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CONTEMPORARY GESTALT THERAPY

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Gordon Wheeler (Lobb & Wheeler, 2013) described the focus of Gestalt therapy as understanding the processes and structures by which human beings organize and interpret their perceived worlds, that is, a process of discovery. It is a hermeneutic and phenomenological perspective achieved in the course of Gestalt therapy through the relationship between therapist and client in the midst of a complex situation.

In this chapter, I provide a theoretical overview of the core theory of contemporary Gestalt therapy. It has come a long way since the days of Frederick and Laura Perls, who focused on the revision of psychoanalysis (Perls, 1947/1969) in an early theoretical integration of existential, phenomenological, and organismic theories (Brownell, 2010; Perls, Hefferline, & Goodman, 1951/1972). Since then, classical Gestalt therapy's pragmatic roots have developed into a grounded faith in process. Its phenomenological roots evolved from awareness of current experience to appreciation for embodied cognition (Frank &

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La Barre, 2011; M. Johnson, 2007) and the interpretation of experience (Gallagher & Zahavi, 2008). Its emphasis on contacting, the meeting of the organism at the boundary with others in the environmental field, became both an enriched understanding of relationship and a more complex understanding of causation in the organism–environment field itself. The field theory of Kurt Lewin and others became refined in the understanding of intersubjective processes occurring in groups, societies, and cultures. The experiential aspects of Gestalt therapy matured into an understanding of kinesthetic processes at the base of primordial experience (Frank, 2001).

GESTALT THERAPY AS AN INTEGRATIVE APPROACH

As Gestalt therapy emerged in the middle of the last century, it became identified with humanistic psychology; however, it is apparent that Gestalt therapy actually formed as an early case of theoretical integration, which is more than a technical blend of methods—it is a conceptual framework and a synthesis of theories or approaches that is more than the sum of its parts (Norcross, 2005). The question in such an integration concerns how far it goes. Does it, for instance, extend to a common anthropology, theories of personality and psychopathology, worldviews, or epistemological commitments (Lampropoulos, 2001)? Theoretical integration of otherwise disparate approaches requires some kind of organizing center—an attractor that draws the parts together, holding them in place and guiding the extent to which the integration reaches. The organizing center for the integration that became Gestalt therapy is its anthropology—the concept of the person as emerging from the organism–environment field through contacting. That is, the human being in early Gestalt therapy was conceived of as an organism–environment entity, not just an organism in an environment.

THEORETICAL OVERVIEW

The options available to a Gestalt therapist are derived from the four main tenets of its theory, unified in a process of contacting in the therapist–client field. That process illuminates the patterns and sequences people use to make meaning. The therapist can (a) follow the emerging experience of the client through a modified phenomenological method, (b) engage the client through dialogue, (c) strategically address aspects of the field, and (d) negotiate an experiment—a move to enactment in the service of awareness and learning (Brownell, 2008; Mackewn, 1997).

Modified Phenomenological Method

The modified phenomenological method used in Gestalt therapy is an adaptation of Edmund Husserl's philosophical method. It has the rule of epoché, the rule of description, and the rule of *horizontalization* (Spinelli, 2005), a philosophical method that is adapted for a psychological purpose (Giorgi & Giorgi, 2003). In the rule of epoché, therapists set aside initial biases and suspend assumptions and expectations to pay attention to what is unfolding in their presence. In the rule of description, the therapist describes what is observed rather than explaining it. The rule of description avoids premature modeling to gather as much as possible of the available information. In the rule of horizontalization (also referred to as the *rule of equalization*), the therapist treats all observed data with equal importance and without assigning value or structuring a hierarchy. For the therapist, these rules can be synthesized in the procedural dictum: "Observe, bracket, describe."

Phenomenology is the *logos* of *phenomena*, the study of how things appear to a conscious subject (Spinelli, 2005). Because a phenomenon is an appearing (arising from the Greek *phainō*, a verb form meaning "to appear"), then the method used in studying that phenomenon is a showing. One can explain the theory of chess or one can simply show someone how one plays the game (Hass, 2008). In Gestalt therapy, the therapist is in the process of showing the client to the client (i.e., showing the client how the client plays the game of life), bringing to the client's awareness, in various ways, the what and the how of the client's appearing.¹ This phenomenological work is the focus of concern for the Gestalt therapist. It is the therapist's tracking of the "aboutness" of experience, the unfolding subjective awareness of events and the meanings given to any particular aspect of that experience by the client.

Dialogical Relationship

The relationship between therapist and client in Gestalt therapy is often referred to as a *dialogical* relationship. This is because Gestalt therapy borrowed significantly from the relational philosophy of Martin Buber (Buber, 1923/1958; Mann, 2010). Buber proposed two modalities of relating: *I-It* and *I-Thou*. The *I-Thou* modality is the primary construct for personal relationships, for knowing and being known by another, and it points like an icon² to the meeting between one subject and another. It is characterized by mutuality,

¹This same focus has often been attributed to the influence of Taoism and Buddhism in the formation of Gestalt therapy, with their respective interests in awareness in the current moment and the way in which any given thing is taking place.

²An icon points to something more significant beyond itself and is in contrast to an idol, which points to itself as that which is of most importance.

directness, and presence. This personal connecting can exist between persons, between humans and animals, and between humans and God (Brownell, 2012; Friedman, 2002). The *I-It* modality is the primary construct for experiencing and using, for getting business done; it is goal directed, pointing to a meeting between a subject and an object of utility.

Both *I-It* and *I-Thou* can be seen in relationships, and it is helpful to realize that there are different kinds of relationships. When I am in contact with the world, a meeting takes place, and if I am routinely in such contact with the same things, places, or persons, then I will establish some kind of relationship with those things, places, and persons, because relationship can be understood as contact over time (Yontef & Bar-Joseph Levine, 2008). Consequently, there are different kinds of relationships and various degrees of depth and complexity that describe them, with the nature of those various relationships linked to the field conditions, the contexts, in which such meetings take place.

The therapeutic relationship in Gestalt therapy contains elements of *I-It* as well as *I-Thou*. Therapists conduct mental status evaluations (in one way or another) because they must understand what they are dealing with and what kind of professional response is called for. They create treatment plans. They must attend to issues related to informed consent and payment for services. “In *I-It* relating we are objectifying, goal oriented, concerned with doing rather than being. The task becomes figural whilst the other recedes into the ground” (Mann, 2010, p. 175).

The relationship between therapist and client in Gestalt therapy is non-independent in nature (Kenny, Kashy, & Cook, 2006); the therapeutic actions of the therapist arise from the meeting of the two subjects—therapist and client—and the embodied postures and enactments emerging between them provide a primordial discourse that is read neurologically and consciously understood hermeneutically (Ginot, 2009; Ziv-Beiman, 2013). It is primordial because it is preverbal. It is read neurologically as embodied cognition, as in the action of mirror neurons. It is understood hermeneutically through the interpretation of experience.

In terms of this relationship with an emphasis on therapist presence, Geller and Greenberg (2012) wrote,

Therapeutic presence is the state of having one’s whole self in the encounter with a client by being completely in the moment on a multiplicity of levels—physically, emotionally, cognitively, and spiritually. Therapeutic presence involves being in contact with one’s integrated and healthy self, while being open and receptive to what is poignant in the moment and immersed in it, with a larger sense of spaciousness and expansion of awareness and perception. This grounded, immersed, and expanded awareness occurs with the intention of being with and for the client, in service of his

or her healing process. . . . Being fully present then allows for an attuned responsiveness that is based on a kinesthetic and emotional sensing of the other's affect and experience as well as one's own intuition and skill and the relationship between them. (p. 7)

Gestalt therapists attempt to support the development of a dialogical relationship by practicing presence and inclusion. Inclusion encompasses empathy in that it is a throwing of the self on the part of the therapist as much as possible into the experience of the client (Yontef & Fuhr, 2005). It is the attempt to open up the mystery of the client's subjective experience (Staemmler, 2012).

Field Theoretical Strategies

Gestalt therapy is a field theoretical perspective. It is a system of dynamics in which the experience of the person is a result of awareness of the organism–environment boundary (me–not me; self–other). This boundary develops from the thinking of two German scientists—Kurt Goldstein and Kurt Lewin. Goldstein (1995) indicated that one could not understand the neurological reflex arc³ outside the brain in which it occurred, nor could one understand the functioning of the whole brain outside the person in whom it was located or the person outside the context in which that person lived. Lewin (1943, 1951, 1999) investigated the causative relationships between factors in the field, pointing to the scientific method in the work of Galileo, who examined the way things worked together, as opposed to the philosophical approach of Aristotle, which was focused on the nature of things themselves. Because of Goldstein and Lewin, it is not a stretch to view Gestalt therapy as an application of clinical neuropsychology (Philippon, 2012) on the one hand and of social psychology on the other—the brain science behind individual experience and the study of people in groups (Archer, 1982; Elder-Vass, 2007).

Understanding the field in Gestalt therapy is a mix of two ways of contemplating this construct (O'Neill & Gaffney, 2008). The field is at once the subjective experience of a system and the action of the system itself.⁴ This implies the ontic primacy of phenomena—that is, we are in touch with things and people that actually exist in a world and that are not simply our representations, our subjective constructions concerning them (Carman, 2006/2007). The phenomenologist Maurice Merleau-Ponty, for instance, conceived of the lived body as a phenomenon to include both the immanent agency of conscious life and the transcendent world of objects (Dillon, 1988/1997)—that

³A reflex arc is a neural pathway that controls an action reflex.

⁴System is too limiting a construct, but it is similar enough at this point for the sake of illustration.

is, the ability of persons to create their own experiences and the pushback from a world that exists outside of any given person's thoughts about it. The field consists of both subjective needs and objective press.

The field is all things having effect; thus, it concerns questions of causation. Fields are overlapping spheres of influence (Crocker, 1999). They are also complex, adapting systems—dynamic systems and environmental structures such as cultures and societies, weather fronts, ecologies, or interconnected economies. Thus, the field can be conceived of as a phenomenal field (pointing to the subjective organization of the processes of contacting) and an ontic field (pointing to the impact of a sphere of influence that exists outside anyone's subjective organization of it).

Robert Stolorow (2011) pointed to the connection among the phenomenal field, the ontic field, and the emergent sense of self, describing Heidegger's conception of the structure of affectivity as consisting of "both how one feels and the situation within which one is feeling, a felt sense of oneself in a situation" (p. 25).

Existential Experimentalism

Theoretical knowledge is made tangible through experience; imaginations are rejected or confirmed experientially. Dramatic and emotionally illuminating results often erupt as a result of moving from talking about something that happened outside the therapeutic session to exploring the experience of the client in the current moment. This can be accomplished through phenomenological inquiry and dialogue, but it can also be done using experiment, which is often much more vivid.

Enactment in this context is a move to action. A supervisor might say, "Be your client." A therapist might say, "Be your husband." Enactment is a "be-ing," an embodied expression of what one senses in another, what one feels in oneself, what one fears in the future, and so forth. Such enactment allows implicit life patterns to be experienced within the therapeutic process. It enables both therapist and client to attain an unmediated connection with what cannot yet be verbalized. This is significant because a "growing body of clinical work and neuroscientific research has demonstrated that what enactments communicate in such gripping and indirect ways are implicit, neurally encoded affective and relational patterns. Patterns formed before verbal memory was fully developed" (Ginot, 2009, p. 294).

The enactment of experiment is not a technique. A *technique* is a rigid procedure that is fixed in form and used over and over. It is a prefabricated exercise, bottled like medication and waiting in the therapist's cabinet, to be taken out and given to the client in a certain dosing regimen to bring about a state or lead the client to a preconceived result (Roubal, 2009). In contrast,

an *experiment* is an embodied move to enactment in the service of increased awareness and learning.

Experiments are also existential leaps of faith, because one does not know how things will turn out. Indeed, the purpose of an experiment is to find out what might happen and to notice just how things do turn out. This relies on faith, which is critical to the experimental process. In the worldview of the founders of Gestalt therapy, faith was conceived as “knowing, beyond awareness, that if one takes a step there will be ground underfoot; one gives oneself unhesitatingly to the act, one has faith that the background will produce the means” (Perls et al., 1951/1972, p. 343). Thus, in Gestalt therapy faith becomes an instrument of knowing and an essential, supporting principle of contact.

For example, in working with couples I often ask the couple to interact, to look at one another, to engage one another in some way. While working in a community resource center for children and families, I began working with a man and his wife. She was frustrated with his emotionless way of attending to facts and trying to “fix” her concerns. While we were talking about these things, I noticed the muscles contracting at the corners of his jaw.

I said, “Touch the side of your face right here” (indicating where I saw his muscles contracting). He touched that place, and I said, “Now talk from that place.”

“I don’t see what the big deal is,” he started to say, talking from that place (but, as he continued talking, his throat became constricted and his voice took on a whisper, heavy with emotion. It became difficult for him to speak).

I turned to the wife and said, “What do you hear?”

She replied, “He’s feeling something,” and started laughing.

Beyond the scope of specific experiments, the entire Gestalt therapeutic process can be considered experimental. Perls et al. (1951/1972) claimed that psychotherapy “is a process of experimental life-situations that are venture-some as explorations of the dark and disconnected, yet are at the same time safe, so that the deliberate attitude may be relaxed” (p. 266).

Intrinsic to the existential experimentalism of Gestalt therapy is Gestalt’s paradoxical theory of change. Beisser (1970) asserted that change occurs when one becomes what one is, but not when one tries to become what one is not. Change cannot be coerced through attempts by the client or efforts by therapist to cause it; rather, change takes place when a person is invested in actualizing an authentic self in the current, situated moment. Thus, change will take care of itself if one trusts in the process.

Experiments in Gestalt therapy are multitudinous in that they are novel creations arising from the flow between therapist and client. However, they do fall into some familiar categories. Experiments include augmentation, imagination, and diminishment (Brownell, 2010; Kim & Daniels, 2008).

These kinds of experiments are also examples of high-process guiding (as compared with relatively low-process guiding as in person-centered therapy); Lambert (2013) and his colleagues have established that high-process guiding approaches such as emotion-focused and Gestalt therapies show larger effect sizes in various meta-studies. *Process guiding* refers to the activities of the therapist in directing therapeutic sequence, pointing out qualities and aspects of that process to the client, calling the client to focused attention, inviting the client to action, and so forth.

A Cohesive Unity in Practice

The meeting between therapist and client takes place in a context that is at once physical, material, phenomenal, and relational. Both client and therapist bring something to their meeting from outside the context of therapy. Both of them assimilate from this meeting what they can and reject what they cannot; it is the creative adjustment they make in the process of their meeting (Bandín, 2012).

Contacting is the best term for this meeting, because it is a process and not a static event. Contacting takes place between persons, but it also takes place between any given person and the environment. This contacting, including the sensory quality or nature of it—what some in Gestalt therapy call an *aesthetic criteria*⁵ (Bloom, 2003, 2011)—is a center of gravity that pulls together the core of Gestalt therapeutic practice into one, unified, approach.

In Gestalt therapy, all the various core tenets are active simultaneously. It is not simply multimodal. The phenomenological method of tracking the emerging experience of the client, the dialogical relationship in which each grows in experiential knowledge of one another, the field-theoretic strategies in which causative influences are both understood and initiated, and the experimentalism in which both client and therapist move to enactment are all in play at the same time, during the very first meeting between therapist and client.

SUMMARY OF RESEARCH, 1940–2000

When Gestalt therapy formed in the middle of the last century, its founders were not interested in research. In spite of this, over time scattered research was conducted in a few places, and studies of one kind or another were reported in the first edition of this book. Strümpfel and Goldman (2002)

⁵The word *aesthetic* refers to the senses, so in this context it is about what can be known through the senses, through meeting others and the environment.

referred to numerous examples of using chair work, because the use of the term *Gestalt* was evident as a technique in the studies they chose. For instance, W. R. Johnson and Smith (1997), who studied the use of Gestalt therapy in the treatment of phobias, divided their subjects into three groups (Gestalt empty-chair dialogues, systematic desensitization, and no treatment). They found that empty chair and desensitization worked equally as well as no treatment (Melnick, 2013). Aspects of Gestalt therapy such as chair work have been woven together to form other approaches, and such hybrids using Gestalt techniques are ubiquitous. Chair work, whether that be empty chair or two chair, has at this point been widely supported by research and scholarship connected with Gestalt therapy, emotion-focused therapy and process-experiential therapy, rededication therapy, cognitive-behavioral therapy (CBT), and schema therapy (Kellogg, 2004; Kramer & Pascual-Leone, 2013).

Gestalt therapy has also been supported through investigations of humanistic psychotherapy. For example, Elliott and Hendricks (2013) offered an online list of 19 abstracts briefly depicting research that described Gestalt-oriented growth groups, phenomenological explorations of experience, and use of Gestalt techniques in various quasi-research designs. The studies established a general impression of the value of Gestalt therapy in dealing with various subjects. For instance, Beutler et al. (1991) found that Gestalt-influenced experiential therapy was especially consistent in treating externalizing and internalizing depressed patients, with moderately positive results for both. Of importance in Beutler's studies using a manualized version of Gestalt therapy was the observation that effect sizes increase over time after the end of therapy, which is an advantage over CBT (by comparison; Melnick, 2013).

Ryan and O'Leary (2000) conducted an outcome study of Roman Catholic seminarians based on randomized groups (treatment and control) using 20 hours of Gestalt group work to investigate acceptance of self and of others. The study was an exploratory project of the effectiveness of "I" statements in Gestalt therapy, which verbally express observed bodily phenomena. It used a 7-month follow-up, quantitative assessment (analyses of covariance, *t* tests) and qualitative assessment (content analysis). Gestalt therapy was shown to be effective for older seminarians. In another example, follow-up research using the model of Seligman's Consumer Reports study was conducted (Strümpfel & Goldman, 2002) to show that 73% of the clients had strong to mid-level improvement in a diversity of symptoms and problems and were pleased with the results. As a general observation, extensive research for several decades now has substantiated an equivalence between the outcomes of humanistic-experiential psychotherapy and other approaches, including CBT.

REVIEW OF RESEARCH 2000–PRESENT

In this section, I examine more current research, including research trends, and I do so in four parts, using the categories of Gestalt-specific research, Gestalt hybrid research, Gestalt consilient research, and trends in the developing Gestalt therapy research tradition. Gestalt-specific research includes research that is focused on the practice of Gestalt therapy as described above, not simply research on approaches that use Gestalt techniques but actually remain something other than Gestalt therapy; that is covered under Gestalt hybrid research. In the Gestalt-Consilient Research section, I examine research relevant to the Gestalt approach because major features of some other clinical theory and practice so closely resemble Gestalt therapy in some way as to make that research applicable to the Gestalt approach as well. The last section concerns the increasing development of a Gestalt therapy research tradition.

Gestalt-Specific Research

Stevens, Stringfellow, Wakelin, and Waring (2011) reported on a 3-year quantitative outcomes study conducted in the United Kingdom that showed Gestalt therapists were as effective nationally as clinicians using other therapeutic approaches. They used the Clinical Outcomes in Routine Evaluation (CORE) instrument. The CORE database, widely used in the National Health Service in England by therapists from a wide variety of clinical perspectives, contained data for 50,000 clients at the time of the study's publication. CORE involves a self-report questionnaire filled in by the client at the beginning and end of therapy. It also includes assessment and end-of-therapy forms completed by the therapist. The 34 items cover four dimensions: subjective well-being, problems or symptoms, life functioning, and risk or harm. The scores from the questionnaire are averaged to give a mean score to indicate current level of psychological distress, ranging from *healthy* to *severe*. The comparison of pretest and posttest scores offers a measure of outcome—whether the level of distress has changed and by how much. The system is designed to be completed for each client by each practitioner in a service, thus providing comprehensive profiling rather than focusing only on the clients likely to do well.

Gestalt therapists in both the public and private sector participated in the Stevens et al. (2011) study, and data for 180 Gestalt clients, largely in their 30s and 40s, were included. About 22% had anxiety, 18% had depression or interpersonal relationship difficulties, 11% had self-esteem difficulties, and the rest presented with bereavement, work or academic issues, physical problems, trauma or abuse, personality issues, primary support, addictions, eating disorders, or psychosis. Most (81%) were seen weekly, with 91% attendance.

The overall results for cognitive-behavioral, person-centered, and psychodynamic approaches were equivalent in this large study, and the results for Gestalt therapy were comparable (Stevens et al., 2011). The study indicated that clients in the Gestalt cohort started off slightly more distressed than those in the benchmark and comparison cohorts (CBT, person centered, and psychodynamic). The pre-post mean difference for the benchmark group was 9.0; pre-post mean differences were 8.8 and 8.9 for the comparison cohorts and 8.4 for the Gestalt group. The effect size for the benchmark cohort was 1.42, with the effect sizes of 1.36 and 1.39 for the comparison cohorts and 1.12 for the Gestalt group. Using a separate metric, the study examined for reliable, clinically significant improvement; in that regard, 53.8% of the benchmark group showed improvement; the comparison cohorts had 58.3% and 61%, respectively; and the Gestalt cohort had 56.3%. Thus, Gestalt therapy was seen to be roughly equivalent in effectiveness to the therapeutic approaches widely used in the National Health Service in England, which consisted of cognitive-behavioral, person-centered, and psychodynamic therapies.

Yousefi et al. (2009) compared the effectiveness of logotherapy with Gestalt therapy for the treatment of anxiety, depression, and aggression. Ninety students referred to the student counseling center at Islamic Azad University of Mahabad in Iran were randomly assigned to an experimental group for logotherapy, a group for Gestalt therapy, or a control group, with 30 in each group. The experimental groups received Gestalt and logotherapy for 12 one-hour sessions. Students were evaluated before any treatment using a symptom checklist and a diagnostic interview based on the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; American Psychiatric Association, 2000). They were also evaluated at the end of therapy and then 6 months after treatment concluded. No significant difference was found among the pretest means for the three different groups; however, the treatment groups using Gestalt and logotherapy were both found to have reduced symptoms for aggression and anxiety, a reduction that was still observable at the 6-month follow-up. Logotherapy showed an advantage over Gestalt therapy in the treatment of depression.

Saadati and Lashani (2013) conducted a study randomly assigning 34 divorced women to a treatment group and a control group. The treatment consisted of Gestalt therapy using traditional Gestalt techniques such as the empty seat, assuming responsibility, and attending to unfinished business. They used Sherer et al.'s (1982) General Self-Efficacy Scale in pre- and posttesting to assess the effectiveness of the Gestalt intervention for increasing general and social self-efficacy in women who usually suffer losses in self-esteem and confident self-regulation after divorce. The pretest means were 46.17 ($SD = 4.9$) for the experimental group and 46.18 ($SD = 3.94$) for the control group. The posttest mean for the experimental group was 5.82 ($SD = 4.21$), whereas that

for the control group was 45.64 ($SD = 3.95$). The researchers concluded that the use of Gestalt therapy significantly ($p < .001$) raised the divorced women's self-efficacy.

In an uncontrolled effectiveness study conducted among mental health professionals in Hong Kong to evaluate the effect of Gestalt therapy with regard to emotional well-being and hope, Man Leung, Ki Leung, and Tuen Ng (2013) found that subjects had a significant decrease in anxiety and depression and a significant increase in agency and hope pathways. This study was also related to the issue of self-efficacy through the construct of hope. Researchers used the State Hope Scale (Feldman & Snyder, 2000), which has two dimensions: sense of agency and hope pathways to meet one's goals. *Sense of agency* involves a belief in one's capacity to initiate and maintain action with reference to a goal, and *hope pathways* relate to the ability to generate alternative ways to achieve a goal. Both of these would be related to one's sense of self-efficacy and self-regulation, an important construct in Gestalt therapy.

In this study, Man Leung et al. (2013) also used the Hospital Anxiety and Depression Scale (Bjelland, Dahl, Haug, & Neckelmann, 2002) to assess the presence and levels of apprehension and gloominess. Fifty-five participants were asked to fill out these instruments before participating in the Gestalt intervention and then again after it. The Gestalt intervention was aimed at developing participants' awareness of the current moment (the "here and now" of subjective experience), and all sensory modes were addressed through an interactional and experiential group process that also fostered dialogue among group members. Paired t tests were conducted to compare subjects' scores for anxiety, depression, hope agency, and hope pathways. Man Leung et al. found a statistically significant decrease in anxiety, $t(54) = 5.41$, $p < .001$, $d = 0.73$, and depression, $t(54) = 2.88$, $p < .01$, $d = 0.39$, from pre- to posttest. They also found a statistically significant increase in both agency, $t(54) = -6.71$, $p < .001$, $d = 0.90$, and hope pathways, $t(54) = -5.93$, $p < .001$, $d = 0.79$. In addition, qualitatively the researchers observed a high level of participation among participants, which they attributed to the care given to before contact (the developing of contacting) that was built into the awareness, experiential, and dialogical elements of the Gestalt intervention. This was culturally relevant, because the researchers noted that Chinese people are "face sensitive" and reluctant to disclose vulnerabilities and past hurts in front of strangers.

Kelly and Howie (2011) used narrative inquiry and analysis to explore the influence of Gestalt therapy training on the practice of psychiatric nurses. Four registered psychiatric nurses in Victoria, Australia, were chosen for this qualitative approach; they came from adolescent mental health services, specialty mental health services, education and professional development, and private practice. Data were collected through semistructured, individual

narrative interviews involving reduction, synthesis, and reconfiguration to produce stories for the research outcome. A thematic analysis across the storied database was conducted, involving the systematic, rigorous, and careful examination of the plots and subplots featured in all stories to identify common elements and experiences across the stories.

Kelly and Howie (2011) developed a synthesis of these plots and subplots to inform eight emerging themes: growing professionally in fertile ground, resonating with the Gestalt potential, emerging Gestalt potential in psychiatric nursing settings, Gestalt learning: the self in process, bringing Gestalt into psychiatric nursing practice, expressing the multidimensional influence of Gestalt therapy on advanced psychiatric nursing practice, integrating and assimilating Gestalt, and making sense. The study supported a congruence between the philosophical values of Gestalt therapy and core psychiatric nursing—the value of Gestalt therapy training to holistic person-centered, psychiatric nursing practice—as mapped on the Gestalt cycle of experience. It showed a progression in the development of nurses' philosophies, influenced by the Gestalt continuum of experiencing.

Mackay (2002) conducted a study of Gestalt two-chair work to resolve interpersonal conflict. A structured Q-sort was constructed using the factors of conflict resolution and the Gestalt concept of contact in a 2×2 factorial design. Each factor was divided into two levels: conflict resolution resolved versus unresolved and contact versus interruption of contact. The factors of conflict resolution and contact were expected to interact before and after successful and unsuccessful therapy for decision making. Eight participants who were ambivalent about staying married performed the Q-sort before and after six sessions of Gestalt therapy in which the two-chair technique was used as the primary intervention to facilitate their pre-decision making regarding their marriages. Moderate support was found for the three stages of the model: opposition, merging, and integration. When therapy was successful, the factors of conflict resolution and contact interacted as predicted. When therapy was unsuccessful, the factors did not interact as predicted. They did not interact for individuals who were experiencing a great deal of interruption of contact, indicating that the model has a possible prestage.

Knez, Gudelj, and Sveško-Visentin (2013) discussed the use of Gestalt psychotherapy with a 30-year-old woman with borderline personality disorder. This is relevant because Gestalt writers have provided a theoretical foundation for working with narcissistic and borderline clients (E. Greenberg, 2005; Salonia & Müller, 2013; Spagnuolo Lobb & Stevens, 2013). Although case reports are considered low-level evidence, they are acceptable as contributing to a form of evidence-based practice. The client had been experiencing sensations of walking between life and death, feeling empty, and being

unwell. She could not make sense of her life, and she was sad and dissatisfied with it. Unable to establish an intimate relationship for a period of 7 years, she reported a history of dysfunctional family life characterized by consistent physical and psychological abuse. Gestalt therapy was conducted in the course of 75 sessions, carried out over 3.5 years (because at first compliance was an issue). Emphasis was on building the client–therapist relationship, developing the client’s groundedness in her own values, instituting personal boundaries, developing adequate verbal expression, and ensuring compliance with therapy.

Initially, she attempted to control therapy, to make it conform to her sense of how it “should” be, either retreating or attacking in the process (Knez et al., 2013). Attention was given to the awareness of her feelings, leading to choices in appropriate behaviors toward others and retroreflecting, or pulling back, in her impulsive tendencies to evaluate the potential consequences of her actions. She routinely externalized blame for failures in her life; however, as therapy progressed, she was able to tolerate personal responsibility. During the last year, she maintained continuity of therapy, mostly on a weekly basis, graduated from the university, entered a graduate program, moved out of her parents’ home, bought her own apartment, established an intimate relationship that resulted in marriage, kept her permanent job, and started her own business. Change achieved in the process revealed both a reduction in symptoms and a fundamental impact on aspects of personality functioning, as evidenced by success in developing and maintaining an intimate relationship and friendships and having greater capacity to function in educational settings, occupationally, and in general social contexts.

In a dissertation conducted through the University of South Africa, Van Huyssteen (2010) built on Gestalt foundational theories concerning executive functions as self-regulatory processes in Gestalt therapy (Brownell, 2009) and the Gestalt concepts of field and self-configuration–formation as seen in adolescent sex offenders (Brownell, 2005). Van Huyssteen conducted a qualitative study of the experience of juvenile sex offenders in South Africa using an unstructured interview that started with the words “Tell me about you.” By this method, the researcher explored the perspective and experience of the juvenile sex offenders. To supplement the exploration, the researcher conducted additional semistructured interviews with primary caretakers of juvenile sex offenders as well as the social workers or therapists who worked in the field with these children. Analysis of the interviews followed. Van Huyssteen found poor awareness of developmental field forces in the ground of offenders (i.e., poor attachment), poor awareness of self and other (not in touch with one’s own experience and unable to take the perspective of others), and poor self-regulation. These were in accord with points in the theoretical foundation described in the literature review.

Gestalt Hybrid Research

As has been observed in other contexts, emotion-focused therapy, formerly known as process-experiential therapy, and schema therapy integrate Gestalt features and techniques with other constructs. These hybrids proliferate. Emotion-focused therapy, in particular, is a blend of Gestalt, experiential, and person-centered therapy. Including it here as a true hybrid, I refer the reader to research data on this approach found elsewhere in this volume (see Chapter 10).

Schema therapy is a blend of cognitive therapy, Gestalt therapy, and dialectical behavior therapy (DBT; Kellogg, 2004; Young, 2005) used to treat personality disorders. Malogiannis et al. (2014) tested the effectiveness of schema therapy for patients with chronic depression. Twelve patients with that diagnosis participated in a single case series of A–B–C design, with a 6-month follow-up. Clients were assessed with the Hamilton Rating Scale for Depression three times during baseline, at the end of phase B, and then every 12 weeks until the end of treatment and at 6-month follow-up. At the end of treatment, seven patients had a satisfactory response, and the mean score on the Hamilton Rating Scale for Depression dropped from 21.07 during baseline to 9.40 at posttreatment and 10.75 at follow-up.

Gestalt therapy, defined as a field-theoretical approach to the study of the Gestalt formation process, complements the schema-based understanding and practice in cognitive therapy, making the blend a cohesive hybrid. Schemas are the residuals of experience; thus, field factors have effects on people's lives. In a 7-year single case study using schema therapy for the treatment of psychopathy, Chakhssi, Kersten, de Ruiter, and Bernstein (2014) found significant effect sizes in the change along several parameters: disconnection–rejection ($ES = 1.62$), impaired autonomy–performance ($ES = 0.98$), impaired limits ($ES = 2.15$), other-directedness ($ES = 0.53$), and overvigilance–inhibition ($ES = 2.43$). After the 4-year treatment and 3-year follow-up, the subject displayed more empathy, guilt, and insight and better communication, no longer showing prominent features of psychopathy.

Butollo, König, Karl, Henkel, and Rosner (2014) conducted an uncontrolled pilot study with 25 subjects with posttraumatic stress disorder (PTSD) who were treated with dialogical exposure therapy (DET), combining elements of CBT and interpersonal therapy in a Gestalt therapy frame. Twenty-one subjects completed therapy, with a significant reduction in symptoms by self-report from pre- to posttreatment.

DET aims to restore the traumatized person's contact-ability. The term "contact" is used here in a Gestalt therapeutic sense, and refers to the touching of boundaries between "me" and all that is "not me," that is, the

process of experiencing and organizing these boundaries and—thereby—the ongoing organization and shaping of one’s own self in its relationship to others and the world in general. (Butollo et al., 2014, p. 515)

Their full study (Butollo, Karl, König, & Rosner, in press), a randomized, controlled trial comparing Gestalt-based treatment for PTSD with cognitive processing therapy (CPT) for PTSD, showed effect sizes better than those in the pilot study. The effect sizes were high for PTSD measures and general psychopathology and moderate to high for posttraumatic cognitions. Notably, effect sizes for DET tended to increase over the follow-up period, whereas those for CPT tended to stay stable or show a small decline. When Butollo et al. (in press) calculated effect sizes using the pooled standard deviation from the whole sample as the denominator, effect sizes were similar (at posttreatment, 2.06 for DET and 2.17 for CPT; at follow-up, 2.04 for DET and 2.06 for CPT; Posttraumatic Diagnostic Scale [Foa, Cashman, Jaycox, & Perry, 1997] total at posttreatment, 1.09 for DET and 1.22 for CPT; at follow-up, 1.27 for DET and 1.22 for CPT).

The results of using chair work have been well established (Kramer & Pascual-Leone, 2013) and continue to be studied. Elliott, Watson, Goldman, and Greenberg (2004a, 2004b) have provided ample evidence of that fact. The empty-chair task for unfinished business is based on the Gestalt principle that significant unmet needs do not fully recede from awareness (Perls et al., 1951/1972; Polster & Polster, 1973). When associated schemas are triggered in the present, a person can reexperience these unresolved emotional reactions; the empty chair is a means of meeting the unfinished situation through the imagination.

In a study by L. S. Greenberg and Malcolm (2002), the presence of the specific process of resolution in the clients’ empty-chair dialogues was also found to be a better predictor of outcome than the working alliance. Shahar et al. (2012) examined the efficacy of the Gestalt two-chair dialogue task at times of stress with nine clients who were judged to be self-critical. The clients became significantly more compassionate and reassuring toward themselves, experiencing significant reductions in self-criticism and symptoms of depression and anxiety. The effect sizes were medium to large, with most clients exhibiting low or nonclinical levels of symptoms at the end of therapy, with maintenance of gains over a 6-month period (see also Lambert, 2013). Cheung and Nguyen (2012) used Gestalt empty-chair techniques in social settings to help nonexpressive Asian clients deal with bereavement issues, confront parent–child relationship issues, and express feelings. These dialogues supported positive outcomes in engaging in therapeutic work on their issues, responding to treatment within one session and showing progress within two sessions, and expressing emotions or unresolved conflict throughout the

therapeutic process. Gestalt techniques were seen to be culturally sensitive with Asian clients and families.

Gestalt-Consilient Research

Although there are consilient (overlapping) features between Gestalt and many other approaches to psychotherapy, mindfulness, therapeutic presence, acceptance and commitment therapy (ACT), behavioral experimentation, and DBT stand out.

Qualitative research (Bennett-Levy, 2003) comparing behavioral experiments (an obvious overlap with the experiment as found in Gestalt therapy) with automatic thought records in studies of CBT have shown that significant improvement over the latter can be achieved by experiments. Participants attributed the difference to the impact of evidential experience. Although new and alternative cognitions derived from automatic thought records were believed cognitively, resulting in the sense that a subject knew them rationally, clients were still left feeling unfinished. By contrast, the new cognitions resulting from experiments were more likely to be believed and accepted as being true because the subjects had actually experienced them (Bennett-Levy et al., 2004).

Mindfulness is literally the process of staying present to one's awareness; thus, it is rooted in the current moment. It has been defined as a moment-to-moment awareness of one's experience without judgment (Davis & Hayes, 2011). This is the essential connection to Gestalt therapy with its quintessential concern for here-and-now awareness and bracketing through a modified phenomenological process. In addition, Geller and Greenberg (2012) made a solid case for the relevance of mindfulness in Gestalt's processes of dialogue, because the presence of both therapist and client requires a mindful awareness of their meeting in the current moment.

Arch et al. (2013) compared a mindfulness-based intervention with CBT for the group treatment of anxiety disorders. After randomized assignment to adapted mindfulness-based stress reduction (MBSR) or CBT, 105 veterans with one or more *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; American Psychiatric Association, 1994) anxiety disorders began group treatment. Both groups showed large and equivalent improvements on principal disorder severity through a 3-month follow-up ($p < .001$, $d = -4.08$ for adapted MBSR; $d = -3.52$ for CBT; Arch et al., 2013).

CBT outperformed adapted MBSR on anxious arousal outcomes at follow-up ($p < .01$, $d = 0.49$), whereas adapted MBSR reduced worry at a greater rate than CBT ($p < .05$, $d = 0.64$) and resulted in greater reduction of comorbid emotional disorders ($p < .05$, $d = 0.49$). Bergen-Cico and Cheon (2014) conducted a longitudinal study using a mindfulness meditation

treatment ($n = 108$) and comparative control ($n = 94$) designed to examine relational changes in mindfulness, self-compassion, and trait anxiety (prevalent in many psychological disorders), with data collected in three waves: (a) baseline, (b) mid-program, and (c) postprogram (Arch et al., 2013). The cross-lagged analysis indicated that mindfulness was the key mediating variable preceding substantive changes in self-compassion and trait anxiety.

Rimes and Wingrove (2013) conducted a pilot study of a mindfulness-based cognitive therapy (MBCT) intervention adapted for people with chronic fatigue syndrome who were still experiencing excessive fatigue after CBT. The study investigated the acceptability of this new intervention and the feasibility of conducting a larger scale randomized trial in the future. Preliminary efficacy analyses were also undertaken. Participants were randomly allocated to MBCT or a waiting list. Sixteen MBCT participants and 19 waiting-list participants completed the study, with the intervention being delivered in two separate groups. Analysis of covariance controlling for pretreatment scores indicated that, at posttreatment, MBCT participants reported lower levels of fatigue than the waiting-list group. Similarly, significant group differences were found in fatigue at a 2-month follow-up, and when the MBCT group was followed up 6 months posttreatment, these improvements were maintained. The MBCT group also had superior outcomes on measures of impairment, depressed mood, catastrophic thinking about fatigue, all-or-nothing behavioral responses, unhelpful beliefs about emotions, mindfulness, and self-compassion. In conclusion, MBCT proved effective for people still experiencing excessive fatigue after CBT for chronic fatigue syndrome. All of these studies suggest that the mindful aspects inherent to Gestalt therapy would be as active as in the mindful aspects of cognitive therapy.

ACT is a form of behavior therapy that encourages people to experience their thoughts, emotions, and physiological sensations without evaluation, as well as to act in accord with whatever values emerge for them in the process (Thorpe & Sigmon, 2009). This is consistent with the paradoxical theory of change in Gestalt therapy and the general ethos for paying attention, building awareness, and being mindful. Often one finds both mindfulness and acceptance, for instance, linked even outside the Gestalt therapy literature.

Berman, Boutelle, and Crow (2009) evaluated the effectiveness of ACT for treatment of anorexia nervosa, using a case series methodology among participants with a history of prior treatment for anorexia nervosa. Three participants enrolled; all completed the study. All participants had a history of intensive eating disorder treatment before enrollment (1–20 years). Participants were seen for 17 to 19 twice-weekly sessions of manualized ACT. Symptoms were assessed at baseline, at posttreatment, and at a 1-year

follow-up. All participants experienced clinically significant improvement on at least some measures; no participants worsened or lost weight even at the 1-year follow-up. Simulation modeling analysis revealed for some participants an increase in weight gain and a decrease in eating disorder symptoms during the treatment phase compared with a baseline assessment phase. These data, although preliminary, suggest that ACT could be a promising treatment for subthreshold or clinical cases of anorexia nervosa, even with chronic participants or those with medical complications.

The DBT processes of awareness, mindfulness, sensory body experience, emotion regulation, acceptance, and the client–therapist relationship overlap with Gestalt therapy (Williams, 2010). The dialectic itself is a meta-stance highlighting the difference between the therapist and the client, with difference being one indicator of contact between self and other in Gestalt therapy (Fruzzetti & Skuch, 2012). Radical genuineness in DBT validates the client, because the therapist treats the client as an equal person (Fruzzetti & Skuch, 2012), as with the dialogical element in Gestalt therapy. Mindfulness and emotion regulation are two primary skill sets in DBT, with the therapist working to build awareness of how the client routinely goes from a state of emotional regulation to dysregulation (Fruzzetti & Skuch, 2012); this is one of the central tenets of Gestalt therapy, in terms of an awareness of “what and how, here and now,” achieved through a descriptive phenomenological method. Feigenbaum et al. (2012), in a study using CORE, found DBT likely to be an effective treatment delivered by community outpatient services for individuals with a Cluster B personality disorder.

In another study, Pasioczny and Connor (2011) examined the clinical and cost effectiveness of providing DBT over treatment as usual in an Australian public mental health service. Forty-three adult patients with borderline personality disorder were provided outpatient DBT for 6 months, with outcomes compared with those obtained from patients in a waiting-list group receiving treatment as usual. After 6 months, the DBT group showed significantly greater reductions in suicidal and nonsuicidal self-injury, emergency department visits, psychiatric admissions, and days in residential treatment. Self-report measures were administered to a reduced sample of patients. Within this group, DBT patients demonstrated significantly improved depression, anxiety, and general symptom severity scores compared with treatment as usual at 6 months. Average treatment costs were significantly lower for patients in DBT than for those receiving treatment as usual.

Beyond this, Geller and Greenberg (2012) made a strong case for therapeutic presence as a Gestalt therapy-related factor in the therapeutic relationship. They conducted qualitative research (Geller & Greenberg, 2002) surveying established therapists (each with more than 10 years of experience) from experiential, interpersonal, cognitive, and Eriksonian clinical

perspectives, finding the following elements true of therapeutic presence for these clinicians:

- putting aside self-concerns;
- bracketing theories, preconceptions, or treatment plans;
- adopting an attitude of openness and non-judgment;
- being attentive and receptive to client verbal and nonverbal discourse;
- extending self for contact;
- offering intuitive responses;
- being absorbed, aware, and alert; and
- being with and for the client, while remaining grounded in one's own experience.

Geller and Greenberg (2012) went on to describe *presence* as “bringing one's whole self to the engagement with the client and being fully in the moment with and for the client, with little self-centered purpose or goal in mind” (p. 17). With direct regard to Gestalt therapy, they said,

I–Thou is the natural connection that occurs when a person becomes fully present to another . . . healing emerges from the meeting that occurs between the two people as they become fully present to each other. The purpose of presence, from this perspective, is the power it has in allowing one to meet and hence understand the other, for the purpose of healing. . . . Inclusion is another part of the I–Thou encounter and is closely linked to presence because it involves being in direct and immediate contact with another person without losing contact with one's self. (p. 22)

Geller and Greenberg (2012) tested the psychometrics of their construct of presence by creating and validating the Therapeutic Presence Inventory (TPI), including several versions and subscales related to it such as the TPI–T, a measure of the therapist's experience of presence in the process, and the TPI–C, a measure of the client's experience of therapist presence in the process.

In randomized controlled studies for therapists using process–experiential therapy, CBT, and client-centered therapy, the items on the TPI–T fell under one factor called Therapeutic Presence (with an eigenvalue of 10.50, accounting for slightly more than 50% of the variance). On the TPI–C, items fell under the same single factor with an eigenvalue of 2.03, accounting for 67.59% of the variance. After supporting the construct validity of therapeutic presence, Geller and Greenberg (2012) went on to establish the reliability of the scales and the predictive validity of the construct by comparing them with outcomes using established instruments such as the Working Alliance Inventory (Horvath & Greenberg, 1989) and the Client Task Specific Measure (Watson & Greenberg, 1996).

Developing Research Tradition

Practitioners in the field of Gestalt therapy have embarked on an organized and ambitious effort to establish a research tradition for Gestalt therapy. No longer satisfied with relying on the occasional research-specific project, and realizing that Gestalt hybrid research does not address the features of Gestalt therapy proper as a whole approach with its own integrity, Gestalt practitioner-researchers have created a biennial research conference, established research funds, and embarked on several research projects. Both the European Association for Gestalt Therapy and the Association for the Advancement of Gestalt Therapy have created research committees and committed to the support of the growing research tradition.

Individual initiatives are also continuing. In Hong Kong, for instance, Man Leung is beginning a 2-year study to enhance children's awareness of their emotions and to promote their ability to express them. In a concomitant parent group, she hopes to enhance parents' awareness of their anxieties about their children's education, adding components of mindfulness and compassion. In Chile, Pablo Herrera Salinas heads up an international research project for outcomes of Gestalt therapy using a single-case, timed-series design. The study uses Gestalt practitioner-researchers in practice-based research networks that span several geographic regions and people groups. In Eastern Europe, practice-based research networks are developing CORE studies of Gestalt therapy outcomes and qualitative research using grounded theory.

FROM RESEARCH TO PRACTICE

Bermuda is beautifully deceptive. The warm aqua waters are a playground for tourists, and there are rich people who live in huge, air-conditioned homes next to private docks with expensive boats. Most of the population, however, struggles because of the extremely high cost of living. Generations of families live together in homes that have been expanded to accommodate the children as they grow into young adulthood. Most young adults live with their parents, and people often work two or three jobs at a time. It is a largely matriarchal society in which women take responsibility and are the glue holding families together.

Cecile,⁶ a Black Bermudian grandmother, 58 years old and heavysset, entered the office, sat on the couch, and immediately started crying. Her tears formed in silence, because she had not yet spoken a word, but they spilled out and down her cheeks.

⁶Specific identifying information on this client has been changed to protect her identity.

They caught me by surprise. I took a breath and purposefully relaxed into my chair. I kept my eyes on her. I could see her sniffing and taking short, choppy breaths. She pulled a tissue out of her purse and dabbed at her face. She was not looking at me consistently; she was looking past me, over my right shoulder, toward the blank wall.

I said, "Tears?"

She said, "My grandson." Her eyes darted to me and back to the wall.

"Can you tell me more?" I asked.

"He was the one shot at the night club," she replied.

"Oh," I said. "I'm so sorry for your loss."

I did not fill in the space more than that, but I kept watching her, following her eyes with mine, and I shifted in my chair more toward her. I felt the intensity of her emotion, and I could relate immediately to the extratherapeutic situation (the field conditions) affecting us and in which we met.

In Bermuda, young men are killing each other in a tenacious gang war. They have climbed on board a bus to murder a helplessly disabled victim, shot up restaurants and church picnics where children were playing, and driven into private yards on their motorbikes to assassinate people sitting on their front porches. I have conducted critical incident stress management interventions for hospital units and other organizations at which this situation has touched someone. I have attended the funerals of former clients. When Cecile said what she did, I joined her sorrow, because the gang war is a national tragedy.

Cecile engaged my eyes with hers. She said with a note of pride, "I raised him. He was my boy," and her sobbing increased. Her tissue wore out, so I got up, retrieved the box of tissues from the corner table, and brought it to her.

"You raised him," I said.

Another extratherapeutic field dynamic is that in many families the grandparents, and often it is the grandmother, end up raising the children (spending the most time with the children and nurturing them) because the parents are both working long hours to make enough money for the family to survive.

"How can I help you?" I asked. "What made you come in to see me today?"

She said, "I just need to sit with someone. I don't let other people see how I feel, and I know family members have been to see you."

"Ah," I said. "You want me to share your grief?"

"Uh-huh," she replied.

I said, "I am the oldest of five; I am a former pastor, and I've met with grieving people and conducted funerals. I thought I knew what grief was. Then my youngest brother was killed in a road accident, and when his wife called to tell me, it cut through me [I made a slicing motion with my hand across my heart] like a knife."

Her head turned more toward me. Her eyes met mine and lingered there. Her sobbing became more relaxed and her tears subsided. We felt the contact.

I said, "You're breathing easier."

She smiled.

"It's a terrible thing that's happening in Bermuda with all these young men killing and being killed."

She nodded. "It ain't goin' away. The pain ain't never goin' away."

"Never going away?" I asked.

"Feels like it," she replied.

Process Comments

In this excerpt of clinical process, the presence of the therapist was immediately evident through both his verbal and nonverbal discourse. He was there for and attentive to the client. He allowed himself to be touched by the client and self-disclosed in various ways how the client affected him. At the same time, he practiced a here-and-now awareness that is characteristic of both Gestalt therapy and mindfulness, and his approach was relational and largely dialogical.

Geller and Greenberg's (2002, 2012) work on therapeutic presence provides a Gestalt-related research perspective on the therapeutic relationship that is at the same time relevant to Gestalt's adapted phenomenological method. In presence, for instance, whereas the therapist might self-disclose in the service of dialogue, he or she would bracket theories about the client or the process between them to remain available to the moment-by-moment process, simply describing what is available in mindful attention to what is taking place between the therapist and the client. Thus, it is through presence and mindfulness that the Gestalt therapist pays attention to the unfolding subjective experience of the client and puts together the facets of a dialogical relationship between the client and the therapist.

Following the therapist's self-disclosure, the client was called into closer contact with him, and her embodied experience became more relaxed. The therapist switched to an adapted phenomenological method and described what he observed. He simply said, "You're breathing easier."

At one point, the therapist reached for the client's figure of interest by asking what the client wanted to accomplish by coming in for the appointment. The client was able to say that she simply wanted someone to talk with about her grief, someone outside of her family.

At various stages in the pericope, recognition of field factors affecting the client, the therapist, and the meeting between them was mentioned. Simply to recognize some of these influences is often all that is necessary in touching the schemas that are involved. For instance, the therapist "touched" a schema

around grandparents raising their grandchildren; it is an expectation in many families and a badge of honor by which grandparents in many cases confirm that they are responsible and loving. To lose a grandchild to murder, then, becomes a social insult and a very painful loss. Many times, the values and social expectations that clients hold can be accessed through dialogue, through observing the client's expression in his or her nonverbal discourse, or through the experimentation in chair work, pitting one end of a polarity against another (i.e., good grandparent vs. bad grandparent). That did not happen in this case, but speaking more generally about the application of research in Gestalt therapy, introjects emerging from the residue of experience in the client's field can often be affected by empty-chair and two-chair work.

Applications From Research More Generally Considered

Butollo et al. (2014) and Man Leung et al. (2013) referred to the construct of contact (and the process of contacting) as being important in their research. Man Leung et al. attributed the contacting through dialogue, experiment, and the aware presence of those concerned to the increase in agency and hope in their study subjects. In turn, they related those increases to Gestalt's construct of self-regulation. Butollo et al. claimed that the research conducted that showed Gestalt therapy was effective in the treatment of PTSD implied the relevance of contact and contacting as skills that facilitate the organization of experience. Thus, contacting is a skill that Gestalt therapists can manifest through their work in following the subjective experience of their clients, meeting their clients through presence in the dialogical relationship, and supporting clients for behavioral experimentation.

The research on ACT supports the Gestalt therapy construct of the paradoxical theory of change—acceptance of what is and the actualization of the person in the current moment. This construct allows the Gestalt therapist to work in a descriptive manner, using the phenomenological method without having to make sense of the client's presentation; the therapist simply accepts the process as it unfolds, trusting that, paradoxically, the increased awareness of what is in the current moment will develop into something more. It is an existential and pragmatic trust that the field will, indeed, supply what is needed.

The CORE study conducted in England (Stevens et al., 2011) provided evidence that, when Gestalt therapists work naturally in accord with their training, they can be every bit as effective as therapists from other clinical perspectives, including CBT, for clients with anxiety, depression, and relationship and self-esteem issues, among other disorders. This is encouraging. It should settle the issue and free up Gestalt therapists simply to work in accordance with what they have learned.

SUMMARY AND CONCLUSION

Contemporary Gestalt therapy has come of age as an integrative approach closely associated with humanistic psychotherapy. Although Gestalt-specific research has been sparse, researchers have generated enough of such research, in all categories, to inform an evidence-based practice of Gestalt therapy. With the growing movement to establish a research tradition for Gestalt therapy, it is likely that the research literature will look quite different with regard to Gestalt therapy within the next 5 years, with many and diverse research articles becoming available in peer-reviewed journals.

Gestalt thinkers and practitioners have developed its original integration into a sophisticated approach that is more than multimodal. It is undergirded by a well-thought-out philosophical foundation that rests on continental philosophy and science. It is phenomenological. It is relational and dialogical. It is field theoretical and strategic, and it is existentially experimental. It is unified in the practice of contacting, and this contacting is what pulls the various tenets of Gestalt therapy into a theoretically integrated approach. A growing research tradition is adding evidence to Gestalt's philosophical foundation, and that research has already demonstrated that Gestalt therapy is at least as effective as other approaches to psychotherapy. Contemporary Gestalt therapy is not the same thing many people observed in Fritz Perls's work with "Gloria" (Shostrom, 1963). It is not an anachronism, a relic of the 1960s. It is a sophisticated approach that provides a solid platform for assimilating from other clinical systems, and it is consilient with mindfulness, behavioral experiments, embodied cognition, relational systems psychoanalysis, hermeneutic-phenomenological psychotherapy, and ACT.

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