. In each case the subject made it clear – unless you've experienced the loss of your child, or your brother or your best friend, you have no clue how the bereaved person feels. That is not to say, no-one can support them. The support desired is not meaningless words, or a list of tasks to follow. The support required is of the kind that allows the bereaved the space to cry in public if they need to; to stand there and listen, if they need to talk- not be quieted because the listener doesn't know how to deal with it.

The religious aspect was also contrary to my expectations. Subjects 4 & 5 identified themselves as Christians, attend church weekly and are heavily involved in the activities of their church. Subjects 2 & 3 are Catholics, though not practicing. Subject 1 identifies as Buddhist and lives his life according to that philosophy and subject 6 defines herself as spiritual. I expected to find that the various religious or spiritual beliefs of these subjects would support them in their grief. This was not so for any of them, particularly in the early days. In fact, the reverse was true for the Catholics. Subject 3 stated, "What sort of God takes a mother from her children". He sent his children to Catholic schools, to appease his children's grandparents, who are staunch Catholics, rather than any personal beliefs of his own. The Christian couple found support from their church in matters such as the funeral, and some short-term counselling. Both felt they initially wanted and needed support from family and friends and turned to counselling and other forms of support from their church later. The Buddhist felt the large number of rituals attached to a death were overwhelming. He said that being in Australia, away from his birth family was a blessing, as he could grieve the way he wanted to. His biggest support was his Australian wife. The spiritual way of thinking supported subject 6 in that it led her to recognize she needed counselling and support from outside herself.

This project had several limitations:

1. There would need to be many more subjects interviewed to draw on a larger cross-section of the population.

2. The length of time since the death of the loved one (e.g. 1 year *vs* 4 years *vs* 16 years) was not considered. There is no comparison

made to cater for changes in grief over time.

3. There has been no reference made to whether the counselling some of the subjects have had, or if medication was required and if so, what the impact of that may be.

I asked each subject what message they would like to impart to those that have not experienced bereavement. I have collated these answers into a letter from the bereaved to the non-bereaved, based on the common traits found among all the subjects. I deliberately kept it somewhat light-hearted, so the content would be less threatening to the reader. The intention is that the non-bereaved take notice, not to shame them.

Letter to the Non- Bereaved

***Dear Non-Bereaved*,**
For all those that have not experienced the loss of a loved one to death, there are things we would like you, the non-bereaved to know, that will support us, the bereaved. So, we've written a list of 'Do's' and 'Don'ts' that will help you support us in a meaningful way.

The Don't List

- *Talking about the death without checking with us first*

  If *you* want to talk about our loved one's death and we don't accept that, don't push it. Ask us first if we're ok to talk in that minute, on that day – because in an hour, or tomorrow, we may react differently.
- *Change the subject – especially if we bring it up first.*

  This means we need and want to talk about it.
- *Avoid us*

  We get you're uncomfortable with death – but hey – we didn't ask for this either. We're in a lot of pain already. Having you avoid contact with us is just adding to our pain. We understand you may not want to upset us, but by avoiding us, you achieve exactly that. We just feel abandoned. We miss our loved one – do we have to miss you too?
- *Assume there is an end to the grief.*

It's with us for the rest of our lives. The dead don't come back!

- *Expect us to 'get over it'.*

If that's your belief, clearly, you've never experienced grief. We will, in our own individual time adjust our lives and learn to live without our loved one, but life will always be different.

- *Feed us cliché's like 'he's in a better place now', or 'she's with Jesus' or ' God has a plan for us'.*

Regardless of what our religious or spiritual beliefs may be; those lines come across as offensive; telling us our loved one would rather be anywhere but with us. Do you, or any of us, *really* know what happens to a person when they die?

- *Tell us another child is a replacement or balm for the pain of losing one*

No-one that has lost a child thinks like that. No one.

- *Belittle our experience or assume each loss is the same*

You have no idea what the relationship was between us and our loved one. Just because it was a great-grandmother, don't assume it matters less than if it were a daughter. We humans are complex beings and the reaction to the loss of a partner, friend, close relative, distant relative and so on, is therefore different each time. Our reaction is influenced by our relationship with the person, not your perception of it.

- *Ask us to follow tasks or expect us to go through stages, offer a cure, or a pill, or a solution.*

We are not broken. We don't need fixing. There is no rule book. We are all individual and deal with loss our own way and in our own time. We understand it's messy and uncomfortable for you to be around us, but without you we just feel lonely.

- *Pity us*

Looking at us as if we have an affliction that we could somehow have prevented is demoralising and isolating. It may affect how we view our relationship with you in the long term. Depending on the level of discomfort and lack of support this creates; you may find yourself removed from our Christmas list, because being around you has become painful.

If you really want to help, here's another list:

The Do List

- *Say nothing – just stand there.*

  Your physical presence is sometimes all we need.
- *Use the words – dead, death, dying*

  It's ok – we get it – they are gone. There is no need to sugar coat the reality with phrases such as 'passed away', 'we lost someone' or any other such euphemism.
- *Listen*

  Perhaps the overall most important 'do' of all. It's my bereavement – let me cry if I need to. If we're ready to talk – or cry - or scream – let us do just that.
- *Acknowledge you don't know how we feel.*

  Lucky you – you've not been there.
- *Remember our loved one*

  One of our biggest fears is that the person that meant so much to us will be forgotten.
  That really hurts.
  Our loved one was real and we want to feel their presence long after they have physically left us. So please, join with us when we celebrate their birthday, or light a candle for them at Christmas or just bring them up in everyday conversation. Even if it's 20 or more years later - to us it still matters.

Have you noticed how short the 'do' list is in comparison to the 'don't' list?
That's because it's really not that hard to support us in our bereavement. Really, anyone can do it.
If you've never lost a loved one – don't worry, your turn will come. Feel free to call on us when it does – we know what to do and we will certainly be there to support you.
Yours sincerely,
The Bereaved.

Self-evaluation Comments.

My skill as a Gestalt practitioner was put into practice while listening to the subject's stories. Achieving the right mix of questions that demonstrate Gestalt principles, bracketing my own feelings being present for the subject, and ensuring they feel safe throughout the process presented a considerable challenge to myself at this stage of my studies. My own reticence to upset my subjects came into play at times. I felt I could have been more in control of my own feelings – particularly when interviewing the couple that lost their child. Having children of my own, I found it difficult to find the balance between empathy and truly being with these subjects.

Conclusion

I would be interested in a full scale research project of this nature, addressing all the limitations of this small-scale endeavor, answering the questions that were raised as the project unfolded. I enjoyed the process this assignment offered me. Some of what I had learned while writing the literature review came to life and truly demonstrated the value of Gestalt methodology when dealing with the bereaved.

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Letter of gratitude.

Dear Hui Facilitators and Convener,

Michael Reed, Brenda Levien, Gabe Phillips, Alan Meara and Ashleigh Power

I want to express my personal gratitude and appreciation for what was a wonderful, heartfelt and inspiring gathering…. a real meeting across tribal lines to work and commit to what is most needed. I think in many ways it has the potential to mark a turning point for GANZ, laying a different path for a way forward, but that is something I will pick up and respond to in my President's role.

But for now I want to thank you for all the work (and it's not lost on me just how much work was required) and very great gift you have given the community. There are many moments that will stay with me, gifts of connection, moments of insight, shared experiences of frustration, playfulness, irreverence… but what abides is the power of community united by purpose.

There is more I could say, and more I will say in other forums, but for now I wanted to express my heartfelt gratitude to each of you and to you all together and for the gift that was the Hui.

Leanne O'Shea

President GANZ

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