

Handbook for Theory, Research, and Practice in Gestalt Therapy (2nd Edition)

Edited by Philip Brownell

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Handbook for Theory, Research, and Practice in Gestalt Therapy
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Edited by Philip Brownell

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I believe it is appropriate to dedicate this book to colleagues in the global research movement in gestalt therapy. As this book will show, they are many. They are intelligent. They are accomplished, and they have enriched my life tremendously. They are the people engaged in research. They are the chapter contributors, the participants in research conferences, and the people who interact online around issues pertinent to research in gestalt therapy–and they are present, one way or another, in these pages.

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PREFACE

This book is a true second edition. There are few duplications from the first edition. They could rightfully be considered two different books, and the reader might enjoy having copies of each. Comparing the two, with the distance of an entire decade between them, is an interesting exercise. One thing that will be consistent, I'm unfortunately sure, will be my mistakes as an editor. So, I apologize to the chapter contributors. I have attempted to let stand the phrasing and positioning of what these authors have given. I have tried to put the elements of their chapters into a consistent style, but I've made concessions as well. After all, the content is what is important, not so much the style. Style, punctuation, spelling mistakes, and even reference citations can be distracting–and for that I apologize–but read beyond, through, and around such things. It's what these people say that really counts.

And my goodness. Do they ever say it. This is a long book, and it is a thick book. I challenge people to read it, because it is a wonderful collection of thinkers all focused on the emerging gestalt therapy research tradition. Far from the dry and tedious subject many people might think research is, I have been revitalized in my appreciation of gestalt therapy by becoming involved with colleagues in this movement. I delight every time I witness someone surprised by the fascinating things gestalt practitioner researchers are investigating and how they are going about it.

We are moving most certainly beyond the needed, but rudimentary establishment of an empirical support base for gestalt therapy–the evidence that gestalt therapy works. We are beginning to conceptualize research into the processes of change that make gestalt effective. We are beginning to see how research can improve our training practices. We are open to expanding this research tradition to include research into the application of gestalt therapy theory and practice in organizational work and coaching.

We are also seeing the emergence of gestalt therapy research communities and the teaching and supporting of research at the institute level. As a result, ours is a much richer global gestalt community.

So, I give this book up now, having lived with it in one form or another for the last ten to twelve years.

I look out of the window in my study. The days are growing shorter. There is a coolness to the breeze that sweeps across the high desert and

gently shakes the sage brush. In the evenings I can hear the roar of Shoshone Falls. I know that in a couple of months it will be cold here, and I'll have to put the heater on when I go out to my study to write.

At that time I want to sit on the deck with my wife, Linda, and watch the raptors soar above the Canyon. I want to relax with no deadline coming down over my shoulders like a heavy harness driving me to work, to think, to be careful about words, periods, commas, dates, and the correct form of all those things.

I hope you, the reader, will enjoy this book. It is leaving me now, and after awhile I won't think about it. It will become as if someone else's work.

Then I will pull weeds and water my trees until the snow arrives.

Philip Brownell
From the rim of the Snake River Canyon,
Above Shoshone Falls,
Twin Falls, Idaho, USA
Autumn, 2018

PART ONE

A GROUND BY WHICH TO THINK ABOUT RESEARCH IN GESTALT THERAPY

CHAPTER ONE

INTRODUCTION AND FRAMING OF THE BOOK

PHILIP BROWNELL, PETER PHILIPPSON, MADELEINE FOGARTY, VINCENT BEJA, PABLO HERRERA SALINAS, JAN ROUBAL, AND TOMÁŠ ŘIHÁČEK

The first edition of this book came together between 2006 and 2008. It became translated into several languages. It called for gestalt therapists to take on the challenge of establishing a research tradition for gestalt therapy, and it described both the core theory of gestalt therapy and also various approaches to research. It is now some ten years later. The gestalt community *has* undertaken to establish its own research tradition. It has held three major international research conferences and an international research methods training seminar. It has compiled a book based on these meetings,[1] and it is moving toward the creation of its own, dedicated research organization. It's fourth international research conference is set to be held in 2019, and it is already beginning to look toward 2021. This book is an update on the progress of the gestalt research movement and a true update of the first edition published in 2008.

This chapter is an introduction. First, I want to include some information from the first edition that is a good way of orienting to the issues of warrant or justification for anything, including any given practice of psychotherapy, and an orientation to evidence-based practice. Second, I want to move on to the gist of a conversation about research among some of the contributors to this book that was brought about through reflecting on the new Gestalt Therapy Fidelity Scale (GTFS) (see Madeleine Fogarty's chapter on that elsewhere in this book). What we discussed is also basic to our orientation

[1] Roubal, J. (Ed). (2016). *Towards a research tradition in gestalt therapy*. Newcastle upon Tyne, United Kingdom: Cambridge Scholars Publishing.

towards research and reflective of our state of growth at the time this book went to press.

Recalling Issues Related to Warrant, Evidence, and Evidence-Based Practice

In the beginning of the first edition of this book the authors raised the issue of warrant: what constitutes sufficient justification for the practice of gestalt therapy? Might it be, they wondered, the so-called evidence provided through randomly assigned clinical trials (Goodheart, Kazdin and Sternberg 2006, Nezu and Nezu 2008)? Might it reasonably include other types of "interventions," treatments, and techniques like those listed by the American Psychological Association (APA 2006)? Indeed, what constitutes the "evidence" in the construct of "evidence-based practice?" Is it process outcomes studies? Is it gestalt-informed qualitative research? Is it the common factors research or the practice-based or client-centered outcomes such as those suggested in the writings of Barry Duncan and Scott Miller (2000) or Hubble, Duncan and Miller (1999)? What is it? Do we look exclusively to the university and its largely group studies using convenient student populations or do we move beyond the university and its reduction of variables to the messy world of larger clinical practice? The answer relates to the issue of the gulf between research findings and clinical practice–the application of research to practice.

Relative Evidence

Certainty "is either the highest form of knowledge or is the only epistemic property superior to knowledge" (Reed 2008, np). In a world in which certainty escapes us, no form of evidence can rise above the need for degrees of confidence and measures of error, or random variance. In such a world, we can only have relative forms of support and more or less warrant.

Thus, while we may have a sense of the truth of a reality that is ontically independent, we only have a relative understanding of it, and even that comes from a subjective experience within it. With such a critically realist perspective as ground, what are acceptable ways of justifying one's interpretation of experience and thereby supporting one's beliefs?

Personal experience and assertion. One way is that people can contemplate the assertions of others regarding what they have experienced. This is what resides behind the use of self-report tests and the testimony of witnesses-of-fact in forensic psychology. The problem is that taking

someone's word for something doesn't seem to carry enough heft. In and of itself it does not seem justified or warranted.

Adler (2006) claimed that a testimonial chain of knowledge must arrive at a speaker who knows directly by perception in first-hand experience. The view that the reliability of testimony can be justified by inference and induction based on such testimony is called reductionism– that it reduces to the inferences. That view is opposed by anti-reductionists who hold that testimony is a source of warrant in itself. Anti-reductionists also view reductionists as holding to an individualist epistemology. Conversely, they favor a social epistemology, which holds that the possibility of knowledge we gain from testimony depends essentially on our membership in an epistemic community. It is evaluated by the context of the person giving testimony and his or her place within it.

Thus, testimony is relative, not only in terms of absolute truth, but also in terms of its context and etiology in an "epistemic community." People in such a community ask if there is social validity associated with any given inquiry (Gresham and Lopez 1996). How does it fit? Is there social significance and importance associated with research and are the interventions and procedures socially acceptable? Some will say one thing and others will say something else. There will be those who emphasize the need for internal validity (the context of the laboratory) versus those who emphasize the need for external validity (the context of the clinic).

What people say arises out of the relational matrix in any given research or epistemic community. Gestalt therapists recognize this as reference to the spheres of influence that comprise the *field*. Thus, the evidence of testimony is relative to a context.

The report from personal experience, in and of itself, is often regarded by some as constituting sufficient warrant; however, it is insufficient for others. When gestalt therapists assert the effectiveness of gestalt therapy and refer to their clinical experience, that would be acceptable to some, but when the lens of the field is widened it becomes lacking. Testimonial is a means for establishing warrant, but its degree of relativity is too high. In the context of an evidence-based practice, testimonial alone cannot stand alone.

Rejection of warrant based on foundationalism. Sometimes people will attempt to justify one belief or assertion based on another (more foundational assertion), but if that supporting assertion is not warranted, one simply creates an epistemic regress. The skeptic would maintain that such regress is inescapable, that it constitutes an infinite regress, and therefore warrant is impossible. That would make all research futile, and therein resides the flaw in the skeptical stance. It is practically unacceptable,

because within limits we can justify various kinds of beliefs and assertions and we simply must be responsible. Thus, Kvanvig (2007, np), speaking of coherentist epistemic justification stated, "This version of coherentism denies that justification is linear in the way presupposed by the regress argument. Instead, such versions of coherentism maintain that justification is holistic in character."

In Quine's (Quine & Ullian, 1978) version of coherentism, for instance, our "web" of beliefs forms an interconnection in which the structure hangs or falls as a whole. Thus, justification is a feature of a system of beliefs–a gestalt.

This is an attractive way for gestalt therapists to consider the construct of warrant, because holism is already a central component in the belief system inherent to gestalt therapy. Thus, research in support of gestalt therapy would be most helpful if it provided many strands and intersected many other strands at points in such a web of meaning.

The rejection of conclusive evidentialism. There is no way to escape the point that all "evidence" in support of practice is relative. At this point it might be helpful to establish some of the implications of that statement. Evidentialism in psychotherapy claims that unless there is conclusive evidence for the efficacy of a certain practice, one lacks warrant and should not engage in that form of practice. Addressing evidentialism in religion, Forrest (2006) observed the evidentialism suggests a full religious belief is not justified if there is not conclusive evidence for it, and since known arguments for the existence of God, including experiential ones, are probable ones, no one would be justified in having a full belief that there is a God.

This is the crux of the problem with regards to the efficacy of psychotherapy. Some might claim that belief in gestalt therapy's efficacy/effectiveness is not justified unless one has conclusive evidence to support its practice (and that is impossible).

Some in the EBP movement take an evidentialist approach to warrant. I once met a psychologist trained in a strict application of such evidentialism. She found herself in a dilemma. She needed to conduct assessments for, and provide therapy to, an offending population, but she could not find specific instruments and interventions that were documented in the research literature for her particular population (a certain culture of people on a particular island nation where virtually no specific research had been conducted). Thus, she needed to operate with a relative degree of confidence, extrapolating from the research literature that she could find. This, however, flew in the face of her training, a training asserting the limits of application based on the model of empirically supported treatments

(ESTs). ESTs not only describe intervention procedures, but also describe the appropriate populations for which such procedures apply. Thus, she was lost. She could not, in good conscience, do the job for which she was hired in accord with the training that she had received.

Consequently, the magnitude of evidence necessary to attain warrant is a relative quantity, and it cannot be ascertained in isolation. In every case, it must be assessed in connection with other components of a given situation. Warrant is contextual and the evidence that is available and applicable is relative to one's context.

Evidence-Based Practice

The American Psychological Association adopted a working definition of evidence-based practice, and they asserted that *evidence-based practice in psychology* (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences (APA 2006). They went on to make a critical distinction between empirically supported treatments and evidence-based practice and to open up multiple and relative streams of support as "evidence:"

> ESTs start with a treatment and ask whether it works for a certain disorder or problem under specified circumstances. EBPP starts with the patient and asks what research evidence (including relevant results from RCTs) will assist the psychologist in achieving the best outcome. (APA 2006, 273)

They went on to say that ESTs are specific treatments that are shown to be efficacious in controlled circumstances, but that EBPP include a broader range of clinical options that include clinical interview and assessment, case conceptualization, and the therapy relationship itself. Evidence-based practice includes multiple streams of research evidence–including but not limited to the controlled efficacy studies.

The APA task force pointed to a range of research designs that all contribute to the body of knowledge relevant to evidence-based practice. They include clinical observation, qualitative research, systematic case study, single-case experimental designs to examine causal factors in outcome with regard to a single patient, process-outcome studies to examine mechanisms of change, effectiveness studies in natural settings, Random Controlled Treatments and efficacy studies for drawing causal inferences in groups, and meta-analysis for observing patterns across multiple studies and for understanding effect sizes. With regard to any particular treatment intervention, the task force identified two considerations: does the treatment work, does it cause change--a question of its efficacy, which is most related

to internal validity, and does it generalize or transport to the local setting where it is to be used–a question of its effectiveness, which is most related to external validity.

In spite of the variety of these methods, globally a number of problems have been observed with EBPPs. They are limited in regard to the generalizability of the results in their empirical supports, and that leaves a lack of confidence in them among clinicians. Furthermore, clinicians are often distant in many ways from the processes involved in such research, and the results have low transportability to clinical practice. In addition, evidence-based movements overemphasize treatments and treatment differences, ignoring outcome results on psychotherapy demonstrating variation among psychologists, the impact of relationship, and other common factors (Wampold and Bhati 2004).

In contrast, Practice-based Evidence (PBE) provides a bridge for this gap between research and practice (Evans, Collins, Barkham, et.al. 2003).

Practice-Based Evidence

Practice-based evidence has been characterized as a bottom-up process of gathering data that relies on the experience of practicing clinicians to inform treatment (Dupree, White, Olsen and Lafleur 2007). It is research that takes place at the level of the practice. Practice-based research networks (PBRNs) have been utilized to cooperate among clinician-researchers across diverse organizations in preventative medicine (Green 2007); such PBRNs seek to increase external validity and the generalizability of results. The mental health system in one locality, for instance, discovered that linking EBP with the research strategies associated with practice-based evidence (PBE) could improve service to clients. Outcome measurements were used to bridge between EBP and PBE, and they were based upon objective factors and clients' perceptions of care, often utilizing standardized measures at referral, during moments of assessment, the beginning of therapy, at discharge and then again at some interval following. In the agencies in question, this process became systemic and often provided useful clinical information as well as a read on client progress (Lucock, Leach, Iveson, et.al. 2003). Wade and Neuman (2007) found that integrating research skills into clinical processes could correlate clinical practices with treatment outcomes, providing helpful feedback to clinicians regarding the effectiveness of their methods. Unfortunately, they also observed that the average clinician lacks the time, resources, and expertise to work out such an integration without support. Several studies in the United Kingdom argued for utilization of an outcomes instrument known as the Clinical

Outcomes in Routine Evaluation (CORE) to assess the effectiveness of treatments from such a bottom-up, practice-based perspective (Barkham, Mellor-Clark, Connell 2006; Stiles, Leach, Barkham, et.al. 2003; Barkham, Margison, Leach 2001, Mellor-Clark, Barkham, Connell, et.al. 1999).

Although many people have bridged the gap between EBP and PBE with outcome studies, surveys, and qualitative studies to discover patterns in actual practice, one of the research designs identified by the APA task force serves as both a form of evidence in support of EBPs and as a form of PBE. That is the single case time trial, otherwise also known as case-based time-series analysis, or single case, timed series research design (SCTS). Borckhardt, Nash, Murphy, et.al. (2008) pointed out that the

> ...practitioner-generated case-based time-series design with baseline measurement fully qualifies as a true experiment and that it ought to stand alongside the more common group designs (e.g., the randomized controlled trial, or RCT) as a viable approach to expanding our knowledge about whether, how, and for whom psychotherapy works. (p. 77)

They also pointed out that the APA Division 12 Task Force on Promotion and Dissemination of Psychological Procedures recognized such time-series designs as important and fair tests of both efficacy and/or effectiveness. Thus, the single-case research design can do a great deal for gestalt therapists. It is a design individual gestalt therapists can utilize at the level of the clinic to track the process of therapy with individual clients, and if they collect the data across several clients, they can make observations about patterns emerging in the way they practice. Further, aggregates of several gestalt therapists using the same designs could be used to observe still larger patterns.[2]

Would these patterns provide conclusive evidence that gestalt therapy works? No. However, they would contribute to a growing body of relative warrant.

What Makes Good Research: A Conversation

We have come a distance from the nature of the situation when the words above were first written. Single case, timed series research is well underway. The first such project arose out of conversations at the first research conference at Cape Cod in 2013. As mentioned, the first research

[2] In fact, SCTS design has been used recently to establish the efficacy of gestalt therapy in working with patients suffering from anxiety (Herrera, P., Mstibovskyi, I., Roubal, J., Brownell, P., 2018.)

paper, reporting on this first project, has been published (Herrera, et al., 2018). The practice-based research network started through that first study has been expanded in a large, funded research project involving groups from Europe, North America, Mexico, South America, Australia, and Russia, all using the single case experimental design.[3] We have also addressed the need for more accountability in our research by the creation of a fidelity scale for gestalt therapy. The research movement has momentum, and at times it seems that everyone in the gestalt community is suddenly concerned to appear as if they are interested in or actually involved with research. But what is it that makes for good research?

Following the writing of the chapter in this book on treatment manuals, a group of people who have been instrumental in leading gestalt research discussed research-related issues when considering the development of the Gestalt Therapy Fidelity Scale (GTFS), which is also described later in a chapter in this book. The discussion is captured in part here as an example of the kinds of discussions needed in the gestalt community and because of the points people mentioned.

After Philip Brownell pointed out that the chapters in the book being suggested as a treatment manual included the newly formed GTFS, Peter Philippson responded, and the discussion ensued. Peter said that Phil pointed to the GTFS, adding that it was created in part by expert raters in the field of gestalt therapy and had been validated as a descriptive list of things gestalt therapists do when they are doing gestalt therapy.

> He continued: People who were at the panel in the Paris conference know that I believe that Madeleine's "fidelity scale" is fatally flawed and would pass through any reasonably competent person-centered therapist. Worse still, the "validation" did not compare the Gestalt people with anybody close to that person-centered side. Worse still, I was told after the panel by people who were involved in the validation that this objection was raised by them, and neither addressed nor published as a caveat in the literature on the scale, which in the *real* world of research would mean the journals involved would repudiate the research and question the motives of the authors.
>
> Worse still, it is now becoming easy to say that the scale is a "list of things gestalt therapists do," and I have seen that approach taken on a training workshop at a major Gestalt training institute. Put aside the idea of

[3] This is a project funded by the John Templeton Foundation and administered through Brigham Young University. "Spiritually Integrated Processes in Gestalt Therapy: An Investigation of Faith, Awareness, and Spontaneity in Psychotherapy." Philip Brownell (Principal Investigator), Mark Reck, Jelena Zeleskov Djoric, Pablo Herrera Salinas, and Hannah Acquaye (core team).

making gestalt therapy (or psychoanalysis from which it came) a list of things to do, the list is almost entirely "one-person psychology," with an overwhelming bias towards paying attention to what the client does (e.g. noticing the client's physical experience, not the therapist's). The work which I would do and see as most fully gestalt therapy, the kind of work described by Gianni, Jan, Michela, Margherita, would not be passed as gestalt therapy by using the list.

I am strongly in favour of research in gestalt therapy, and I am not even against manualization or a fidelity scale, but it has to be gestalt therapy that is being researched, not that gestalt therapy has to play what Fritz Perls called the 'fitting game' to fit a more easily researched dilution of gestalt therapy, and then in order to get supported as a training institution, an institute will have to show that this is what they teach, and so on. The real story of this scale is that to capture what gestalt therapy is is a difficult task, maybe also that there is still a lot of one-person psychology going on out there among the expert raters, or that it was easier for the initial proposers of list items (of which I was one) to speak about the one person aspects than to put the relational aspects into succinct words.

Peter then pointed to his article in the *British Gestalt Journal* in which he inscribed his objections as raised during the panel at the third international gestalt therapy research conference in Paris, France, which was held in 2017. Vincent Beja, one of the co-conveners for that conference, responded.

Vincent Beja: I am resonating with Peter's comments on the GTFS. The question of the person-centered therapist has been one of my earliest concerns regarding the scale's validity. As I was one of the 60 people involved with the poll, I can say that there wasn't much space to think outside the box, which would have made the whole process much more hazardous in reaching a tangible result.

Peter Philippson: Thanks Vincent. I don't know if there are ways to set up a more relational scale. It is not my area of expertise. If not, we need to face that and its consequences rather than falsifying what we do to fit it into an easier paradigm.

Vincent Beja: Well Peter, I don't think that using the GTFS is falsifying our practice. We collectively have to be cautious and critical in using already made categories of any kind. Science reduces the richness, thickness, of what it studies, but in the process we may gain valuable insights. We need to stay aware to the fact that science is not "the truth" nor "the real."

Peter Philippson: Dear Vincent, if the practice is relational, and the scale doesn't support a relational practice but one that is easier to describe, and is already being used in some places as a paradigm of good practice, I don't know what else it is. Quite simply, since my practice has become more and more relational, its effectiveness has increased, and our connection to the latest neuroscience research has deepened (I write about this in my BGJ

article). We have the prospect of putting in place a scale that takes us away from what I see as both most central and most effective in our therapy.

Then, Philip Brownell joined the conversation more fully. He and Peter share a long history of interacting with one another and so their style with each other does not hold back and seems more confrontational. However, as admitted by both people, it simply reflects a ground of familiarity that allows them to be more direct.

Philip Brownell: As far as the GTFS you [Peter] say some challenging things. The fidelity scale is not an exhaustive test of all things gestalt. It cannot capture the nuances of theory; it relates to theory but it is not the theory itself. As such it cannot satisfy our hunger for such nuances of theory. Second, it only attempts to be an observer of the therapist. *That* is the nature of a fidelity scale. It speaks as if to ask, "What is the therapist doing? Does that look like gestalt therapy?" So, when you complain that it doesn't capture the nuances of *relational* gestalt therapy (which by definition has to look not at what the therapist does but at what the interaction between therapist and client does), then it seems to me like complaining that an apple is not an orange. Of course you are correct. It isn't. Third point: the GTFS *was* created by expert raters, and then it was validated. As Vincent points out, the science is not the truth; at best our research can observe some things that have some measure of correlation, some measure of causality, some emerging themes, etc. No, we do not live in a positivistic, or as Husserl put it a "naturalistic," day in science. We realize we know in part, but we assert that we *do* know. So, the GTFS does discern when people are practicing what many in the gestalt world would recognize as being gestalt therapy. As you imply toward the end of what you wrote, perhaps we should look at that. Perhaps a more worthwhile consideration would be what the GTFS found out rather than trying to knock it down as if it were a liar who needed to be discredited and rejected. Fourth, you may have a point about not discriminating between gestalt and person-centered; one form of validity is called discriminative validity, and so further research could be done to investigate that. And to this point of validity, there are several kinds of validity, so tearing down the "validity" of the GTFS *in general* is not helpful. The point being that it can have high validity in one way and not so high in another. But that is something that can still be investigated.

As I say in the chapter on manuals, what we are doing as we really start gearing up in the generation of research is to mark out fields of research within the larger gestalt therapy movement. What starts out simply wanting to show that gestalt therapy "works" must evolve into specialties (if you will) focal points in ongoing research in which people dig down into tenets of our theory and check them out, develop ever more useful and valid tools by which to evaluate our practices, our teaching and training methods, and by which we evaluate our sacred cows.

So, we have made a start with this section of the book that I am suggesting as a treatment manual. My goodness, *no*. It's not perfect. It certainly can be improved upon and I can imagine a whole new genre of gestalt literature: gestalt treatment manuals focused on work with specific populations. The wonderful book edited by Gianni, Jan, and Michela is in that direction. However, what I think is necessary is that we turn from tearing down and destroying the work of others and turn toward making something better ourselves. If you don't have the expertise to create a better, more relational fidelity scale, then partner with people who make scales and together with others make something better. That is how research is done; it's very much team oriented, groups of people working together to create. As such, ironically, the process of doing research has to be relational. At least in my opinion.

Asynchronous process poses some unusual demands. People must be patient, remember what someone said and come back to it later. Sometimes this can be jarring until one recalls the previous day or even the previous part of the same day. Consequently, Phil recalled something Peter had said about the GTFS not reflecting a relational style, and he went back to it.

"If" is a small word with big implications. It introduces a conditional phrase, and if you accept the condition, then you have to deal with its consequences. I don't accept the condition you continue with after you use "if." I don't reject it either. I don't believe enough has been demonstrated to be able to assert one way or the other that the GTFS "doesn't support a relational practice." This is simply an assertion on your part, one person at this point backed up by some people in France. What does "support" in your assertion actually mean? What are you asserting? Are you actually saying that there is nothing in the GTFS that relates to a dialogical relationship? That there is nothing in the GTFS that touches on what happens when the therapist considers field dynamics or that nothing takes place, nothing in the GTFS in which experiments are carried out? Really? There is nothing connected to relationship in the phenomenological observations and descriptions of the therapist?

As I've said before, the GTFS is not a statement or development of theory. You have to know that theory to be able to understand what it is tapping into. And if you do, then I believe you can find relationship and intersubjective relational dynamics between its lines (given that the very nature of this beast AS a fidelity scale is focused on what the therapist does). As such, the fidelity scale does not address the effectiveness or efficacy of the therapy itself. It just asks, "Was this gestalt therapy?" I believe that what Madeleine and her colleagues have done is to chisel out of the swamp of theory about gestalt therapy, and the ever-present contention that there I*is* no defining description of gestalt therapy possible (for various reasons in our gestalt ethos and history), a good-enough description of it.

For me it works well enough until something better comes along. And we are going to be using it in the research project on spiritually-integrated processes in gestalt therapy. We will use it in a novel kind of way. We will put its various descriptions in at the front; that is, we will list them and ask gestalt therapists to check off which ones they used in that session. Then, for at least one session, we will record the session and have someone use the fidelity scale to be able to claim (hopefully) that what was conducted was indeed gestalt therapy. So, later on one thing that would be possible is to see what the emphases in gestalt practice might be over a broad array of geographic and cultural regions (i.e. how much are people "checking off" this or that, here or there?). We will also be able to compare what therapists thought they were doing with what they were observed doing. And, no, *that* will not be perfect either.

Then, Tomáš Řiháček, a European researcher and colleague of Jan Roubal, entered the discussion.

Tomáš Řiháček: Hi Phil and all. Thanks for sharing your and Jan's chapter which is, in my opinion, a very nice take on the subject. We live in an era of manualization and we have to adapt to this fact in order to survive (as Gestalt therapists). Would it be possible to share also the fidelity scale with us who are not familiar with it yet?

Philip Brownell: Dear Tomáš, the chapter in the book on the fidelity scale is actually a summary of a more elaborate article that Madeleine and her colleagues have submitted to a peer-reviewed journal (possibly *Psychotherapy Research*). The summary describes briefly the way in which the GTFS has taken shape, and it gives the format of it that was used in the validation studies. It refers to previous articles about it in the *British Gestalt Journal* and also the *Gestalt Journal of Australia and New Zealand*. I will share it as I have the manual chapter, in pdf form with the same caveat to quote only from the original, which is not out yet (and will be in probably two or three months).

Tomáš Řiháček: Phil, thanks for a prompt reply. Before I immerse myself in the chapter, one more thought parallel to a gestalt-specific fidelity scale, there are other options that can be considered (which are not to replace the idea of GTFS but to widen the scope of our considerations). One of them is the *Psychotherapy Process Q-Set* (PQS) developed by Enrico Jones and used by Stuart Ablon and others. It is a 100-item observer-rated descriptive measure of the psychotherapy process. Although it was not initially developed to study treatment fidelity, it was used in that way in a couple of studies. A treatment-specific prototype was constructed using a group of experts and the degree of fit between this prototype and an actual psychotherapy session was then used to measure therapist adherence (i.e., treatment fidelity). There are prototypes developed for CBT, interpersonal therapy, and psychodynamic therapy (and maybe others). Of course, the downside of using such a measure is that it may not contain items crucial for

defining gestalt therapy. However, an advantage of using such an instrument is the comparability across studies on diverse modalities. Just something to think about.

Then Peter went back to something Phil said about the role of expert raters in the construction of the GTFS.

Peter: No, it was not 'created by expert raters'. A number of I guess kind of experts in gestalt therapy (including me) were asked to send in statements of what we would see ourselves doing in being Gestalt therapists. That would tend to produce more statements about the things it is easy to make statements about, and some more diverse statements about what is more complicated. The Delphi process would then weed out the latter, and leave the simple, but not sufficiently discriminative statements.

But there was nothing wrong with the original statement-gathering. Yet it does not necessarily mean that the scale is able to discriminate properly what is or is not gestalt therapy. That would be why there was a need for a second stage, a validation. I think where it went wrong was that the evaluation didn't take into account the kind of lack of discrimination which might be a weakness in the scale. And then it went further wrong in not publishing the caveats that came out of the validation process. So rather than showing that a piece of work is highly likely to be gestalt therapy, all it shows is that it is not definitely not gestalt therapy!

Phil: You raise important issues. Read the summary I just sent. There was a process, and part of the process was the generation of descriptions by expert raters, and then along the way the refinement of that initial set. I am comfortable asserting that the process reflects a consensus of expert raters. No, there was not a meeting of expert raters who all sat in a room and hashed out together the GTFS. I don't think it works that way.

I notice you pointing out things that are certainly part of the research process. The one about creating simplified statements (and leaving out the more complex ones). You know, it's not just in research that we encounter such things. I find it happening in the editing process, whether I'm editing someone else or they are editing me. Complexity in written word is difficult to follow. In philosophy it's called being "thick." Research only tolerates "thick" in the discussion of the results of its process. The method itself must be simple simple so that people can follow, not read into it what they *think* the writer meant or interpret the complexity, go off on tangents because of associations, etc. Research in this way, as I've been trying to say, is not theoretically satisfying in the way that many of us have been writing. I think the research has to address the theory in the literature review and discussion sections of what we do, but in the methods section it's just not going to satisfy [people who want theoretical precision and complexity].

The point about discriminative validation is important. And that study should follow. What the GTFS claimed was to confirm criterion validity. I think it actually confirmed construct validity. So, what that means is that on

the basis of what gestalt therapists themselves claim, in theory, is gestalt therapy (i.e. their constructs), it found that the GTFS accords with such claims. I would need to see what kinds of therapies were used to discriminate between gestalt and not gestalt. The summary does not say that, but from other explanations I can see there was a comparison between three gestalt people on the one hand (Michael Clemens, Bob Resnick, and Gordon Wheeler) and Jeff Young representing Schema Therapy on the other. That is not enough for discriminative validity.

Then Peter took a different tack and went beyond the direct issue of the GTFS to issues of research in the gestalt community more generally.

Peter: The problem is that what is called "research" in this company is not real. Real research is trying to *invalidate* the accepted truth, to see if it is robust. I don't see any of that, more trying to use research as a new form of marketing of gestalt therapy. The "validation" of the Fidelity Scale was trying to validate it, not choosing the comparisons that are most likely to *invalidate* it, as real science would do. And weasel words like "we will have to do that later" merely point to the problem. In any reputable research set-up, the scale would not be used as part of research projects until that had happened. This is so obvious that it takes a particular kind of blindness not to see it.

I want to support research, but more than that, I want to support honour and integrity, and I am not seeing that shown. I'm sorry about the hard words, but that is how I see it.

Phil: I am glad very glad that you speak in the way you do. Nothing false about me saying that Peter. For years and years I found people rejecting the need for research in the Gestalt community and then as if suddenly, around 2013 or so it just tipped. That is simplifying but it seemed as if everyone began jumping on the research bandwagon. I knew the resistance had not simply disappeared. So I am happy when it comes out in the open. It feels like when a person can breathe again.

You said that research in this company is not real. Aside from that being an absurd assertion, it is insulting to the integrity of good people who are indeed doing real research. You are a good man, brilliant thinker, and clear voice. You don't need to make sweeping generalities like that. Madeleine's research is real research. I don't know if you actually read any research literature, but if you did you would find near the end of every article statements describing what was not done or what was incomplete or could have been done better and certainly suggestions about what might be done next. Or be done later. Real research is always just a piece of the puzzle and there is always *always* something to be done later.

Then Pablo offered his perspective on the situation and the conversation that had been unfolding.

Pablo: Dear colleagues, I just want us to remember the original aim of the fidelity scale: to help us survive the era of empirically validated therapies and not be banned excluded from mental health policies. What's the role of the fidelity scale in that context?

1. To avoid disappearing we need to show some evidence of our efficacy. As Peter correctly states, this is not a pure scientific goal, it's more a sales pitch to the local authorities and policy-makers.
2. To show evidence of our efficacy, one of the methodological requisites is to have some evidence of treatment fidelity. Currently our only evidence is "the therapist has Gestalt training." This is barely acceptable, and the fidelity scale (even with its limitations) is vastly superior as treatment fidelity proof.

I wish we could concentrate more on true scientific studies that challenge our beliefs and practices; I would like to dedicate most of my research towards that goal. However, this other kind of research (the efficacy study) is vital to be able to survive and also have funds to do the more interesting kind of research. This has been said to us by Leslie Greenberg and other prominent researchers who have supported us at the research conferences.

Regarding the limitations of the fidelity scale, I completely agree that they should be stated in the papers as that is a basic scientific practice. Also I remember that the scale originally compared gestalt therapists with Kellog's transformative chairwork (or some other therapist who uses a similar method), so we have some discriminative validity. Also, it's a big mistake to use the scale for something that it doesn't intend to do, like showing how gestalt therapy must be done or within our community to exclude colleagues who work differently. The scale is "*just*" a methodological instrument to do efficacy studies, nothing more and nothing less than that.

And Jan Roubal added his perspective.

Jan: Hi Pablo, I completely agree with you. And, I just want to add a personal experience: participating in the video ratings of the GTFS was really inspiring and a discussion-provoking experience for the whole of our team of trainers. For example, it provoked us to see the difference between behavioral markers of Gestalt therapy that, quite surprisingly, clearly distinguish this approach from other approaches, and therapists' competency to use them in a way supportive for the therapeutic relationship. It was very learningful to see: yes, this therapist is practicing Gestalt therapy as an approach, and he is at the same time not doing it in a competent way. It led us into a discussion of how to train competent therapists instead of therapists who simply "do Gestalt", as we often hear. Well, this is just one example. Enriching experience, thank you Madeleine!

Phil came back to the things that Pablo observed and also responded to Peter's previous comments about invalidity.

> Phil: Dear Pablo, few things are just one thing or another. While I agree that we are engaged in a political process to provide proof to policy makers that Gestalt therapy works, I think we are also doing science real research. As such we can learn things. Our work needs to be about more than rubber stamping Gestalt practice as we've known it.
>
> I think it is a false dichotomy to place public policy making at the other end from "true science/research." For one thing, if there is no real science, no respected research, then no one is going to build policy on fantasy. There is pressure and political action, and there is group think and so forth, but there is also valid outcomes research. You need one to do the other. So, it may be that in the research movement we have various focal points, interests, and committees. One committee or sub-group could be dedicated to advocating for gestalt practice using the outcomes generated by others. And, by the way, that is another reason to finally create our own research organization to have such advocacy.
>
> [To Peter]The issue of invalidity is not the same as what I think you are referring to. Internal invalidity is when there is something wrong with a person's research design or when the assumptions don't pan out. There is a kind of invalidity as well in hypothesis testing. Rejecting the null hypothesis is used to establish the validity of the hypothesis. So, people intentionally attempt to refute their assumptions and discredit their findings. Is that what you mean? Hypothesis testing is still done of course, but it is far less important these days than establishing the strength of the significance, which is associated with the effect size.
>
> I don't think real research is trying to invalidate the accepted truth. Rather, we live in an age in which abduction (recourse to the best explanation among competing hypotheses and paradigms) is more the norm (than even Kuhn's ideas about paradigm change; one dominant idea swaying all other options). Here is a description of this taken from an excellent article in Nature (How scientists fool themselves and how they can stop, by Regina Nuzzo, 10/7/15).
>
> > "One solution that is piquing interest revives an old tradition: explicitly considering competing hypotheses, and if possible working to develop experiments that can distinguish between them. This approach, called strong inference, attacks hypothesis myopia head on. Furthermore, when scientists make themselves explicitly list alternative explanations for their observations, they can reduce their tendency to tell just-so stories."

But I think what you were referring to is the idea of falsifiability rather than some kind of invalidity or invalidating. Karl Popper advocated falsifiability, but I prefer the thinking of physicists Alan Sokal and Jean Bricmont. They said that science does not progress by refuting ideas but by taking note of

ideas that pan out. There is a good description of this in the Wiki on "Falsifiability:"

In their book *Fashionable Nonsense* (published in the UK as *Intellectual Impostures*) the physicists Alan Sokal and Jean Bricmont criticized falsifiability on the grounds that it does not accurately describe the way science really works. They argue that theories are used because of their successes, not because of the failures of other theories. Their discussion of Popper, falsifiability and the philosophy of science comes in a chapter entitled "Intermezzo," which contains an attempt to make clear their own views of what constitutes truth, in contrast with the extreme epistemological relativism of postmodernism.

Sokal and Bricmont write, "When a theory successfully withstands an attempt at falsification, a scientist will, quite naturally, consider the theory to be partially confirmed and will accord it a greater likelihood or a higher subjective probability. ... But Popper will have none of this: throughout his life he was a stubborn opponent of any idea of 'confirmation' of a theory, or even of its 'probability'. ... [but] the history of science teaches us that scientific theories come to be accepted above all because of their successes." (Sokal and Bricmont 1997, 62f)"

Then Phil turned more directly to Peter's previous assertions.

[Peter said] "The 'validation' of the Fidelity Scale was trying to validate it, not choosing the comparisons that are most likely to *invalidate* it, as real science would do. And weasel words like 'we will have to do that later' merely point to the problem. In any reputable research set-up, the scale would not be used as part of research projects until that had happened. This is so obvious that it takes a particular kind of blindness not to see it."

So, first off: blindness? To whom or what are you referring?

Of course the effort was to validate the GTFS. Of course. And there is nothing wrong with that. But I think what you are implying is that people were not honest, that they were choosing weak opponents, making things easy on themselves and not being ruthless in their comparisons with other modalities so that they could arrive at the destination they had already decided they needed to achieve. Think about it. The effort to invalidate it could have been just as dishonest if that had been the ultimate goal, and then what? Neither kind of dishonesty is worthy of the people, the real people about whom we are talking.

And I'm sorry but research is accomplished in steps; so, it's not blindness to indicate what might have to be accomplished "later." You don't want to appreciate it, apparently, but research advances in steps, a little here and a little there. I think we have established that more could be done. My bet is that it will be done. And by honest people doing credible research.

Peter: I know the words. Philosophy of science, Popper, Kuhn, Feyerabend, Lakatos, etc. were part of my doctoral thesis. I am not here talking about falsifiability. Gestalt therapy is certainly falsifiable. I am saying that the way

to validate something properly is to look at what might invalidate it and show that it doesn't. Even on a political level, if we don't do it, someone else will, assuming they take what we are doing seriously. We have been buffered from that because we haven't been taken seriously in the research community, but if what you and I both want happens, we will then come under a lot of scrutiny.

Phil: So I think I understand that what you want is for Gestalt research to be powerful enough to be able to endure criticism from the wider field. The strength of our research.

Here's a true story. At the second research conference that took place at GISC in Cape Cod Les Greenberg was being skeptical that we could successfully carry out single case research and have it stand. We were presenting the initial data on single case studies in Chile, including the design of the subject being their own control. This was largely Pablo's work. When we showed him the effect sizes and the graphs, his expression changed. I can still hear the tone of his voice when he said, "Well, that's pretty *good*!" Then he told us what would make the studies stronger was to account for treatment fidelity. So, remember what Pablo said about that? We have accounted for it in the past by saying all therapists were trained Gestalt therapists. Having the GTFS is better still, even though it's not perfect. And my point about strength is in the design and the effect sizes. Treatment fidelity has to be accounted for but it becomes a minor thing in the study once it is there. We now have two ways to account for it so it will be there (and recede to the background).

Here is another point about our research being respectable: we are doing efficacy studies. Our design is strong. Single Case Timed Series projects are efficacy studies. They are acceptable by the APA as being equivalent to RCTs the gold standard in outcomes research. So in our choice of design we have progressed beyond the CORE studies done in the U.K. as those were effectiveness studies correlative rather than causal.

Third, we are attempting to be published in journals outside of the Gestalt cloister where the competition is rigorous. If our work is not competitive, it won't be published there. If our work *is* competitive and is published there, it will still be criticized because nothing is perfect and academia survives on criticism.

Fourth, we started doing these research conferences inviting world class researchers to come be our mentors precisely to have them help us up our game. We are still improving. I am satisfied that we have growth and momentum. And we must keep improving.

On the objections you and other people raise some of it is in my opinion well founded but some of it seems based more in a fear of scientism, a tilting at the windmills of positivism, or a fear that cherished aspects of Gestalt therapy are being eroded by an insidious attack from within our own ranks.

Pablo came back, reflecting again on the course of the conversation.

Pablo: I think it's essential that we have strong critical voices within our community, because if we don't have them, we risk going out with half-baked work and wasting a lot of time and effort doing something that gets easily rejected. So, I thank Peter, Vincent and others who have been vocal about their concerns and suggestions for improving the research we're doing.

At the same time, we have some preliminary good news: the design we are using for doing efficacy research (Single Case Time Series studies, which we are also using for the more interesting process research) has been reviewed recently by world renowned psychotherapy research experts and has been regarded as solid, so at least I can finally breathe and have some relief that we are doing good work not only for us, but for external reviewers too.

Postscript

I inserted this conversation as a window for the reader into the kinds of discussions that are ongoing in the gestalt community as it changes. It is changing. It is one thing to say that we are going to now do research (because we have to). It is another to start doing it and having that affect the way we see what we are doing. The process of beginning to actually establish a research tradition for gestalt therapy is beginning to change gestalt therapy.

Because so much of the conversation involved comments on the GTFS, and Madeleine Fogarty's work to create it, I asked her to provide a postscript to the discussion. Here it is:

Thanks to Phil for inviting me to respond to the conversation about the GTFS, and thanks to those who participated in that conversation. As explained in the chapter on the GTFS, it is a consensus instrument, and as such cannot be all-inclusive. Instead, it represents a broad and collective view. The GTFS has been designed to capture what is essential to GT and to that extent it has been validated (Phil discusses the different types of validation in his contribution to the conversation). However further studies may find that there are overlaps between GT and other modalities. The nature of research is a step by step process. Without a fidelity scale, valid research into the efficacy of GT cannot be conducted. The GTFS is a foundational step, and one that will be referred to and augmented over time. It is organic and developing, and this conversation represents a part of that development.

As discussed in the chapter on the GTFS, the process of developing the GTFS involved more than 60 experts participating in two online surveys. Participants were given multiple opportunities to articulate their differentiation and also to add ideas and concepts to the discussion. The first

survey comprised questions about eight Gestalt concepts identified in a literature review. For each concept, participants were presented with:

- *A label or descriptor for the concept (for example, "developing awareness");*
- *A description of the concept's theoretical foundations and clinical manifestations; and*
- *A list of associated therapist behaviours.*

For each concept, participants were asked a combination of qualitative and quantitative questions. The response option for the quantitative questions was based on a 5-point Likert scale (strongly agree, agree, neither agree nor disagree, disagree, strongly disagree). The questions included:

- *Do you agree that the concept is fundamental to Gestalt therapy? (Likert scale).*
- *Can you think of a more accurate label/descriptor for this concept? (Qualitative).*
- *Do you agree that the description of the concept is an accurate description? (Likert scale).*
- *Can you suggest a more accurate way to describe the concept? (Qualitative).*
- *Do you agree that the following therapist behaviours reflect the concept (as described in the survey)? (Likert scale for each behaviour).*
- *Can you suggest any modifications or additions to these therapist behaviours? (Qualitative).*

Participants' responses were used to identify items that needed to be revised eliminated or added. In the second survey, participants were asked about the resulting 25 behaviours. These were again grouped according to concept. For each concept, participants were asked (using the same Likert scale as the first survey) "Do you agree that the following therapist behaviours reflect the concept?" At the end of the survey, participants were given the opportunity to provide qualitative feedback in response to the question "Would you like to suggest any modifications or additions to these therapist behaviours?"

At the end of both rounds of the Delphi, a descriptive analysis of the participants' qualitative responses was conducted in order to identify whether there were any recurrent themes that might indicate that further behaviours needed to be added to the GTFS in order to ensure that it adequately reflected the clinical practices of GT. No such themes were identified.

The validation of the study involved almost 200 people from 18 different countries. Participants had the opportunity to assess whether the scale was effective at determining GT practice by watching videos of clinical work. Notably, there is only one person who contributed to the above conversation about the GTFS who actually took part in the validation study: Jan Roubal. This raises the issue of the weight that should be given to criticism that is made without a full experiential basis of the object of critique. Given that

GT is a phenomenological practice which focuses on primary experience, it is perhaps not surprising that the person who had the most positive things to say about the GTFS was the only person who had any experience in using it!

One of the main criticisms of the GTFS is that it does not account for the relational practice of GT, because it focuses on observable therapist behaviours. This presented an ongoing quandary in the operationalisation of GT concepts and great effort was made to account for this foundational aspect of contemporary GT. For example, the following items are included in the scale:

- *The therapist draws on their relationship with the client as the ground for challenge and growth,*
- *The therapist describes and validates the different experiences of the therapist and client*
- *The therapist works with the interactional patterns as they emerge between client and therapist*
- *The therapist and the client identify the figure together*
- *The therapist co-creates a space in which the client and therapist explore how they are impacting each other.*

Almost 200 people around the world took part in the validation study. And those that did observed these behaviours in two videos that showed very different styles of GT therapy. They did not observe these behaviours (or observed them to a much lesser extent) in the non-GT videos.

Are these items sufficient to account for the relational aspect of GT? This is a question that was asked of experts during the Delphi process and since; no one has yet presented any further operationalisations for consideration. Perhaps this is because, like me, those who critique the scale find it difficult to articulate philosophical concepts into observable behaviours. If anyone wishes to undertake another Delphi study, in which additional operationalisations are drafted and submitted to an expert panel, they are welcome to do so. In the meantime, critique is important and valued, but unless those who criticize also offer substantive and detailed alternatives, it is difficult to respond.

Tomáš Řiháček offers options for us to consider, and these options are useful. But they lack parsimony. One of the strengths of the GTFS is that, like the Cognitive Therapy Rating Scale (CTRS), it is a simple 20-item scale that raters have found easy to use. A Q-set for GT was developed by Dr. Meghan Case (2010, unpublished Doctorate) and presented at the first International GT Research Conference in Cape Cod. This was a useful and interesting study, but the Q-set was long and many items overlapped with common factors.

As others have described, the GTFS is already being used in research. Many GT trainees and practitioners have also reported to me that using the GTFS has deepened their own sense of their GT practise and helped them to describe that to others, including colleagues and clients. Others have found the GTFS to be useful for writing case notes in a mental health setting, where

describing interventions is a required practice, but where they have not previously had GT-appropriate descriptions of interventions to draw on. Some GT centres and practitioners are also finding the GTFS useful in supervision, and in developing training. In the end, it is really up to individual practitioners and training centres to decide for themselves whether or not they find the GTFS useful, and to identify the purposes for which they wish to use it.

Malcolm Parlett suggested that GT needed some kind of recognisable "branding" in order to survive the evidence-based era of mental health services. Phil Brownell is proposing the manualisation of GT. The GTFS can be seen as part of this endeavour, and yet, this is not an endeavour that all in GT are comfortable to pursue. The diversity of GT is a rich aspect of its history and vitality and will continue. How the GTFS is taken up by the wider psychotherapy community is just beginning to emerge and I am happy to have played my part in contributing to this important and ongoing conversation. The task of developing the GTFS was more ambitious than I had anticipated, and it has brought me into contact with so many wonderful GT practitioners around the world. For this I am deeply grateful. It has also enriched my and others' understanding of the practice of GT and my hope is that this will be on ongoing process that will be shared by many.

Turning the Corner

This book is an update to the first edition, but it is a volume that stands uniquely on its own. The chapters one can scan at the table of contents. As Madeleine says, I am advocating that we provide manuals for the use of gestalt therapy, and I suggest a whole section of this book as an initial example of a descriptive manual for the practice of contemporary gestalt therapy. I hope the book will provide plenty reason to think about what we are doing, both in the effort to establish a research tradition for gestalt therapy and in the practice of gestalt therapy itself.

Resources

Adler, Johathan. 2006. Epistemological problems of testimony. In the *Stanford Encyclopedia of Philosophy*, Edward Zalta, ed. Stanford: Stanford University. Accessed March 25, 2008 from http://plato.stanford.edu/entries/testimony-episprob

APA Presidential Task Force on Evidence-Based Practice. 2006. Evidence-based practice in psychology. *American Psychologist.* 61(4) 271-285

Asay, T. & Lambert, M. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. Hubble, B. Duncan, & S. Miller

(Eds.) *The heart and soul of change: What works in therapy*, pp. 33-56. Washington: American Psychological Association.

Barkham, M., Mellor-Clark, J., Connell, J. & Cahill, J. (2006). A core approach to practice-based evidence: A brief history of the origins and applications of the CORE-OM and CORE System. *Counselling & Psychotherapy Research.* 6(1) 3-15.

Barkham, M. Margison, F., Leach, C., Lucock, M., Mellor-Clark, J., Evans, C., Benson, L., Connell, J., Audin, K., & McGrath, G. (2001). Service profiling and outcomes benchmarking using the CORE-OM: Toward practice-based evidence in the psychological therapies. *Journal of Consulting and Clinical Psychology.* 69(2), 184-196.

Beitman, B. (2005). To the editor: Defining the core processes of psychotherapy. *American Journal of Psychiatry.* 162(8), 1549-1550

Borckardt, J.J., Nash, M. R., Murphy, M. D., Moore, M., Shaw, D., & O'Neil, P. (2008). Clinical practice as natural laboratory for psychotherapy research: A guide to case-based time-series analysis. *American Psychologist, 63*(2), 77-95.

Duncan, B. & Miller, S. (2000). *The heroic client: A revolutionary way to improve effectiveness through client-directed, outcome-informed therapy.* San Francisco: Jossey-Bass, Inc.

Dupree, J., White, M., Olsen, C., & Lafleur, C. (2007). Infidelity treatment patterns: A practice-based evidence approach. *American Journal of Family Therapy.* 35(4), 327-341.

Evans, C., Connell, J., Barkham, M., Marshall, C. & Mellor-Clark, J. (2003). Practice-based evidence: Benchmarking NHS primary care counselling services at national and local levels. *Clinical Psychology & Psychotherapy.* 10(6), 374-388

Forrest, P. (2006). The epistemology of religion. In the *Stanford Encyclopedia of Philosophy.* Edward Zalta, ed. Accessed March 26, 2008 from http://plato.stanford.edu/entries/religion-epistemology

Gallo, E., Ceroni, G., Neri, C. & Scardovi, A. (2005). Specific common therapeutic factors in psychotherapies and in other treatments. *Rivista di Psichiatria.* 40(2) 63-81

Goodheart, C. D., A.E. Kazdin and R.J. Sternberg. (2006). *Evidence-based psychotherapy: Where practice and research meet.* Washington: American Psychological Association.

Green, L. (2007). The prevention research centers as models of practice-based evidence: Two decades on. *American Journal of Preventive Medicine.* 33(1,Suppl), S6-S8

Gresham, F. & Lopez, M. (1996). Social validation: A unifying concept for school-based consultation research and practice. *School Psychology Quarterly*, 11(3), 204 – 227

Herrera, P., Mstibovskyi, I., Roubal, J., Brownell, P. (2018). Researching gestalt therapy for anxiety in practice-based settings: A single case experimental design. *Revista Argentina de Clinica Psicologica, Practice Oriented Research Special Issue*. 27(2), 321-352.

Hubble, M., Duncan, B. & Miller, S. (1999). *The heart and soul of change: What works in therapy*. Washington: American Psychological Association.

Kvanvig, J. (2007). Coherentist views of epistemic justification. In the *Stanford Encyclopedia of Philosophy*. Edward Zalta, ed. Stanford: Stanford University., accessed March 25, 2008 from http://plato.stanford.edu/entries/justep-coherence

Lucock, M., Leach, C., Iveson, S., Lynch, K., Horsefield, C., & Hall, P. (2003). A systematic approach to practice-based evidence in a psychological therapies service. *Clinical Psychology & Psychotherapy*. 10(6), 389-399.

Manderscheid, R. (2006). Some thoughts on the relationships between evidence-based practices, practice based evidence, outcomes, and performance measures *Adminstration and Policy in Mental Health and Mental Health Services Research*. 33(6), 646-647

Mellor-Clark, J., Barkham, M., Connell, J. & Evans, C. (1999). Practice-based evidence and standardized evaluation: Informing the design of the CORE system. 2(3), 357-374

Nezu, A. & Maguth Nezu, C, (Eds.) (2008). *Evidence-based outcome research: A practical guide to conducting randomized controlled trials for psychosocial interventions*. New York: Oxford University Press.

Quine, W. & Ullian, J. (1978) *The web of belief, 2nd edition*. New York, NY: McGraw Hill

Reed, B. (2008). Certainty. In the *Stanford Encyclogpedia of Philosophy*. Edward Zalta, ed. Stanford: Stanford University. Accessed March 25, 2008 from http://plato.stanford.edu/entries/certainty

Sprenkle, D. & Blow, A. (2004). Common factors and our sacred models. *Journal of Marital & Family Therapy*. 30(2), 113-129.

Stiles, W., Leach, C., Barkham, M., Lucockk, M., Iveson, S., Shapiro, D., Iveson, M. & Hardy, G. (2003). Early sudden gains in psychotherapy under routine clinic conditions: Practice-based evidence. *Journal of Consulting and Clinical Psychology*. 71(1), 14-21.

Wade, K. & Neumann, K. (2007). Practice-based research: Changing the professional culture and language of social work. *Social Work in Health Care*. 44(4), 49-64.

Wampold, B. and Bhati, K. (2004). Attending to the omissions: A historical examination of evidence-based practice movements. *Professional Psychology: Research and Practice*. 35(6), 563-570.

CHAPTER TWO

THE NEED FOR GESTALT THERAPY RESEARCH

EVA K. GOLD AND STEPHEN G. ZAHM

> When planning a piece of psychological research, there is of course one particular step which needs to be taken first, and that is to identify and select a topic to study.
>
> Martyn Barrett

The gestalt approach to psychotherapy has not been well researched; it was not until many years after its development that it was even written about extensively. A number of factors have contributed to this. During gestalt therapy's early years, there was an anti-intellectual bias among many gestalt therapy practitioners, partly in reaction to the perceived over-intellectualization of the theory out of which it developed – psychoanalysis. Also, the developers of gestalt therapy, and many of its early adherents, tended toward creative unconventionality, non-conformity, and even anarchism in thought and political persuasion. They had little interest in bringing mainstream academics and psychotherapists into their "camp." For example, Erving Polster, a founder of one of the first gestalt therapy institutes, the Gestalt Institute of Cleveland, has said that the original trainers thought that if they were attracting too many trainees to their program, they must be doing something wrong (Polster, 2006). Gestalt therapy was not seen as an approach that would be accepted by, or appeal to, the masses. And it has continued to be less in the mainstream than other approaches. Also, because gestalt therapy has always been taught experientially, trainees experience the effectiveness of the approach first-hand, as they learn by observing and participating in workshops and training demonstrations, not primarily by reading about or discussing it in academic settings. As gestalt therapists work with patients, they also see its power to evoke life-changing insights and awareness, creating possibilities for growth, and a new sense of self, along with expanded potential for novel behavior and ways of relating to others. This may have also resulted in less perceived need to explain gestalt therapy or to try to "validate" its benefits.

And, along with other psychodynamic and humanistic approaches, gestalt therapy involves the artful application of method informed by theory and grounded in relationship. It is an improvisation rather than a scripted method that can be easily quantified and replicated. This makes some types of research more difficult than with those easily quantified methods that lend themselves to manualized treatment protocols. The bias against writing has shifted significantly since gestalt therapy appeared on the scene in the early 1950s. Much important writing has more fully developed the ideas contained in the seminal theoretical perspectives, and many books and journal articles have contributed to the elucidation of gestalt therapy theory and practice. Significant progress in gestalt therapy research has been slower, however, and has not kept pace with research on many other approaches. The result is a current dearth of literature supporting the use of gestalt therapy in treating clinical populations, or specific disorders, compared to some other psychotherapy orientations (Werner 2005). The research that has been done on gestalt therapy has not always been sufficiently rigorous to meet today's research standards that would allow the results to be viewed with confidence.

For many years gestalt therapy was not alone in this lack of focus on research. The field of psychotherapy was not yet dominated by behavioral approaches, and so-called "evidence-based" practice was not the primary focus, nor required for third party payments. Nor was this the standard for consideration as an appropriate and ethical treatment. Clinicians generally remained focused on deepening their knowledge and honing their own skills and craft with an ongoing attention to what seemed to benefit their patients rather than demonstrating effectiveness to other professionals, insurance companies, or academic institutions. But over the last three decades there has been a sea change in the entire field of psychology resulting in increasing emphasis on empirical validation of approaches to psychotherapy, and this shift has impacted every school of psychotherapy, gestalt therapy included. In the United States, when health insurance companies began to pay for psychotherapy provided by psychologists and other mental health professionals - not just psychiatrists - a gradual move away from psychotherapy as an art and a relationship, to a medical-model focused on symptoms and their amelioration in the most effective and efficient way possible began. Over time this wave has gained momentum and has created an ongoing tension in the field. Currently, for example, the standard of "medical necessity" holds sway and is applied when determining payment for psychological services. The definition of medical necessity includes treatment of specific symptoms and disorders and requires generally accepted standards of medical practice based on credible scientific evidence

published in peer-reviewed medical literature that is generally organized by the relevant professional community. Medical necessity is typically found to be present only as long as symptoms are, and therapy goals mainly involve returning the patient to his or her previous level of functioning.

In 1993, in part due to the pressure from managed care insurance companies, the American Psychological Association created a task force to develop a list of "empirically supported" treatments. This resulted in researchers in academic settings conducting hundreds of psychotherapy outcome studies on particular treatments with the goal of having these treatments added to the list. Of course, which methods are researched is influenced by funding, and also by which approaches are popular with academics and easy to quantify and manualize, lending themselves to efficacy studies. Consequently, the behavioral and cognitive behavioral approaches became the most studied, since efficacy research, by its nature cannot test longer and more complicated modalities.[1]

As this research has been done, what has generally been demonstrated, with rare exceptions, is that the different psychotherapy treatments produce about the same level of modest results. Of the treatments that have been studied, meaningful differences between the approaches are practically non-existent (Wampold 2001). In fact, the equivalence of methods is consistently the most replicated result in the literature, according to meta-analysts (Hubble, Duncan and Miller 1999). This holds true across a variety of research designs, diagnoses, and settings. Based on this meta-analysis, it has been concluded that the list of empirically supported treatment approaches primarily reflects simply that these methods have been researched and others have not. Nevertheless, in order for an approach to make it onto the list, research has to have been conducted. Interestingly, the limited research that has been done on gestalt therapy also shows that it is as effective as, or more effective than, other approaches it has been compared to, even using the limited criteria of symptom reduction – which is not gestalt therapy's primary focus. So while these more easily manualized approaches have been more studied using qualitative research designs, there has not necessarily been clear evidence of some approaches being significantly more effective than others.

Practitioners of the approaches are nevertheless quick to claim their status as empirically validated, or evidence based, with the implication that other approaches are less valid. The pragmatics of this process has

[1] Editor's note: this is a debatable point. Practice-based research, especially single-case timed series research, is being successfully employed by gestalt therapists to evaluate the efficacy of gestalt therapy.

importantly influenced those seeking services, those seeking training as psychotherapists, and academic institutions. Many psychology graduate programs have moved away from offering a broad education covering a variety of approaches, allowing students to discern which approach best suits them. Instead, they emphasize the cognitive behavioral approaches that are easy to teach and learn and consist of readily quantifiable techniques. That move has gone so far as to call into question the ethicality of using psychotherapy methods not "evidence based" for the symptoms being treated. The APA has become increasingly stringent about requirements for training programs to show that the methods they are teaching are evidence based as well. All of this ignores the generally understood and accepted finding of the equivalence of studied methods and the fact that particular methods lend themselves more readily to certain types of research. It also ignores the ongoing question of the applicability of controlled laboratory research studies to the more complex real-world situations in which psychotherapy approaches are practiced.

As the field has shifted toward a medical model focused on symptom reduction, with requirements for empirical validation, there has been a lack of serious critique and questioning of what this means for the practice of psychotherapy. As the medical model has become the dominant paradigm, therapy is increasingly seen as clinical treatment, minimizing or even eliminating the importance of the healing interpersonal relationship (Elkins, 2016). The discussion has been dictated by and limited to a focus on symptoms, time, and cost effectiveness, leaving out the values of holistic approaches such as relationship, the person's total well-being, and ability to function in the world in a satisfying way. This in spite of the fact that a wealth of evidence supports the fact that healing occurs not as a result of particular modalities or techniques, but through the relationship and human connection of patient and therapist (Elkins, 2016). Although gestalt therapy has survived (and even thrived in some areas of the US and other countries) for almost sixty years, this shift threatens it, along with the other existential/humanistic and dynamic models, as evidence-based practice is now increasingly linked to what is taught in academic institutions and training programs, funding, and credibility.

This threat to gestalt therapy is exacerbated by a parallel process. Other contemporary approaches have adopted or incorporated aspects of gestalt therapy into their theory and practice but have not recognized or given gestalt therapy credit for the original ideas they assimilated. For example, the self-psychology/intersubjective approach, in its move away from traditional psychoanalysis, embraces a philosophical and theoretical viewpoint which had previously been developed in gestalt therapy

(Breshgold & Zahm, 1992). Intersubjective psychodynamic theory has conceptualized and articulated important aspects of psychotherapeutic treatment and human functioning in ways very similar to those previously described by gestalt theorists. These include the view of the unconscious, resistance, and transference (Breshgold & Zahm, 1992). The therapeutic stance, which is phenomenological and relational, is also contained in gestalt therapy theory and method. Another example is the influence of mindfulness, and the importance many approaches now place on acceptance of what is, awareness, and the present moment–as if these are novel concepts for psychotherapy when they are, in fact, cornerstones of gestalt therapy theory and method. These approaches have also recently recognized what gestalt therapy has always understood, that trying to get rid of thoughts or feelings often only makes symptoms worse, adding another layer of "should" and self-criticism, and leaving the authentic energy of these disowned feelings and experiences unexplored and therefore poorly understood. Steven Hayes, developer of acceptance and commitment therapy, or ACT (Hayes, 2007) writes that in the last ten years, a number of approaches to therapy have entered the mainstream based on the core idea that the more we struggle to change or get away from our experience, the more stuck we can become. He lists mindfulness based cognitive therapy (MBCT), dialectical behavior therapy (DBT) and ACT, as all agreeing that a first step toward fundamental change is to embrace the present moment, even if the experience is difficult or painful. Although these may be novel concepts to those steeped in the behavioral traditions, they sound like textbook descriptions of gestalt therapy! Likewise, emotionally focused therapy (EFT) borrows heavily from gestalt therapy principles and methods. A description of emotionally focused couples' therapy (Johnson, 2004) states that a therapist must have a theory of healthy functioning, an understanding of how this functioning becomes disrupted, and a theory of therapeutic change. EFT is described as process-oriented, integrating humanistic experiential and systems approaches. The therapist is seen as a process consultant and collaborator, and clients are viewed as non-pathological, responding rigidly for psychological survival. The therapy seeks to teach flexibility, with identification of disowned emotions and aspects of the self. Not only does this read–at times word for word–like a description of gestalt therapy, but reading transcripts and watching EFT therapists, one also recognizes gestalt therapy's here and now oriented, phenomenological and experimental methodology.

Gestalt therapy is based less on abstract theory than on empirical observation of functioning and on self-regulation, so it is not surprising that other approaches, either knowingly or not, end up "rediscovering the

wheel." While these approaches either draw heavily on gestalt therapy theory and practice, or "discover" these aspects of functioning through their own empirical observation, there is no acknowledgement of Gestalt therapy. The ideas are generally presented as novel and newly minted. Some of these other approaches are among those that have been extensively researched and, as a result, sanctioned and supported while using the principles and methods originally developed by gestalt therapy.

Although gestalt therapy has survived to this point as a more "alternative" therapy, there are currently three processes that combined threaten its continued survival. These are: (1) The focus on empirical validation and evidence based practice in the field as a whole, along with the fact that gestalt therapy has not been extensively or rigorously researched; (2) the fact that other approaches are either borrowing from or discovering for themselves gestalt therapy's concepts and methods; and (3) the fact that these other approaches do not acknowledge and credit gestalt therapy as the groundbreaking psychotherapy system it is in its implementation of these ideas and methods over the past sixty years.

While it would be just for gestalt therapy to get credit where credit is due, the larger and more important issue is the potential extinction of gestalt therapy, and the loss that would be to the field. It is ironic that the threat of losing this original, integrated, holistic theory and method may occur at the very juncture when these ideas are being recognized, and becoming mainstream and widely accepted by other schools of therapy. And it would be a significant loss, because gestalt therapy offers what these other approaches cannot. It provides a comprehensive theory and method based on understanding and observation of healthy human functioning–organismic self-regulation. When this theory was developed, psychotherapy stepped into a new paradigm in which healthy functioning and its disruptions, including how the change process occurs, were observed rather than theorized about. Gestalt therapy is broad based, encompassing all aspects of human functioning: Cognitive, affective, behavioral, and embodiment. This was the brilliance of Laura and Frederick Perls, Paul Goodman and others over a half century ago. Gestalt therapy offers a methodology based on theory that is not a cookie cutter collection of techniques, but an experiential and experimental approach broadly encompassing many types of interventions, and a theoretical understanding of when and why these interventions are employed. For example, our understanding of the paradoxical theory of change and knowledge of what is required for closure of a unit of experience, lends depth to what some contemporary approaches describe with the slogan "change follows acceptance." This in-depth understanding allows the practitioner to grasp

why a particular method is effective, not just that it is. Such theoretical understanding prevents clinicians from applying techniques or methods to patients randomly or indiscriminately and assists in an individually tailored approach. Another example is our understanding of the concepts of so-called resistance and the yes-no of ego functioning, which clarifies why trying to forcefully change or eliminate feelings without a full phenomenological exploration is doomed to failure, and why we will be ineffective if we form an alliance with the part of the person that is trying to coerce change. So, the essential issue here is not simply credit for gestalt therapy but ensuring that the field and its practitioners continue to gain from the depth, creativity, strengths and benefits of the gestalt approach.

Gestalt therapy has contributed much to the field of psychotherapy. In order for it to continue to do so, it must move into the mainstream, and become more widely accepted, practiced and taught. Gestalt therapy itself must "creatively adjust" to the zeitgeist of the times in order to survive. This means that there must be research done that allows it to take its place on the list of evidence-based approaches, giving gestalt therapy needed validation and credibility. This designation will help prevent gestalt therapy from being absorbed by other theories and being relegated to a kind of second-class citizenship or disappearing completely. This is essential even if it continues to disappear from academic institutions. In the US at least, for gestalt therapy training programs to be viable, they need to continue to be able to offer continuing education through bodies such as APA. If research is not done to demonstrate gestalt therapy as empirically supported, other approaches may well supplant it, and the value and contribution of a powerful approach that has survived for almost sixty years may be lost while its methods could be practiced without the solid theoretical framework that gestalt therapy provides.

In addition to jumping on board and doing what is needed for gestalt therapy to be considered empirically validated and evidence based, gestalt therapy researchers can contribute to the field by doing research that is actually meaningful and clinically relevant. As long as the efficacy method of research owns the empirically validated stamp of approval, and the threats to external validity with this approach are not considered, more complex and longer-term therapies will never be empirically validated (Seligman 1998). From our perspective, the craft of psychotherapy must be researched without reducing it to a set of specific procedures that can be mechanically taught, learned and applied as the current research paradigm dictates. For example, Orlinsky and Ronnestad (2005) describe the dominant research paradigm as sanctifying and perpetuating a constricted and concrete conception of clients, disorders, therapists and the change

process. They conclude that as a result the kinds of symptoms and methods academicians study have little relevance to the practitioner's world.

With increased research studies on gestalt therapy, gestalt therapy will not only take its place among the treatment modalities considered effective, but the types of research conducted by gestalt therapists and gestalt therapy researchers can also be more relevant to the real world issues with which practitioners and patients are grappling. Researchers have paid disproportionate attention to efficacy trials (where treatments are studied under controlled conditions and it is possible to have randomized control groups) and not enough attention to effectiveness studies where treatments are looked at in "real world" conditions. Most of the problems dealt with in psychotherapy are complex, and research should be designed to include this complexity. We must marry the rigor of scientific technology and empirical study to the wealth of methods and practices that gestalt therapy has developed. If we, for example, could measure behavioral and neurophysiological correlates of specific gestalt therapy concepts, we could contribute to an expanding rather than a narrowing field. Instead of simply measuring symptoms and their reduction, how might we assess for such personal characteristics as authenticity, and how it relates to relationship satisfaction? We might look at increased self-awareness, its relationship to self-criticalness and self-compassion/self-support. The quality of the therapeutic relationship could be studied comparing gestalt therapy and other modalities that do not place the relationship as front and center as gestalt therapy does. While some aspects of the relationship are surely determined by therapists' innate qualities, these may be also influenced by skills such as those gestalt therapy teaches – exploration of a patient's phenomenological world and adherence to the principles of a dialogic relationship. Many of the newer therapies have returned to a focus on the individual, leaving out interpersonal elements. Gestalt therapy maintains a focus on the centrality of the relationship, which lines up with research findings on the importance of the patient's experience of the therapist and the relationship (Lambert and Barley, 2001). In addition to the required standard efficacy research protocols, the next refinement for gestalt therapy could be more detailed understanding of elements of the process involved in organismic self-regulation; for example the figure formation/destruction process, awareness, assimilation and closure. Further, the new neuroscience research, as it increases our understanding of brain function and neuroplasticity, opens up new areas to research in terms of such concepts of how awareness and specific types of experience lead to change.

Psychotherapy research consistently shows that much of therapeutic impact is related not to a particular method or technique, but to what are

referred to as common factors. That is, in every approach there is the person of the patient, the person of the therapist, the relationship that develops, and the level of empathy and rapport experienced by the patient. Studies on the efficacy of evidence-based practices have the challenge of separating out the common factors of treatment from the particular method being employed. Some of these factors are the effect of the patient being in an environment perceived to be healing, a relationship with a clinician who is experienced as empathically attuned, hope or optimism, and expectation and anticipation of a positive outcome. Gestalt therapy offers the dialogic relationship model as well as the skills for phenomenological investigation of the patient's moment-to-moment experience of the therapist and the relationship and can offer much in terms of researching psychotherapeutic relationship dynamics.

Fortunately, in the years since we wrote this chapter for the first edition of this book, more research has been done and many gestalt therapy practitioners, writers, and researchers have committed to establishing a research tradition for gestalt therapy. An international biennial research conference has been created, research funds established, and a number of research projects embarked upon, including development of a treatment fidelity scale for gestalt therapy using the Delphi method (Fogarty, M., et al, 2016). Both the Association for the Advancement of Gestalt Therapy and the European Association for Gestalt Therapy now have research committees and a commitment to supporting research.

There is much to be gained in this process. In addition to keeping gestalt therapy relevant and in the map in the new evidence-based paradigm, if gestalt therapy researchers can generate research that is clinically relevant to our real-world work with patients, we can learn more about what we do that is effective, and use this to refine our practice. And it is also important to be vigilant about what may be lost. With the increased commodification of everything in our contemporary culture, along with increased focus on results–and quick results at that–it is easy to lose track of the ineffable in psychotherapy that is part of any process of true personal growth and transformation. In this sense, the relative merits of alternative approaches cannot necessarily be measured by outcome studies. Thinking in terms of measurable outcomes, necessary as it may be, also poses the threat of focusing the practitioner on outcome measures rather than staying grounded in the bases of gestalt therapy that involve the felt experience and commitment to an ongoing process of self-inquiry and self-discovery. In this process, we are not product or outcome oriented, and the therapeutic interaction is not a means to an end. Rather, we are called upon to be in awe of the gradual unfolding and illumination of human experience that is

possible within the intimacy and sanctity of the therapeutic relationship. If Gestalt therapy can hold the "both/and" of these two perspectives, we stand to gain from the benefits of research, without losing the soul of gestalt therapy.

By doing research, and testing out hypotheses, we follow Frederick Perls' injunction laid out in a 1945 preface to *Ego, Hunger and Aggression* (Perls, 1992) in which he says that there are many schools of psychology and that every school is right–at least in part–but that every school is also "righteous," and too attached to a favorite viewpoint. Perls makes a case for integration and the need to build bridges across the gaps between the various schools. He describes the ultimate and ambitious goal of an integrated, unified theory for understanding human functioning, going on to say that the goal can be reached through synthesis and cooperation of the various schools and theories in existence, and that this synthesis requires "...A ruthless purge of all merely hypothetical ideas; especially those hypotheses which have become rigid, static convictions and which, in the minds of some, have become reality rather than elastic theories which have yet to be re-and re-examined." (Perls 1992, p.xiv) As we re-and re-examine our methods, and test our hypotheses in ways that refine the gestalt therapy approach, we help to ensure the preservation of a theory and method of great value. Just as gestalt therapy once revolutionized the field of psychotherapy, it can also have an important and much needed impact on the current state of the field of psychotherapy research.

Resources

Breshgold, E. & S. Zahm. (1992). A case for the integration of self psychology development theory into the practice of gestalt therapy. *Gestalt Journal*, 15 (1).

Elkins, D. (2016). *The human elements of psychotherapy: A nonmedical model of emotional healing.* Washington, DC: American Psychological Association

Fogarty, M., Bhar, S., Theiler, S., & O'Shea, L. (2016). What do gestalt therapists do in the clinic? *British Gestalt Journal*, Vol. 25, No. 1: 32-41.

Hayes, S. (2007) Hello, darkness. *Psychotherapy Networker*, September/ October, 2007.

Hubble, M., B. Duncan & S. Miller. (1999). *The heart and soul of change: What works in therapy.* Washington, DC: American Psychological Association.

Johnson, S. (2004). *The practice of emotionally focused couples therapy.* New York, NY: Brunner-Routledge.

Lambert, M. and D. Barley (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy,* 38 (4).

Orlinsky, D. and M. Ronnestad (2005). *How psychotherapist develop: A study of therapeutic work and professional growth.* Washington: American Psychological Association.

Perls, F. (1992). *Ego, Hunger and Aggression.* Highland: The Gestalt Journal Press, Inc.

Polster, E. (2006) Interviews with Gestalt Elders, AAGT Conference. Vancouver, BC.

Seligman, M. (1998). Managed care policies rely on inadequate science. *Professional Psychology Research and Practice.* 29 (3).

Wampold, B. (2001). *The great psychotherapy debate: Models, methods and findings.* Mahwah: Lawrence Erlbaum Associates.

Werner, N. (2005). Unpublished doctoral dissertation.

CHAPTER THREE

AN ADEQUATE PHILOSOPHY OF SCIENCE TO INFORM GESTALT RESEARCH: THE VIEW FROM GESTALT RESEARCH MENTORS

This chapter provides several perspectives on a philosophy of science adequate to sustain research in gestalt therapy. They illustrate many of the considerations in thinking about why and how people do research. These particular essays are presented as a way of stimulating thinking and are not intended to be prescriptive in every respect nor exhaustive. They are suggestive.

The reader would do well to glean from these essays (as well as the chapters in the first edition that addressed more pointedly a critical realist approach to the philosophy of science) to make for him or herself a personal philosophy, a personal ground for doing research that is a ground for methodology rather than the kind of pragmatic ground that asserts we need to do research in order to survive.

Included are examples from people associated as mentors for gestalt practitioner-researchers who spoke and interacted with participants at various international gestalt research conferences or were slated to do so. Two are Executive Editors of peer-reviewed journals published by the American Psychological Association and the other two are well-respected researchers. The conferences with which they are also associated began in 2013 in Cape Cod, Massachusetts, USA at the Gestalt International Study Center (GISC). At that time Linda Findlay and Ansel Woldt served as mentors. At the next such conference in 2015, also held at GISC, Leslie Greenberg and Scott Churchill served as mentors. At the research conference held in Paris, France, in 2017 Louis Castonguay, Wolfgang Tschacher, and Xavier Briffault were mentors. The 2019 research conference, scheduled for May of 2019 in Santiago, Chile, anticipates seeing Clara Hill, Michael Lambert, and Mariane Krause as mentors. Brent Slife was scheduled originally to also be there, but he retired from teaching

before the conference and so bowed out. Here we include four perspectives from among them.

Perspective One: Scott Churchill Adapting to a Changing Epistemology– Emerging Methods and Paradigms[1] Scott D. Churchill & Rolf von Eckartsberg (deceased)

What has come to be called a *human science* paradigm is both a renewal of research interests that have existed for some time now, and a call for a program of research and pedagogy that is mindful of more recent developments in the epistemological foundations of psychology. For almost a century psychology has sidestepped the study of those mental functions and cultural phenomena that were a part of the overall plan of foundational thinkers such as Dilthey, Wundt, and Fechner. Dazzled almost to the point of blindness by the efficacy of experimental methods, psychologists have often lost sight of the very phenomena that inspired them to become psychologists in the first place: the so–called "higher" forms of thought and behavior. We have operationally defined the psychological as that which can be studied by means of experimentation, which means that only those dimensions of individual and collective experience that lend themselves to direct physical observation and quantification are given scientific credibility as psychological "knowledge." The absurdity of this measurement obsession being taken as a totalizing approach to human nature is evidenced by studies of human sexuality and pornography that attempt to measure human sexual response (and thereby to better understand love and violence) using penile circumference meters and devices that measure vaginal contractions. Not only in the study of humans but also in the study of animals do we find the reduction of behavior to the trivial: Wolfgang Köhler observed a century ago that "the farther we push the analysis in striving for...objectivity, the less we are inclined to call the description one of...behavior...and the more it dissolves into purely physiological statements" (1921/1971, p. 205). He proposed that it was only in "the whole impressions of an observer that (one finds) psychological meaning" (p. 210).

To the extent that the emerging paradigms for human science research can be characterized as calling for a more holistic approach to the meaning

[1] Based on contributions that appeared in *Methods: A Journal for Human Science*, Special Issue 1991, with von Eckartsberg's original material incorporated into Churchill's updated article (as a subsection on "Paradigm Shifts").

of human conduct, we have not yet come up with anything new. What is new is the way in which our understanding of "meanings" and "wholes" has been transformed, first by Gestalt psychology and more recently by postmodern thought. Humanistic psychologists have turned our attention away from meaning as a content of consciousness, toward an appreciation of meaning as an activity of consciousness. Experience taken as a "whole" is not thought of as something static, but as something that unfolds in a process of becoming. Furthermore, the "whole" is understood not to be circumscribed by the boundaries of one's own body but to include those transpersonal realms that are invoked within one's own experience.

Postmodern thinkers, for their part, have made us aware that meanings consist of "texts" through which we inscribe ourselves in the world, and that the act of inscription, like the act of reading, is not the recording of an already existing meaning but rather is itself the birth of meaning. (As Merleau-Ponty had already observed, language does not *express* thought; it *accomplishes* thought.) With regard to "wholes," postmodern thinkers are wary and prefer to allow for disunities; the search for essences, structures, and identities is reframed as serving a political establishment of norms that are intolerant of individual and cultural differences. The concept of "wholeness" must therefore be tempered to embrace rather than to exclude the accidental, the variable, or the "abnormal." Finally, both humanistic psychology and postmodernism have served to stretch the boundaries of disciplinary studies. Teaching, doing research, practicing psychotherapy, and meditating would all be considered part of the same life process for the humanistic psychologist, whose interests span from neurocellular phenomena to those of cosmic proportion. For postmodern thinkers, issues such as gender, work, film, history, and intellectual life cut across the arbitrary boundaries found within disciplinary academic institutions and challenge us to engage ourselves in non-categorical worlds of ever-changing discourses.

If postmodern thought acknowledges and celebrates diversity and change, then these very qualities embodied in our human capacity for transcendence will enable us to surpass the postmodern situation itself. "New selves," writes Howell (1991), "transcend interior boundaries and social walls"–"as though the world is a glove which one puts on and everything is virtually there and touchable–where mind is cybernetic and reality is internally created." Such an expansive (and even implosive!) impression of the human context might indeed be disorienting–and that is before one pauses to consider the problems of method in what is being called the "postmodern" context.

We are not the first to attempt to develop methods addressing internal

realities, human diversity, transcendence, and change. Phenomenologists and existential psychologists as well as social historians (especially those of the social constructivist school) have for a long time affirmed the dynamic nature of human reality as well as the intentional (or "internally created") nature of the lived world.

A methodology for human science research in a context of change– where change is itself understood to be a function of conscious creativity– must target not "the objective, natural world" (which is a product of the Enlightenment epistemology) but rather the subjective, human world that supersedes all subordinate systems or orders of reality. In other words, methodology will have to be able to adapt to the changing nature of the subject matter. This will mean, in turn, that the methods of investigation cannot be pre-set, and that the aims of research will be more tentative: less "universal" and more cognizant of the limiting conditions within which phenomena show themselves. As the intentionalities of consciousness and the structures of the lifeworld become our targets of investigation, we will be better able to address postmodern interests (while necessarily abandoning earlier methods aimed at establishing fixed laws pertaining to static or otherwise invariant realities).

The conventional "empirical" methods of the natural sciences work optimally under circumstances where the objects of investigation are samples from homogeneous classes of individuals. For example: the atoms, crystals, and raindrops studied by chemists, geologists, and meteorologists are, for all intents and purposes, all interchangeable with other members of the same class of objects: "the laws of nature have to be formulated with respect to classes: we can say very little about an individual" (Elasser, 1966, p.47). Once we move from inanimate to animate nature, we have already entered the realm of "inhomogeneous" individuals (ibid.). By the time we reach the orders of consciousness and culture, it becomes more and more difficult to accommodate our subject matter to the methods of the empirical physical sciences. But this is not to say that there can be no methods appropriate to our subject matter. Even if meaning is to be found in the particularities of individual experience rather than in the universalities or typicalities sought by modern scientists, a phenomenological method nonetheless turns out to be well suited to our purpose.

Postmodern thinkers seem to have moved away from phenomenology as a method because they have been put off by the Husserlian search for essences or unities and instead prefer to speak of differences or "disunities." It was the phenomenologist Jean-Paul Sartre, however, who showed that we need not be deterred by such difficulties as indefinable or inhomogeneous objects of investigation:

> This is because there can be descriptions which do not aim at the essence but at the existent itself in its particularity. To be sure, I could not describe a freedom which would be common to both the Other and myself; I could not therefore contemplate an essence of freedom...actually the question is of my freedom. Similarly when I described consciousness, I could not discuss a nature common to certain individuals but only my particular consciousness, which like my freedom is beyond essence. (Sartre, 1943/1956, p. 438).

If postmodern thinkers have a tendency of wanting to abandon method altogether in view of a multiverse irreducible to any knowable essence, phenomenologists like Sartre still offer hope by suggesting and demonstrating that a diversity or heterogeneity of individual experience is no deterrent to developing a methodology for a psychological science. The new human study will be a study precisely of human variance, rather than an effort to control or otherwise eliminate variance. This means there will be less concern with making claims for "external validity" and thus a change in attitude regarding the conventional ideal of randonmess in sampling procedures. We will see a shift away from nomothetic studies, toward the idiographic.

Paradigm Shifts [*contributed by von Eckartsberg*]

During the second half of the Twentieth Century there were increasing discussions of the nature of scientific activities and revolutions, beginning with Kuhn's (1962) *The Structure of Scientific Revolutions*, and with the emergence of an autonomous philosophical-reflective discipline called "Meta-Science", that is, a science of scientific activity (Radnitzky, 1970). In this approach researchers are seen as belonging to "schools" or "research traditions." It is within such a social structure and within the conceptual framework of a "paradigm" characterizing a school that research proceeds. Kuhn (1962) stated:

> By the concept of paradigm...I mean to suggest that some accepted examples of scientific practice--examples which include law, theory, application, and instrumentation together--provide models from which spring particular coherent traditions of scientific research. (1962, p.10)

> Men whose research is based on shared paradigms are committed to the same rules and standards for scientific practice." (1962, p.11)

A paradigm thus constitutes a particular school of thought. Kuhn's work was based on the history of the natural sciences in which "scientific

revolutions" occur. New paradigms replace old paradigms. The innovation comes as new observations are made which cannot be accommodated by the ruling paradigm. A new model is created, typically by a member who is new or marginal to the discipline, who is not yet fully socialized. As the new paradigm is articulated, it draws adherents to itself and grows in prestige and numbers until it replaces the old paradigm whose proponents are seldom converted but just fade away in influence or die.

We realize that the situation in the humanities and the social sciences is different. In these disciplines, as well as in religion, philosophy, and political persuasion, paradigm-replacement does not really occur. New paradigms are created, it is true, but the old paradigms continue to exist and perpetuate themselves. They exist side-by-side, sometimes in critical dialogue with each other but mostly as self-perpetuating and self-reinforcing communities of discourse. These disciplines are inherently poly-paradigmatic.

In the social and human sciences we are dealing with a situation of epistemological pluralism. All conflicting schools of thought coexist and compete for followers and audience in a dynamic fashion. There is a socio-political battle for "ways of seeing" and "ways of speaking" shared by a network of participants, that is, by a school of thought that promotes its own paradigm. In the human and interhuman sciences paradigms do not replace and supersede each other but they wax and wane in distribution, popularity, and credibility. The human sciences are poly-paradigmatic because human behavior involves action that is a result of human deliberation, choice, and the attribution of motives, goals, and values about which there is no universal agreement. Another way of saying this is that human action–as contrasted with animal behavior–is evoked, conceived, and executed in a cultural context along parameters of a historically created way of life to which one is existentially committed, but which allows various interpretations. Historically, several distinct ways of thinking such as materialism, rationalism, idealism, and gnosticism, have been created which continue to be options for looking at and interpreting the meaning of human action. Psychological paradigms coexist and continue to be available in the total epistemological field. Sometimes a genuinely new vision is revealed, as in psychoanalysis, Marxism, and existential-phenomenology.

As they draw adherents and become popular movements, paradigm shifts may seem to take place. Sociologically speaking, however, we merely witness a shift of membership and popularity but never really a paradigm replacement. Each articulated theoretical position, once it has been named and has achieved a certain level of articulation, seems to become institutionalized by a coterie of adherents constituting a cross-generational orthodoxy thatdefends the purity of its own creed. Paradigm shifts occur,

however, quite frequently within the career of particular psychologists who come to believe in and represent a new school of thought, undergoing something like an intellectual conversion experience. Paradigms stand in critical dialogue and in competition for proselytes in the tradition of democratic pluralism that is ruled by the implicit ideal of the "communicative free society" in which everyone who is able is invited to speak out and contribute. This situation of dialogue is also called the "criticist frame," the shared fundamental agreement and commitment to communicate through critical dialogue (Radnitzky, 1970). Even if we disagree violently on the issues, we nevertheless trust the process of communication and language itself to find and set truth free; and we give all participants a fair hearing.

The coexistence of a plurality of paradigms is comparable to life in a multi-religious society under democratic pluralism. Paradigms are "conviction communities" (Bruteau, 1979) in the sense that the shared commitment to and the grounding assumptions about the essentials of human nature assume the strength of an indubitable faith that is shared by the members. Unfortunately, these groups often develop xenophobia and avoid critical dialogue with each other. There are dimensions of power, politics, and success–or marketing thinking–operating in the complex field of discourse and debate we call social psychology. Radnitzky (1970) spoke of sciences, and hence also of the schools of social psychology, as "knowledge-producing industries" with a complex set of role-types which aim for market share in the market place of ideas, practices and programs. One important role type is that of the critic of the tradition: the internal critics--those who draw out the consequences, expose tensions, etc. and the external critics--those who, from a platform outside the tradition, attack the very program of the tradition and the adequacy criteria assumed by it. More and less outside of the tradition, yet related to it, are the sympathizers of a tradition.

Radnitzky presents a schematic model of the dynamics of the research process within an intellectual tradition or school that holds true for all specific schools of thought. It is a fruitful approach to develop a meta-science, that is, a science of scientific activity. Our contemporary world-market civilization certainly makes the economic metaphor of knowledge-production and knowledge-distribution, as well as knowledge-and discourse–competition very attractive and relevant. Paradigms thus compete for acceptance just like political ideologies do. Both paradigm-conviction and ideology-conviction are species of faith commitments that cannot be rationally justified (von Eckartsberg, 1983). The foundational concepts expressive of one's beliefs about the essentials of human nature (one's philosophical anthropology) act as axioms that cannot be proven by

the theory itself. Myth is another example of a foundational story as origin and basis for a conviction and a shared way of life that transcends logical argumentation. We live in these stories and identify with them. This is the source of their truth-value for us. It grounds our conviction and practices.

As we have indicated, a paradigm is a way of seeing reality. It is a way of speaking together in a group, a school of thought, and of using an agreed upon vocabulary of concepts. These concepts together map the territory of relevant processes for the group and they prescribe the accepted way of doing research, the methodology. The school or research tradition typically has a founder whose name is associated with the school: Freudian Psychoanalysis, Skinnerian Behaviorism, Marxist Psychology, and so on; or the school is a group name which characterizes the work of several founding members each of whom can be said to be a founder such as "Existential Phenomenology" which represents the aftermath of Husserl's phenomenology in the work of Heidegger, Sartre, and Merleau-Ponty, or "Hermeneutic Dialectics" which encompasses the work of Gadamer and Ricouer among others. Human experienced reality is so rich and complex that it allows many types of conceptualization and mapping, that is, many ways of interpretation, all of which yield valid insights and plausible understanding.

There is an irreducible relativity in our attempts to understand and explain human affairs and human motives, which founds the poly-paradigmatic nature of psychology and all of the social sciences and humanities. The important distinguishing characteristics of any paradigm or research tradition are two assumptions that may be hidden and need to be articulated:

1. *The philosophical anthropological question*: Who and what is a human being? Any attempt to understand human action and experience already brings certain automatic convictions into play. We already think we know what is important and essential about human personality and motivation to interpret and explain the action. These philosophical anthropological assumptions always already rule our thematizations. They can be investigated and identified by critical reflection and dialogue but they cannot be removed from the epistemological scene.
2. *The research-guiding interest:* What and whom is the knowledge for? Our quest for knowledge and understanding serves our purposes. We have motives for our study and research. Habermas has used the notion of "research guiding interest" to identify this dimension of human sense-making. In his analysis of the relationship

> between knowledge and interest he has debunked the idea that knowledge is interest-free. He has shown that natural science and hence also traditional social psychology is ruled by a technical interest, that is, the prediction and control of behavior, while existential-phenomenology and hermeneutic-dialectical approaches serve the epistemological interest of understanding, that is, becoming cognizant of the meanings that animate and rule our actions and expressions.

The creator of a new paradigm always hopes to find the last word, the ultimate vision of a theory that will make all other paradigms superfluous. Perhaps every founder needs this illusion to sustain the conviction in the validity and truth claim of his paradigm. Is the integrative vision of the essence of human nature as a way of life creator and the research guiding interest of life-style creation the ultimate insight leading to paradigm replacement in the spirit of Kuhn's model? We wish it were so, but we suspect that the adherents and creators of other paradigms will not be convinced to abandon their positions and switch over to way of life study. Social psychology will remain a poly-paradigmatic discipline and this is no wonder in the face of the indubitable truth that social life is always more than what we can say about it. Our theories remain partial approximations and incomplete maps of the existential theatre. In matters of intellect and rationality we sooner or later realize with Adorno that it is an illusion to believe that thought is able to grasp reality as a whole. We probably have to learn to proceed in the manner of "negative dialectics" by "realizing an insufficiency and incongruence of (our) conceptual tools." (Dallmayr, 1987, p. 62)

If we study the life of a person as a pattern, as a way of life, we realize that the individual actor is involved with others as an existential cast of characters. The individual creates and maintains many relationships simultaneously. He or she plays many roles in one-on-one relationships: friendships, love-relationships, functional partnerships: the small groups: family, teams, congregations, fellowships, and so on; and in larger collectivities: citizenship, political parties, audiences, masses, and so on. Every person is simultaneously a unique and irreplaceable individual actor, a member, a co-actor in myriad social bodies constituting cultural life, and an anonymous functionary in collectivities. We seem to be obliged to take a holistic and ecological point of view.

Questions in a Context of Diversity and Change

Where does this leave us, then, with regard to establishing the foundations for a program of research? There are three basic questions that must be addressed by any methodology, and we will attempt here to sketch a tentative methodology for the new *Geisteswissenschaft* by addressing these issues: First, what kinds of questions shall we pose? Second, what kinds of data shall we collect and interrogate? Third, what kinds of knowledge (or formulations of "truth") will result?

(1) In the questions that we pose we will be addressing ourselves to the idiosyncracies of ever-changing human realities. Having transcended the modern preoccupation with universals and essences, we can follow our interests into the realm of the individual and the accidental where intentionalities and contingencies intertwine to co-constitute human existence.

The contribution of humanistic psychology within this research tradition has been its willingness to affirm the creative potential of humanity; the contribution of postmodern thought is its reminder that whatever we strive to create, we must do so without being able to claim any universality or permanence to our creation. The "new" questions for human science research thus become: "How do human beings create reality in a time when reality appears to be more and more transient?" and "To what extent can any of humanity's creations be taken as reflective of 'humanity itself'?" These lead to a third question: "What kind of 'realities' (actual or virtual) are created by humanity?" These questions are not of the kind that one would normally develop a methodology to address: they are reflective questions of a foundational nature that one might pose in the wake of inquiries already undertaken. It will be important, then, to maintain a distinction between questions of an overarching nature that provide a context as well as an inspiration for research, and questions of a more circumscribed nature that can be addressed more directly using qualitative or quantitative methods.

(2) Researchers typically address general questions by "operationalizing" the questions into observable events and finding adequate means of sampling the target population. With "humanity" itself as the population of interest, there is an immediate problem with respect to the external validity of any research investigation. The challenge will be for methodologists to design studies that reflect "humanity" without being either reductionistic or totalizing, and this will require some new thinking with regard to what constitutes "data" and how one arrives at "results."

It was R. D. Laing who suggested that we refer to the subject matter of psychology as *capta* rather than *data* because "the data" (given) of research

are not so much given as taken out of a constantly elusive matrix of happenings" (1967, p.62). What he is acknowledging here is the peculiar nature of both the process and content of psychology: As a logos psychology selectively illuminates its subject matter, and in effect its findings are captured by a creative mind rather than merely recorded on a blank slate. Moreover, the "constantly elusive matrix" that forms the subject matter of psychology is an ever–changing nexus or totality (Dilthey called it a *Zusammenhang*) that includes the presence of the psychologist. For postmodern psychologists, this matrix is understood to be a system of discourse that is elusive only to the extent that it is essentially idiosyncratic: each moment of psychological insight represents a "happening" that takes place between an instance of human conduct and the narrative context that is the researcher's presence.

(3) The implication is that we need no longer search for "objective" truths or feel obliged to make claims that our knowledge is based on "fact": "Facts, as Heidegger has pointed out, only come into view...after nature has been set up as possessing a purely objective character.... Science is a highly creative human endeavor, not the uncovering of determinate facts, of things as they always were" (Fuller, 1990, p.20). In a new human science we will acknowledge that our starting point is not "an accumulation of "bare facts" but rather a linguistic act of positing by which we co-constitute our very sense of what it is we are studying. As Polkinghorne (1991) observed, "each language system has its own particular way of distorting, filtering, and constructing experience...Each language system is to be recognized and honored as one among the many systems by which order can be constructed in experience...Rather than reproductions of clear pictures of the real as it is in itself, human experience consists of meaningful interpretations of the real." It may be even more appropriate to say that human experience consists of meaningful interpretations that are the real. If psychological reality is our subject matter, then it is already a narrative reality. What is true for us in everyday life is every bit as true for us as researchers: we respond not to "objective" qualities of our subject matter but to qualities that are a function of our perspective upon our subject matter.

Toward an Epistemology for the Human Sciences

Almost a century ago, Wilhelm Dilthey (1894/1977) remarked that in understanding we draw upon all of the powers of the psyche: sensing, judging, remembering, imagining, intuiting, feeling, and thinking. How ironic, then, that when empirical psychologists go to the encounter with their subject matter, they bring with them a truncated understanding whose

claim to fame is its reliance upon sense data and calculative thinking, to the exclusion of other modes of understanding such as feeling, intuiting, and imagining. In aspiring to be scientific, psychologists have adamantly based their theories upon observation, and yet they have restricted themselves to essentially one mode of observation: sensation. Unfortunately, we have forsaken the very modes of perception that might conceivably offer us the most direct and faithful access to our subject.

If a methodology for the new "human science" methodologies would raise questions about the meanings of consciousness, conduct, and culture in a context of diversity and change, then the methods employed would be predicated upon a sensitivity to meanings requiring some form of direct existential contact between the researcher and the phenomenon. Such contact could be achieved by establishing an empathic relationship with the "data." Human science researchers can take as data and thereby submit to their powers of understanding just about any form of human expression: verbal testimony, written protocols, observed behavior, gestures and drawings, art works, cultural artifacts, and media presentations. To be sure, these data must be perceived by the senses in some way or another in order for them to be understood. But understanding exceeds the powers of sensation in the same way that psychological meaning transcends the purely material events occurring in the brain while experience takes place. Material events of behavior and the sensations that register them in the brain of the researcher are both merely superficial occurrences. Meaning is an event that reflects what we might call the "depths" of the psyche. It is what inspired Freud to invent his depth-psychology, which sought the meaning or "intent" of the symptom over and above its material cause (see especially Freud 1905/1963, pp. 59-61).

What is important to bear in mind is that the relationship between a behavior and its meaning or intent is not a simple "correspondence," such as might be understood to exist between a material object and its weight. This is what has led philosophers of science to contrast "narrative truth" with objective or "historical truth" and to speak of "interpretation as an artistic and pragmatic creation that is always oriented toward the future" (Spence, 1982, p. 287). If our understanding of behavior, like behavior itself, is always oriented toward the future, then we need not "look back" (to some original sense datum); perhaps it is even the case" that we cannot look back. This of course raises a problem with respect to the validation of our findings. To simply ask for a good story leaves one open to too many inadequacies: using narrative fit alone as a criterion for adequacy, we discover that there are numerous plausible accounts that might never be proven (or disproven).

Psychoanlytic therapy, however, does not require that the analyst's reconstruction of a childhood event be objectively confirmed for it to have "subjective truth value"--that is, pragmatic value for the present and future of the patient. Feyerabend (1975) takes this position to the extreme, suggesting "once it has been realized that close empirical fit is no virtue and that it must be relaxed in times of change, then style, elegance of expression, simplicity of presentation, tension of plot and narrative, and seductiveness of content become important features of our knowledge."

In practice, we believe that aesthetic criteria for validity will not suffice and that we need to strive for both coherence and correspondence, even if of a limited nature, and that perhaps we should consider a third term that embraces both of these criteria. The term "connectedness" might serve to suggest the need for description to be adequately grounded in evidence (albeit not a simple "self-evidence") while expressed in a way that preserves the *Zusammenhang* or *Gestalt* of human experience. Furthermore, it suggests the need for understanding to be connected to our future, in the Heideggerian sense of a "project" (see Churchill, 2018). That is, our formulations of truth should be facilitative of our journey through life.

In the end, the value of research will depend on its capacity to help ourselves and those whom we serve to gain insight into the vicissitudes of human experience. Further investigations from other viewpoints may then supplement and possibly even radically decenter what remains a forever limited knowledge of human life.

References

Bruteau, B. (1979). *The psychic grid.* Wheaton: The Theosophical Publishing House.

Churchill, S.D. (2018). Explorations in teaching the phenomenological method: Challenging psychology students to "grasp at meaning" in human science research. *Qualitative Psychology, 5* (2), 207-227.

Dallmayr, I. (1987). *Critical encounters.* Notre Dame, 111: University of Notre Dame Press.

Dilthey, W. (1977). *Descriptive psychology and historical understanding.* (R. M. Zaner & K. L. Heiges, Trans.) The Hague: Martinus Nijhoff. (Original work published 1894)

Elasser, W. M. (1966). *Atom and organism: A new approach to theoretical biology.* Princeton: Princeton University Press.

Feyeraband, P. (1975). *Against method: Outline of an anarchistic theory of knowledge.* London: Redwood Bam.

Freud, S. (1963). *Dora: An analysis of a case of hysteria.* (P. Rieff, Ed.)

New York: Collier Books. (Original manuscript written 1900 and published 1905)
Fuller, A. (1990). *Insight into value: An exploration of the premises of a phenomenological psychology.* Albany: SUNY Press.
Howell, P. (1991). Introduction. *Methods: A Journal for Human Science (Special Issue).*
Köhler, W. (1971). Methods of psychological research with apes (M. Henle, Trans.). In M. Henle (Ed.), *The selected papers of Wolfgang Köhler.* New York: Liveright. (Original work published 1921)
Kuhn, T. (1962). *The structure of scientific revolutions.* Chicago: University of Chicago Press.
Laing, R. D. (1967). *The politics of experience.* New York: Bailentine Books.
Polkinghorne, D. E. (1991). *Postmodern epistemology of practice.* Unpublished manuscript, University of Southern California.
Radnitzky, G. (1970). *Contemporary schools of meta-science.* (Second and Enlarged Edition). NY: Humanities Press.
Sartre, J-P. (1956). *Being and nothingness: A phenomenological essay on ontology* (H. Barnes, Trans.). New York: Philosophical Library. (Original work published 1943)
Spence, D. P. (1982). *Narrative truth and historical truth: Meaning and interpretation in psychoanalysis.* New York: Norton
von Eckartsberg, R. (1983). Existential-Phenomenology, validity and the transpersonal ground of psychological theorizing. In A. Giorgi, A. Barton, and C. Maes (Eds.), *Duquesne studies in phenomenological psychology Volume IV* (pp. 199–206), Pittsburgh: Duquesne University Press.

Perspective Two: Wolfgang Tschacher
Gestalt Therapy in the Light of Current Developments
Prof. Dr. phil. Wolfgang Tschacher

Gestalt therapy as a psychotherapy approach is a method to induce a psychological learning process, which can facilitate profound changes of a client's experiencing, behavior and social relations. Psychotherapy is personalized and specifically tailored to reduce a client's psychological disorder and/or suffering, and/or increase the client's well-being and functioning. Like all psychotherapeutic approaches, gestalt therapy is based on three components.

First, general mechanisms of change (so-called common factors) are the vehicles of therapeutic action. A well-studied example of a common factor

is the quality of the therapeutic alliance, i.e. the bond and working relationship between therapist and client. Second, this and other common factors are implemented by a number of specific therapy techniques, such as the chair technique in gestalt therapy. Third, psychotherapy is based on philosophical and theoretical convictions, i.e. on assumptions concerning the nature of experiencing, behavior and social relations of people.

Current psychotherapy research (Lambert, 2013) assumes that the mechanisms of change are shared by many different approaches, and gestalt therapy is no exception. The distinctive features of a psychotherapy approach, however, predominantly rest in the techniques and in the theoretical propositions based on which such techniques have been developed.

The goal of the present discourse is to demarcate the foundations of gestalt therapy, and then link these to modern developments in psychology, philosophy of mind, and philosophy of science. As a result of this procedure, I will finally formulate three theoretical and philosophical propositions for gestalt therapy to inform and support gestalt research.

Foundations and Assumptions of Gestalt Therapy

Gestalt therapy is one of the prominent humanistic approaches of psychotherapy. According to the humanistic tradition, the individual person is first of all viewed as a conscious and sentient agent. Consciousness implies that the world is experienced (only) at the present moment, and that experiences concern the environmental context, which is present exactly at this moment.

The environmental context has different layers: the most proximal layer is one's own sensed and sensing body, more distal layers are constituted by the physical surroundings as perceived from one's own perspective, which is again mediated by the body. A further layer that is addressed by consciousness is the cognitive and valent life-space (Lewin, 1936), i.e. a person's representations of things, events, memories, and goals. Consciousness in the therapeutic setting thus has two dimensions, a spatial dimension (the client's environment and mental representations thereof) and a temporal dimension (the client's present moment). Both dimensions together make up the 'here-and-now', which is the very starting point of gestalt psychotherapy.

At the same time, the hallmark of any therapeutic setting is a social encounter between clients and therapists. Accordingly, Gestalt therapy also focuses on this social relationship, the therapeutic alliance. The individual self is conceived of as having been co-created previously by the individual together with care-givers and other relevant others throughout development.

Processes of co-creation remain essential especially in the therapeutic setting. Hence this setting is dialogical, and we are dealing with a shared context in the here-and-now. This is also true for the present moment, which becomes a shared present moment because the client's awareness of possessing present-time consciousness meets with the presence of the therapist (Geller, Greenberg, & Watson, 2010).

Gestalt therapy was developed on the basis of inspirations that Fritz and Laura Perls had received from Gestalt psychology (Goldstein, 1939; Köhler, 1920) and Gestalt theory (Lewin, 1936). The core tenet of Gestalt psychology was that the primary quality of perception and, more generally, mental functioning is holistic: in the first place, we directly perceive, and deal with, wholes (i.e. gestalts). Gestalts are assembled from parts, but a gestalt is different from the sum of its parts. In this, gestalt psychology criticized associationism and behaviorism as too-elementaristic theories in psychology. Gestalt psychology instead formulated principles or 'laws', which explicate how coordinated wholes arise from parts. Gestalt laws concern the qualities of the holistic level, not of the elementary level–hence, top-down influences reign over bottom-up influences. In ambiguous circumstances, the 'best' gestalt commonly wins out, i.e. is finally perceived and/or realized in mental experience (Figure 1). This principle of good gestalt is the *Prägnanzgesetz* (Koffka, 1935).

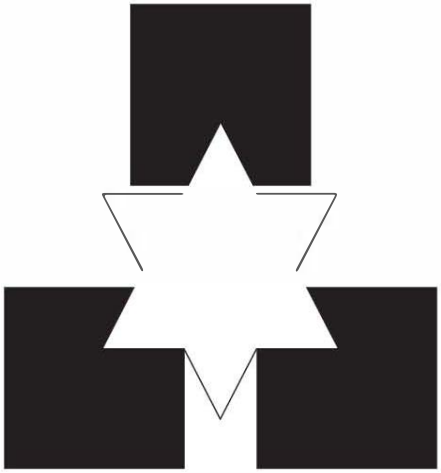

Figure 3.1. Illustration of the principle of good gestalt

This holistic layout of the gestalt concept comes with an important corollary: when a gestalt is unfinished and 'open', gestalt laws will exert a tendency towards gestalt closure. This is true in perception and likewise at the level of voluntary action, where unfinished business is preserved in memory until the action can be completed (Zeigamik, 1927). According to the *Prägnanzgesetz,* the parts will be coordinated in such a way that they approach an optimal gestalt. Hence, the background of gestalt theory also predicts that constellations will show growth until the gestalts are closed. Gestalt therapy and other humanistic approaches applied this theoretical concept to the character of clients. In the case of imbalance or incompleteness of character, we may expect that forces of self-actualization and completion of personality are activated. Personality growth thus directly follows from the gestalt principles.

Gestalt therapy focuses on emotions (Greenberg, Rice & Elliott, 1993). Contacting, expressing and accepting one's emotional impulses constitute core processes in therapy. The James-Lange theory of emotion (James, 1894) plays an important role in the theory of gestalt practice. The James-Lange theory says that people perceive and recognize emotions through perceiving their own bodily changes that are associated with the emotions. Hence, I feel angry because I sense the muscular and physiological correlates of anger in my body. Experiencing emotion is a result of reading my own somatic markers of the emotion. Laura Perls' background in dance and movement therapy is consistent with this emphasis on the emotional expression of the body.

This short list of theoretical convictions of gestalt therapy is largely based on the psychology of the early 20th century. Thus, one may question the linkage between the theory of gestalt therapy and contemporary psychology. I will therefore analyze the theoretical foundations of gestalt therapy in the light of current theories of psychology and philosophy.

Gestalt Therapy in the Light of Current Developments

It is my general impression that there is a solid convergence between the theory of gestalt therapy and current thinking in psychology and the philosophy of mind. I will organize this impression in the form of three propositions, which build on each other. The first proposition is the multidisciplinary concept of embodiment, the second addresses the philosophy of mind, and the third proposition links the gestalt concept with a structural theory of complex systems.

Proposition 1: Embodiment–embodied mind and embodied communication. Embodiment has become a pervasive approach in many

fields of psychology (Niedenthal et al., 2005), neuroscience (Rizzolatti, Fogassi, & Gallese, 2006), computer science (Pfeifer & Bongard, 2006), psychiatry (Tschacher, Giersch & Friston, 2017) and further disciplines (Tschacher & Bergomi, 2011). The concept of embodiment suggests that mental processes should be regarded always on the background of the movement and activity of the body. A large number of studies have shown the bidirectional relationship between mind and body–meaning that mental states are expressed in the body, and, vice versa, body states are echoed in mental processes. Embodiment denotes a pronounced shift from long-standing cognitivist assumptions that the mind and communication are based on abstract information processing–the so-called "computer metaphor" of the mind. This metaphor has considerably shaped cognitive psychology and university-based psychotherapy since the 1960s.

Current quantitative research increasingly shows, however, that (and how) therapeutic interaction is grounded in therapists' and clients' posture, body motion, gesture and prosody–in short, in their bodies. This may be no novel insight for Gestalt therapists, who have always emphasized the here-and-now of therapeutic encounters. But it is still uncharted territory for academic psychotherapy research, and the body together with nonverbal behavior and ecological aspects of the therapy setting were accordingly neglected.

The embodiment of psychotherapy is likely true for all approaches, hence also for cognitive-behavioral psychotherapy sessions, where seemingly abstract mental issues are the subjects of verbal exchanges. Even 'talk therapy' is insufficiently conceived of by a merely cognitivistic framework: the degree of nonverbal synchronization of clients and therapists in randomly picked cognitive-behavioral sessions was found significantly predictive of therapy outcome (Ramseyer & Tschacher, 2011). The empirical evidence also supports the idea that the quality of alliance is embodied by the degree of nonverbal synchrony between therapist and patient (Imel et al., 2014; Ramseyer & Tschacher, 2016). In schizophrenia patients, nonverbal synchrony with healthy partners during role-plays was significantly related to symptom profiles of the patients (Kupper et al., 2015). The evidence accumulated so far suggests that the degree of nonverbal (including physiological, e.g. Karvonen et al., 2016) synchrony may be a pivotal predictor of features of social interaction, of individual emotion regulation, as well as an indicator of the severity of psychopathology in schizophrenia and other disorders. Seen this way, embodied synchrony belongs to the canon of therapeutic common factors.

There is an interesting extension of synchrony research to the temporal dimension of the here-and-now. Therapeutic nowness, i.e. the experienced

present moment, can be operationalized by the duration of significant synchrony levels of people interacting, which is at the range of five to six seconds. Embodied synchrony was found associated with personality features of patients such as attachment styles and interpersonal problems (Tschacher, Ramseyer & Koole, 2018).

This means that the bidirectional ("dialogical") relationship between mind and body, which is the core of the theoretical approach of embodiment, at the same time constitutes a foundation of interaction and also psychotherapeutic intervention. The social function of embodiment rests on this intra-individual mind-body relationship, and again comes to the fore in inter-individual nonverbal synchrony. The dialogical relationship between therapist and client (and in general, between self and other) can be cast in terms of embodied communication.

Embodied communication has also been studied and corroborated by neuroscience. In social contexts, perceiving the other's behavior automatically induces a motor simulation of this behavior in the observer (Rizzolatti, Fogassi, & Gallese, 2006), the neuronal basis of which is the mirror-neuron system of brain functioning. In addition, there are bidirectional parasympathetic pathways that support social engagement in that they convey an individual's present physiological state via prosody, posture and facial expression to others and vice versa (Geller & Porges, 2014). Such central-nervous and parasympathetic couplings are the physiological correlates of the behavioral synchrony findings. Quite generally, the bodies and nervous systems of social agents are coupled and synchronized at a considerable number of levels – motoric, prosodic, linguistic, and physiological (Koole & Tschacher, 2016).

Proposition 2: Non-reductionism in mind-body philosophy. The perspective of embodiment, which has initiated a novel paradigm in psychology and neuroscience, has a close correspondence to philosophical positions in the mind-body debate (Chalmers, 2002). If both the mind and communication are embodied, and the body in turn has mental and social impact, we need to come to grips with the relationship between mind and body. Roughly, we may classify the philosophical positions into reductionist-monist conceptions and dualistic ones (Figure 2).

Reductionism in the philosophy of mind basically comes in two versions. The first is materialism according to which mind is nothing but matter. Only matter is viewed as ontologically real whereas mind is not. In a not so distant future, brain science may have described all mental processes as neuronal processes and thus mind can be completely reduced to material process (Churchland, 1986). As a consequence, the mind and the

self may be shown to be an illusion (much like virtual reality: Metzinger, 2003)

The second version of reductionism is objective idealism (such as in Hegel's *Phenomenology of Spirit*) or, especially in the post-modern psychotherapeutic context, radical constructivism (Maturana & Varela, 1980). In its reductionist versions, constructivism proposes that the world is a narrative generated by observers. Observers' cognitive constructions are viewed as ontologically real whereas material objects may be hallucinatory. In the solipsistic extreme, one may say: only I exist, all other things are my products.

Both reductionist positions are not very attractive as foundations of a gestalt psychotherapy that regards and addresses the client's mind *and* body. For the same reason, reductionism appears incompatible with the embodiment proposition. Therefore, we need to consider dualist positions in the mind-body debate. Dualism in modernity is still strongly influenced by the philosophy of René Descartes, who proposed that body and mind (soul) are both ontologically real "substances." The body as a material substance is extended and localizable in space, whereas mind is *res cogitans*, cognitive substance, which is characterized by intentionality (Brentano, 1874). Conscious thinking in the present moment is proof of existence (*cogito ergo sum*). This classical dualism would be easily consistent with the bi-directionality of embodiment research, yet it opens up a series of problems: how may one envisage the interactions between mind and matter, if they are such contrary substances? Descartes and contemporary dualists have looked for brain sites (the 'liaison brain': Popper & Eccles, 1982) where these interactions may occur, still to no avail. A different form of dualism is property dualism. Matter is viewed to be ontologically given, but some material systems (e.g. brains) have not only material but additionally mental properties. Mental properties emerge from material systems and attain their own quality, but they are commonly viewed as meta-phenomena of brain activity without causal power.

Some modern approaches claim that neither mind nor body are ontologically real, but that they are (merely) epistemological aspects of an underlying ontology. Atmanspacher (2014) has reviewed different brands of such dual-aspect thinking. An early one was constituted by Spinoza's philosophy in the 17th century: like Descartes, Spinoza acknowledged the differences between mind and matter, yet he argued they were just different attributes of the same substance. Modern dual-aspect philosophers are e.g. Bertrand Russell (neutral monism), C.G. Jung and Wolfgang Pauli (complementarity of mind and matter), David Bohm (quantum-theory and 'implicate order') and David Chalmers (mind and matter as differently

composed information structures). The thinking of the systems theorist Hermann Haken (circular causality of mind and matter) is also based on a dual-aspect foundation (Tschacher & Bergomi, 2013).

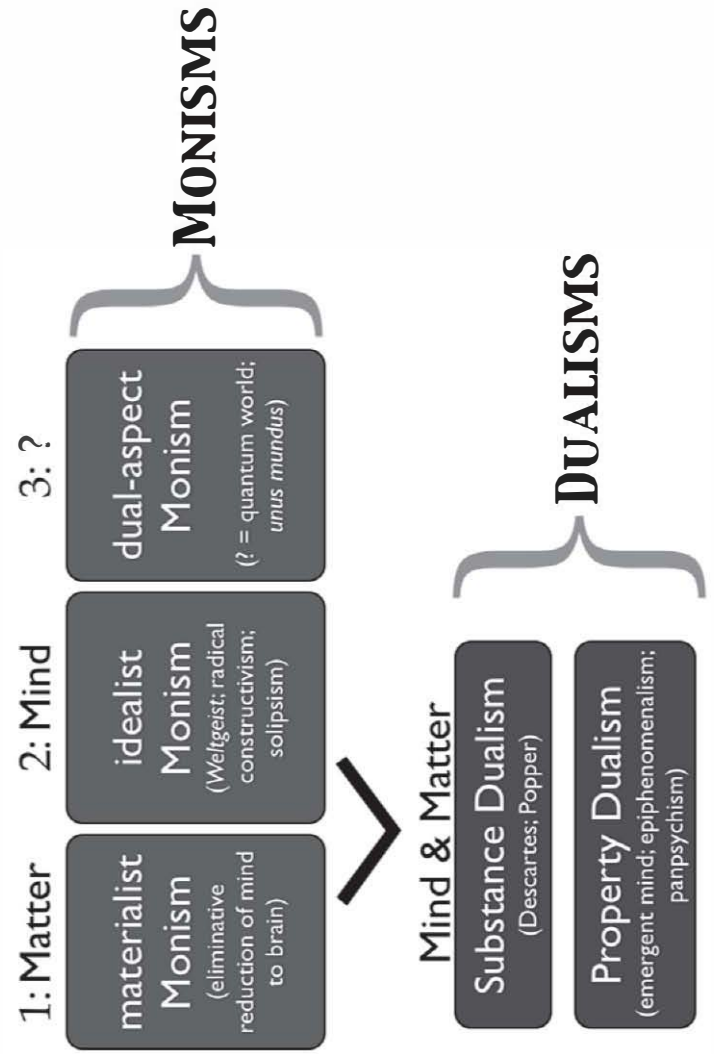

Figure 3.2. Illustration of positions in the mind-body debate

A problem with dual-aspect philosophy may be that an underlying ontology is postulated that itself is not directly observable. One may say that the dualistic problem of the unclear mind-body interaction has been replaced by the monistic problem of a non-observable reality beyond the (observable) material and mental aspects. The advantages of dual-aspect philosophy for gestalt therapy are that the material and mental aspects in psychotherapy are supported, and that there is no need to reduce one to the respective other. Also, the monistic basis of these complementary aspects can be considered a holistic reality such as Jung's *unus mundus* or Bohm's holo-movement, which would preserve the holism emphasized by gestalt theory.

Proposition 3: Dynamical systems theory. Gestalt psychology has been dormant in academic psychology for several decades. There was however one major development in systems theory that has led to a renewed interest in gestalts: the theory of self-organization. Self-organization theory was established in the early 1970s by two scientists, the chemist Ilya Progogine (Nicolis & Prigogine, 1977) and the physicist Hermann Haken. Both were intrigued by phenomena of spontaneous pattern formation in their respective disciplines. In physics, Haken mathematically modeled a system that initially emits unordered light (lamp light of many different frequencies), but when a certain threshold is crossed, emits highly coordinated and synchronized light (the laser light of exactly one frequency). The phase transition from lamp to laser is a rapid, avalanche-like event, which is associated with an enormous reduction of complexity in the system. The transition to the coordinated dynamical regime occurs as soon as the externally applied 'control parameter' (in the laser system, the voltage) passes a critical value.

From early on, Haken realized the interdisciplinary implications of this phenomenon. Spontaneous pattern formation can be observed ubiquitously (Haken, 1977), in many open complex systems that are permeated by free energy (Friston, 2012). Haken's interdisciplinary field of synergetics, the science of parts "working in sync", was accordingly applied to gestalt perception and psychology (Haken & Stadler, 1990) and psychotherapy (Tschacher, Schiepek & Brunner, 1992). In synergetic terms, a gestalt is a (complex) system of several or many elements from which a unitary gestalt impression emerges (Figure 3). The macroscopic order parameter (the gestalt) then entrains all the single microscopic systems components.



Figure 3.3. An image of complex black and white areas. View it rotated by 90°

An image of complex black and white areas, when viewed at a different angle, gives rise to the perception of a face. In terms of synergetics, this pattern recognition process represents an example of self-organization with "viewing angle" as the control parameter.

Synergetics is a stochastic mathematical elaboration of deterministic dynamical systems theory. As such, synergetics emphasizes the dynamical aspects of the patterns that arise through self-organization. The coordinated and highly synchronized gestalt patterns are thus based on and maintained by a constant flux, they are not frozen ontologies or solid structures; they are 'processual gestalts' (Tschacher, 1997).

Synergetic models have been put forward in several areas that are relevant to understanding people's minds and bodies in the here-and-now. One area is body movement: motor activity is usually highly coordinated and synchronized. Walking, for instance, requires the concerted and coordinated action of dozens of muscles yet it is not necessary to consciously attend to this coordination because it is self-organized. Haken, Kelso & Bunz (1985) explored the nature of such motor coordination in hand movements their 'HKB model' became an influential paradigm in movement science and sports science. The synergetics of movement comes to the fore also in social interaction, where it is commonly observed as nonverbal synchrony (Tschacher, Rees & Ramseyer, 2014). Thus, synergetics

offers formal models for many of the phenomena elaborated as embodied communication in Proposition 1. In this perspective, the formation of therapeutic synchrony can be understood as an emergent feature of a complex self-organizing system. This also opens up opportunities to model the therapeutic alliance based on systems theory (Tschacher, Haken & Kyselo, 2015).

In the framework of self-organization, pattern completion rests on the same dynamics as pattern formation, as was shown in experiments with neural network implementations on computers (Haken, 1987). Synergetic neural networks yield connectionist models of associative memory. Pattern completion is the process by which open gestalts become closed, a core tenet of gestalt therapy. Therefore, the humanistic assumption of a tendency towards individual growth and self-actualization may be grounded in principles of self-organization theory. In sum, today's systems theory addresses the core phenomena of past Gestalt psychology in a novel and mathematically based way. This opens up an opportunity for Gestalt therapy to connect with interdisciplinary science.

Proposition 2 addressed the dual aspects of reality, and there are diverging ideas about the nature of the underlying monistic reality that mind and matter are aspects of. Interestingly, we may observe a corresponding dual-aspect situation in the philosophy of science. The sciences are distributed largely into two camps – the natural sciences and the humanities. Natural sciences address the material world: physics, biology or astronomy all rely on objective data. Observations concern objects that are independent of the observer. This is different in the humanities (*Geisteswissenschaften* in the German tradition): literature, anthropology or theology have as their objects mental, cultural or political phenomena. Studies of the humanities are often phenomenological and qualitative, using hermeneutical methodology. The difference between the natural sciences and the humanistic disciplines resembles that between material and mental aspects in the philosophy of mind.

There is however a third group of disciplines, which are neither natural nor humanistic–this is the group of structural sciences such as mathematics, informatics, and systems theory. These disciplines do not have natural occurrences as their objects, but artificial items created and invented by humans. Such items are, for instance, the numbers in mathematics, bits in computer science, and networks or feedback relations in systems theory. In contrast to the humanities, the methodology of structural sciences is not hermeneutical but strict and objective. Synergetics is in all these respects a prototypical structural science.

Discussion

In this chapter, I have sampled several ideas that can connect gestalt therapy to modern developments in the psychological and neurocognitive sciences and philosophy. Proposition 1 stated that we are presently observing a transition from cognitivistic notions of the mind and communication towards an embodied understanding of both. Proposition 2 elaborated on the embodiment stance of proposition 1 by exploring an appropriate philosophy of mind. Presumably, current dual-aspect thinking offers a philosophical framework that is consistent with the practice of gestalt therapy. Finally, proposition 3 recognized in self-organization theory a framework that enables modeling the core phenomena of gestalt therapy. The discipline of synergetics was developed to model self-organizing systems; it is a structural science, i.e. a scientific discipline that integrates features of the natural sciences with those of the humanities.

My review of theoretical foundations has shown that gestalt therapy, with its roots in the psychology of one century ago, can be blended well with today's theoretical and philosophical frameworks. The current integrative approach in psychotherapy research says that psychotherapy as a social practice is made up of unspecific 'common factors', specific techniques, and the theoretical and philosophical convictions that ground a psychotherapy approach. In this chapter I have focused on the last point, and I have translated the gestaltist convictions into theoretical propositions. I have however not addressed the empirical questions that are raised by the other two therapeutic ingredients of psychotherapy, its common factors and techniques. In fact, gestalt therapy has somewhat neglected, due to its criticism of positivist science, empirical trials (of course, with notable exceptions, e.g. Greenberg & Malcolm, 2002; Strümpfel, 2006). More of such research is needed to evaluate the working mechanisms of gestalt therapy and their effectiveness.

In conclusion, my general finding is that gestalt therapy is highly consistent with modern theoretical frameworks – it is a practice of embodied communication. Its wholistic approach is supported by contemporary systems theory. And lastly, gestalt therapy may choose to consider as its philosophical roots not post-modern constructivism, but dual-aspect thinking.

References

Atmanspacher, H. (2014). 20th century versions of dual-aspect thinking. *Mind and Matter*, 12, 245-288.

Brentano, F. (1874). *Psychologie vom empirischen Standpunkte*. Leipzig: Duncker & Humblot.

Chalmers, D.J. (Ed.) (2002). *Philosophy of Mind: Classical and Contemporary Readings*. Oxford: Oxford University Press.

Churchland, P. (1986). *Neurophilosophy: Toward a Unified Science of the Mind-Brain*. Cambridge: MIT Press.

Friston, K.J. (2012). A Free Energy Principle for Biological Systems. *Entropy*, 14, 2100-2121.

Geller, S.M., Greenberg, L.S., & Watson, J.C. (2010). Therapist and client perceptions of therapeutic presence: The development of a measure. *Psychotherapy Research*, 20, 599-610.

Geller, S.M., & Porges, S.W. (2014). Therapeutic presence: Neurophysiological mechanisms mediating feeling safe in therapeutic relationships. *Journal of Psychotherapy Integration*, 24, 178-192.

Goldstein, K. (1939). *The Organism: A Holistic Approach to Biology Derived from Pathological Data in Man*. New York: American Book Company.

Greenberg, L.S., Rice, L.N., & Elliott, R. (1993). *Facilitating emotional change*. New York: Guilford.

Greenberg, L.S. & Malcolm, W. (2002). Resolving unfinished business: Relating process to outcome. *Journal of Consulting and Clinical Psychology, 70*, 406-416.

Haken, H. (1977). *Synergetics – An Introduction. Nonequilibrium Phase-Transitions and Self-Organization in Physics, Chemistry and Biology*. Berlin: Springer.

Haken, H. (1987). Synergetic Computers for Pattern Recognition and Associative Memory. In H. Haken (Ed.), *Computational Systems – Natural and Artificial* (pp. 2-23). Berlin: Springer.

Haken, H. & Stadler, M. (Eds.) (1990). *Synergetics of Cognition*. Berlin: Springer.

Haken, H., Kelso, J.A.S., & Bunz, H. (1985). A theoretical model of phase transitions in human hand movements. *Biological Cybernetics, 51*, 347-356.

Imel, Z.E., Barco, J.S., Brown, H.J., Baucom, B.R., Baer, J.S., Kircher, J. C., et al. (2014). The association of therapist empathy and synchrony in vocally encoded arousal. *Journal of Counseling Psychology*, 61, 146-153.

James, W. (1894). The physical basis of emotion. *Psychological Review*, 1, 516-529.

Karvonen, A., Kykyri, V.-L., Kaartinen, J., Penttonen, M., & Seikkula, J. (2016). Sympathetic Nervous System Synchrony in Couple Therapy. *Journal of Marital and Family Therapy*, 42, 383-395.

Koffka, K. (1935). *Principles of Gestalt Psychology*. New York: Harcourt, Brace and Company.

Köhler, W. (1920). *Die physischen Gestalten in Ruhe und in stationärem Zustand*. Braunschweig: Vieweg.

Koole, S.L. & Tschacher, W. (2016). Synchrony in psychotherapy: A review and an integrative framework for the therapeutic alliance. *Frontiers in Psychology, 7*, 862.

Kupper, Z., Ramseyer, F., Hoffmann, H., & Tschacher, W. (2015). Nonverbal synchrony in social interactions of patients with schizophrenia indicates socio-communicative deficits. *PLoS ONE* 10(12): e0145882.

Lambert, M.J. (Ed.) (2013). *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change (6th ed.)*. New York: Wiley.

Lewin, K. (1936). *Principles of Topological Psychology*. New York: McGraw-Hill.

Maturana, H.R. & Varela, F.J. (1980). *Autopoiesis and Cognition. The Realization of the Living*. Dordrecht: Reidel.

Metzinger, T. (2003). *Being no one: the self-model theory of subjectivity*. Cambridge: MIT Press.

Nicolis, G. & Prigogine, I. (1977). *Self-Organization in Nonequilibrium Systems: From Dissipative Structures to Order through Fluctuations*. New York: Wiley-Interscience.

Niedenthal, P.M., Barsalou, L.W., Winkielman, P., Krauth-Gruber, S., & Ric, F. (2005). Embodiment in attitudes, social perception, and emotion. *Personality and Social Psychology Review*, 9, 184.

Pfeifer, R. & Bongard, J.C. (2006). *How the Body Shapes the Way We Think: A New View of Intelligence*. Cambridge: MIT Press.

Polster, E. & Polster, M. (1973) *Gestalt Therapy Integrated: Contours of theory and practice*. New York, NY: Brunner-Mazel.

Popper, K.R. & Eccles, J.C. (1977). *The self and its brain*. Berlin: Springer.

Ramseyer, F. & Tschacher, W. (2011). Nonverbal synchrony in psychotherapy: Coordinated body movement reflects relationship quality and outcome. *Journal of Consulting and Clinical Psychology*, 79, 284-295.

Ramseyer, F. & Tschacher, W. (2016). Movement coordination in psychotherapy: Synchrony of hand movements is associated with session outcome. *Nonlinear Dynamics, Psychology, and Life Sciences*, 20, 145-166.

Rizzolatti, G., Fogassi, L., & Gallese, V. (2006). Mirrors of the mind. *Scientific American, 295*(5), 54-61.

Strümpfel, U. (2006). *Therapie der Gefühle*. Bergisch Gladbach: EHP-Verlag.

Tschacher, W. (1997). *Prozessgestalten*. Göttingen: Hogrefe.

Tschacher, W., & Bergomi, C. (Eds.) (2011). *The implications of embodiment: Cognition and communication*. Exeter: Imprint Academic.

Tschacher, W. & Bergomi, C. (2013). Conversation with Hermann Haken. *Mind and Matter*, 11, 7-20.

Tschacher, W., Giersch, A., & Friston, K. J. (2017). Embodiment and schizophrenia: A review of implications and applications. *Schizophrenia Bulletin*, 43, 745-753.

Tschacher, W., Haken, H., & Kyselo, M. (2015). Alliance: A common factor of psychotherapy modeled by structural theory. *Frontiers in Psychology, 6*, 421.

Tschacher, W., Rees, G.M. & Ramseyer, F. (2014). Nonverbal synchrony and affect in dyadic interactions. *Frontiers in Psychology*, 5, 1323.

Tschacher, W., Schiepek, G., & Brunner, E.J. (Eds.) (1992). *Self-Organization and Clinical Psychology*. (Empirical Approaches to Synergetics in Psychology). Berlin: Springer.

Tschacher, W., Ramseyer, F., & Koole, S. L. (2018). Sharing the now in the social present: Duration of nonverbal synchrony Is linked with personality. *Journal of Personality*, 86, 129-138.

Zeigarnik, B. (1927). Über das Behalten von erledigten und unerledigten Handlungen. *Psychologische Forschung*, 9, 1-85.

Perspective Three: Brent Slife
The Excluded Other in Psychological Research: Diary of a Probing Theist
Brent D Slife, Elijah Möller, Sami Chun

Research methods in psychology are often presented as if they can study anything relevant to the discipline (e.g., Haworth, 1996). Yet we will attempt to explain how there is an enormous exclusion in their relevancy to a whole range of phenomena and issues associated with psychology's largest group of clients and consumers–theists. Theists are those who assume that a difference-making god is currently active in psychological

events (Slife & Reber, 2009; Slife, Reber, & Lefevor, 2012; Taylor, 2007). As theists ourselves, we will describe how we have frequently felt like the "excluded other" of psychological research, with special emphasis on the first author's career-long experiences and his intellectual "diary" during that career. He has not only probed into the reasons for this exclusion but also puzzled about the *lack* of probing among fellow psychologists who are theists. Indeed, we will contend that even non-theists should be interested in this career-long journey, because it exposes an extraordinarily pervasive and yet utterly underestimated disciplinary prejudice.[3] Let's have him tell his story in first-person for ease of reading.[4]

God's Irrelevance

My story began many years ago when it seemed I was compartmentalizing my faith and my profession. Where God was a vital part of my Sundays, I seemed to overlook this divine personage during my workday as professor and psychotherapist, no matter what I tried. My theistic colleagues reminded me repeatedly of psychology's secular status and seemed to be totally unconcerned about the issue. Yet, it bothered me. So, I decided to bring my meager academic powers to bear by posing a fairly straightforward question: what difference would it make if one of the grounding assumptions of my discipline was a currently active and difference-making God? It perhaps goes without saying that the secular discipline of psychology does not actively consider this question. Disciplinary texts in psychology–often the compendiums of settled knowledge in the profession–tend to evidence not the slightest interest in this query (Morris & Maisto, 1999; Slife & Reber, 2009; Starks, 2014). Moreover, the initial answers among my colleagues were clear about the irrelevancy of the question: the assumption of God would make *no* difference in psychology, because psychology is an

[3] We have learned through experience to issue a cautionary note regarding the term "prejudice." As we will show, this term is used in the Gadamerian sense of background interpretive slant or what Taylor would call the social imaginary of the academy. We are not meaning it in the common sense of racial or sexual prejudice. Our reactivity to accusations of prejudice stems from what Gadamer considers our prejudice against prejudice, our extreme sensitivity to the possibility we might be prejudiced, even though we doubt that some sort of interpretive framework can be avoided.

[4] This first-person story would typically be sole-authored, and, indeed, was sole-authored as a presentation to the Psychology and the Other Conference of 2017. However, the junior authors of this chapter played a substantial role in its reformulation and reorganization.

objective discipline, with spiritual content only incidentally involved in its research, if at all. "Add a god onto the findings of psychology, if you wish," they would say, "but it won't change those findings."

Dualism. As it turns out, this answer was one of my first encounters with what I now know to be subject/object dualism in psychology–the notion that the subjective realm (biases, values, opinions) can and should be separated from the objective realm (data of reality). Beliefs in God, from this perspective, are typically located in the subjective part, and psychology's research and practices are, or should be, in the objective part. This sort of dualism makes God not only irrelevant to an objective discipline but also more like a subjective bias that no self-respecting scientist would want to hold professionally. The only problem with this dualistic view, I realized later, is that it is a *view*–a philosophy of science, rather than a fact of science (Richardson, Fower, & Guignon, 1999; Slife, O'Grady, & Kosits, 2017).

Indeed, recent scholarship has deemed this form of dualism impossible (Bishop, 2007; Goodman & Freeman, 2015; Richardson, Fowers, & Guignon, 1999; Slife, Reber, & Faulconer, 2012). Even if the latest research methods are used to produce "objective" data, there are always dozens of methodological "choice-points" where the researchers' "subjectivity" enters this production, from the choice of subject, research design, and operationalization to the choice of statistic, data presentation, and interpretation of results–just to name a few (Porpora, 2006; Slife & Reber, 2009). As the "sponsor effect" in the natural sciences and the "allegiance effect" in the social sciences show, there are always researcher biases and values inherent in research, perhaps especially psychological research (Bhandari et al., 2004; Gantt & Slife, 2016; Kjaergard & Als-Nielson, 2002; Lexchin, Bero, Djulbegovic, & Clark, 2003; Luborsky & Barrett, 2005; Taylor, 2007). In any case, this dualistic conception of psychological science merely begged my original question and put it in a slightly different form: what if God mattered in the so-called *objective* psychological world? Clearly many theists presume that God does matter in this world (Richards & Bergin, 1997). Psychological researchers can, of course, dismiss this worldview out of hand, but thoughtful examination rather than dismissal seems more in keeping with the spirit of science, especially when theists are the primary population served by psychologists (Richards & Bergin, 1997).

Deism. As my exploration of this theistic question continued, it was stymied by yet another argument for God's irrelevance to psychology, coming from perhaps an unlikely source–my Christian colleagues in the natural sciences. They pointed to all the natural laws God had created and now lovingly hopes we will use appropriately. The gist of their argument,

especially as they developed it further, was that God is the Creator of these wonderful natural laws but is essentially irrelevant in natural events of the present. God is not currently a difference-maker. For this reason, psychology (or any other science for that matter) need not take this divine entity into account for understanding the present state of the world. God may exist, in some sense, but is not practically relevant.

In considering this new argument, I realized that it begged the theistic question again, because this conception is deism rather than theism. With deism God is limited, by definition, to the role of past creator (e.g., of the natural laws); God is no longer active. God may exist, but is not practically relevant, and thus not a theistic God. This conception does not rule out theism through logic or evidence; it rules it out through definitional fiat. In other words, deism is merely a different rather than a refuting conception. Indeed, deism would leave me compartmentalized again–worshiping, perhaps, the Creator on Sundays but having no reason to consider this divinity's relevance in my professional activity. Moreover, a deistic God is not a Christian God (e.g., Yoder, 2008). When I offered this clarification to these Christian natural scientists and asked them where they saw God's current, difference-making activity in their research findings or in their disciplines, they were frankly puzzled. As a physicist friend put it, "I've never really thought of God's activity in the natural world. I've always thought of God's activity as me receiving spiritual promptings from him in the supernatural realm."

Supernaturalism. Now we can omit for the moment that my physicist friend is obviously receiving these prompts in the natural realm. His assumption, especially as the conversation continued, was that God was limited, or self-limited, to a realm that did not bother the natural world. Otherwise, of course, my friend would have had to take God into account in his physics, which he admitted he never did. Indeed, the phrase he used–the phrase "supernatural realm"–was essentially spawned by the secular separation of the natural and the supernatural worlds–to distinguish any reference to the supernatural from the natural world (Bernstein, 1983; Reber & Slife, 2005). Theists actually have no reason to separate or even distinguish the two, because they do not view their God as limited to either. In this sense, supernaturalism limits God's activity to some comer of the universe, such as a distinctly spiritual realm; deism relegates this activity to some particular time, such as Creation; and dualism restricts the activity to subjectivity. These conceptions allow for God to exist perhaps, but, knowingly or unknowingly, they disallow God's involvement in the current, objective, and natural world. The upshot is that these conceptions–deism,

dualism, and supernaturalism–do not consider, let alone examine, a theistic understanding of the psychological world. They define theism away.

At this point, my early sojourn through deisms and dualisms helped me to understand what a thorough-going theistic worldview would need to be: it would require the primary assumption of a God who is currently active and difference-making in *all* the world. Please note that this theistic assumption does not necessarily make God the object of study; this assumption, rather, is part of a psychological theory that guides study. At the very least, this theistic approach would provide a framework for how researchers explain their data. Instead of always assuming a secular interpretation of data, which is itself guided by assumptions (Kemp, 1998), the theist could assume the influence of God is at least a necessary condition for all the events and things of the world–the internal combustion of a car engine, the falling of apples from an apple tree, and people's lives, whether or not these divine influences are recognized. From a thorough-going theistic perspective, explanations of *anything* that exclude this divine necessary condition would either be incomplete or wrong. The typical engineer's assertion that a car engine is merely the work of mechanical laws is an explanation that is ultimately incomplete, if not fundamentally in some error. This mechanical explanation may be useful, but it cannot be the whole story when a theist assumes the significance of an active God.

Theism as More Value-laden

With these early clarifications, I could now ask how this primary assumption of theism could conceivably matter to psychological science. However, when interacting with other psychologists over this question, I discovered an intriguing variation of the objectivity objection again. It went something like this: theism is so undeniably laden with subjective assumptions and values, how could it possibly work in an objective science? My initial response was a simple one: all the theories and hypotheses that psychologists attempt to test are laden with assumptions and values, yet these theories are still considered part of the process of science. The personality theory tradition, for instance, is rife with such values and assumptions (e.g., Rychlak, 1981), but even such fields as neuroscience, clinical psychology, and social psychology test conceptions that are riven with assumptions (Batson, 1998; Beutler & Bergan, 1991; Griffin, 2000; Slife, Reber, & Richardson, 2005; Slife, Smith, & Burchfield, 2003; Slife & Williams, 1995; Swanson, Lufkin, & Colman, 1999; Tjeltveit, 1991). Indeed, this is part of the reason for empirically testing these conceptions–to see if these assumptions hold up under real world conditions. In this

sense, at least, theistic hypotheses are no different; all theories have subjective assumptions.

But are theistic theories *more* assumption-laden? Are they somehow less objective than the theories and hypotheses of conventional psychology? Many of my interlocutors pointed to the secularism of psychology in this regard (e.g., Hibberd, 2011). They contended that secularism is basically a neutral or more objective general framework for theories and hypotheses, and thus produces assumptions that are more "scientific." This contention intrigued me greatly, yet as I delved into secularism, I realized that even a tiny bit of its history belies this contention. As Wolfhart Pannenberg (1996) chronicles, original secularism was never intended in this manner. If anything, it was a pluralism of *value-laden* perspectives, including theistic perspectives, not the value-free, anti-theism that some psychologists seem to consider it to be (Helminiak, 2010; Hibberd, 2011).

My research into this more recent, non-theistic secularism revealed another important fact: its popularity is at least partially due to its association with reductive naturalism. Reductive naturalism assumes the study and interpretation of the world should be kept solely to natural events and explanations. Secularism may be a bit more visible than its naturalism cousin as a framework for psychology, but naturalism is just as prevalent (Leahey, 1991). Its prevalence does not mean that science was derived from reductive naturalism; it was not (Bishop, 2007; Smith, 2014). Nevertheless, a quick scan of virtually any scientific literature will show the many scientists who believe their findings "prove" the correctness of a naturalistic (or secular) worldview.

As a quick case in point, consider the renowned British anthropologist, Evans-Pritchard, who was aghast at the spiritual claims of a central African tribe, the Azande (Evans-Pritchard, 1937/1976; Slife, Starks, and Primosch, 2014; Starks, 2014). He even attempted to convince the Azande that science had proven there can be no witches, violating his own anthropologist ethic in asserting his personal beliefs. More to the point, his contention is simply false; science has not even investigated the influence of witches with the Azande, let alone proven their absence. Evans-Pritchard was merely extending what he figured was an implication of all the other findings of science--naturalism.[5] The point here is that naturalism and science are highly associated (Bishop, 2007), and it is the persuasiveness of science that has led to our modern conceptions of non-theistic (naturalistic) secularism.

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[5] As Gantt and Williams (In Press) have shown, this understanding is scientism not science.

What is forgotten here, unfortunately, is that naturalism is itself a modern philosophy, replete with its own assumptions and values like all philosophies. Its philosophical status prohibits it from claiming any "objective" status, even though there is little question that many scientists, such as Evans-Pritchard, tend to treat it this way. In this sense, I realized that naturalism and theism are both philosophies or worldviews with whole systems of assumptions that define their perspectives on the world. Indeed, as Huston Smith (2003) notes, naturalism and theism are the two great worldviews of Western culture. Much like any set of worldviews they each appeal to a certain segment of the culture: the assumptions of naturalism are the more popular in science, and the assumptions of theism are the more popular in religion. Even so, this popularity does not rule out either for use by the other segment. There is no question the Enlightenment period of modern history turned off many scientists to theism, but there is also no evidence that a sophisticated theism was ever seriously considered in this historical light. Serious examination of such a thorough-going theism for psychology still remains.

At this point in my journey, I felt I had come to two major clarifications. First, theism is not inherently irrelevant to psychology; God's supposed exclusion to the subjective world, the supernatural realm, or the creator role is exclusion by conceptual fiat, and is not what most theists believe anyway. Most theists believe that God is not limited to either that those locations or that role. Second, what many psychologists consider to be the current frameworks for psychology–secularism and naturalism–contain subjective assumptions themselves. Their greater familiarity and acceptance in psychology is more a product of history than empirical evidence (King, Viney, & Woody, 2013).

Prejudice Against Theism

These clarifications allowed me to return to my initial query–could the assumptions of theism be practically relevant to psychology? I realized, of course, that theism had never been developed in psychology, but I also began to realize how it could never be explored professionally with the incredible headwind of prejudice against it (Brown, 2005; Slife & Reber, 2009). I was told that psychology is secularistic, and its research is naturalistic, period. Examination of alternative worldviews was thought to be not only unneeded but also unwanted, a kind of threat to the very identity of the discipline and psychologists themselves, or at least their pocketbooks (Helminiak, 2010). Moreover, it was offensive to postulate prejudices

against theism because professional psychologists are scientists, and as such do not engage in prejudices professionally.

Here I realized that my meaning of prejudice was being misunderstood. I did not intend it to be comparable to racial or sexual prejudice. I meant it more as a Gadamerian prejudice, what Charles Taylor would call the "social imaginary" of the discipline (Gadamer, 1995; Taylor, 2007, p. 171). Gadamer calls attention to our singular prejudice against prejudice, our extreme sensitivity to the possibility we might be prejudiced, even though he doubts that we can avoid some sort of interpretive slant. Psychologists, in this Gadamerian sense, are not consciously prejudicial, nor are they intending to do theists harm. Still, as we now understand about implicit prejudice (Dovidio, Kawakami, & Gaertner, 2002), this lack of conscious intention does not mean they are not doing harm to theists. Consider just a few examples that I've encountered in my scholarly odyssey, first in philosophy and then in psychological research and theory.

I obviously cannot do a survey of professional philosophy, and I certainly recognize that some philosophers straddle both theology and philosophy in some institutions. Nevertheless, consider the Oxford Dictionary of Philosophy as a case in point for mainstream philosophy (Blackburn, 2005). Here, the renowned Cambridge philosopher, Simon Blackburn, lists what are often considered non-theistic religions[6]–Buddhism, Taoism, Hinduism–as "philosophies" or even "philosophical systems." Yet theistic traditions, especially the Abrahamic conceptions of Islam, Judaism, and Christianity, are not listed in the dictionary at all. The term "theism" is only provided with one basic phrase, "belief in the existence of God" (p. 361). This term not only has no philosophical status; there are also no theistic religions that have any philosophical status in this dictionary. However, non-theistic religions, along with myriad other value-laden systems of various stripes, are all accorded this status. This type of exclusion is obviously not merely secularism in the modem sense, because many other religions are granted philosophical existence and allowed an intellectual voice. The bias here, as we will see in psychology, is more an implicit bias against theism (Slife & Reber, 2009).

Has this type of implicit prejudice infiltrated psychological theory and research? Consider two brief examples, one in psychological theory and one in psychological research. As an example of theory, Martin Buber has always been completely clear about the necessity of God in all of his work

[6] We recognize that some variations and/or interpretations of these religions may include a God or Gods of sorts. Our point here is that any emphasis of such divinity would have likely disqualified this "philosophical system" for philosophy status. against the activity of God, and thus is better considered a prejudice of naturalism.

and ideas (Buber, 1958; Friedman, 1981; Watson, 2006). However, when his I-Thou philosophy, for instance, is applied as a theory of psychotherapy, there is no trace of God's influence to be found (Buber, 1958; Chiari & Nuzzo, 2006; Fishbane, 1998; Hess, 1987; Slife & Reber, 2009). There are not even notes from the authors who do this application that this divine influence had been excluded, nor is there a defense of their decision to exclude. How might a currently active God change, if any, these therapy strategies? We do not know at this point, because Buber's clearly theistic philosophy has yet to be developed in this regard.

Consider also psychological research on the representation or image of God, a program of research that would clearly seem to be theistic by its very nature. This research shows that the image people form appears to be pivotal to their development, their interpersonal relationships, and a host of other significant things (Basset & Williams, 2003; Cassibba, Granqvist, Costantini, & Gatto, 2008; Demoulin, Saroglou, & Van Pactherbeke, 2008; Granqvist, Ivarsson, Broberg, & Hagekull, 2007). However, in a recent review of this literature, we found that none of these studies considered the possibility that God could have some influence on the participants' image of God (Reber, Slife, & Downs, 2012; Slife & Reber, 2009). The implicit prejudice against theism is so intense in psychology that no one seemed to consider it, in spite of what would appear to many Western theists to be a common-sense hypothesis, given the topic of study. In fact, we added a few questions about God's influence to the usual questionnaire for these studies and found that theistic factors accounted for the greatest amount of variance (Reber, Slife, & Downs, 2012).

Theistic Approach to Psychological Science

These types of findings suggested to me at least the possibility of a full-blown program of psychological research founded on theistic assumptions. But now I had to consider what such a program would look like? First, as my previous examples suggest, such a program could generate theistic hypotheses that are testable in the usual manner. Again, God would not necessarily be the object of study; divine activity is an assumption at the foundation of theistic theory, much like lawful activity is an assumption at the foundation of naturalistic theory. Theistic hypotheses are overlooked in the research literature, not because investigators are all atheists but because even avowed theists have been trained to think of their theories and studies from a naturalistic perspective only. As the research I described (above) exemplify, however, theistic theories and studies are quite possible. Indeed, my co-investigator, Jeff Reber, and I have conducted other studies of this

nature (e.g., Reber, Slife, & Downs, 2012), and Scott Richards and I have developed and tested theistic strategies of psychotherapy (Richards & Bergin, 1997; Slife & Richards, 2001).

Even so, I realized that this hypothesis-testing approach assumes that psychological methods are fundamentally neutral to the subject matter being tested, regardless of the worldview assumptions entailed by that subject matter. In other words, the design of investigations–their ultimate epistemology or theory of how knowledge is acquired–is assumed not to affect the investigation conducted and thus the data collected. But is this true? I knew, for example, that qualitative researchers were extremely skeptical of this assumption (Packer, 2017). Coming from a different epistemology of knowledge acquisition, these researchers see every day how the traditional epistemology of mainstream quantitative research affects not only the way that topics are studied but also what investigative questions are asked and how the data are eventually interpreted. Yes, I realized, we could study theistic hypotheses in the usual hypothesis-testing manner, but I couldn't help wondering if we were selling the other main worldview of Western culture, theism, short. Just as naturalism birthed a general method of knowledge acquisition, should theism be allowed to spawn its own? Theologians have developed methods for theological topics, but they are not typically intended for psychological topics. What would a truly theistic method be like for psychology?

As I studied these questions, I became aware that philosophers of science had long considered the scientific method to consist of two basic phases: the context of discovery and the context of justification (Bishop, 2007; Evans, 1989). The context of discovery involves the creative generation of the ideas, hypotheses, and topics to be studied. Interestingly, at least to me, this first phase has traditionally been quite open to even frankly religious explanations (Evans, 1989). Brilliant ideas and insightful hypotheses have frequently been viewed unabashedly as "inspired" and even "a gift from God" (Slife & Richards, 2005, p. 10). O'Grady & Richards (2005) surveyed natural and behavioral scientists in the United States and found that the majority had no problem believing that God inspires scientists and researchers in this discovery phase of research and scholarship.

Still, I learned quickly that the context of justification–what most scientists consider to be *the* scientific method–is another matter entirely. This context involves the procedures or logic that scientists use to test the ideas generated in the context of discovery. As Christian philosopher C. Stephen Evans (1989) put it, "Christian convictions must be put aside [in the context of justification]; here objectivity reigns . . . Distinctly Christian values [and assumptions] do not reappear until knowledge is being applied"

(p. 14). Why are Christian values put aside, we could ask, especially by those psychological researchers who might consider them to be true? As we have described, methods of justification were formulated with a naturalistic world in mind, a world in which God, if this divine being exists at all, is functionally passive or irrelevant. Researchers are allowed to have informal ideas that are inspired by God, but they are trained, often unknowingly, in an epistemology of method that assumes God does not matter.

So, I asked the question that began my journey with a new slant: What would a method be like that assumes God is integral to the context of scientific justification? I knew that the details of such a method would require the collaboration and development of many interested researchers over time, but I could not help but wonder what a first foray into an epistemology would be like–one of perhaps several possibilities, but all of them centered on the assumption of a currently active and difference-making God. Is such an epistemology even possible, especially in view of Blackburn's presumption (above) in his *Dictionary* that theism is not even a proper philosophy?

Theistic Hermeneutics

To answer this question, I began with a lesson from the early part of my story: no methods, whether therapeutic or scientific, occur without assumptions to guide them. In fact, there is unusual agreement among the observers and scholars of science that we will never escape assumptions and values–that all methods, all approaches to studying any phenomena will require pre-investigation assumptions and biases (Beutler and Bergan, 1991; Kelly, 1990; Slife, Smith, & Burchfield, 2003). Indeed, even to approach a phenomenon for the purpose of study is already to have assumed: 1) that it is a phenomenon, 2) that it deserves study, and 3) that it can be studied. The upshot is that debatable, pre-investigatory biases are inescapable for all methods. They will always govern to some degree how we study, what we see, and how we interpret what we see.

Still, this lesson led me then to wonder–if all our methods are inescapably assumption-based, and thus biased to some degree, are we then doomed to confirm our own biases and never see the world for what it truly is? Some postmodernists would undoubtedly answer this question affirmatively. However, there are those who recognize the import of assumptions and values in methodology but who do not believe we are relegated to merely confirming our biases. This tradition of epistemology is the hermeneutic tradition. Scholars such as Alasdair MacIntyre (1981), Hans-Georg Gadamer (1995), Charles Taylor (1989), and Paul Ricoeur

(1981) describe a hermeneutic approach to knowledge advancement where assumptions and biases are viewed as unavoidable in our methods, but they do not lead us necessarily to mere opinion or relativism. Microscopes and telescopes, for example, always bias their viewers in the particular way they illuminate the phenomena of interest–in the angle they take or the enlargement they offer–but this bias does not mean the phenomena are not illuminated in some fashion. Similarly, researcher biases allow important facets of psychological phenomena to be selected, focused upon, and illuminated–from a particular assumptive or worldview perspective. Yet these perspectives on phenomena can be incredibly useful, especially for those who may share in the worldview. The key is to take into account the biases or assumptions, rather than to ignore them. The obvious utility of traditional methods, in this sense, stems not from their bias-free nature, but from their application of the useful bias of naturalism.[7]

As apparently useful as naturalism has been for psychology, it is still a *particular* perspective, implying that other perspectives might also be useful. Moreover, some perspectives might be better than others for particular topics in psychology, and we cannot rule out the possibility that some might even be wrong. How, then, is the hermeneutist able to make these discernments without investigators forever confirming their own biases? The answer from many hermeneutists is that researchers need to be surprise-able (Marion, 2002; Slife, 2014; Slife, Johnson, & Jennings, 2015; Sugarman & Martin, 2005). They need to have enough openness to the phenomenon of their study that they can sense it is not being properly understood with the perspective inherent in their methods. This surprisability or openness requires not only humility about one's current assumptions concerning the phenomenon under study but also thorough knowledge of alternative assumptions, including basic method assumptions, that could–potentially at least–serve the phenomenon better. Such a "surprise" should allow us to adjust our assumptions and thus methods, so that when we engage the phenomenon again, we can perhaps illuminate it better. This tacking back and forth between engaged study and adjustment of method assumptions is often called the hermeneutic circle (Richardson, Fowers, & Guignon, 1999). We never escape our biases in this hermeneutic circle, but we can replace them with better biases.

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[7] Here, many scholars of science would distinguish between methodological (or epistemological) naturalism and metaphysical (or ontological) naturalism, but it is difficult, if not impossible, for this distinction to be sharp. Blurring of the distinction is inevitable because the methodological and metaphysical obviously share many assumptions.

This replacement process made good sense to me, but I found myself pondering how these researchers knew when to shift from current to alternative assumptions. How do we sense the inadequacy of our assumptions or biases for the phenomenon at hand, especially when we perceive the phenomenon *through* these assumptions and biases? This question is pivotal because there is considerable theoretical, scientific, and historical evidence that humans steadfastly cling to their biases and assumptions, frequently in spite of evidence to the contrary. Indeed, virtually every major theory of psychotherapy describes some mechanism whereby people routinely become stuck in their biases and beliefs, from Carl Jung to George Kelly to Aaron Beck (Beck, 1991; Rychlak, 1981). And social science is full of studies indicating that we continually confirm our own biases, in our everyday lives and in our science (Nickerson, 1998). How then can we know when these implicit assumptions are inadequate or wrong, especially when our experiences are bathed with the assumptions in the first place?

I found that those who have studied this issue have long pointed to certain experiential indicators that at least hint something is amiss. They fall under a variety of labels. Gadamer (1995) calls them surplus of meaning; Ricoeur (1981) terms them affectivity; Levinas (1969) labels them exteriority or alterity; Heidegger (1982) refers to them as the unveiling; Taylor (1985) often puts them as surprise; Marion (2000) terms them saturated phenomena; and Faulconer (2005) considers them interruptions or ruptures. Differing labels notwithstanding, all these varied scholars agree that somehow there is a rupture of our biased world that originates from *beyond* that world. Now what "beyond that world" might mean also differs, but some of these scholars more than hint that a divine personage is behind these ruptures (Faulconer, 2005; Levinas, 1969; Marion, 2000; Ricoeur, 1981; Taylor, 1985). Indeed, many in the field of phenomenology–the rigorous study of subjective experience–point to various forms of divinity as the source of these other-worldly ruptures. Some have called this disciplinary turn the *theological turn* of phenomenology (e.g., Janicaud et al., 2000). It is considered a "turn" because the secular and naturalist roots of this discipline make it an improbable turn. Still, many phenomenologists feel that they cannot ignore their data, which seem increasingly to reveal that the rupturing of deeply held assumptions often stems from transcendent origins.[8]

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[8] Emmanuel Levinas (1969) may be one of the more noted of these scholars, pointing explicitly to divinity as the *Other* of this assumption correction (p. 78, 88, 92, 211, 226). In discussing the "dialogue" between researchers and their subject matter, for example, Mikhail Bakhtin (1984) talks of the "invisibly present third party who

As I attempted to absorb this incredible turn in phenomenology, I couldn't help but wonder: what if this understanding of ruptures was true? Could it be, for example, that these ruptures are one of the ways in which a theistic God acts in the world, perhaps subtly correcting us, if we are willing to heed the correction? If so, could this type of divine correction be part of a serious theistic epistemology? It could, for instance, mean that God is responsible, at least part of the time, for combating our tendencies toward confirmation bias. It could imply that divine influences provide at least some of the other-worldly ruptures that prompt us to change our theoretical and methodological assumptions and bring us closer to true understanding of whatever we are studying.

Moreover, this theistic epistemology could apply to all types of correction and learning, both prosaic and professional. As an example of the prosaic, consider the rupturing of assumptions that occurs in reading a book. Mature readers typically scan the text until their assumptions about the story or plot are ruptured. They then reflect upon the rupture, adjust their assumptions, and read on until a rupture occurs again–a hermeneutic circle. Professional methods are frequently thought to operate similarly (Gadamer, 1995; Sugarman & Martin, 2005). In this theistic hermeneutic sense, both quantitative and qualitative researchers already take advantage of this rupturing/adjustment process, whether or not they acknowledge it. They sense somehow the need for an adjustment to their method of inquiry, which ultimately results in a better study. One would not have to believe in theism for God to work in this manner. However, this pivotal rupturing process might work better if these methods were explicitly formulated to take better advantage of this divine activity.

Distinguishing Characteristics of a Theistic Epistemology

What, then, might a more explicit formulation of this theistic epistemology mean, especially in relation to the rival method assumptions of naturalism? This is the final chapter in my journey thus far. First, unlike conventional naturalistic methods, where the investigator is required to set up a particular research design in advance and then stick rigidly with its

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stands above all participants in the dialogue" (p. 126). And when this improbable surprise or rupture prompts us to adjust our guiding assumptions, Gadamer calls this a "miracle of understanding" in which "religious concepts [are] thus appropriate" (1995, p. 145). Jean-Luc Marion is perhaps the most explicit when he identifies the intuition that transcends or exceeds our grasp as "revelation," with one type of revelation being "theophany." (Faulconer, 2005, p. 7; see also Gschwandtner, 2007; Marion, 2000).

procedures throughout the study (Bohman, 1993; Feyerabend, 1975), a theistic perspective would be open to, and perhaps even expect, the questioning and replacing of core method procedures, along with the assumptions and logic that spawned them. In other words, whatever served the investigator's understanding of the phenomena of interest, including changing the method procedure and even the logic of science itself, would have the highest priority. Indeed, some historians of science, such as Paul Feyerabend (1975), contend that the major contributions of the natural sciences occurred not by following the logic or procedures of the scientific method, but by disobeying them. Could these major contributions have been "prompted" by other-worldly ruptures to disobey the usual assumptions of method? Feyerabend does not raise this particular question, but he recommends that scientists should be ready at all times to violate the logic of scientific method, whatever the source of the knowledge prompting the violations.

Feyerabend's call for readiness implies a second characteristic of a fully theistic inquiry: researchers should maximize the possibility of assumption ruptures in their studies so that they do not merely confirm their own biases. This maximization would require a twofold knowledge or skill (Jung & Hull, 1960; Kelly, 1963; Rychlak, 1981; Slife, Johnson, & Jennings, 2015; Slife, Reber, & Richardson, 2005). First, researchers would need to become aware of their most cherished assumptions so that they *can* be ruptured, a practice that is distinctly missing from current naturalistic methods. In fact, psychological researchers often proceed as if they have no assumptions and their data reflect an uninterpreted reality.

This common research practice is mainly because psychological investigators rarely have the second type of knowledge that is needed to maximize ruptures: alternative assumptions. When viable alternatives are realized, cherished assumptions can truly become assumptions, rather than truisms. Knowledge of alternatives provides the contrast necessary for long-hidden assumptions to stand in bold relief. This knowledge also allows current assumptions to be examined and even rejected if our ruptured experience indicates they should. Alternatives are vital to what many theists call humility. As C.S. Lewis (1976) put it for Christian theism, God is "the great iconoclast" (p. 76), the breaker of our reified images of the world. As such, a humility that allows strongly held images or assumptions to be "broken" would seem to be imperative to avoiding confirmation bias.

This radical openness to theistic ruptures leads to a third difference from natural science methods in psychology: fully theistic psychological researchers must revise their traditional reliance on predictability. These researchers would not abandon predictability altogether, because it remains

important for testing hypotheses and discerning the divinely sustained regularities or "laws" of the natural world. However, these theistic inquirers must also value the violations of their expectations and hypotheses that divine ruptures could ultimately bring. In other words, theistic researchers should learn from expectational unpredictability as well as hypothesis predictability. As Kuhn (1970) has observed, it is the unpredictability of research anomalies, not the predictability of confirmed hypotheses, that leads to the questioning of our basic assumptions and thus paradigm shifts. Feyerabend (1975) appears to agree with Kuhn in this regard, because he contends that the serendipitous and anarchic in science, not the intentional and systematic, result in the most significant contributions to science.

To truly apprehend the serendipitous as well as the predictable, the fourth and final distinction from naturalistic methods is the need to truly engage rather than disengage the phenomenon we are studying. Researchers are traditionally taught that careful detachment or objectivity is the best approach to studying phenomena (Haworth, 1996). However, as Charles Taylor (1989) has put it, this prevents us from taking advantage of the interruption that truly teaches.

> ...when we see something surprising, or something which disconcerts us, or which we can't quite see, we normally react by setting ourselves to look more closely; we alter our stance, perhaps rub our eyes, concentrate, and the like. Rather than disengaging, we throw ourselves more fully into the experience, as it were (p. 163).

As important as this engagement is for a theistic epistemology, some theists have contended that it does not go far enough. Rohr (2009) and Marion (2007), as examples, argue that the best engagement, or even the best mode of knowing, is the kind of intimacy we have when we truly love and respect an object of inquiry–understanding not only its similarity to but also its radical otherness from us. This type of knowing fits nicely with Christian theism, for instance, because "knowing" in the Biblical sense is not a detached incorporation of facts but a relational intimacy with what or whom we care about deeply. Unfortunately, as Manoussakis (2016) describes, naturalistic researchers singled out the wrong sensory experience in their development of knowing–the sense of vision or observation. He contends that this sense allows for and even encourages passive disengagement, because metaphorical or literal distance is needed for full observation. The sense of touch, on the other hand, is the better sensory experience for true knowledge, because it is difficult to experience without the radical intimacy of theistic empiricism.

Conclusion

So, as we end the story of the first author's attempt to recover the excluded other of theism in research, we realize how wild the notion of a theistic approach to psychological research might seem. If nothing else, his experiences have shown us how often this notion shakes psychologists to their Enlightenment "bones." Indeed, it has seemed to some psychologists that this scholarly journey is an attempt to transport us back to the Middle Ages (e.g., Helminiak, 2010). The differences, however, between our fledgling proposal of a theistic epistemology and one from the Middle Ages are stark.

We conclude with two important differences. First, this proposal seeks a pluralism of methods in psychology, not the domination of a theistic epistemology. Our proposal, perhaps ironically, seeks an original or authentic secularism, where in today's secularism theism is an excluded other in the academy, especially as a method for advancing knowledge. The pluralism we are seeking would also imply a second vital difference from Middle Ages theistic science: closed-minded approaches to knowledge advancement would be considered problematic, whether theism or naturalism. As we described above, humility and openness to experience would be one of the hallmarks of a theistic epistemology. If anything, naturalism is currently, as the historian of psychology Thomas Leahey (1991) put it, "the dogma" of psychology (p. 379). Why not at least stir the psychological pot by mixing in a pinch of theism, if for no other reason than to understand our naturalistic underpinnings just a bit better?

References

Bakhtin, M. M. (1984). *Rabelais and his World* (Vol. 341). Bloomington, IN: Indiana University Press.

Basset, J. F., & Williams, J. E. (2003). Protestants' images of self, God, and Satan as seen in adjective check list descriptions. *International Journal for the Psychology of Religion, 13*, 123–135.

Batson, C. D. (1998). Prosocial behavior and altruism. *The handbook of social psychology, 4*, 282-316.

Beck, A. T. (1991). Cognitive therapy: A 30-year retrospective. *American psychologist, 46*(4), 368.

Bernstein, R. J. (1983). *Beyond objectivism and relativism: Science, hermeneutics, and praxis.* Philadelphia, PA: University of Pennsylvania Press.

Beutler, L. E., & Bergan, J. (1991). Value change in counseling and psychotherapy: A search for scientific credibility. *Journal of Counseling Psychology, 38*(1), 16.

Bhandari, M., Busse, J. W., Jackowski, D., Montori, V. M., Schünemann, H., Sprague, S., ... & Devereaux, P. J. (2004). Association between industry funding and statistically significant pro-industry findings in medical and surgical randomized trials. *Journal of the Canadian Medical Association, 170*(4), 477-480.

Bishop, R. (2007). *The philosophy of the social sciences: An introduction.* New York, NY: Continuum International Publishing Group.

Blackburn, S. (2005). *The Oxford dictionary of philosophy.* Oxford, UK: Oxford University Press.

Bohman, J. (1993). *New philosophy of social science.* Cambridge, MA: MIT Press.

Brown, K. (2005). Does psychology of religion exist?. *European psychologist, 10*(1), 71-73.

Buber, M. (1958). *I and thou* (2nd ed.). New York, NY: Charles Scribner's Sons.

Cassibba, R., Granqvist, P., Costantini, A., & Gatto, S. (2008). Attachment and God representations among lay Catholics, priests, and religious: A matched comparison study based on the adult attachment interview. *Developmental Psychology, 44*, 1753–1763.

Chiari, G., & Nuzzo, M. (2006). Exploring the sphere of between: The adoption of a framework of complementarity and its implications for a constructivist psychotherapy. *Theory & Psychology, 16*, 257.

Demoulin, S., Saroglou, V., & VanPachterbeke, M. (2008). Infra-humanizing others, supra-humanizing Gods: The emotional hierarchy. *Social Cognition, 26*, 235–247.

Dovidio, J. F., Kawakami, K., & Gaertner, S. L. (2002). Implicit and explicit prejudice and interracial interaction. *Journal of Personality and Social Psychology, 82*, 62– 68.

Evans, C. S. (1989). *Wisdom and humanness in psychology: Prospects for a Christian approach.* Grand Rapids, MI: Baker Book House.

Evans-Pritchard, E. E. (1937/1976). *Witchcraft, oracles and magic among the Azande.* Oxford, UK: Oxford University Press.

Faulconer, J. (2005). Knowledge of the other. *European Journal of Psychotherapy, Counseling, and Health, 7*(1-2), 49-63.

Feyerabend, P. (1975). *Against method.* London: Verso.

Fishbane, M. (1998). I, thou, and we: A dialogical approach to couples therapy. *Journal of Marital and Family Therapy, 24*, 41.

Friedman, M. (1981). Buber's way to "I and Thou." *Judaism, 30*, 363–368.

Gadamer, H. G. (1995). *Truth and method*. (J. Weinsheimer & D. G. Marshall, Trans.). New York, NY: Continuum. (Original work published in 1975)

Gantt, E. E., Slife, B. D., (2016). *Taking sides: Clashing views on psychological issues*. McGraw-Hill.

Gantt, E., Williams, R. (In Press). New York, NY: Routledge Publications.

Gschwandtner, C. (2007). *Reading Jean-Luc Marion: Exceeding metaphysics*. Bloomington, IN: Indiana University Press.

Goodman, D., & Freeman, M. (Eds.). (2015). *Psychology and the Other*. Oxford, UK: Oxford University Press.

Granqvist, P., Ivarsson, T., Broberg, A. G., & Hagekull, B. (2007). Examining relations among attachment, religiosity, and new age spirituality using the Adult Attachment Interview. *Developmental Psychology, 43*, 590 – 601.

Griffin, D. R. (2000). *Religion and scientific naturalism: Overcoming the conflicts*. Albany, NY: SUNY Press.

Haworth, J. T. (Ed.). (1996). *Psychological research: Innovative methods and strategies*. New York, NY: Taylor & Francis US.

Heidegger, M. (1982). *The basic problems of phenomenology*. (Albert Hofstadter, Trans.). Bloomington, Indiana: Indiana University Press. (Original work published in 1927)

Helminiak, D. A. (2010). Theistic psychology and psychotherapy: A theological and scientific critique. *Zygon, 45*(1), 47-74.

Hess, A. K. (1987). Psychotherapy supervision: Stages, Buber, and a theory of relationship. *Professional Psychology: Research and Practice, 18*, 251–259.

Hibberd, F. J. (2011). Sham reasoning, Humpty Dumpty and the burden of proof. In S. Boag, N. Tiliopoulos, S. Boag, N. Tiliopoulos (Eds.), *Personality and individual differences: Theory, assessment, and application* (pp. 163-170). Hauppauge, NY: Nova Science Publishers.

Janicaud, D., Courtine, J., Chretien, J., Henry, H., Marion, J., & Ricoeur, P. (2000). *Phenomenology and the" theological turn": the French debate* (No. 15). New York, NY: Fordham University Press.

Jung, D., & Hull, R. F. C. (1960). *The collected works, volume 8*. London, UK: Routledge and Kegan Paul.

Kelly, G. A. (1963). *A theory of personality: The psychology of personal constructs*. New York, NY: W. W. Norton.

Kelly, T. A. (1990). The role of values in psychotherapy: A critical review of process and outcome effects. *Clinical Psychology Review, 10*(2), 171-186.

Kemp, G. (1998). Meaning and truth conditions. *Philosophical Quarterly, 48*, 483-494.

King, D.B., Viney, W., & Woody, W. D. (2013). *A History of Psychology: Ideas and Context* (5th ed.). New York, NY: Routledge.

Kjaergard, L., & Als-Nielsen, B. (2002). Association between competing interests and authors' conclusions: Epidemiological study of randomised clinical trials published in the BMJ. *British Medical Journal, 325*, 249-253.

Kuhn, T. S. (1970). *The structure of scientific revolutions* (2nd ed.). Chicago: The University of Chicago Press.

Leahey, T.H. (1991). *A history of modern psychology*. Englewood Cliffs, NJ: Prentice Hall.

Levinas, E. (1969). *Totality and infinity: An essay on exteriority* (A. Lingis, Trans.). Pittsburgh: Duquesne University Press.

Lewis, C. S. (1976) *A grief observed*. New York, NY: Seabury Press, Inc.

Lexchin, J., Bero, L. A., Djulbegovic, B., & Clark, O. (2003). Pharmaceutical industry sponsorship and research outcome and quality: Systematic review. *British Medical Journal, 326*, 1167-1170.

Luborsky, L. B., & Barrett, M. S. (2005). Theoretical allegiance. In J. C. Norcross, L. E. Beutler, & R. F. Levant (Eds.), *Evidence-based practices in mental health. Debate and dialogue on the fundamental questions*, 257-267. Washington, DC: American Psychological Association.

MacIntyre, A. (1981). *After virtue*. Notre Dame, IN: University of Notre Dame Press.

Manoussakis, J. P. (2016). *The Ethics of Time: A Phenomenology and Hermeneutics of Change*. New York, NY: Bloomsbury Publishing.

Marion, J. (2000). The saturated phenomenon. In Janicaud, Dominique, Jean-François Courtine, Jean-Louis Chrétien, Michel Henry, Jean-Luc Marion, and Paul Ricoeur, *Phenomenology and the "Theological Turn."* (Bernard G. Prusak and Jeffrey L. Klosky, Trans.). New York, NY: Fordham University Press.

Marion, J. L. (2002). *In excess: Studies of saturated phenomena* (No. 27). New York, NY: Fordham University Press.

Marion, J. L., & Lewis, S. E. (2007). *The erotic phenomenon*. Chicago, IL: University of Chicago Press.

Morris, C. G., & Maisto, A. A. (1999). Psychology: An introduction (10th ed.). Upper Saddle River, NJ: Prentice Hall.

Nickerson, R. S. (1998). Confirmation bias: A ubiquitous phenomenon in many guises. *Review of General Psychology 2*(2), 175–220.

O'Grady, K., & Richards, S. (2005). Unpublished doctoral dissertation. Brigham Young University.

Packer, M. (2017). *Science of Qualitative Research.* Cambridge, UK: Cambridge University Press.

Pannenberg, W. (1996). How to think about secularism. *First Things*, 27-32.

Reber, J. S., Slife, B. D., & Downs, S. (2012). A tale of two theistic studies: Illustrations and evaluation of a potential program of theistic psychological research. *Research in the Social Scientific Study of Religion, 23*, 191-212.

Richardson, F. C., Fowers, B. J., & Guignon, C. B. (1999). *Re-envisioning psychology: Moral dimensions of theory and practice.* San Francisco, CA: Jossey-Bass.

Richards, P. S., & Bergin, A. E. (1997). *A spiritual strategy for counseling and psychotherapy.* Washington, DC: American Psychological Association.

Ricoeur, P. (1981). *Hermeneutics & the human sciences.* Cambridge, UK: Cambridge University Press.

Rohr, R. (2009). *The naked now: Learning to see as the mystics see.* New York, NY: Crossroad Publishing Company.

Rychlack, J. F. (1981). Introduction to personality and psychotherapy. Boston, MA: Houghton Mifflin.

Slife, B. D., Johnson, C. T., & Jennings, A. C. (2015). Surprisability and practical rationality. *The Wiley Handbook of Theoretical and Philosophical Psychology: Methods, Approaches, and New Directions for Social Sciences*, 392-408.

Slife, B. D., O'Grady, K. A., & Kosits, R. D. (Eds.). (2017). *The Hidden Worldviews of Psychology's Theory, Research, and Practice.* Taylor & Francis.

Slife, B. D., & Reber, J. (2005). Comparing the practical implications of secular and Christian truth in psychotherapy. In A. Jackson & L. Fischer (Eds.) *Turning Freud upside-down: Gospel perspectives on psychotherapy's fundamental problems.* Pp. 160 – 182. Provo, UT: Brigham Young University Press.

Slife, B. D., & Reber, J. S. (2009). Is there a pervasive implicit bias against theism in psychology?. *Journal Of Theoretical And Philosophical Psychology, 29*(2), 63-79. doi:10.1037/a0016985

Slife, B. D., Reber, J. S., & Faulconer, J. E. (2012). Implicit ontological reasoning: Problems of dualism in psychological science. In R. Proctor & J. Capaldi (Eds.), *Psychology of science: Implicit and explicit reasoning.* Pp. 459-478. New York: Oxford University Press.

Slife, B. D., Reber, J. S., & Lefevor, G. T. (2012). When God truly matters: A theistic approach to psychology. *Research In The Social Scientific Study of Religion, 23,* 213-237.

Slife, B. D., Reber, J. S., & Richardson, F. C. (2005). *Critical thinking about psychology: Hidden assumptions and plausible alternatives.* Washington, DC: American Psychological Association.

Slife, B. D., & Richards, P. S. (2001). How separable are spirituality and theology in psychotherapy?. *Counseling and Values, 45*(3), 190-206.

Slife, B. D., & Richards, S. (2005). Toward a theistic approach to psychological method. In *meeting of the Psychology of Religion, Columbus, Maryland.*

Slife, B.D., Smith, A.M., & Burchfield, C. (2003). Psychotherapists as crypto-missionaries: An exemplar on the crossroads of history, theory, and philosophy. In D.B. Hill & M.J. Kral (Eds.) *About psychology: Essays at the crossroads of history, theory, and philosophy.* Pp. 55 – 72. Albany, NY: SUNY Press.

Slife, B. D., Starks, S., & Primosch, M. (2014). Questioning the presumption of naturalism in the social sciences: a case study. *Pastoral Psychology, 63*(3), 339-353.

Slife, B. D., & Williams, R. N. (1995). *What's behind the research?: Discovering hidden assumptions in the behavioral sciences.* Thousand Oaks, CA: Sage.

Slife, N. (2014). *An examination of implicit values in cornerstone student affairs textbooks* (Doctoral dissertation). Retrieved from Univeristy of Nevada Las Vegas Theses, Dissertations, Professional Papers, and Capstones. 2298.

Smith, H. (2003). *Beyond the postmodern mind: The place of meaning in a global civilization.* Wheaton, IL: Quest Books.

Smith, J. K. (2014). *How (not) to be secular: Reading Charles Taylor.* Grand Rapids, MI: Wm. B. Eerdmans Publishing.

Starks, S. (2014). *Objective Science of Biased Philosophy: Does Naturalism Play a Dogmatic Role in Psychology?* (Master's Thesis, Brigham Young University). Retrieved from https://scholarsarchive.byu.edu.

Sugarman, J., & Martin, J. (2005). Toward an Alternative Psychology. In B. D. Slife, J. S. Reber, & F. C. Richardson (Eds.), *Critical thinking about psychology: Hidden assumptions and plausible alternatives* (pp. 251-266). Washington, DC: American Psychological Association.

Swanson, L. W., Lufkin, T., & Colman, D. R. (1999). Organization of nervous systems. *Fundamental neuroscience,* 9-37.

Taylor, C. (1985). *Philosophy and the human sciences: Philosophical papers.* Cambridge, England: Cambridge University Press.

Taylor, C. (1989). *Sources of the self: The making of the modern identity.* Cambridge, MA: Harvard University Press.
Taylor, C. (2007). *A secular age.* Cambridge, MA: The Belknap Press of Harvard University Press.
Tjeltveit, A. (1999). *Ethics and values in psychotherapy.* London: Routledge.
Watson, N. J. (2006). Martin Buber's I and thou: Implications for Christian psychotherapy. *Journal of Psychology & Christianity, 25,* 34 – 43.
Whitley, R. (2012). Religious competence as cultural competence. *Transcultural Psychiatry, 49*(2), 245-260.
Yoder, T. S. (2008). Hume on God: irony, deism and genuine theism. Bloomsbury Publishing

Perspective Four: Leslie Greenberg
My Views on Psychotherapy Research.
Leslie S Greenberg

I take a pluralistic view on research method, in which I believe the best way to attain knowledge is to use a method best suited to answering the question being investigated. This means that I don't find the current tension between so called, qualitative and quantitative research, a distinction that has arisen in the social sciences in the last decades, that meaningful. They simply are different methods of doing research for different purposes and the distinction between using numbers or metrics (quantitative) versus categorization (qualitative or semantic) is not exactly a dichotomy as categorization is the first form of measurement. Another possible distinction is that qualitative research gets at meaning and understanding while quantitative gets only at frequency of occurrence and statistical predictions. In my view they complement each other rather than oppose each other. They actually serve different purposes, one to understand the other ultimately to predict.

Often, in my experience, there has been a flight into qualitative research because students who are not well versed in statistics, and find numbers both challenging and less meaningful, are avoiding doing statistics. Because statistics its partner the experiment, and their offspring, the randomized clinical trial, have become so dominant, as the only way to do psychotherapy research, this has spawned the opposition -a qualitative research movement. Rather than being religiously methodolatrous sects, qualitative and quantitative research are simply different procedures that serve different functions - those of describing, theory building, understanding or, correlating, validating refuting, or explaining. These all are different

procedures, rather than having anything to do with quality and quantity. Hence in my mind the notion qualitative/quantitative is a false dichotomy, or a less than meaningful distinction. For example, does the distinction between internal and external, a descriptive coding with two categories, belong either to a qualitative or a quantitative approach.? It is a difference that makes a difference, involving categories that make a qualitative distinction, but there are two of them, a quantitative observation, and we also could count the number of people belonging to each style and this would give investigators some meaning . Wouldn't the use of the two methods together increase both our understanding and our predictive abilities more than either one alone? I hope my tongue in cheek example helps make the point I am trying to make. All methods help us understand.

Proponents of *qualitative* research approaches often argue against measurement, assuming that the difference between qualitative and quantitative is based on measurement. Observing distinctions and forming categories however is at the basis of both measurement and of meaning. Measurement is merely putting some estimate of degree of strength or sureness in one's category system. It is in this sense that measurement makes categories of meaning more discriminating and is needed to be able to reliably see differences in phenomena and then combine the observed differences into meaningful patterns to explain processes of change. For example (Greenberg & Bolger 1991) found that the essence of the experience of pain is feeling "broken or shattered". This was arrived at as the core category of a grounded theory qualitative study. In this study clients were asked, while watching video segments of their own painful emotion segments in their own therapy sessions, to report on what they had been experiencing while expressing their pain. This yielded the finding that "brokenness" captured their core experience. A questionnaire or rating scale could then be developed by means of quantitative procedures and these used to have people, in further studies, validate the measure by being given samples of different emotional states including painful experience and see if brokenness was chosen significantly more often than other descriptors for the painful states. Once validated people could use the measure to rate their degree of brokenness, and this could be used in various ways. All this adding of quantity to quality could make a useful contribution even though it might make a purist qualitative investigator shudder. But it makes sense to a pluralist such as myself, who finds the distinction between discovery and prediction more meaningful than qualitative vs quantitative. More on the first distinction later.

I think that the rope that ties us to the truth can be thought of as consisting of a number of threads or strands and that the more strands

wound together the stronger the rope we have tying us to reality and the closer we get to knowing what is out there. So in order to truly believe something we need be able to observe it, have some type of observation, have a good explanation, have a theoretical framework into which the observation and explanation fit, have scientific proof, have experience that confirms the finding, have faith that it is true and have social validation by others that they see it this way too. All these strands make for a stronger rope to bind us to what is true and the more strands we have to connect us to reality the more we believe.

In line with this perspective science, in my view, is best thought of as proceeding by a set of steps (Hempel 1966). Starting with intensive observation and *description* of phenomena of interest, scientific research moves to *measurement*, then to *explanation* of the phenomena and only finally to *prediction*. Psychotherapy research is an extremely young endeavor and unfortunately in its efforts to emulate natural science and because of external pressure to compete with medical treatments, is trying to run before it even can crawl. It has privileged prediction above the early steps of rigorous description and measurement which form the base of any science. What is needed in the young science of psychotherapy research is observation, and plenty of it, to isolate and define phenomena of interest

Epistemologically speaking I take a critical realist (Bhaskar 1975) position in which there is a reality out there in the world but we can only get at our constructions of it. We (Greenberg & Pascual Leone, 1995, 2002).) have developed a *Dialectical Constructivist approach* which positions itself between the two extremes of realism and radical constructionism, holding that reality, although constructed to some degree can be partially known. As we work to study phenomena, as they appear to us, our constructions may become closer and closer approximations of what exists out there but they always remain our constructions and that is all we will ever be able to know. The world as it appears to us. So this is both a phenomenological but also constructivist view. Although it is not possible to be completely objective, and observation is not theory free, reality is seen as offering constraints from which we construct what we know. Thus although we can never know what is really out there it is possible to make progressive approximations towards describing constraints that do exist in reality. Investigation then results in the construction of explanatory models that mediate between empirical reality and social construction (Neimeyer & Mahoney, 1995; Greenberg & Pascual Leone, 1995, 2002). We thus adopt a rational/empirical methodology for studying how people change in psychotherapy, which is called task analysis.

What makes any study scientifically rigorous is that the observations on which it is based can be shown to be reliable across situations and across observers and what makes it interesting is a capturing of meaningful, repeatable regularities and patterns that clarify and sharpen theory. In addition, it has been shown that progress in science occurs through the development of research programs (Lakatos, 1970) that accumulate knowledge rather than in single studies. In this spirit a research program that develops a number of cumulative research steps and a variety of studies that attempt progressively to describe, measure, explain and only ultimately predict, the effects on outcome of a key change process in therapy is probably one of the optimal ways of developing a solid evidential base for a particular approach to psychotherapy. An approach of this nature would utilize pluralistic methods and engage in a variety of different types of studies including intensive observation, model building, measurement construction, and testing of hypotheses, and would work both in the context of discovery and in the context of justification, to investigate how people change in psychotherapy. As such, this type of research program would be a true attempt to get at the complexity of human change.

Gestalt Therapy

Modern dialogical approaches to gestalt therapy have particularly emphasized working at the contact boundary and the resulting interpersonal, uniquely individual, spontaneous, improvisational nature of the gestalt therapy endeavor. Relational therapists in general have been particularly critical of "technical rationality" in approaches to therapy (Hoffman, 1998), and they have questioned the idea that there could be any single correct standard technique or basic treatment mode emphasizing instead the uniqueness of each dyad and the necessity of discovery in each treatment.

Relational therapists of all schools question any standardization of treatment that emphasizes technique at the expense of the unique personal relationship. How compatible could this approach ever be with "standardized treatment manuals?" Critiques of an instrumentalist emphasis on technique go hand in hand with a field theoretical view critique of a tendency to approach the psyche and human relations reductively in mechanistic terms. Where does this leave dialogical Gestalt therapists, who are urged or more recently even required to justify their practice as empirically supported?

Gestalt therapists however are still clinicians and practitioners who are reminded daily of the pragmatic, goal-oriented, purposive nature of therapy.

The focus on practical attention to results, symptoms, and the patient's subjective reports of improvement govern all therapy. Gestalt therapists have argued that knowledge cannot be considered objective in any traditional sense of the word and that we need to think in terms of a category that lies between the categories of objectivism and relativism. In this view empirical studies may influence thinking, but it is a mistake to hand over ultimate authority to empirical research. Therapists generally believe that they have a perfect right to claim validity (the non-statistical sort) for their ideas because they are grounded in rigorous thinking and continually cross-checked with clinical experience. One possible stance would be simply to reject the relevance to gestalt of any empirical research conducted within a positivist paradigm. But if we do so, what alternative form of validation can be substituted?

The evidence-based treatment (EBT) controversy brings increased urgency to discussion about the role that empirical research should play in the development of gestalt and in the evaluation of its efficacy. One possible response is to reject psychotherapy research as meaningless, on a priori grounds, because it does not deal with the complexity of the gestalt therapy situation. Another is to take the position that gestalt has no aspirations to any type of scientific status, to ignore the EBT controversy, and to continue with "business as usual."

Gestalt concepts, however, are often vaguely defined and working with them can therefore be detrimental to both clinical practice and clinically relevant research. Conceptual and empirical research must proceed hand in hand; they must be considered not as disjunctive arenas, but as complementary processes. By relying on the therapists' memories of their encounters with their patients, we can take account only of what they can remember; happenings outside awareness slip by undetected. By moving from individual case or event to the more general, we may be able to find repeatable regularities that will please both those who favor individual differences and those who look for general laws or patterns. On the hermeneutic/qualitative side, these units can be translated into recognizable clinical happenings; on the scientific/quantitative side, they can be treated with standard statistics and give us a way of joining the other sciences. But these regularities can be discovered only by leaving behind the traditional clinical anecdote and moving to a deeper level of analysis. The discovery of such regularities would go far toward convincing our patients, the public and funding agencies of the value of the gestalt approach. It would support a vision that gestalt therapy is not a purely individual, idiosyncratic process but rather that regularities proposed by gestalt theory can be observed across situations across people.

The history of other sciences prompts us to believe that even where surface features seem haphazard and irregular, persisting patterns may be discovered just below the surface (beyond the awareness of therapist or patient), and it is here that we need to focus our efforts. Could these be found? If so then we could convince the other sciences that now, at least, we are qualified to join their ranks. And the gap between hard and soft approaches would be reduced. I suggest that a way of closing the gap would be to find significant clinical moments that happen more than once, across hours and across cases. This would give us the best of both worlds. It satisfies the hermeneutics in their quest for meaning and the hard scientists in their search for repeatable regularities open to statistical analysis.

A Research Strategy

The art and science of research is to reliably identify and explain certain *phenomena* that occur with repeatable regularities so that certain statements can be made that generalize beyond a single case or a single instance. Research of this type provides quality control on the ideas by systematically comparing the theories with observations. The observations change the original ideas. They may confirm or disconfirm the theory, or, more modestly, strengthen or weaken them. More often, however, the change involves extending, elaborating, modifying, or qualifying the theory. Thus, the theory is modified to become more general, more precise, and more realistic. Through research, then, observations accumulate in theories. New research results permeate the theory, but earlier thinking and results are retained. A living theory must be able to change, to accommodate this continual infusion of new observations; an impermeable theory is scientifically dead.

What does this view of science mean for psychotherapy research? This means we need to expend much effort observing and describing clinically relevant *phenomena* and developing reliable ways of measuring their occurrence. Creating observable distinctions and coding schemes to guide in the reliable coding of therapeutic phenomena rather than quantifying should be at the heart of psychotherapy research. This is the business of psychotherapy *process research* rather than *outcome research.* Thus we need to think of psychotherapy research as an observational endeavor that is made rigorous by measurement.

In a field in which there are many findings of general equivalence between treatments (Wampold, 2001) research that does not specify and look at the process of change begs the question of the nature of each treatment's active ingredients. How psychotherapy works is a crucial

question in need of empirical investigation if we are to establish a scientific understanding of treatment effects. Without knowing the specific processes and causal paths to the outcome, we do not have a scientific understanding of the treatment. Manuals specify how therapists implement specific treatments, but they are not clear on what constitutes competent delivery, nor do they specify the clients' contributions to the process. For a true science, we need to specify the client and therapist processes as well as their interaction. Process research is necessary to explicate, test, and revise the theoretical premises and technical ingredients of specific treatments, as well as to enable researchers to identify the active change ingredients.

We have engaged in research that showed that this therapist action, at this patient problem marker, led to this complex change process, and this related to outcome (Greenberg 2010). This type of endeavor has been referred to as *change process research* (Greenberg 1986), where the emphasis is not on just studying process but on studying *change processes* or *mechanisms of change*. This type of research helps reveal which process is responsible for change, regardless of treatment or individual difference. The importance of specifying the change process can be seen by an analogy with the use of medication. When we deliver a treatment, if we do not know the active ingredients, we are not able to assess whether the active ingredient worked in this patient. This is similar to not knowing whether a person in a drug treatment absorbs the medication. In psychotherapy absorption is measured by patient's degree of engagement in the process. Clinical trials provide only the crudest index of a treatment's effects because people who absorb the treatment are being lumped together with those who do not. If psychotherapy research is to be a true science it needs not only provide evidence of the general efficacy or the effectiveness of a treatment but also specify the processes of change that produce the effects. To do so effectively, researchers need to identity therapists' contributions, clients' contributions, and the interaction between them. Without knowing the specific processes and causal paths to outcome, we do not have a scientific understanding of the treatment Only converging strands of evidence will provide a convincing evidentiary base for the effectiveness of a treatment.

Reports of overall treatment effects that ignore the important role of the client's process of change fail to recognize the two distinct groups in any treatment: those who fully engage in the change processes and those who don't. This factor has a major influence on outcome. For example the findings of studies on the resolution of unfinished business and trauma (Greenberg & Malcolm, 2002; Paivio, et al.), demonstrated that treatment does not fully engage all the clients in all the active treatment ingredients established as necessary for resolution. Only some of the clients engaged

fully in the specific mechanisms of change, others engaged partially, and others only minimally. These studies demonstrated that those who engaged fully in the change processes benefited more than those who did not, and they benefited more than those who experienced the more general effects of a good therapeutic alliance.

Change Processes and Task Analysis

In my view psychotherapy research needs to study change by considering sequences or patterns of events, incorporate context, and recognize that critical incidents or significant events may relate to change (Greenberg, 1986; Rice & Greenberg, 1984). To investigate these, a moment-by-moment change process needs to be studied understanding complex interactions in which given behaviors have different meanings and impacts in different in-session contexts. When and in what context a particular kind of process appears needs to be investigated in innovative ways with intensive observation and with sequential analytic methods. This is change process research.

The York studies start out with more of a discovery focus to identify the processes of change. They also start with an event based approach and then use task analysis, which consists of fine-grained descriptions of tape-recorded events representing successful and unsuccessful resolutions of a common feature problem to identify the process of change in successful events. After building an explanatory model of how change occurs, measures are developed that capture this process and these are used to validate the model and finally predict outcomes and follow-up.

Task-analysis was developed for use in psychotherapy research (Greenberg 1984, 2007) to study change events in therapy. Greenberg (1984) combined both Pascual-Leone's (1987) and Newell and Simon's (1972) ideas on task analysis to propose a combined rational-empirical methodology of studying change processes in therapy. The whole process of change in therapy can be looked at as involving a number of steps in clients experience. A client needs to successfully complete one experiential step before moving onto the next. Task analysis delineates the necessary steps that clients need to take in psychotherapy to achieve a positive outcome. As the name implies, task analysis aims to analyze the tasks and identify the component steps that clients need to complete in order to reach successful resolution of their psychological predicament (Greenberg & Foerster, 1996).

An overall task analysis proceeds in two general phases–a discovery oriented and a validation-oriented phase. The first, model building, phase

emphasizes working within the context of discovery (Reichenbach 1949, Rice & Greenberg 1984). In this phase cases are studied intensively to observationally identify significant processes that differentiate between successful and unsuccessful cases (Greenberg, 1992). This phase uses both a rational and an empirical task analysis to rigorously conjecture, observe and categorize. The second validation phase, works within the context of justification, and emphasizes validation, hypothesis testing, group design and statistical evaluation to validate the model and relate process to outcome. The investigation of the phenomenon begins with a rationally derived model grounded in the investigator's own cognitive map of how resolution is hypothesized to occur. Then some actual resolution performances are studied and this empirical investigation is used to refine the rational model, until an adequate performance model of change has been developed. There are seven main steps to task analysis: clarification of the researcher's cognitive map, description of the therapeutic task, evaluation of the potency of the processes under investigation, rational analysis and model, empirical analysis, constructing a rational-empirical model, and verification of the constructed model (Greenberg, 2006).

Task analysis thus involves the investigation of moment-to-moment behaviour of clients engaging in key psychotherapeutic events. The beginning of these events in therapy is identified by the presence of "markers" (Rice & Greenberg, 1984). Markers are circumscribed client behaviours that provide a signal to the therapist that the client is currently experiencing a particular cognitive-affective problem that requires attention. Examples of markers drawn from Gestalt therapy that have been investigated previously include unfinished business (Greenberg & Safran, 1987; Greenberg, Rice, & Elliott, 1993), intrapersonal conflict (splits) (Greenberg, 1984b), and interruption of emotion (Weston, 2005). The client in-session performance is then intensively examined identifying what appear to be the crucial experiential states clients enter into between the marker and the problem resolution. For example, a resolution of a marker of a self-critical split would be self-acceptance and the states in between might include contempt for self, hopelessness, anger and sadness, unmet need, compassion etc.

During this process the researcher alternates between observing the data and conjecturing about the required states in order to construct a model of the steps necessary to resolve the problem (Greenberg, 2007a). The initial resolution models, such as the model of resolution of conflict splits in two-chair dialogues for, unfinished business in empty-chair dialogue described the important steps on path to resolution of these emotional difficulties (Greenberg, Rice, & Elliott, 1993; Rice & Greenberg, 1984). More recent

task analyses add to these original models by analysing the process of resolution of specific problematic emotions such as anger, hopelessness, shame, vulnerability, anxious insecurity and self soothing (Sharbanee, Goldman & Greenberg 2017).

Engaging in a *rational task analysis* involves building a theoretical model from the clinician's or investigator's rational understanding of the steps in the client performance that are believed to lead to resolution. The investigator asks; "how do I think clients resolve this particular task?" The answer comes from explicit theory in the literature and from any understanding gleaned from an explication of the clinician's implicit cognitive map, which guides the clinician's work of how this type of problem is solved. Based on these conjectures a diagram, called the rational model, is drawn to represent a hypothesized *possible* task performance. This represents the investigators best guess as to what happens. In order to demonstrate that something new has been discovered, it is important first to specify what one thinks one knows. This acts as a baseline or a type of hypothesis against which to evaluate what aspects of what one later observes is actually a discovery. In addition, in order to observe something as freshly as possible in the empirical analysis, it helps to specify one's pre-conceptions, assumptions, intuitions and hunches brought into the observational aspect of the study so that an effort can be made to put them aside. This attempt to put pre-conception or bias aside is described by phenomenologists as bracketing.

The rational analysis is followed by the *empirical task analysis,* which involves the rigorous observation of samples of *actual performance* of clients who are working on the affective- cognitive processing task of interest. The investigators look intensively at the in-session performances in order to discover the essential steps of change. As we have said the investigators, as best they can, attempt to bracket their pre-conceptions, and suspend their anticipations, hunches and expectations, made explicit in the rational model, to receive, in as un-invested a fashion as possible, what is there to observe in the actual performance. The building of the empirical model involves a form of qualitative content analysis that describes a sequence of events that unfold over time.

The next major step involves comparing the newly observed steps of the empirical model with the steps of the rational model. The components of the rational model are alternately supported, refined or modified by the observations. This process of comparing rational and empirical models integrates what was actually observed with what was expected and a synthesized rational/ empirical model is built to represent one's current state of knowledge. This model now acts as one's best guess and the process of

observing new performance and comparing them to the existing model is repeated again. When constructing these models researchers attempt to set aside past conceptualisations and describe what they observe anew. Laying out one's suppositions initially helps bracket them and observe freshly. In this way the process stays creative and encourages the possibility the researchers will notice novel aspects of the therapy process beyond what they hypothesised in their rational model.

The model building phase, as outlined above, involves an iterative procedure of moving back and forth between possible and actual performances, obtained by conjecture and observation respectively. The empirical task analysis, in addition, involves a further process of moving back and forth between observation and specification of categories. This process promotes discovery by going beyond the use of induction, to the use of a form of inference termed abduction by Pierce (1965). He maintained that, in addition to the conventional means by which empirical science explains how knowledge is gained, namely; induction which involves making generalizations from specific observations, and deduction which starts with the general and goes to a specific logical conclusion, science proceeds by another mode of inference, which he terms abduction which involves imagination. In this view new knowledge never comes from deduction, which like mathematics contains its findings in its premises. Nor does it come from induction alone, because observation alone does not account for the imagination needed in the recognition and constructive description of something truly novel. One cannot easily see what one does not attend to, and does not expect, because it has never been seen and therefore is not easily envisaged. Instead the truly novel emerges from the interaction of induction and abduction. In induction the investigator empirically observes phenomena. In abduction the investigator oscillates between imagination and observation guided by imagination to *create* a type of picture (Hansen, 1958) or a hypothesis to explain an observed novel finding.

The constructed picture of what is occurring then is tested *progressively by the next observation and by ongoing data collection* (Rennie, 2000). In abduction the investigator thus gathers data inductively, and as new or surprising material is encountered the investigator configures the material in a new way thereby imaginatively creating an explanation of the data (abduction) and proceeds to test this inductively with further observation. This iterative procedure, of observation, imaginative construction to provide novel explanation and further observation to check the explanation is at the heart of task analytic model building, and results in a form of self-corrective induction. Thus, the investigator having first laid out an imagined

performance by rational means, and bracketed it, to allow for as open observation as possible, reads the transcript and possibly listens to a session or key event and begins to form descriptive categories to imaginatively understand (develop a new picture), and then explain (describe relationships between elements) what is occurring. Each category, created through imagining the significance of what was observed, is then checked against a next occurrence of the phenomena.

It is important to note that the components being constructed by this method are always tentative, never absolute and their development is a function of growing consensus among the investigators involved in its construction over repeated sets of observation. Thus, any category or component of the model is an abduction (a constructed hypothesis), awaiting validation by continuing observations. Components (hypotheses) are altered, discarded, or combined with other components, depending on an ongoing understanding of the process in the case being studied and in further cases. At this point of the process there is no concern with inter-rater agreement through statistical means but with the development, over time, of more useful descriptions of components. Shared observations rather than inter-judge agreement allows the investigators to develop a rich and thick description of the phenomena under study.

At the end of the inductive/abductive spiral involved in building the empirical model based on the current set of cases (usually three at a time) the results of the empirical analysis are also compared with the bracketed initial pre-conceptions and assumptions, to build a rational/empirical model. Throughout Task Analysis three exemplars are generally first chosen, as this is the minimum number in which one can begin to have some confidence that observed commonalties are unlikely to be due to chance. The synthesized rational/empirical model represents a theory, grounded in observation that acknowledges the theoretical assumptions from which it arises and demonstrates what has been newly discovered. Although it is impossible during an empirical analysis to bracket all assumptions, especially those of which the researcher is unaware, nevertheless every effort is made to bracket assumptions that are in awareness. By making explicit, the perspectives brought to the study, and the expected process of resolution, what is truly discovered in the empirical analysis is more easily revealed.

The Validation–Oriented Phase

This second validation-oriented phase of task analysis involves procedures for testing how well the model constructed through the steps

above describes the nature of the resolution performance and how well the model predicts therapeutic outcome. Two more traditional studies in the context of justification, to help test hypotheses, that can be undertaken are validating the model and relating process to outcome. These are done at the end of a research program based on much prior research involving, description, discovery, and measurement construction.

The question posed in the model validation step is:

1. Do the components of the model discriminate between resolved and unresolved performances? This is evaluated by comparing a group of resolved and unresolved events in a comparative group design.

The question posed in the next and final step, relating process to outcome, is:

2. Do the components of resolution that discriminate resolved performances relate to outcome? This involves relating process to outcome in a group design and involves a test of the model's predictive validity

Conclusions

In this paper, I have argued we need information from multiple sources to understand the complex relationship between specific techniques, therapist actions, and client processes that effect changes in psychotherapy. In particular, change process research should be one of those multiple sources in that it reveals the actual mechanisms of change, which is the active ingredient in psychotherapy.

I have proposed one method, task analysis, as a helpful research strategy for understanding how change actually occurs that can be useful in studying key events as well as how change in performance occurs across a whole therapy. This type of study could provide empirical evidence in support of different specific mechanisms of change for gestalt psychotherapy, such as the process and effects; of change in interactions around moments of contact; of effects of therapist disclosure of current experience. ; of key moments, such as undoing retroflections, reowning projections, resolving unfinished business or splits. This form of integration of descriptive, empirical and conceptual research could contribute significantly to the development of gestalt.

References

Bhaskar, R. (1975). *A realist theory of science.* Leeds: Leeds Books.

Greenberg, L. (1976). *Task analytic approach to the study of psychotherapeutic events.* Unpublished doctoral dissertation, York University.

Greenberg, L. (1984). Task analysis: The general approach. In L. Rice & L. Greenberg (Eds.), *Patterns of change: Intensive analysis of psychotherapeutic process.* New York: Guilford Press.

Greenberg, L. (1986). Change process research. *Journal of Consulting and Clinical Psychology.* Special Issue: *Psychotherapy Research, 54,* 4-9.

Greenberg, L. (1991). Research on the process of change. *Psychotherapy Research, 1,* 14-24.

Greenberg, L. (1992). Task Analysis: Identifying components of intrapersonal conflict resolutions. In S. Toukmanian & D. Rennie. *Psychotherapy Process Research.* Sage.

Greenberg, L. (2002). *Emotion-focused therapy: Coaching clients to work through feelings.* Washington, D.C. American Psychological Association Press.

Greenberg, L. (2007). A guide to conducting a task analysis of psychotherapeutic change. Psychotherapy Research,17,15-30.

Greenberg L. (2010; 2nd edition 2016) *Emotion-focused therapy: Theory and practice.* Washington, D.C. American Psychological Association Press.

Greenberg, L. & Foerster, F. (1996). Resolving unfinished business: The process of change. *Journal of Consulting and Clinical Psychology, 64(3),* 439-446.

Greenberg, L. & Newman, F. (1996). An Approach to Psychotherapy Change Process Research: Introduction to the Special Section. *Journal of Consulting & Clinical Psychology, 64(3),* 435-438.

Greenberg, L. & Johnson, S. (1988). *Emotionally focused couples therapy.* Guilford Press.

Greenberg, L. & Malcolm, W. (2002). Resolving Unfinished Business: Relating Process to Outcome. *Journal of Consulting & Clinical Psychology, 70, 2,* 406-416.

Greenberg, L. & Pascual-Leone, J. (1995). A dialectical constructivist approach to experiential

change. In R. Neimeyer & M. Mahoney, *Constructivism in Psychotherapy.* (pp 169-194) Washington, D.C. APA Press.

Greenberg, L. & Pascual-Leone, J. (2001). J. A dialectical constructivist view of the creation of personal meaning. *Journal of Constructivist Psychology, 14(3),* 165-186.

Greenberg, L. Rice, L. & Elliott, R. (1993). *Facilitating Emotional Change: The Moment-by-Moment Process:* New York Guilford Press.

Greenberg, L. & Safran, J. (1987). *Emotion in Psychotherapy: Affect, cognition and the process of change.* New York: Guilford Press.

Hansen, N (1958). Patterns of Discovery. Cambridge: Cambridge University Press

Hempel c (1966) *Philosophy of Natural Science*, Englewood Cliffs, NJ: Prentice-Hall

Hoffman, I.Z. (1998). Ritual and Spontaneity in the Psychoanalytic Process: A Dialectical-Constructivist View. New York: Analytic Press

Lakatos, I. (1970). *Falsification and the methodology of scientific research programmes.* In I. Lakatos & A. Musgrave, (Eds.). Criticism and the Growth of Knowledge. Reprinted in Lakatos, I. Philosophical Papers Vol 1.

Neimeyer, R. & Mahoney, M. (1995). *Constructivism in psychotherapy.* Washington, DC: American Psychological Association.

Newell, A. & Simon, H. (1972). *Human problem solving.* New York: Prentice-Hall.

Paivio, S. & Greenberg, L. (1995). Resolving Unfinished Business: Experiential therapy using empty chair dialogue. *Journal of Consulting & Clinical Psychology, 63(3),* 419-425.

Pascual-Leone, J. (1976). Metasubjective problems of constructive cognition: Forms of knowing and their psychological mechanisms. *Canadian Psychological Review, 17,* 110-122.

Pascual-Leone, J. (1991). Emotion, development, and psychotherapy: A dialectical constructivist perspective. In J. Safran & L. Greenberg, L. S. (Eds.), *Emotion, psychotherapy and change.* (pp. 302-335). New York: Guilford Press.

Pascual-Leone, J. (1978). Compounds, confounds, and models in developmental information processing: A reply to Trabasso and Foellinger. *Journal of Experimental Child Psychology, 26,* 18-40. Pascual-Leone, J. & Johnson, J. (2004). Affect, self-motivation, and cognitive development: A dialectical constructivist view. In Y. D. Dai & R. J. Sternberg (Eds.), Motivation, emotion, and cognition: Integrative perspectives on intellectual functioning and development. Mahawh, NJ: Lawrence Erlbaum Associates.

Peirce, C. S. (1965). *Collected papers of Charles Sanders Peirce.* Cambridge, MA: Belknap

Reichenbach, H. (1951). *The rise of scientific philosophy*, Berkeley: University of California Press (1949)

Rennie, D. (2000). Grounded theory methodology as methodical hermeneutics: Reconciling realism and relativism. *Theory & Psychology, 10,* 481-502.

Rice, L. & Greenberg, L. (Eds.) (1984). *Patterns of change: An intensive analysis of psychotherapeutic process.* New York: Guilford Press.

Weston, J. (2017). *Interruption of emotional experience in psychotherapy.* Unpublished doctoral dissertation, Toronto, York

Paivio, S. C., I.E. Hall, K.A.M. Holowaty, J.B. Jellis and N. Tran. 2001. Imaginal confrontation for resolving child abuse issues. *Psychotherapy Research,* 11, 56-68.

Paivio, S.C. and Nieuwenhuis, J. A. 2001. Efficacy of emotionally focused therapy for adult survivors of child abuse: A preliminary study. *Journal of Traumatic Stress, 14,* 115-134

Sharbanee, J Goldman, R & Greenberg, L. (2017). Task analyses of emotional change. In L Greenberg & r Goldman. (eds) Handbook of emotional change. Washington, D.C. American Psychological Association Press

Wampold B. (2013).The great psychotherapy debate:Models, methods and findings NewYork Erlbaum Models,methods, and findings New York Erlbaum.

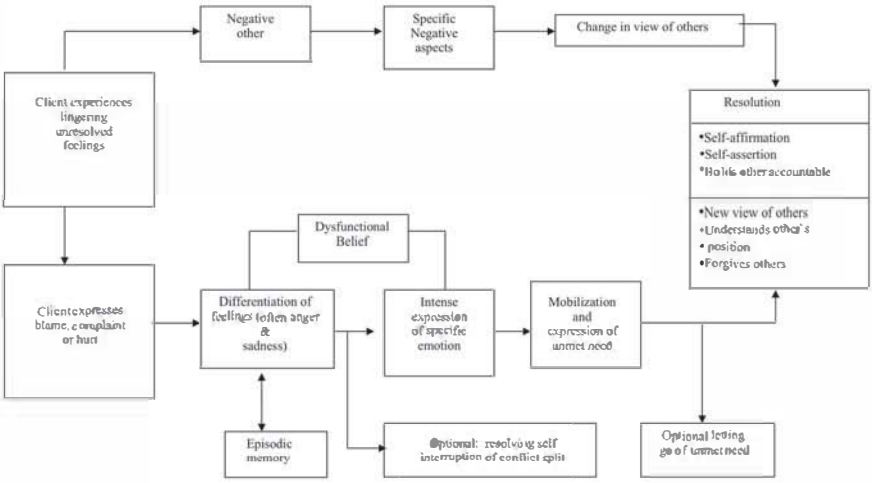

Figure 3.4. Resolution of Unfinished Business

CHAPTER FOUR

USEFUL METHODOLOGY IN GESTALT RESEARCH

JELENA ZELESKOV DJORIC

"Every living being is an engine geared to the wheelwork of the universe. Though seemingly affected only by its immediate surrounding, the sphere of external influence extends to infinite distance."

Nikola Tesla, *Did the War Cause the Italian Earthquake, New York American, February 7, 1915*

Interest in research amongst gestalt therapists and practitioners has been increasing in recent years. Even though gestalt practitioners follow fundamental principles of research when providing therapy to their clients, the lack of scientifically published articles in peer-reviewed journals has led to misperceptions of the gestalt therapy approach and its merit among other therapies. Gestalt therapy is a humanistic approach in psychotherapy based on phenomenology as its framework. Gestalt practitioners apply basic theoretical concepts with clients, clueless that, while working with them here and now using field theory, the cycle of contact experience, and the aesthetic dimension, a significant co-creating research field is emerging and becoming more vibrant.

This chapter provides a very brief overview of the basic qualitative and mixed research methods, along with recent quantitative measurements, which are particularly applicable in gestalt research. It proposes more understanding on questions of *"when," "how," and "under which circumstances."* It is hoped that the reader will understand the research stages, processes, and communication with the excitement necessary to conduct his or her own research. By achieving this, the gap between practitioners and academics will be diminished. Moreover, gestalt practitioners will be able to support the gestalt academic community in their further steps toward positioning gestalt therapy among other approaches and

within professional authorities, health insurance policies, and government bodies.

Capturing Principles of Practicing Qualitative Research: Gestalt Therapy and Zen Buddhism

The principles of qualitative research practice highlight particular processes and philosophical foundations; the imagination, intuition, and creativity of the practitioner-researcher are pivotal parts of the research process. In a previous edition of their book, Barber and Brownell (2008) stated that the journey of a qualitative researcher could be divided into six phases: pre-contact, orientation, identification, exploration, resolution, and post-contact. In line with this—and relying on the phenomenological field, where the research is embedded and the aesthetic dimension is emphasized (Francesetti, 2012, 2015; Francesetti & Spagnuolo Lobb, 2013)—the contact cycle experience can be considered as a form of art, with psychotherapists as artists. Art is always dynamic, holistic, and intuitive; hence, psychotherapy research should have these characteristics as well. Relaying the historical development of gestalt therapy, the aesthetic dimension is conjugated with Zen Buddhist concepts representing an inevitable part of gestalt therapy (Naranjo, 2000; Stevens, 1989). Further explorations of the philosophical foundations of Zen thinking represent fertile ground for culturally sensitive research, especially in cultures where collectivism and ancestors are important, as well as in the present, daily lives of clients, through their thoughts, values, and beliefs. By understanding research from this perspective, gestalt practitioners could feel more comfortable in the research arena. To start with, the qualitative research process will be discussed within this framework.

Conducting research usually starts with asking a question; the aim of the research method is to give the answer. According to Zen Buddhist practice, the answer is embedded in the question with three basic concepts, which are particularly important for research designs that implement holistic perspectives: *impermanence* (everything is changing), *non-self* (a separate existence does not exist), and *nirvana* (peacefulness with the universe and pain). All three concepts from Zen could be connected with the qualitative research perspective. Janesick (2015) proposed a comparison between Zen and the qualitative research perspective, which is presented in Figure 4.1.

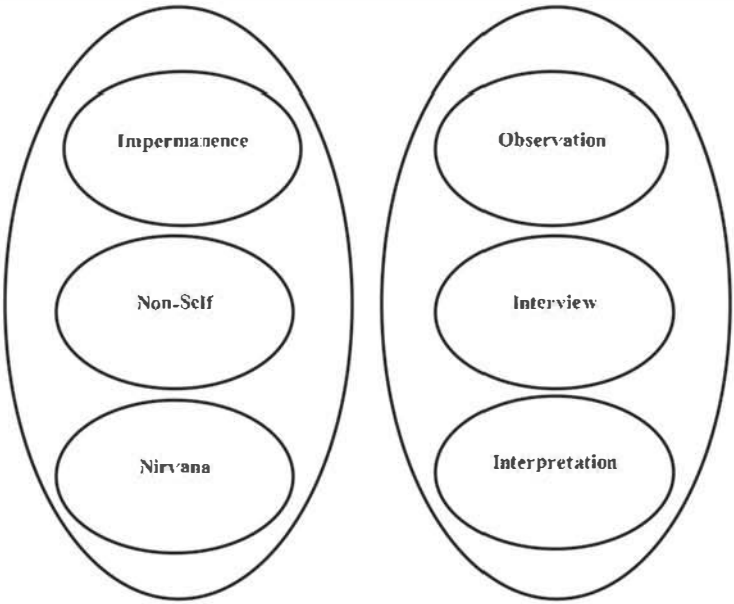

Figure 4.1. Zen and Qualitative Research Methods (Janesick, 2015)

First, awareness of impermanence is tremendously important when using the *observation* technique in qualitative research. In the light of impermanence, the phenomena we observe are always changing. Observation has been defined as "the fundamental base of all research methods" in the social and behavioral sciences (Adler & Adler, 1994, p. 389). Participant observation is an integral part of ethnographic fieldwork, as it includes "active looking, improving memory, informal interviewing, writing detailed field notes, and perhaps most importantly, patience" (DeWalt & DeWalt, 2002, p. 105). By participating in the field, researchers are enabled to learn about the natural setting and the activities people perform. In many situations, the complexity of the phenomenon can be reached through direct participation and observation. Data collection should be descriptive, allowing the researcher to understand what happened and how. According to Neuman (2006), researchers should follow several recommendations while taking field notes, such as: record notes as soon as possible, do not talk with others until observations are recorded, begin the record of each field visit with a new page with the date and time noted, use wide margins, record events in the order in which they occur, record small talk or routines, let your feelings flow, include diagrams and maps, record

emotional feelings and private thoughts in a separate section, avoid evaluative summarizing words, reread notes periodically, and record ideas.

Notes are always viewed through a particular philosophical perspective. In gestalt therapy, this perspective is phenomenology, with the extension achieved through the narrative description of observed phenomena. Practicing observation techniques relates to the basic gestalt principles of *here and now*, as well as the contact process in the field, which co-emerges between the practitioner-researcher and the client-researcher.

Second, it is important to explore qualitative research from the perspective of *non-self*, which is defined in Zen practice as existence within. The *interviewing technique* can be explained using the *non-self* framework. Even though the practitioner-researcher could apply different types of questions in the interview process (paradigmatic, clarifying, example, and contrast questions), the interview process is a contemplative and creative act of non-self.

The final stage of the research process is embedded in the concept of *nirvana*, which is defined as the state of peacefulness and unitedness with the universe achieved through the acceptance of impermanence and the non-self; this concept could help in organizing the data collected through the qualitative research process. The style of writing and the use of photography, art, or poems illustrate the aesthetic dimension of this process and represent the crucial element of the concept of nirvana in Zen Buddhism; the compassionate aspect of writing is consistent with the Zen teaching to do no harm, where joy and mindfulness are present in both.

The exploration of similarities between Zen Buddhism and the qualitative research process provide creative ground for introducing these concepts through the lens of gestalt therapy theory. The acceptance of impermanence during observation could be understood from the perspective of field theory in gestalt therapy. The concept of field theory is defined through numerous perspectives (Parlett, 2000; Philippson, 2009; Robine, 2015), where the field is phenomenological and experiential, constituting us and giving shape to our experiences (Francestti, 2015). Therefore, *observation is happening within the field itself, and impermanence is the necessary aspect of the field.*

On the other hand, the concept of *non-self* and the usage of interviews as a common method in qualitative research can be discussed through the concept of *contact*. Contact occurs at the contact boundary where the self is emerging. The meeting and co-creation between therapist and client at the contact boundary is embedded in the contact itself. The qualities of the contact experience during interviews provide self/non-self-discovery in the field. The gestalt concept of *contact experience constitutes the non-self-*

perspective of the interviewing process. Furthermore, narrative writing and the interpretation of collected data through the aesthetic dimension, proposed as *nirvana* in this model (Janesick, 2015), could be defined within the concept of the *aesthetic dimension in the here and now*. Being with the whole experience and peaceful with the wholeness in nirvana is very similar to interpreting and writing about the research data through the aesthetic dimension of the process of here and now. The proposed diagram in Figure 4.2 captures the qualitative research process, Zen Buddhism, and gestalt therapy based on the model discussed.

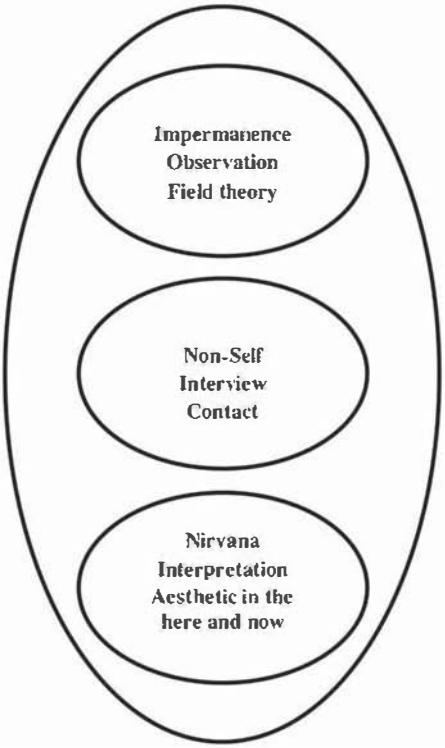

Figure 4.2. Gestalt Therapy, Qualitative Research and Zen Buddhism

Gestalt therapists and practitioners could easily apply these principles in their work with clients by embracing and transferring these well-known concepts in gestalt therapy into the research field. However, as qualitative research implies research design, sampling, data collection, analysis, and

interpretation, openness to theoretical considerations, which emerge from various perspectives, will be briefly presented.

Qualitative Research Methods

Qualitative research is characterized by its aims related to understanding aspects of social life. The methods used in qualitative research generate *words rather than numbers* as data for analysis. The suitability of qualitative research methods is estimated by the research question itself. So, when is it appropriate to use qualitative methods? When we want to understand the experiences, perspectives, and attitudes of clients, therapists, or trainees. Therefore, these methods aim to answer questions about the *"how"* or *"what"* of a phenomenon instead of answering questions about *"how much"* or *"how many,"* which are answered by quantitative methods.

The next step is to obtain ethical approval for the study of human subjects. Depending on the country and legislative regulations, a research study will undergo various committee and ethical review boards for approval. Nevertheless, in any research project, the researcher should be aware of two main ethical issues: *consent* and *confidentiality*. Everyone who participates in the research study should feel unpressured and free to talk about personal experiences. The best way to support clients is to inform them about what participation entails and to obtain written or verbal consent. Exploration of phenomena and experiences that others have in their lives, as well as attitudes toward social relationships, represent sensitive material, which should be treated with high confidentiality. It is enormously significant for the client to understand that the information they share with the researcher is protected.

The starting point for the research study is to conduct the *literature review* and check if previous researchers have tried to answer the research question. The next step is to understand if the proposed research will address the problem and to reflect on what exactly will be researched. If the answer is to *understand* the *perspectives of participants*, explore the *meaning* they give to *phenomena,* or *observe the process* in depth, then the use of the qualitative research methodology is appropriate. A summary of qualitative traditions is presented in Table 4.1.

Each research protocol consists of clearly stated parts, such as the aim of the study, objectives, background (why it is interesting to do this particular research), methods (how the data will be collected, the participants who will be the sampled in the study, the plan for analysis, ethical issues, resources (cost, travel, translation, etc.), the time scale with milestones (how long it will take and when particular phases will be

finalized), and dissemination (where and to whom the research will be presented: conferences, journals, governments, the community, etc.).

Table 4.1. The Qualitative Traditions (Creswell & Plano Clark, 2007)

Dimension	Narrative	Phenomenology	Grounded Theory	Ethnography	Case Study
Focus	Exploring the life of an individual	Understanding the essence of experiences about a phenomenon	Developing the theory grounded from data in the field	Describing and interpreting a cultural or social group	Developing an in-depth analysis of a single case or multiple cases
Data collection	Primary interviews and documents	Long interviews with up to 10 people	Interviews with 20-30 individuals to "saturate" categories and detail a theory	Primarily observations and interviews with additional artefacts during extended time in the field (e.g. 6 months to a year)	Multiple sources including documents, archival records, interviews, observations, physical artifacts.
Data analysis	Stories Epiphanies Historical content	Statements Meanings Meaning themes General description of the experience	Open coding Axial coding Selective coding Conditional matrix	Description Analysis Interpretation	Description Themes Assertions
Narrative form	Detailed picture of an individual's life	Description of the "essence" of the experience	Theory or theoretical model	Description of the cultural behaviour of a group or an individual	In-depth study of a "case" or "cases"

Participants in a qualitative research study are chosen by the purpose of the research aim. This means that statistical representativeness is not the aim and that people who agree to be in the sample are there because the researcher believes that exactly these participants are likely to generate useful data for the study. Sample credibility is achieved through the strategy of maximum variation of the sample (selecting key demographic variables), but the sampling itself is determined by the purpose of the research study. Various types of sampling methods are presented in Table 4.2.

Table 4.2. Types of Sampling Strategies for Qualitative Studies (Ellsberg & Heise, 2005)

Type of sampling	Purpose	Example
Intensity sampling	To provide rich information from a few selected cases that manifest the phenomenon intensely (but are not extreme case)	Interviewing survivors of date rape to learn more about how coerced sex affects women's sexuality
Deviant case sampling	To learn from highly unusual manifestations of the phenomenon in question	Interviewing men who do not beat their wives in a culture where wife abuse is culturally accepted.
Stratified purposeful sampling	To illustrate characteristics of particular subgroups of interest; to facilitate comparisons	Interviewing different types of service providers (police, social workers, doctors, clergy) to compare their attitudes toward and treatment of abuse victims.
Snowball or chain sampling (locate one or two key individuals, and then ask them to name other likely informants.)	To facilitate the identification of hard-to-find cases	Finding commercial sex workers to interview about experiences of childhood sexual abuse by getting cases referred through friendship networks.
Maximum variation sampling (Purposely select a wide range of variation on dimensions of interest.)	To document diverse variations; can help to identify common patterns that cut across variations	Researching variations in norms about the acceptability of wife beating by conducting focus groups among different sub groups: young urban women, old urban women, young rural men, old rural men, women who have been abused women who have not experienced abuse.
Convenience sampling (select whoever is easiest, closest, etc.)	To save time, money, and effort. Information collected generally has very low credibility.	Forming focus groups based on who is available that day at the local community center, rather than according to clear criteria.
Criterion sampling	To investigate in depth a particular "type" of case; identify all sources of variation.	Specifically interviewing only abused women who have left their partners within the last year in order to better understand the variety of factors that spur women to leave.

The next step in the qualitative research methodology is to *collect data*. As previously stated, a *collection of words*, not numbers, is a peculiarity of this approach. The most common data collection methods are *individual interviews* and *group discussions*.

Interviews

Interviews are conducted in the most rigorous way to ensure the reliability and validity of the data. There are different types of interviews, but the most common are semi-structured and in-depth interviews. While semi-structured interviews have a loose structure with some open-ended questions and topic guides, in-depth interviews are less structured and usually

cover one or two issues. One type of in-depth interview is a life history, which provides a broad understanding of a person's life in a general context.

Basic recommendations when asking questions of participants should be followed in every research study. By asking questions in an order from the general to the specific, participants can orient themselves. Furthermore, the language should be easy to understand; complex vocabulary should be avoided, and sensitive questions should be put toward the end of the interview. Also, concrete instead of abstract questions can be helpful for participants in the study.

Besides individual interviews, qualitative researchers use group discussions in the form of focus groups or natural groups. The main differences between a focus group and a natural group are that focus group participants are selected to meet sampling criteria, gather at a formally arranged place and time, and usually have their responses audio-taped and transcribed for analysis, whereas natural group participants exist independently of the research study, meet in an informal or formal format, and are recorded via written notes. Focus groups provide insight into how people think about a specific issue and help researchers to gain a greater understanding of the topic. Group interaction between members usually results in more data than the researcher can collect from individual interviews. A gestalt researcher should be familiar with the five-stage process for conducting focus groups and reporting the results of the research project. These five stages are study purpose, methodology (conceptualization and logistics), facilitation (preparation, pre-session, session), analysis, and reporting.

In the first stage, the researcher needs to define the purpose of the study. The purpose could vary from exploration to evaluation. In the second stage, the researcher needs to conceptualize the population and define the sample. Since the focus group method does not use probability or random samples, researchers need to think about which participants would best fit the purpose of the study. Consisting of seven to 12 participants, the size of the focus group enables the facilitator to lead the group and gain the necessary data. The duration of the group session is between 90 minutes and two hours, and the number of groups that the researcher should run is generated by the saturation point (when additional data collection no longer generates new understanding). Usually, the facilitator asks approximately five open-ended questions, which are checked through a pilot test before use with study participants. Logistics are an important consideration in the focus group stage of the research methodology, as these could be demanding and time-consuming for the researcher. The researcher should plan logistics approximately six to eight weeks prior to the actual focus group. The facilitator could be the researcher or someone else on the research team. The

third stage is the facilitation itself. In the preparation phase, one researcher is leading the group and the other is the note taker. In the pre-session phase, the facilitator becomes familiar with the group and could note peculiarities of group members. In the session phase, the facilitator asks questions and leads the group process. Nonverbal communication by the group is equally as important as verbal communication, and the facilitator (researcher) needs to be aware of that.

After collecting data and managing it through the creation of transcripts, the next step is to *analyze the results.* This is the most challenging part of the qualitative research process and is where the expertise of the researcher is highlighted. Qualitative approaches are incredibly diverse and complex (Holloway & Todres, 2003); however, the *thematic analysis of data* should be discussed as the most fundamental method in qualitative analysis (Braun & Clarke, 2006). This method consists of four key stages: read and annotate transcripts, identify themes, developing a coding scheme, and code the data. The application of the thematic analysis will usually be followed by the *narrative analysis,* as some important information could be lost during the coding system. Sufficient knowledge and understanding gained using both analyses could contribute to a better understanding of the explored phenomena. Recognition of adequate methods for collecting data, as well as the advantages and drawbacks of using individual interviews or group discussions, should be led not only by the research question and the research design, but also by the skills and knowledge of the researcher.

In addition to interviews and group discussions, various methods of inquiry used as part of the qualitative approach include the case study, performance ethnography, narrative ethnography, grounded theory methods, action research, narrative inquiry, critical-art based inquiry, oral history, observation, visual methods, performative autoethnography, online ethnography, and analyzing talk and text. Given the awareness of emerging needs in the gestalt community and the desire to develop research skills among gestalt therapists and practitioners, a brief description of some of these qualitative methods will be presented here.

Case Study

The case study method is a qualitative research approach that facilitates the importance of *exploring a phenomenon in its context* by examining various data. This method is based on the constructivist paradigm that truth is relative and depends on one's perspective. Participants can describe their views of the world and the meaning they create, giving the researcher the opportunity to better understand the participants' actions and behaviors

(Lather, 1992). According to Yin (2003), the case study approach should be considered when the focus of the researcher is to answer *"how"* and *"why" questions* without manipulating participant behavior and when the researcher firmly believes that *contextual factors* can greatly contribute to the explored phenomenon, while boundaries between the context and phenomenon are blurred. The starting point is to define the question of the research: What do I want to research? What case do I want to study? Do I want to "analyze" the individual, the process, or the organization? Examples of question formulation when developing the case study are given in Table 4.3.

Table 4.3. Developing Case Study Research Questions (Baxter & Jack, 2008)

Case Examples	Research Question
1. The decision making process of women between the age of 30 and 40 years	How do women between the ages of 30 and 40 years decide whether or not to have reconstructive surgery after a radical mastectomy? What factors influence their decision?
The experiences of 30-40 year old women following radical mastectomy faced with the decision of whether or not to undergo reconstructive surgery	How women (30-40 years of age) describe their post-op (first 6 months) experiences following a radical mastectomy? Do these experiences influence their decisions making related to breast reconstructive surgery?
The decision making process (related to breast reconstruction post-radical mastectomy) of women between the age of 30 and 40 years attending four cancer centers in Ontario.	How do women (ages 30-40) attending four different cancer centres in Ontario describe their decision making related to breast reconstructive surgery following a radical mastectomy?

The next step is to decide which type of case study will be used. Yin (2003) has stated that three types of case studies could be considered: *explanatory, exploratory,* or *descriptive*. When causal links in real-life interventions are too complex to be explained by experimental design or the survey approach, the explanatory case study is used. When the intervention being evaluated has no single set of outcomes, using the exploratory case study is most appropriate. Finally, the descriptive case study can be used to describe an intervention or phenomenon and the real-life context in which it occurred. Furthermore, Yin (2003) has suggested that, according to the research question, differentiation between *single* and *multiple case study approaches* can be highlighted. Moreover, case studies could be categorized

as *intrinsic, instrumental* and *collective* (Stake, 1995). The intrinsic case study is not used to understand an abstract construct or to build the theory, but to understand the case itself with its own peculiarities. On the contrary, the instrumental case study is used when the researcher wants to understand and refine the theory; here, the case is of secondary interest, representing a supportive element in understanding something else. The third category of case study is the collective case study, which is similar to multiple case studies. The analysis of the data will depend on the chosen case study category.

Performance Ethnography

An art-based method of qualitative inquiry known as performance ethnography uses *theater as a place of research.* The theater is transformed from an entertainment venue to a place for participatory action research (Alexander, 2005; Finley, 2005). The gestalt concept of "here and now" makes this approach interesting for gestalt therapists and practitioners. The impact of performance on understanding an explored phenomenon was first highlighted by American dancer and choreographer Bill T. Jones, who explored the experiences of people suffering from life-threatening illnesses as they participated in a series of workshops where their emotions and life experiences were transformed into dance (Jones, Bender, & Jones, 1997). Denzin (2003) has stated that social change comes from within society rather than being imposed upon it, and that performance ethnography is a valuable method of researching human experience. Performance ethnography is relevant as a method of facilitating students to learn and teach; from that perspective, it can be used in research projects with students and trainees. For example, students in gestalt therapy groups could be sent to explore a topic or social issue in the community. By collecting stories through interviews with research participants and using the observation method, new understandings could emerge in the field through performance as students re-enact their findings in the classroom.

Grounded Theory Method

Grounded theory and its application in gestalt therapy have been discussed recently with a specific focus on depression (Roubal & Rihacek, 2016a, 2016b). The grounded theory method emerged from sociologists Glaser and Strauss, who researched those dying in hospitals (Glaser & Strauss, 1965). This method is rooted in the symbolic, interactionist perspective, which assumes that society, self, and reality are constructed

through interaction and rely on communication and language (Charmaz, 2005).

The grounded theory approach is a systematic and flexible method consisting of guidelines that the researcher should use when collecting and analyzing qualitative data to construct theories. These *theories are "grounded" in the data themselves*. No assumptions are made, and the theory is constructed after collecting the data. Simply put, the act of making an assumption about how to define depression and how it could be classified into a category does not exist. Contrary to the biomedical approaches, researchers explore what the depressive experience is like for clients, in collaboration with the co-construct theory of depression based on clients' stories. Researchers who use this framework are open to what is happening during the research process and to what they hear, see, and sense. Data analysis is constructed through the observations, interactions, and materials that are gathered. Data are sorted and synthetized through *coding*. Codes emerge through emphasizing the actual scene described by researchers. After the codes are established, researchers write preliminary analytic notes that are called *memos*. Basically, studying and comparing the data and writing the memos epitomize an opportunity to define "best fit" ideas and theories for the explored topic. The grounded theory method prioritizes the phenomenon or process instead of the description or setting. As such, grounded theory is a rich method of qualitative research that complies with the gestalt therapy philosophy. For practitioners, more interested in this approach, as well as the steps for collecting and interpreting data, the book *Constructing Grounded Theory* can be a useful resource (Charmaz, 2006).

Action Research

Known by many other names, including participatory research, collaborative inquiry, and action learning, action research represents one of the most widely used qualitative methods in research practice. Originally developed by German social and experimental psychologist Kurt Lewin (1946), one of the founders of the Gestalt school, the main feature of action research is embracing concepts of field theory and group dynamics. The basic aim in this type of qualitative research is to practically support the problematic situation while developing goals at the same time. The system is studied through collaboration with members of that system, who are actively involved in desirable change; therefore, "accomplishing this twin goal requires the active collaboration of researcher and client, and thus it stresses the importance of co-learning as a primary aspect of the research process" (ABL, 1997, p. 3). Simply put, the action research represents

"learning by doing." This research takes place in real-world situations and aims to solve real problems. The action research process has several phases, starting with identifying or defining the problem; then planning action, taking action, and evaluating the consequences of the action; and finishing with identifying general findings. Moreover, several key application principles—from reflexive and dialectical critics, to collaborative resource, to risk and plural structure—have been delineated (Winter, 1987). As a holistic approach to problem-solving, rather than a single method for collecting and analyzing data, various action research tools can be used.

Narrative Inquiry

Exploring human existence and experience apparently involves stories. According to Clandinin et al. (2006), people not only shape their daily lives by stories of their own identity and understanding of others, but also interpret their past in terms of stories. Through story, people gain meaning in their lives and perceive the world as a meaningful place. Respecting the pragmatic philosophy of John Dewey and his definition of experience as interactive and continuous, Clandinin and Connelly define narrative inquiry as an experience based on collaboration between participants and the researcher, which happens over time and includes social interaction and a matrix of "living and telling, reliving and retelling, the stories of the experiences that made up people's lives, both individual and social" (Clandinin & Connelly, 2000, p. 20). The conceptualization of narrative inquiry through three dimensions—interaction, continuity, and situation—provides a good ground for researchers in the field. Those researchers employing narrative inquiry engage participants by *asking them to share and tell their stories, while living together in the field with the participants where the stories are told.* This approach gives a myriad of imaginative possibilities for composing photographs, field notes, interview transcripts, etc.

Oral History

This qualitative method is defined as "collecting memories and personal commentaries of historical significance through recorded interviews" (Richie, 2003). The interviewer is well prepared when questioning the interviewee, and their conversation is recorded in audio or video format. To be more precise, oral history can be used to refer to the recorded in-depth interview. The oral history method is best described through six characteristics that should be followed. The first characteristic is that oral

history is an interview, which underlines the fact that the participant is not just somebody who tells the story, but someone who is answering the queries of another, giving the interview a dialogue shape. Second, the interview is recorded, which makes it accessible to others. Recording is the point of difference between the interview and the oral history as separate methods. Third, the oral history method is characterized by its historical perspective, followed by its interpretative structure. As an in-depth method, oral history is not a serendipitous conversation, but is planned and scheduled. Last, but not least, is the awareness that this qualitative inquiry is fundamentally oral, with all the dynamics of spoken words. This method is used by anthropologists and qualitative sociologists; however, its application and implementation in psychotherapy research could be of high importance.

Reflective Journal

This method is widely used in qualitative research approaches. The researcher's thoughts and reflections on the study and everything that occurred contribute enormously to the interpretation and analysis of the data. Moreover, the reflective journal is the technique that gives an answer to the researcher's role in the research study. It provides details about challenges in the research study, such as translations, transcripts, and the desire to transform a personal life story into a published text. Journal writing represents the way poems, photography, and drawings about a research study are integrated into a meaningful narrative (Janesick, 2015).

Art-Related Research

The philosophical and methodological ground for art-related research is embedded in post-modernism, constructionism, and constructivism. Forms of art-related research are numerous (Savin-Baden & Wimpenny, 2014); still, for gestalt therapists and practitioners, forms of *art-based inquiry and art-informed inquiry* could be interesting to understand the experience that researchers use in the artistic process—the making and doing of art in an art-based inquiry. In an art-informed inquiry, the focus is on the use of art to inform the audience about the research. Researchers and artists communicate findings and results of their studies through the art process. Moreover, art is used to portray the response to the situation that is studied. Even though the use of art in qualitative research methodology is well-known, for the purposes of this paper, just a brief description of some artistic forms, which are enthralling for gestalt practitioners, will be presented.

Poetry. We try to understand the world from numerous perspectives. Our knowledge about the world and others is always constructed through our experience of the world and of the other. Art itself deepens our experience of the world (Dewey, 1934). Expressive characteristics of art can provoke deep and very powerful emotions (Denzin, 1997), which undoubtedly influence our perception and interpretation of data. Using poetry in the research process has been confirmed by the growing literature on qualitative research (Barone, 2004; Leavy, 2009). As a form of expression, poetry represents a dynamic way of communicating feelings and emotions. Through poems, otherness becomes visible, and the heart and the person's world are embraced. According to Janesick (2015), two forms of poems are particularly important for qualitative researchers. These are *found data poems* and *identity poems*. Found data poems can be used in narrative texts, interview transcripts, or any other documents that gather research. Identity poems are captured by researchers, representing their own stories of the conducted study. Moreover, reflection on the study can be transformed into a poem.

Visual methods. Even though our reality is based on a visual society, cautiousness in using visual methods for research projects, except for photography, can be noticed. The term *visual* refers not to the image or the object itself, but more to the perception and the meaning attributed to it. The power of images is that they "evoke deeper elements of human consciousness than do words; exchanges based on words alone utilize less of the brain's capacity than do exchanges in which the brain is processing images as well as words" (Harper, 2002, p. 13).

In general, visual data can be divided into two categories: those produced by the participants and those generated by the researcher. One of the most used visual methods in research is photography (Harrison, 2002). Historically, photography was used in anthropological studies done by Gregory Bateson and Margaret Mead in the early 1940s as part of the visual ethnography method, where photographs were used as an integral part of their observation and fieldwork. Visual elicitation is a technique that involves using photographs, drawings, or diagrams in a research interview to stimulate a response from the participants. In the therapeutical space, therapists use various visual techniques to work with clients. While doing this, the therapist is conducting a research process in collaboration with the client.

Photography. Visual methods have been developed and used in qualitative research projects for the last thirty years (Packard, 2008) with noticeable imbalances between participants and researchers, which can be diminished by using visual methods, such as photography (Didkowsky,

Ungar, & Liebenberg, 2010; Hurworth, 2003;). The power of photography to communicate the field and to aid in the development of self-exploration, resilience, and coping skills is confirmed in various studies (Aldridge, 2007; Fleury, Keller, & Perez, 2009; Harding et al., 2009; Turner, 2005). The distinction between researcher-driven and participant-driven photography should be contemplated when using photography (Clark-Ibanez, 2004). Participant-generated photography is used to explore people's life stories and deliver an understanding of their lifestyles and construction of the world. *Photovoice* is a technique of instructing participants to take a camera and make photos as a part of a research process. This specific type of action research empowers participants to express their feelings and thoughts in relation to a specific topic through a dialogical process (Catalani & Minkler, 2010; Strack, Magill, & McDonagh, 2004). If the gestalt researcher decides to use photography as a method of data collection, it is useful to remember the quote from Harrison (2002), who stated that "photographs are means by which people in everyday life can narrate experience, and in this way, can come to an understanding of what those experiences mean" (p. 109).

Analyzing Talk and Text

The majority of qualitative research studies use interviews or focus groups as the primary methods of research. However, some useful alternative methods include semiotic narrative analysis, discourse analysis, critical discourse analysis, historical discourse analysis, and membership categorization analysis. According to Perakyla and Ruusuvuori (2011), a method of analyzing text should comply with the research questions and the whole design of the research study. Beside these methods of analyzing text, which will not be explored further here, analysis of face-to-face communication is even more challenging from the perspective of psychotherapy research. The most useful method to analyze the organization of communication is called *conversation analysis*. By investigating the structure and process of social interaction between humans, conversation analysis gives deeper understanding and knowledge of co-creating the field between the therapist and the client. In conversation analysis, the researchers make video or audio recordings using the detailed notation system. After that, the researchers search for recurrent interactive practices. The conversation analysis could have various focuses, such as conversation openings and closings (Schegloff & Sacks, 1973) or methods of telling and receiving news (Maynard, 2003). Through the analysis of sequences, particularly adjacency pairs (specific sequences in communication, representing the meeting place of two participants in an interaction), researchers can achieve a better understanding

of the explored phenomenon. Adjacency pairs include question-answer, request-grant/refusal, invitation/acceptance, etc. For those gestalt researchers who are eager to learn more about this type of qualitative research method, the study entitled "The Terms of Agreement" by Heritage and Raymond, conducted in 2005, could serve as a good example of this approach.

In a Nutshell: Qualitative Research Methods

Gestalt therapy foundational concepts could be successfully explored through qualitative research methods. The richness and pertinence of qualitative methods in understanding the human experience and the complexity of human interactions should underpin the future development of this research tradition in contemporary gestalt practice. Hopefully, through this brief description of qualitative methods, gestalt therapists and practitioners can start to embrace research as a part of their daily practice. To support them in this emerging journey toward the research field, some basic assumptions on the implementation of different scientific paradigms will be discussed further.

Research Methodology Through the Lenses of Science

As a humanistic approach, gestalt therapy has been continuously exposed to pressure to develop studies that could evaluate the effectiveness of this treatment. According to Greenberg (2008), quantitative research of psychotherapy outcomes is defined through six widely used methods: randomized clinical trials and comparative studies, controlled studies with comparison against untreated controls, quasi-experimental designs and naturalistic treatments, research-informed case studies, patient preference satisfaction studies, and predictive process-outcome research. Even though each of these methods has limitations and strengths, their contributions to conducting psychotherapy research in a scientific manner are enormous. Nowadays, evidence-based treatment with randomized clinical trial (RCT) design has become a gold standard in psychotherapy; hence, gestalt therapists should be able to follow this current trend in research practice with the aim of positioning gestalt therapy at the psychotherapy horizon in a more scientific way. RCT design or the other quantitative methods are not discussed here, as a discussion on quantitative research can be found in the previous edition of this book, where Leslie Greenberg sharply wrote about quantitative research in detail (Greenberg, 2008). Instead, a brief description of some quantitative measurements useful for gestalt therapists will be introduced. It is important to remember that the research question is the

main guide in choosing whether to use a qualitative or quantitative research approach. For exploration of *causal relationships,* the *quantitative approach* is more appropriate, while the *qualitative approach* is better for *exploring phenomena.* The following basic guidelines can help researchers in defining quantitative study:

1. The research question starts with "what," "why," or "how"
2. Independent and dependent variables must be defined
3. Researchers want to look at connections, relations, or comparisons among variables

Structuring a *quantitative research question* has at least *four steps.* The first step is to choose the type of quantitative research question (descriptive, comparative, or relationship-based). The second step is to define the different types of variables to be measured and/or controlled (categorical/continuous or independent/dependent), and to define any groups for examination. The third step is to select the appropriate structure of the quantitative research question based on variables and groups. The last step is to write out the problem that should be addressed in a very precise and defined research question (Bouma, 2002).

Quantitative studies have objectives and hypotheses. A hypothesis is a statement that asserts a relationship between concepts. Defining the right research question, variables, and sample is a very important process in conducting quantitative study. As was already articulated in the qualitative research approach section, sampling is a complex process and one of the most important steps in creating a research study. Another part of quantitative study is to define the measurements that will be used. The psychometric characteristics of instruments (questionnaires and scales) are tremendously important, and measurements should be reliable and valid. Data analysis consists of numerous statistical options according to the study type, research design, and research structure. Data interpretation and reporting is the last step in the quantitative study, which is similar to the last step in the qualitative study.

Unfortunately, gestalt psychotherapy does not have a long quantitative research tradition. For gestalt practitioners and therapists, the field of quantitative research has been emerging over the last several years. To better introduce quantitative instruments, only four measurements will be briefly described. Two of them are constructed purely relying on gestalt therapy theory: the Gestalt Inventory of Resistance Loadings (GIRL) and Gestalt Therapy Fidelity Scale (GTFS). The other two are widely used measurements in clinical and psychotherapy practice.

Brief Examples of Quantitative Research Instruments

Gestalt Inventory of Resistance Loadings (GIRL). One of the most recent instruments in gestalt therapy, which can be used in quantitative studies, is GIRL, proposed by Kevin Prosnick and Ansel Woldt in 2015. Gestalt quantitative research first started with the Gestalt Q-sort instrument (Byrnes, 1975) and continued with the Gestalt Contact Styles Questionnaire (GCSQ), developed by James Kepner (1982). Apart from these measurements, new scales were created, such as Woldt & Kepner's (1986) Gestalt Contact Styles Questionnaire-Revised (GCSQ-R), Woldt & Prosnick's (1996) Gestalt Contact Scales Questionnaire-150 (GCSQ-150), Prosnick's Gestalt Resistance Scales-I (GRS-I) and Gestalt Resistance Scales-II (GRS-II), and finally, Woldt & Prosnick's (2002) Gestalt Contact Scales Questionnaire-150R (GCSQ-150R). Following difficulties and limitations with these scales, Woldt and Prosnick developed a new scale consisting of 100 items and called it GIRL. Practitioners and therapists interested in the development of this scale are encouraged to contact the authors of the scale directly. The scale reliability ranges from .58 to .82, while correlations between the GIRL scales and some clinical instruments offer evidence of concurrent validity (Prosnick, Ghett, & Summ, 2002; Prosnick & Hizdik, 2002; Prosnick, Jasmine, & Wagner, 2000; Prosnick & Wang, 2004).

The GIRL scale (Woldt & Prosnick, 2015) is based on the Gestalt Cycle of Experience and the interrupting/resisting theoretical concept, as presented in Figure 4.3.

The gestalt cycle of experience consists of several contact functions: sensation, awareness, mobilization, action, full contact, integration, and withdrawal. The healthy and satisfactory functioning of a person leads from the previous contact process to the next without any interruption. When resistance is present in a contact process, gestalt therapists consider it a diagnostic tool. For those not familiar with the gestalt therapy theory, a brief summary of each contact function, as defined by Woldt & Prosnick (2015), is presented below.

Sensation/Perception. This is the first contact function of the cycle of experience. This is the basic function that allows us to make contact with the environment. Our sensory processes (listening, feeling, touching, tasting, smelling, talking, etc.) are important for the organization of our internal processes (desires, needs, impulses, etc.).

Awareness. This second contact function is characterized by the process of experiencing and identifying our behaviors, thoughts, and feelings, which are associated with our sensations/perceptions. It is a process as well as an outcome.

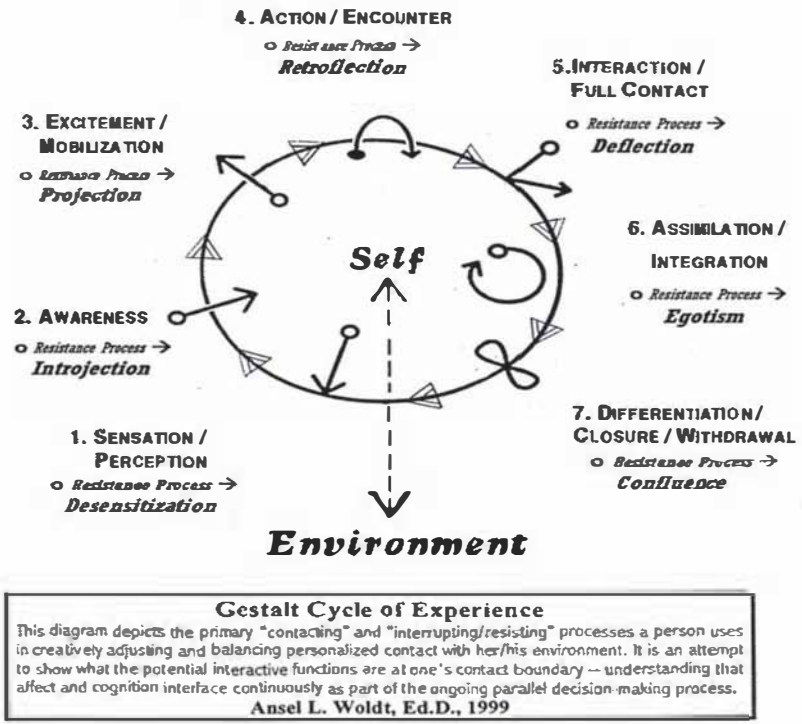

Figure 4.3. Gestalt Cycle of Experience (Woldt, 1999)

Excitement/Mobilization. This contact function is important, as it provides the opportunity for exploration and anticipation of possibilities in the field. It also generates energy for movement, since we are aware of potential contact.

Action/Encounter. This is the contact function in which feelings, ideas, and behaviors are expressed in order to interact with the object in the field. Available resources are manipulated and restructured to fulfill the need. Usually, these movements are defined as "chewing things over."

Full contact/Interaction. This contact function is characterized by inseparability from the focus of attention while being separate at the same time. This is the phase of meeting the other in the field, satisfying the need, and absorbing what is experienced as the "fullness of contact."

Assimilation/Integration. This is the next contact function of the cycle of experience; it basically provides the ground for completing the figure. A

person is able to digest what is assimilable. Good formation of the figure involves a sense of being finished, with no unfinished business left.

Withdrawal/Differentiation. This represents the contact function of closuring, finishing, and ending the contact, and involves the sense of completion and diminishing interest in the object of the contact.

Fertile void. This is not presented in the diagram, but is situated between the phases of sensation and withdrawal, where a person can feel solitude and quiet resolution, and be available and open to new possibilities, new ideas, etc.

These contact functions of the cycle of experience represent the contact process, which is without interruptions or resistances. However, during life, and according to various experiences, people learn to maintain a sense of security, and to keep balance through contact process interruptions, when an individual does not feel safe enough.

Prosnick and Woldt (2015) incorporated the interruptions/resistances of the gestalt cycle of experience in constructing GRL. The interruptions are briefly summarized below for those not familiar with gestalt therapy theory.

Desensitization. This is the primary interruption of the Sensation/Perception phase, involving blinding and anesthetizing one's self by avoiding feeling, limiting stimulation, and becoming "senseless."

Introjection. This is the primary interruption of the Awareness contact function. Defined through passive acceptance from the environment without checking the authentic self, it is experienced as "given things" that are not really ours.

Projection. Projection represents interruption of the Mobilization contact function, where inhibition of excitement is experienced outside even though the experience is based inside one's self. People who interrupt this phase of the cycle of experience often blame others or the environment for what is wrong.

Retroflection. Retroflection is proposed as a main interruption of the Action contact function. The result of this interruption is a high level of anxiety in which a person starts to do things to him- or herself that are supposed to be done to others. Retroflective actions account for depressing emotions, and people can become very self-destructive.

Deflection. This is the primary interruption of the Full Contact function. The process of deflection involves avoiding and turning aside from contact by reducing the intensity of situations or events. Sarcasm can be used, and people may experience difficulty in finishing things.

Egotism. Egotism is the main interruption of the Assimilation contact function. This contact function is defined as being self-centered and feeling assimilation, integration, and full contact. Also, difficulties in truly connecting with others are experienced.

Confluence. Confluence is a primary interruption of the Withdrawal contact function. Not being able to differentiate one's self from the other in the field is the main characteristic of confluence. Difficulty in saying no to other important people and in ending relationships is often experienced.

Avoiding. Avoiding is the interruption of the Fertile Void contact function. The main characteristic of this interruption is conservativism, which manifests as avoiding experiencing new ideas or changes, lacking a desire for freshness or creativity, etc.

The GIRL measurement scale consists of seven subscales:

1. Desensitization (Ds)—14 items
2. Introjection (Ij)—14 items
3. Projection (Pj)—10 items
4. Retroflection (Rf)—17 items
5. Deflection (Df)—16 items
6. Egotism (Eg)—16 items
7. Confluence (Cf)—13 items

The participant should answer concerning each item using the Likert scale, which is defined through five responses: *strongly disagree* (1), *disagree* (2), *neither agree or disagree* (3), *agree* (4), and *strongly agree* (5). All interruptions are defined as dimension constructs. Higher scores mean a stronger interruption of contact functions of the gestalt cycle of experience (Prosnick & Woldt, 2015). Future research studies should explore the potential of using the GIRL scale in gestalt research, and publishing results relying on quantitative data could support the evidence-based practice of gestalt therapy.

Gestalt Therapy Fidelity Scale (GTFS). As previously discussed, psychotherapists' accountability and application of evidence-based practice provoke the gestalt psychotherapy tradition. For gestalt therapy embedded in phenomenology, compliance with evidence-based practice requirements seems very complex, as measurements and quantification of the explored phenomena are not in alliance with basic gestalt theoretical concepts (McConville, 2014; Yontef & Jacobs, 2013). However, by challenging this perspective, a new scale has recently been created using the Delphi study (Linstone & Turoff, 1975), with the aim of defining the therapeutic encounter between gestalt therapists and their clients (Fogarty, Bhar, Theiler, & O'Shea, 2016). The GTFS was developed at Swinburne University in Australia, and a detailed explanation of its development has been published (Fogarty, 2015; Fogarty et al., 2016). The GTFS provides "means by which an independent rater is able to determine how accurately therapy delivered by a therapist approximates the therapeutic method they

intend to deliver" (Fogarty, 2015, p. 40). The scale can be used not only for research purposes, but also for assessing students in gestalt training as well as for therapist development.

GTFS has seven major concepts. Developing awareness is the basic aim in gestalt therapy; therefore, awareness is central to all concepts, and no specific behaviors were identified for these concepts. The concepts are as follows:

1. Working relationally
2. Working in the here and now
3. Phenomenological practice
4. Working with embodiment
5. Field sensitive practice
6. Working with contacting processes
7. Experimental attitude

Working relationally is defined through concepts of inclusion, confirmation, and presence, and five therapeutic behaviors are rated.

Working in the here and now. This is represented through immediate presence and staying in the encounter while deepening awareness in the client. Three therapeutic behaviors are rated.

Phenomenological practice. This is attunement to the "id of the situation" during the therapist's work with the client, while respecting basic phenomenological concepts of bracketing, describing, and observing. Four therapeutic behaviors are rated.

Working with embodiment. This is defined through body awareness in the therapeutic encounter by both the client and the therapist. Three therapeutic behaviors are rated.

Field sensitive practice. Field sensitive practice refers to supporting the client to identify his or her own contribution in the perception of the environment for the current experience, as well as exploring the ground from which the client's figure emerges. Three therapeutic behaviors are rated.

Working with contacting processes. This is defined not only through the exploration of interactional patterns as they emerge between the therapist and the client, but also through the identification of the figure. Four therapeutic behaviors are rated.

Experimental attitude. Experimental attitude is defined as the readiness of the therapist to use experiments during the therapeutic encounter and the support for the integration process the client is receiving from the therapist. Three therapeutic behaviors are rated.

The next step in development of this instrument is to test its validity and reliability.

Change After Psychotherapy Treatment Scale (CHAP). CHAP was constructed to measure the psychotherapy outcome. Being aware that, in the last century, psychoanalysis used follow-up interviews to measure the outcome of the therapy process (Pfeffer, 1959; Schlessinger & Robbins, 1974), Prof. Rolf Sandell of the Institute of Psychotherapy in Stockholm was interested in developing a new scale which would be applicable in psychotherapy outcomes. He developed CHAP, which has two parts: interviews with clients after psychotherapy, and a set of ratings based on these interviews.

Interviews are based on a client's subjective experience and whether change has occurred. By using semi-structured interviews, the therapist is able to variate some questions. The main types of changes covered by the interview include change in the life situation and way of living; change as a person; change in the environment (significant others); change in the life course with benefits and losses in therapy; change in the fulfillment of expectation; change in the consequences (good or bad); and change in the perception of the reasons for asking for psychotherapy treatment. Moreover, during the interview, clients are asked about the events, processes, or conditions in therapy, which, according to the client's experience, brought the most positive and the most negative outcomes. Apart from this, clients are asked about the processes or events outside of therapy, which, according to the client's experience, positively or negatively influenced changes after therapy.

The second step is the rating procedure done by the therapist and explained in the CHAP Manual (Sandell, 1987). Five indicators are defined and rated by the therapist as either 0 (*no and/or obvious change*), 0.5 (*some and/or less obvious change*), or 1 (*great and/or obvious change*). These indicators are symptom change, adaptive capacity, self-insight, basic conflicts, and extra-therapeutical factors. These five indicators serve as measures of treatment improvement. Scale reliability and validity were deemed satisfactory, according to the author of the measurement (Sandell, 2015). Gestalt therapists have started to use CHAP in their research projects; results using CHAP with specific populations, such as offenders, have been published recently (Zeleskov-Djoric, Cannavo, & Medjedovic, 2016). However, the scale and its contribution to gestalt therapy research studies should be further explored.

Clinical Outcome Routine Evaluation Outcome Measure (CORE-OM). CORE-OM is a self-reported questionnaire designed to measure indicators of psychological and behavioral functioning, especially to evaluate the effects of psychological therapy (Evans et al., 2000). CORE-

●M includes 34 items covering four domains: subjective well-being (four items), problems/symptoms (12 items), life/social functioning (12 items), and risk to self and others (six items). According to research studies, the best practice in using this measurement is to use the mean score for all items or the mean score for all non-risk items (Connell et al., 2●●7). However, depending on the clients explored, sometimes the score for each domain could be important. If scores are higher, more distress is indicated (Evans et al., 2●●2). Currently, 14 measurements and assessment tools make up the C●RE system. From those measurements, C●RE-1●A and C●RE-1●B are particularly useful for research studies. These two forms with 1● items psychometrically-balanced measures are used in alternate therapy sessions, which together make up the original and full C●RE-●M. Using C●RE-1●A and C●RE-1●B instead of C●RE-●M reduces memory effects. Thus, during one session, the therapist will give C●RE-1●A, and in the next session C●RE-1●B. A recently conducted research study with offenders confirmed the usefulness of using two parallel forms for research purposes (Zeleskov-Djoric, Cannavo, & Medjedovic, 2●16). Even though these two forms are very useful for research studies, in clinical practice, session-by-session monitoring using C●RE-1● and C●RE-5 are better options. Form C●RE-1● has 1● items covering anxiety, depression, trauma, physical problems, functioning, and risk to self. The second form, C●RE-5, comprises five items covering anxiety, depression, and functioning. Both short forms are used mainly in clinical practice. Besides these forms, the C●RE system has another form designed for specific populations, such as young persons (YP-C●RE), people with learning disabilities (C●RE-LD), and the general population (C●RE-GP). Moreover, the therapeutic alliance (ARM-5) form comprises five items and assesses the strength of the therapeutic relationship between the client and therapist. Measuring goals and difficulties in the therapy process is possible using the C●RE Goal Attainment Form. The C●RE system of measurement itself has been used in many research studies with various populations (Hodge, Barr, Bowen, Leeven, & Knox, 2●13; Jenkins & Turner, 2●14; McArthur, Cooper, & Berdondini, 2●13; Zeleskov-Djoric, Cannavo, & Medjedovic, 2●16), and the variability and reliability of the scales have been confirmed. The C●RE system is widely used in clinical settings and therapy research. The system is not based on gestalt theory, but could be very useful for further exploration of the efficacy and outcome of gestalt therapy.

To conclude, as therapists and practitioners, we are exposed to intriguing research fields while working with clients. In this paper, the basic qualitative methods and quantitative tools that could be beneficial for gestalt practitioners have been briefly discussed. However, mixed methods

research, the third movement in research practice, should definitely not be forgotten. Therefore, a summary of the basic features of this third movement is presented as the closing point for the discussion.

Mixed Methods Research (MMR)

The "paradigm" debate between quantitatively and qualitatively oriented researchers led to the development of the third movement in research practice, the MMR approach, which emerged in the field of social and behavioral sciences in the late 1970s. The basic assumption of this approach is that qualitative and quantitative methods are compatible and can be fruitfully used together (Tashakkori & Teddlie, 1998). MMR is a methodology for conducting research that involves collecting, analyzing, and integrating (or mixing) quantitative and qualitative research (and data) in a single study or longitudinal program of inquiry.

Ongoing debate among researchers in defining these methods is still present even though a basic consensus has been established. Accordingly, MMR can be defined as "the type of research in which [a] researcher or team of researchers combines elements of qualitative and quantitative approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, interference techniques) for the broader purposes of breadth and depth of understanding and collaboration)" (Johnson, Onwuegbuzie, & Turner, 2007, p. 123). MMR has several characteristics. The first contemporary characteristic is called *methodological eclecticism,* which is based on mixing qualitative and quantitative methods in the same study. However, some authors disagree with this, stating that, due to epistemological differences, mixing these two methods is inappropriate and scientifically disputable (Denzin & Lincoln, 2005; Howe, 2004). Other characteristics involve *paradigm pluralism* (the idea that the underlying philosophy can consist of a variety of paradigms), *an emphasis on diversity at all levels of research enterprise* (a broader view in researching the particular problem), *an emphasis on continua rather than a set of dichotomies* (no either/or option, but a range of options), *a cyclical approach to research* (using inductive and deductive logic in the same study), *a focus on the research question to determine the methods* (emphasizing the importance and centrality of the research question when conducting the study), *a set of basic research designs and analytical processes* (quantitizing and qualitizing), and *a tendency toward balance and compromise* (achieving balance between both orientations). Apart from these basic MMR characteristics, using particular language is the major issue in this approach. The most suitable language when combining

qualitative and quantitative approaches can be defined as a *bilingual language* (Teddlie & Tashakkori, 2009), where both approaches can be expressed. Furthermore, discussion of MMR should underpin the importance of making a distinction between research design type and research data analysis (Greene, Caracelli, & Graham, 1989; Teddlie & Tashakkori, 2009). However, instead of discussing these ongoing scientific debates around MMR, the more significant perspective to understand is the concept that determining whether MMR can be a useful method depends on the research question itself. The next step is to explore whether and how the design can implement both paradigms (qualitative and quantitative), while the last step is to apply the mixed data analysis, if that is found suitable.

Various types of MMR design can be applied in the research study. One possible way is to simultaneously collect data from the qualitative and quantitative perspectives, while the other is to use the qualitative approach and then transform that to the quantitative approach. When discussing various MMR designs, it is necessary to present concurrent MMR designs, which are called *parsimonious designs* (Creswell & Plano Clark, 2007). These authors have stated that the distinction between *triangulation design* and *embedded design* should be highlighted. Both designs are shown in Figure 4.4.

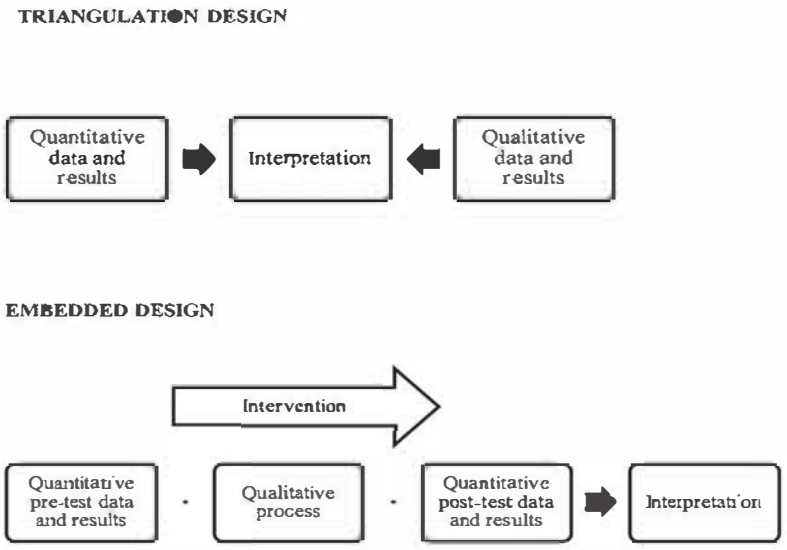

Figure 4.4. Traiangulation and Embedded Design (Cromwell & Plano Clark, 2007)

Besides these two main types of MMR design, these authors also explained sequential MMR designs, defining three main types: explanatory, exploratory, and sequential embedded design. All three designs are presented in Figure 4.5.

In psychotherapy research, triangulation design could be used when researchers would like to explore a phenomenon from both perspectives; in this circumstance, the focus can be either on the triangulation of methods or on the triangulation of subjects/data. An example of the triangulation of methods is combining focus groups and survey data, whereas the triangulation of subjects could be collecting data from various persons (clients, therapists, trainees, etc.). The application of triangulation design should follow some useful strategies, such as balancing individuals and groups, self-reported and facilitated, short-engagement vs. long engagement, etc.

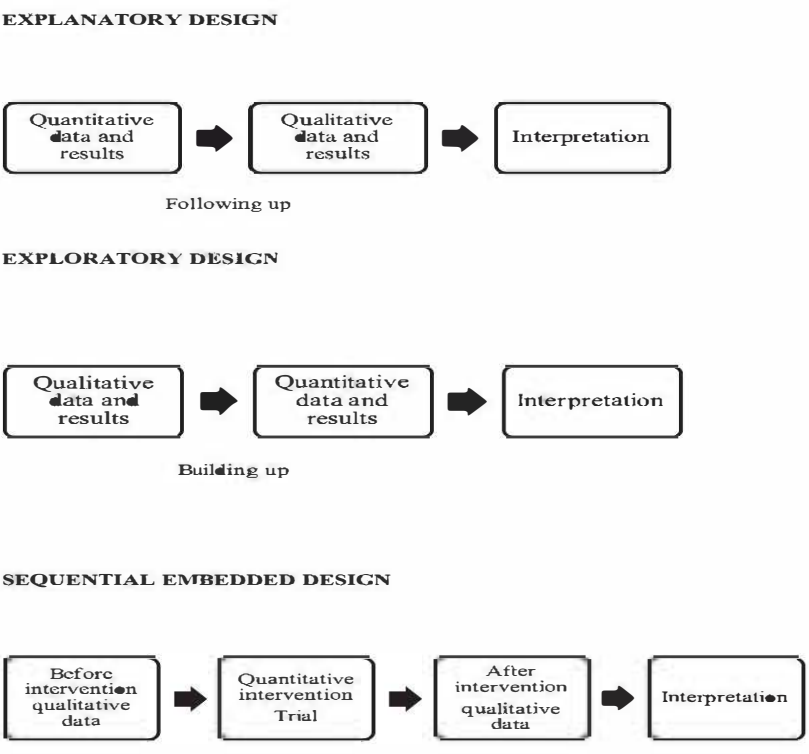

Figure 4.5. Sequential Mixed Methods Design (Creswell & Plano Clark, 2007)

Creswell (2003) proposed the following questions to help the researchers decide on whether to use MMR:

1. What is the implementation sequence of data collection?
2. What method takes priority during data collection and analysis?
3. What is involved in the finding integration stage?
4. Will a theoretical perspective be used?

By answering these questions, researchers could support the research process and choose the method best suited for a specific study.

This "third paradigm" in science has undoubtedly made significant contributions to research methodology, despite critics and debates among scientists. However, the knowledge and skills of the researcher will determine the most appropriate research methodology to use for each gestalt research study.

Conclusion

The contribution of this paper to developing gestalt therapy research traditions will be determined by its readers. Basic descriptions of various research methods, as well as different quantitative tools for conducting research, have been presented. Three main methods in research practice—qualitative, quantitative, and MMR—could be used, depending on the aim of the research question that gestalt therapists and practitioners would like to explore, either to gain a better understanding of the phenomena or to give an explanation of change.

Conducting research is a complex process. It is recommended to clearly define the specific research question before starting a research project. Based on that research question, the type of approach can then be chosen.

A brief overview of the main characteristics of two approaches, together with quantitative tools, has been presented in this paper; researchers are encouraged to read additional resources to gain further knowledge about each approach. When gestalt researchers decide on an approach, the steps proposed should be followed. Gestalt practitioners and therapists who are new to the field of research should be very cautious in how they interpret and write about their research results. Generalization of data results should be carefully considered. Moreover, research study limitations should be recorded, as well as recommendations for the next generation of researchers who are interested in that topic. Finally, researchers usually write acknowledgements to those who helped in the research process.

Gestalt therapy is a holistic approach with foundational concepts and an underlying philosophy that should be taken into consideration when conducting research. The first two paragraphs of the poem, *The Man with the Blue Guitar,* by Wallace Stevens—first published in 1937 and written in the form of an imaginary conversation with the subject of Pablo Picasso's painting *The Old Guitarist* (Stevens, 1937)—could be poetical ground for gestalt therapists and practitioners in nurturing the gestalt approach, embedded in phenomenology, across the world of science:

> The man bent over his guitar,
> A shearsman of sorts. The day was green.
>
> They said, 'You have a blue guitar,
> You do not play things as they are.'
>
> The man replied, 'Things as they are
> Are changed upon the blue guitar.'
>
> Wallace Stevens, *The Man with the Blue Guitar & Other Poems, 1937*

References

ABL Group. (1997). *Future search process design.* Toronto: York University.

Adler, P. A., & Adler, P. (1994). Observation techniques. In Norman K. Denzin & Yvonna S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 377–392). Thousand Oaks, CA: Sage.

Aldridge, J. (2007). Picture this: The use of participatory photographic research methods with people with learning disabilities. *Disability & Society, 22*(1), 1–17. Retrieved from http://www.tandfonline.com/doi/abs/10.1080/09687590601056006?journalCode=cdso20

Alexander, B. K. (2005). Performance ethnography. The re-enacting and inciting of culture. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative inquiry* (3rd ed., pp. 411–441). Thousand Oaks, CA: Sage.

Barber, P., & Brownell, P. (2008). Qualitative Research. In P. Brownell (Ed.), *Handbook for theory, research, and practice in gestalt therapy* (pp. 37–64). UK: Cambridge Scholar Publishing.

Barone, T. (2004). Educational poetry that shakes. *Journal of Critical Inquiry into Curriculum and Instruction Rocks, and Rattles, 5*(2), inside cover.

Bouma, G. D. (2002). *The research process.* UK: Oxford University Press.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. ISSN 1478-0887 Retrieved from http://eprints.uwe.ac.uk/11735

Byrnes, R. (1975). *Examination of Gestalt personality theory using Q-methodology.* Doctoral dissertation, Kent State University, 1982.

Catalani, C., & Minkler, M. (2010). Photovoice: A review of the literature in health and public health. *Health Education and Behaviour, 37*(3), 424–452. Retrieved from http://heb.sagepub.com/content/37/3/424.full.pdf+html

Charmaz, K. (2005). Grounded theory in the 21st century: A qualitative method for advancing social justice research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 507–535). Thousand Oaks, CA: Sage.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* London: Sage.

Clandinin, D. J., & Connelly, F. M. (2000). *Narrative inquiry: Experience and story in qualitative research.* San Francisco: Jossey-Bass.

Clandinin, D. J., Huber, J., Huber, M., Murphy, S., Murray Orr, A., & Pearce, M., et al. (2006). *Composing diverse identities: Narrative inquiries into the interwoven lives of children and teachers.* New York: Routledge.

Clark-Ibanez, M. (2004). Framing the social world with photo-elicitation interviews. *American Behavioural Scientist, 47*(12), 1507–1527. Retrieved from http://abs.sagepub.com/content/47/12/1507.full.pdf+html

Connell, J., Barkham, M., Stiles, W. B., Twigg, E., Singleton, N., Evans, O. & Miles, J. N. V. (2007). Distribution of CORE-OM scores in a general population, clinical cut-off points and comparison with the CIS-R. *The British Journal of Psychiatry*, 190, 69–74.

Creswell, J. W. (2003). *Research design: Qualitative, quantitative and mixed methods approaches (2nd ed.).* London: Sage.

Creswell, J. W., & Plano Clark, V. L. (2007). *Designing and conducting mixed methods research.* London: Sage.

Denzin, N. (1997). *Interpretive ethnography: Ethnographic practice in the 21st century.* Thousand Oaks, CA: Sage.

Denzin, N. K. (2003). *Performance ethnography: Critical pedagogy and the politics of culture.* Thousand Oaks, CA: Sage.

Denzin, N. K., & Lincoln, Y.S. (Eds.). (2005). *The SAGE handbook of qualitative research (3rd ed.).* Thousand Oaks, CA: Sage.

DeWalt, K. M., & DeWalt, B. R. (2002). *Participant observation: A guide for fieldworkers.* Walnut Creek, CA: AltaMira Press.

Dewey, J. (1934). *The art of experience.* New York: Minton, Balch.

Didkowsky, N., Ungar, M., & Liebenberg, L. (2010). Using visual methods to capture embedded processes of resilience for youth across cultures and contexts. *Journal of the Canadian Academy of Child & Adolescent Psychiatry, 19*(1), 12–18. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2809441/pdf/ccap19_1p0012.pdf

Evans, C., Connell, J., Barkham, M., Margison, F., McGrath, G., Mellor-Clark, J., & Audin, K. (2002). Towards a standardised brief outcome measure: Psychometric properties and utility of the CORE-OM. *The British Journal of Psychiatry, 180,* 51–60.

Evans, C., Mellor-Clark, J., Margison, F., Barkham, M., Audin, K., Connell, J. & McGrath, G. (2000). CORE: Clinical outcomes in routine evaluation. *Journal of Mental Health, 9,* 247–255.

Finley, S. (2005). Arts-based inquiry: Performing revolutionary pedagogy. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative inquiry* (pp. 681–694). Thousand Oaks, CA: Sage.

Fleury, J., Keller, C., & Perez, A. (2009). Exploring resources for physical activity in Hispanic women, using photo elicitation. *Qualitative Health Research, 19*(5), 677–686. Retrieved from http://qhr.sagepub.com/content/19/5/677.long

Fogarty, M. (2015). Creating a fidelity scale for Gestalt therapy. *Gestalt Journal of Australia and New Zealand, 11*(2), 39–54.

Fogarty, M., Bhar, S., Theiler, S., & O'Shea, L. (2016). What do Gestalt therapists do in the clinic? The expert consensus. *British Gestalt Journal, 25*(1), 32–41.

Francesetti G. (2012). Pain and beauty. From psychopathology to the aesthetics of contact. *The British Gestalt Journal, 21*(2), 4–18.

Francesetti G., & Spagnuolo Lobb, M. (2013). Beyond the pillars of Hercules. A Gestalt therapy perspective of psychotic experiences. In G. Francesetti, M. Gecele, & J. Roubal J (Eds.), *Gestalt therapy in clinical practice. From psychopathology to the aesthetics of contact* (pp. 393–428). Milano: FrancoAngeli.

Francesetti, G. (2015). From individual symptoms to psychopathological fields. Towards a field perspective on clinical human suffering. *British Gestalt Journal, 24*(1), 5–19.

Glaser, B. G., & Strauss, A. L. (1965). *Awareness of dying.* Chicago: Aldine.

Greenberg, L. (2008). Quantitative research. In P. Brownell (Ed.), *Handbook of theory, research, and practice in Gestalt therapy* (pp. 64–90). UK: Cambridge Scholar Publishing.

Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989). Toward a conceptual framework for mixed-method evaluation designs. *Educational Evaluation and Policy Analysis, 11*(3), 255–274.

Harding, J., Harding, K., Jamieson, P., Mullally, M., Politi, C., Wong-Sing, E., Law, M., & Petrenchik, T. M. (2009). Children with disabilities' perceptions of activity participation and environments: A pilot study. *Canadian Journal of Occupational Therapy, 76*(3), 133–144. Retrieved from http://cjo.sagepub.com/content/76/3/133.long

Harper, D. (2002). Talking about pictures: A case for photo elicitation. *Visual Studies, 17*(1), 13–26.

Harrison, B. (2002). Photographic visions and narrative inquiry. *Narrative Inquiry, 12*(1), 7–111.

Heritage, J., & Raymond, G. (2005). The terms of agreement: Indexing epistemic authority and subordination in talk-in-interaction. *Social Psychology Quarterly, 68*(1), 15–38.

Hodge, S., Barr, W., Bowen, L., Leeven, M., & Knox, P. (2013). Exploring the role of an emotional support and counselling service for people with visual impairments. *British Journal of Visual Impairment, 31*(1), 5–19.

Holloway, I., & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. *Qualitative Research, 3*(3), 345–357.

Howe, K. R. (2004). A critique of experimentalism. *Qualitative inquiry, 10,* 42–61.

Hurworth, R. (2003). Photo-interviewing for research. *Social Research Update, 40*(1), 1–7. Retrieved from http://search.informit.com.au/fullText;dn=879853995749842;res=IELHSS

Janesick, V. (2015). *Contemplative qualitative enquiry: Practicing the Zen of Research.* CA: Left Coast Press.

Jenkins, P., & Tumer, H. M. (2014). An investigation into the psychometric properties of the CORE-OM in patients with eating disorders. *Counselling and Psychotherapy Research, 14*(2), 102–110.

Johnson, R. B., Onwuegbuzie, A. J., & Tumer, L. A. (2007). Toward a definition of mixed methods research. *Journal of Mixed Methods Research, 1*(2), 112–133.

Jones, B. T. (Producer), Bender, G., & Jones, B. T. (Co-directors). (1997). *Still here with Bill Moyers.* [Videotape]. USA: PBS.

Kepner, J. I. (1982). *Questionnaire measurement of personality styles from the theory of Gestalt therapy* (Doctoral dissertation, Kent State University). Dissertation Abstracts International, 44-01, B0312 (UMI No. AAI8311443).

Lather, P. (1992). Critical frames in educational research: Feminist and post-structural perspectives. *Theory into Practice, 31*(2), 87–99.

Leavy, P. (2009). *Method meets art: Art based research practice.* New York; Guilford Press.

Linstone, H. A., & Turoff, M. (1975). *The Delphi Method techniques and applications.* Boston, MA: Addison-Wesley.

Maynard, D. W. (2003). *Bad news, good news: Conversational order in everyday talk and clinical settings.* Chicago: University of Chicago Press.

McArthur, K., Cooper, M., & Berdondini, L. (2013). School-based humanistic counselling for psychological distress in young people: Pilot randomized controlled trial. *Psychotherapy research, 23*(3), 355–365.

McConville, M. (2014). Commentary 1: Gestalt therapy, research and phenomenology. *Gestalt Review, 18*(1), 23–31.

Naranjo, C. (2000). *Gestalt therapy – The attitude and practice of an atheoretical experientalism.* Carmarthen: Crown House Publishing.

Neuman, W. L. (2006). *Social research methods: Qualitative and quantitative approaches.* Boston: Pearson/Allyn and Bacon.

Packard, J. (2008). "I'm gonna show you what it's really like out there": The power and limitation of participatory visual methods. *Visual Studies, 23*(1), 63–77. Retrieved from http://www.tandfonline.com/doi/abs/10.1080/14725860801908544

Parlett, M. (2000). Creative adjustment and the global field. *British Gestalt Journal, 9*(1), 15–27.

Perakyla, A., & Ruusuvuori, J. (2011). Analysing talk and text. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (pp. 529–524). London: Sage.

Pfeffer, A. (1959). A procedure for evaluating the results of psychoanalysis. *Journal of the American Psychoanalytic Association, 7*(3), 418–444. doi: 10.1177/000306515900700302

Philippson, P. (2009). *The emergent self. An Existential-Gestalt approach.* London: Karnac Books.

Prosnick, K. P., Ghett, G. A., & Summ, G. A. (2002). The GIRL with anger: Further construct validation of the Gestalt Inventory of Resistance Loadings. *Australian Gestalt Journal, 6*(2), 39–47.

Prosnick, K. P., & Hizdik, P. P. (2002). Shame on the GIRL: Hearing the positivist-empirical voice of shame in Gestalt resistance research. *Australian Gestalt Journal, 6*(2), 71–77.

Prosnick, K. P., Jasmine, K. T., & Wagner, J. J. (2000). Empirically testing Gestalt diagnostic theory: Axis I clinical syndromes and Gestalt resistance processes. *Australian Gestalt Journal, 4*(2), 55–62.

Prosnick, K. P., & Wang, M. Y. (2004). Axis II personality patterns and Gestalt resistance processes: Part II, empirical analyses utilizing data from the GIRL and MCMI-III. *Australian Gestalt Journal, 8,* 47–56.

Prosnick, K. P., & Woldt, A. L. (2015). *The Gestalt inventory of resistance loadings (GIRL): A guide to its development and use (GIRL test manual).* Howland, Ohio: Gestalt Sanctuary for Personality-Oriented Testing.

Richie, D. (2003). *Doing oral history: A practical guide.* NY: Oxford University Press.

Robine, J. M. (2015). *Social change begins with two.* Italy: Instituto di Gestalt HCC.

Roubal, J., & Rihacek, T. (2016a). *Therapists' in-session experiences* with *depressive clients: A grounded theory. Psychotherapy Research, 26*(2), 206–219. doi: *10.1080/10503307.2014.963731*

Roubal J., & Rihacek, T. (2016b). An adventure in grounded theory method: Discovering a pattern in the flow of a therapy process. In J. Roubal, P. Brownell, G. Francesetti, J. Melnick, & J. Zeleskov-Djoric, *Towards a research tradition in Gestalt therapy* (pp. 92–115). Newcastle upon Tyne: Cambridge Scholars Publishing.

Sandell, R. (1987). Assessing the effects of psychotherapy II: A procedure for direct rating of psychotherapeutic change. *Psychotherapy and Psychosomatics, 47*(1), 37–43. doi: 10.1159/000287996

Sandell, R. (2015). Rating the outcomes of psychotherapy using the Change After Psychotherapy (CHAP) scales. Manual and commentary. *Research in Psychotherapy: Psychopathology, Process and Outcome, 18*(2), 32–49.

Savin-Baden, M., & Wimpenny, K. (2014). *A practical guide to arts-related research.* Rotterdam: Sense Publishers.

Schegloff, E. A., & Sacks, H. (1973). Opening up closings. *Semiotica, 8,* 289–327.

Schlessinger, N., & Robbins, F. (1974). Assessment and follow-up in psychoanalysis. *Journal of the American Psychoanalytic Association, 22*(3), 542–567. doi: 10.1177/000306517402200305

Stevens, J. O. (1989). *Awareness.* London: Eden Grove Editions.

Stevens, W. (1937). *The man with the blue guitar & other poems.* New York: Alfred A. Knopf.

Strack, R. W., Magill, C., & McDonagh, K. (2004). Engaging youth through Photovoice. *Health Promotion Practice, 5*(1), 49–58. Retrieved from http://hpp.sagepub.com/content/5/1/49.long

Tashakkori, A., & Teddlie, C. (1998). *Mixed methodology: Combining qualitative and quantitative approaches.* Thousand Oaks, CA: Sage.

Teddlie, C., & Tashakkori, A. (2009). *Foundation of mixed methods research: Integrating quantitative and qualitative approaches in the social and behavioural sciences.* Thousand Oaks, CA: Sage.

Tumer, D. S. (2005). Hope seen through the eyes of 10 Australian young people. *Journal of Advanced Nursing, 52*(5), 508–517. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2648.2005.03619.x/epdf

Winter, R. (1987). *Action-research and the nature of social inquiry: Professional innovation and educational work.* Aldershot, England: Gower Publishing Company.

Woldt, A. L., & Kepner, J. I. (1986). Gestalt Contact Styles Questionnaire--Revised (GCSQ-R): Item composition of factors I-VI. In A. Carden, *A process typology of men who have abused their female intimate partners: Implications for intervention based on the Gestalt therapy theory of resistance process* (pp. 239–249) (Doctoral dissertation, Kent State University, 1993).

Woldt, A. L., & Prosnick, K. P. (1996). *Gestalt Contact Scales Questionnaire-150 (GCSQ-150).* Unpublished test, Kent State University, Kent, Ohio.

Woldt, A. L., & Prosnick, K. P. (2002). *Gestalt Contact Scales Questionnaire-150R (GCSQ-150R).* Unpublished test, Kent State University, Kent, Ohio.

Woldt, A. L., & Prosnick, K. P. (2015). *Gestalt Inventory of Resistance Loadings (GIRL).* Kent, Ohio: Gestalt Center for Personality-Oriented Research.

Yin, R. K. (2003). *Case study research: Design and methods.* Thousand Oaks, CA: Sage.

Yontef, G., & Jacobs, L. (2013). Gestalt therapy. In D. Wedding & R. Corsini (Eds.), *Current Psychotherapies* (pp. 299–336). Belmont, CA: Brooks/Cole.

Zeleskov-Djoric, J., Cannavo, M., & Medjedovic, J. (2016). Emerging beauty beyond the freedom - Gestalt therapy approach in offenders using the CORE and CHAP instruments. In J. Roubal, Ph. Brownell, G. Francesetti, J. Melnick, & J. Zeleskov Djoric (Eds.), *Towards a research tradition in Gestalt therapy* (pp. 314–335). Cambridge Scholar Publishing.

CHAPTER FIVE

PRACTICE-BASED RESEARCH AND PRACTICE-BASED RESEARCH NETWORKS

PHILIP BROWNELL

The professional world has become a world of evidence-based practice (EBP). This may have come about because of third-party funders of treatment demanding to pay for something that works, but it has become the standard of best practice and guarded by graduate programs and regional licensing or credentialing boards. It is the starting point in considering practice-based research.

The American Psychological Association adopted a working definition of evidence-based practice, and they asserted that *evidence-based practice in psychology* (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences (APA 2006). They went on to make a critical distinction between empirically supported treatments and evidence-based practice and to open up multiple and relative streams of support as "evidence:"

> It is important to clarify the relation between EBPP and empirically supported treatments (ESTs). EBPP is the more comprehensive concept. ESTs start with a treatment and ask whether it works for a certain disorder or problem under specified circumstances. EBPP starts with the patient and asks what research evidence (including relevant results from RCTs) will assist the psychologist in achieving the best outcome. In addition, ESTs are specific psychological treatments that have been shown to be efficacious in controlled clinical trials, whereas EBPP encompasses a broader range of clinical activities (e.g., psychological assessment, case formulation, therapy relationships). As such, EBPP articulates a decision-making process for integrating multiple streams of research evidence including but not limited to RCTs into the intervention process. (APA 2006, 273)

The APA task force pointed to a range of research designs that all contribute to the body of knowledge relevant to evidence-based practice.

They include clinical observation, qualitative research, systematic case study, single-case experimental designs to examine causal factors in outcome with regard to a single patient, process-outcome studies to examine mechanisms of change, effectiveness studies in natural settings, Random Controlled Treatments (RCTs), which are efficacy studies for drawing causal inferences in groups, and meta-analyses for observing patterns across multiple studies by comparing effect sizes. With regard to any particular treatment intervention, the task force identified two considerations: does the treatment work–a question of its effectiveness and efficacy, which are most related to internal validity, and does it generalize or transport to the local setting where it is to be used–a question of its effectiveness, which is most related to external validity.

In spite of the variety of these methods, globally a number of problems have been observed with EBPPs. They are limited in regard to the generalizability of the results in their empirical supports, and that leaves a lack of confidence in them among clinicians. Furthermore, clinicians are often distant in many ways from the processes involved in such research, and the results have low transportability to clinical practice. In addition, evidence-based movements overemphasize treatments and treatment differences, ignoring outcome results on psychotherapy demonstrating variation among psychologists, the impact of relationship, and other common factors (Wampold and Bhati 2004).

In contrast, Practice-based Evidence (PBE) provides a bridge for this gap between research and practice (Evans, Connell, Barkham, et.al. 2003).

Practice-Based Research Networks

Practice-based evidence has been characterized as a bottom-up process of gathering data that relies on the experience of practicing clinicians to inform treatment (Dupree, White, Olsen and Lafleur 2007). It takes place in the clinic where clinicians often join together and cooperate in groups with a mutual focus and research purpose. These groups are called practice-based research networks (PBRNs). "PBRNs are ongoing collaborations between researchers and providers to complete research on topics that are of interest to and have practical significance for practitioners" (Kelly, Davis, Mendon, et al., 2018, np).

Practice-based research networks (PBRNs) have been utilized to cooperate among clinician-researchers across diverse organizations in preventative medicine (Carsley, Anderson, Plumtre, et al., 2017; Green 2007). Indeed, the practice of using such networks started with medical professionals cooperating on research over geographical distances, and it

continues to be a significant factor in patient-centeredness, community medicine, and primary care. Nagykaldi (2014) described PBRNs as the center of the crossroads between research and practice, identifying one of its essential characteristics as their ability to function bi-directionally in the pipeline translating research into practice, extending from clinical trials to health care policy.[1]

The use of PBRNs has since spread to include professionals of various kinds, including mental health practitioners.

Such PBRNs seek to increase external validity and the generalizability of results. The mental health system in one locality, for instance, discovered that linking EBP with the research strategies associated with practice-based evidence (PBE) could improve service to clients. Outcome measurements were used to bridge between EBP and PBE, and they were based upon objective factors and clients' perceptions of care, often utilizing standardized measures at referral, during moments of assessment, the beginning of therapy, at discharge and then again at some interval following. In the agencies in question, this process became systemic and often provided useful clinical information as well as a read on client progress (Lucock, Leach, Iveson, et.al. 2003). Wade and Neuman (2007) found that integrating research skills into clinical processes could correlate clinical practices with treatment outcomes, providing helpful feedback to clinicians regarding the effectiveness of their methods. Unfortunately, they also observed that the average clinician lacks the time, resources, and expertise to work out such an integration without support.

Outcomes Measures and Research Designs to Bridge Between EBP and PBE

The following are two examples of the kinds of support that gestalt therapists cooperating in PBRNs might consider.

Outcomes Measures

Several studies in the United Kingdom argued for utilization of an outcomes instrument known as the Clinical Outcomes in Routine Evaluation (CORE) to assess the effectiveness of treatments from such a bottom-up, practice-based perspective (Barkham, Mellor-Clark, Connell

[1] The reader might find more of interest about PBRNs at the U.S. Department of Health & Human Services web site dedicated to practice-based research networks (https://pbrn.ahrq.gov).

2006; Stiles, Leach, Barkham, et.al. 2003; Barkham, Margison, Leach 2001, Mellor-Clark, Barkham, Connell, et.al. 1999). Gestalt therapists, taking advantage of such technical support joined a practice-based study of psychotherapy outcomes utilizing the CORE in the National Health Service in England, and they found that gestalt outcomes were commensurate with those of cognitive behavioral therapists (Stevens & Stringfellow, et al., 2011).

Another outcomes instrument often utilized is the Outcomes Questionnaire 45, developed by Michael Lambert and associates. It is a proprietary instrument that can be found at the company's website (https://www.oqmeasures.com/measures/adult-measures/oq-45/). Recent studies using the OQ45 (or OQ45.2) have included work with personality disorders (Gordon-King, Schweitzer, & Dimaggio, 2018) and the dynamic nature of emotions in client-therapist interactions (Atzil-Slonim, Bar-Kalifa, & Fisher, et al., 2018). Of note, Levy, Billingsley, & Springer, et al. (2018) found the OQ45.2 most effective when conducting studies with depressed subjects, but less so when studying those with anxiety.

A Research Design to Bridge Between EBP and PBE

Although many people have bridged the gap between EBP and PBE with outcome studies, surveys, and qualitative research to discover patterns in actual practice, one of the research designs identified by the APA task force serves as both a form of evidence in support of EBPs and as a form of PBE. That is the single case time trial, otherwise also known as case-based time-series analysis. Borckhardt, Nash, Murphy, et.al. (2008) pointed out that the

> ...practitoner-generated case-based time-series design with baseline measurement fully qualifies as a true experiment and that it ought to stand alongside the more common group designs (e.g., the randomized controlled trial, or RCT) as a viable approach to expanding our knowledge about whether, how, and for whom psychotherapy works. (77)

They also pointed out that the APA Division 12 Task Force on Promotion and Dissemination of Psychological Procedures recognized such time-series designs as important and fair tests of both efficacy and/or effectiveness. Thus, the single-case research design can do a great deal for gestalt therapists. It is a design individual gestalt therapists can utilize at the level of the clinic to track the process of therapy with individual clients. Further, if they collect the data across several clients, they can make observations about patterns emerging in the way they practice. Finally,

aggregates of several gestalt therapists using the same designs could be used to observe still larger patterns. Indeed, such attempts are being made.

A real-world example: the spiritually-integrated processes in gestalt therapy project. In 2017 a group of gestalt practitioner-researchers received a grant to study spiritually-integrated processes in the normal course of gestalt therapy. The grant was funded by the John Templeton Foundation and administered through Brigham Young University (BYU). The study was scheduled to collect data for one year using a mixed method that included CORE-10, single-case timed series design (SCTS), and a qualitative read on spirituality. It included the work of individual practitioners cooperating in a PBRN under the organization of a core team and site administrators. The core team consisted of practitioner-researchers from the USA/Africa, Chile, and Serbia/Australia. The ten cohorts were from England, Chile, the United States, Italy, Switzerland, Romania, Mexico, Lithuania, Russia, and one "at large" group, consisting of several individuals scattered in various places.[2]

As Kelly, Kiger, & Gaba, et al. (2015) observed, the creation of a PBRN requires the building of trust, the formulation of enough infrastructure to support research (such as the technical tools and process sufficient to collect data), and an appreciation for relative cultural differences. They had in mind a PBRN that was a cooperative engagement between university researchers and clinical practitioners. However, the gestalt therapy PBRN in this case already existed as a creation of the field work of gestalt therapy practitioner-researchers (see also Pablo Herrera Salinas's description of this in chapter twenty). The cooperation with an existing university system (BYU) came after a relationship had been formed among various people and a trusting and collegial nature to their interaction had been established.

Some of the technical infrastructure was provided by BYU in that they furnished three measures to cover demographic subjects, spirituality, and general clinical outcomes, and they offered their statistical resources for data sharing and analysis. The PBRN itself conducted the SCTS procedures, with daily tracking of treatment concerns, and they created their own tracking device to monitor the presence of spiritually-integrated influences.

The expansion of the PBRN for the purposes of the spiritually-integrated research resulted in an even larger potential. Groups of practitioner-

[2] As the study progressed several cohorts dropped out. One observation is that individual practitioners need a great deal of support ,and that support might best be made available through the communities of therapists associated with established gestalt therapy training institutes.

researchers were formed, and clinicians were drawn into research activities they would not have been exposed to otherwise.

Looking Toward the Future

Gestalt therapists largely practice in private; for the most part they are not part of mental health organizations or on the faculties of universities. That is why using SCTS design is helpful and feasible. It is also why banding together in PBRNs makes practical sense. As the evolving research movement in gestalt therapy matures, it may create a stand-alone research association, but it may also simply and organically grow a number of PBRNs. (It might also do both.)

While some PBRNs could replicate various quantitative or mixed methods designs, it is also entirely possible that other PBRNs could conduct qualitative investigations (refer to Jelena Zeleskov Djoric's treatment of methodologies in chapter four). Since gestalt therapy training institutes exist all over the world, one of the benefits of conducting research through PBRNs is that we, in the gestalt world, have a "built in" advantage; research like that would be cross-cultural. One consistent feature of gestalt therapy conducted using PBRNs is that its results would tend to transcend cultural boundaries leading to broadly applied inferences about gestalt processes. Then again, the research could also show how cultural differences across geo-cultural cohorts in a PBRN affirm the influence of cultural distinctives.

Resources

APA Presidential Task Force on Evidence-Based Practice. 2006. Evidence-based practice in psychology. *American Psychologist.* 61(4) 271-285

Atzil-Slonim, D., Bar-Kalifa, E., Fisher, H., Peri, T., Lutz, W., Rubel, J., & Rafaeli, E. (2018). Emotional congruence between clients and therapists and its effect on treatment outcome. *Journal of Counseling Psychology, 65*(1), 51-64.

Barkham, M., Mellor-Clark, J., Connell, J. & Cahill, J. (2006). A core approach to practice-based evidence: A brief history of the origins and applications of the CORE-OM and CORE System. *Counselling & Psychotherapy Research.* 6(1), 3-15.

Barkham, M., Margison F., Leach, C, Lucock, M., Mellor-Clark, J., Evans, C., Benson, L., Connell, J., Audin, K., & McGrath, G. (2001). Service profiling and outcomes benchmarking using the CORE-OM: Toward practice-based evidence in the psychological therapies. *Journal of Consulting and Clinical Psychology.* 69(2), 184-196.

Carsley, S. E., Anderson, L. N., Plumptre, L., Parkin, P. C., Maguire, J. L., Birken, C. S., & TARGet Kids! Collaboration. (2017). Severe obesity, obesity, and cardiometabolic risk in children 0 to 6 years of age. *Childhood Obesity, 13*(5), 415-424. http://dx.doi.org/10.1089/chi.2017.0004

Dupree, J., White, M., Olsen, C. & Lafleur, C. (2007). Infidelity treatment patterns: A practice-based evidence approach. *American Journal of Family Therapy.* 35(4) 327-341.

Evans, C., Connell, J., Barkham, M., Marshall, C. & Mellor-Clark, J. (2003). Practice-based evidence: Benchmarking NHS primary care counselling services at national and local levels. *Clinical Psychology & Psychotherapy.* 10(6) 374-388

Gordon-King, K., Schweitzer, R. D., & Dimaggio, G. (2018). Metacognitive interpersonal therapy for personality disorders featuring emotional inhibition: A multiple baseline case series. *Journal of Nervous and Mental Disease, 206*(4), 263-269.

Green, L. (2007). The prevention research centers as models of practice-based evidence: Two decades on. American Journal of Preventive Medicine. 33(1,Suppl), S6-S8

Kelly, E. L., Davis, L., Mendon, S., Kiger, H., Murch, L., Pancake, L., Giambone, L., & Brekke, J. S. (2018, May 3). Provider and Consumer Perspectives of Community Mental Health Services: Implications for Consumer-Driven Care. *Psychological Services.* Advance online publication. http://dx.doi.org/10.1037/ser0000244

Kelly, E., Kiger, H., Gaba, R., Pancake, L., Pilon, D., Murch, L., Knox, L., Meyer, M., & Brekke, J. (2015). The recovery-oriented care collaborative: A practice-based research network to improve Care for people with serious mental illnesses. Psychiatric Services, 66(11), 1132-1134.

Levy, H. C., Billingsley, A. L., Springer, K. S., Harman, S., Das, A., & Tolin, D. F. (2018). Utility of the outcomequestionnaire-45.2 in outpatient anxiety clinics: A comparison between anxiety patients with and without co-occurring depression. *Journal of Clinical Psychology.* Advance online publication.

Lucock, M., Leach, C., Iveson, S., Lynch, K., Horsefield, C., & Hall, P. (2003). A systematic approach to practice-based evidence in a psychological therapies service. *Clinical Psychology & Psychotherapy.* 10(6), 389-399.

Mellor-Clark, J., Barkham, M., Connell, J. & Evans, C. (1999). Practice-based evidence and standardized evaluation: Informing the design of the CORE system. 2(3), 357-374

Nagykaldi, Z. (2014) Practice-based research networks at the crossroads of research translation. *Journal of the America Board of Family Medicine*, 27(6), 725-729.

Stevens, C., Stringfellow, J., Wakelin, K., & Waring (2011). The UK gestalt psychotherapy CORE research project: The findings. *The British Gestalt Journal, 20*(2), 22-27.

Stiles, W., Leach, C., Barkham, M., Lucock, M., Iveson, S., Shapiro, D., Iveson, M. & Hardy, G. (2003). Early sudden gains in psychotherapy under routine clinic conditions: Practice-based evidence. *Journal of Consulting and Clinical Psychology.* 71(1), 14-21

Wade, K. and Neumann, K. (2007). Practice-based research: Changing the professional culture and language of social work. *Social Work in Health Care*. 44(4), 49-64

Wampold, B. & Bhati, K. (2004). Attending to the omissions: A historical examination of evidence-based practice movements. *Professional Psychology: Research and Practice.* 35(6) 563-570

Part Two

A Therapeutic Method Worth Investigating

CHAPTER SIX

TWO "TAKES" ON TREATMENT MANUALS IN GESTALT THERAPY

PHILIP BROWNELL AND JAN ROUBAL

Part One: Philip Brownell

In the 1980s psychotherapy research methods began including the use of treatment manuals. In fact, they became virtually required (Luborsky & DeRubeis, 1984). The issue that drove such a phenomenon was the need to address treatment fidelity. That is, to make as sure as possible that in group studies of psychotherapy efficacy the therapists were in fact practicing the type of therapy the study claimed was under investigation. In keeping with the idea of reducing extraneous variables such manuals described in detail what was supposed to happen, when, and for how long. They conceptualized therapy as linear, sequential, and goal-oriented. The idea was to make sure that therapists in the studies in question were not introducing elements foreign to the research design. This is likely how one major conception of treatment manuals emerged viewing treatment manuals as cookbooks containing recipes identifying ingredients and how and when to add them to the "stew." What made this even more onerous to many is that following the research model, some approaches to evidence-based practice demanded that therapists in the clinic cook the same brew using exactly the same cook book.

However, in a study conducted some sixteen years after the work of Luborsky & DeRubeis, Addis and Krasnow (2000) surveyed psychotherapists' attitudes toward treatment manuals and found that many did not actually know what a treatment manual was. The therapists had conceptions and misconceptions, and Addis and Krasnow asserted that in fact "manuals themselves vary widely from highly structured outlines of specific techniques (e.g., Craske, Meadows, & Barlow, 1994) to more general conceptual overviews of the treatment process (e.g., Klerman, Weissman, Rounsaville, & Chevron, 1984)." (p. 337)

Eventually, in the course of the development of the evidence-based movement, the use of manuals to systematize the process in research evolved to the use of manuals to influence "best practice." There again, however, resistance to the idea of forcing strict protocols on clinical practice was formidable. Psychotherapy is regarded by many to be just as much, if not more so, an art as it is a science. The artistry, many felt, was lost, smothered by the oppression of rigid prescriptions, when treatment manuals became obligatory.

There is, however, not a one-size-fits-all treatment manual. Just as treatment manuals themselves vary from being highly prescriptive to relatively theoretical, the use of treatment manuals varies across clinical populations. Westen (2002) proposed that extremely specific and prescriptive manuals might be more appropriate for shorter-term treatments and treatments focused on specific associative connections, whereas principle-oriented manuals and manuals more theoretical in nature might find a better fit with longer-term treatments and treatments of generalized affect states and repetitive interpersonal patterns. Carrol and Nuro (2002) proposed a stage model in which styles of treatment manuals used in research might be purposefully generated to fit the phase in evolution of any given clinical perspective under study. Manuals in such a stage model are conceived as evolving with the level of development of the treatment, "from the basic outlines necessary for preliminary evaluation of the treatment in early pilot studies (stage I), to highly defined guidelines that demark the internal and external boundaries of treatment for efficacy studies (stage II), and finally to elaborated systems appropriate for use with diverse clinical populations (stage III)." (p. 396)

Carol and Nuro also identified four reasons that treatment manuals might not be adopted by any given population of clinical professionals:

1. Limited applicability to a wide range of populations and clinical situations
2. Excessive emphasis on technique while neglecting the working alliance and other critical and common elements of psychotherapy
3. Restriction of clinical innovation and expertise on the part of psychotherapists
4. Feasibility when the manual is implemented by clinicians of diverse backgrounds (experience, discipline, and clinical expertise)

Treatment manuals also vary in format. Some are stand-alone books (Faust, 2018). Some are simply chapters within books (Stinson, Becker, & McVay, 2017), and still others are journal articles (Forbat, Robertson, &

McNamee, 2016). Whatever the format, they are identified with the concept of a treatment manual. They point out the clinical approach under consideration, tell what it is, and describe how to do it.

As such we suggest a section of this book as a current treatment manual for the field of contemporary gestalt therapy. "Part Two: A Therapeutic Method Worth Investigating," provides a description of the core theory of gestalt therapy and gives clinical examples. It provides a fidelity scale that was created in part by expert raters in the field of gestalt therapy and has been validated as a descriptive list of things gestalt therapists do.

This is not a prescriptive treatment manual, and it is not restricted to use with any particular clinical population. It is a descriptive treatment manual, and as such it is also a suggestive manual. Thus, it avoids one of the criticisms of treatment manuals, namely that they are often focused tightly on one particular disorder or clinical population. Although technique, in the sense of a description of what gestalt therapists do, is included, this treatment manual avoids an excessive emphasis on technique (in fact, in places it critiques the very concept of technique). This manual does not identify phases of treatment and tell therapists exactly what to do and when to do it. There are also no restrictions on clinical innovation.

We hope that this section of the book might gain wide use as a way of identifying the clinical approach under study as more and more gestalt-oriented research projects emerge from the global movement to establish a research tradition for gestalt therapy. While gestalt therapy as an approach has been around since the middle of the last century, its more nuanced theory has been developing in step with the most current evolution of psychotherapy. As such, we needed a treatment manual reflective of contemporary gestalt therapy. Thus, Giarmi's description of a strategic field approach, Lynne's description of the relational nature of gestalt therapy, Dan's description of the phenomenological features in contemporary gestalt therapy, and Jan's description of the experimental nature and features of gestalt therapy were needed. Sylvia's chapter on the unity of our approach stands from the first edition, and in this edition we have also added Jean-Marie's and Elvira Duenas Jurado's collaboration on the use of self as well as a summary of Madeleine Fogarty's excellent research resulting in the Gestalt Therapy Fidelity Scale. Taken as a unit, then, this section constitutes a treatment manual for contemporary gestalt therapy. There may be others that eventually emerge, but this constitutes a start (see Jan's comments below).

This start can also serve to delineate our understanding of the processes inherent to gestalt therapy and to refine them. Wilson (2007) provided an excellent description and evaluation of the evolution of manualized

treatment in clinical psychology. As he did, it became clear that treatment manuals in research help in further theory development and refinement of practice. That is because they identify what an approach is, and once that is clear it can be examined. This relates to Peter Philippson's issue in his chapter in this book. If we are open to allowing research to refine gestalt therapy, then one way for this to happen is for a treatment manual to find use in research so that the approach can be tested, evaluated. We are not, after all, just looking for ways to rubber stamp practices already established and to which we are committed regardless of anything else.

Part Two: Jan Roubal

Being pushed and limited by a prescriptive step-by-step manual in their work presents a vision deterrent in many ways and for good reasons for Gestalt therapists. However, refusing any kind of manualization keeps our approach in the ever-lasting adolescent, anti-authoritarian position, which in fact points to a lack of inner consistency and self-confidence in our approach. Maybe we can try to creatively adjust instead and develop our own way of producing and using treatment manuals, which would be consistent with our epistemology. A similarly risky step was made recently with the topic of psychopathology, when, instead of confronting and refusing it, the Gestalt approach grew by including the topic into its epistemology (Francesetti, Gecele, Roubal, 2013).

Developing manuals can present an opportunity for our approach to step self-confidently into the psychotherapy mainstream, to show the richness of our approach, and to learn from the research-based feedback. Manuals can help Gestalt therapists to understand more the process of change and raise the effectivity of our approach for clients. Sensitive, flexible and creative use of manualized guidelines can support Gestalt therapists in systematic learning from our own experiences.

It helps to realize we are not alone in the difficult process of looking for our position towards manualisation; a lot has already been done. Manuals do not have to be a prescriptive, step-by-step recipes. Manuals can be seen as guidelines describing conceptual and structural boundaries of a specific psychotherapy approach (Addis, M. E., Cardemil, E. V., Duncan, B. L., & Miller, S. D., 2006) and can also describe more general principles and phases of treatment with examples of appropriate interventions (Chambless & Hollon, 1998). Some new manuals also include guidelines on how to follow the process of therapy or how to include the factor of the psychotherapy relationship between the client and the therapist (Newman, Castonguay, & Borkovec, 1999). Currently there is a move from a whole

packet of interventions prepared in advance to the identification of partial, specific and proven effective elements from which a certain intervention is composed. Manualisation can then be helpful in the development of specific procedures for more effective symptomatic treatment and opens possibilities for their research validation (Stiles, Shapiro, & Elliott, 1986).

Manuals in psychotherapy can be seen as an attempt to identify a specific therapist's behaviour and also the relevant change processes that together create an effective intervention (Chambless & Hollon, 1998). Manuals are important for a description of what is really happening during some specific intervention, they also enable the sharing of the intervention description with therapists from other approaches and with researchers. Psychotherapy, at the same time, should not rigidly apply manuals as though accepting the medical model (Wampold, 2001); rather, manuals might modify the medical model by stressing the uniqueness and complexity of the therapeutic encounter, which also reflects the individual creativity of the psychotherapist.

Manuals differ in the way they delimit the therapist's behaviour. Some approaches prescribe a concrete form of dialogue to the therapist, while others leave a certain flexibility to the therapist so they can react to the specific needs of the client as they appear during the psychotherapy process (Luborsky & DeRubeis, 1984). The latter is the case in Gestalt therapy, because we understand psychotherapy also as a kind of art, an art that takes an individually unique form with every therapist and even every therapeutic situation.

In current research-supported humanistic approaches (Greenberg, Rice, & Elliott, 1993; Elliott, Watson, Greenberg, Timulak, & Freire, 2013; Meneses, & Scuka, 2016) the therapist's approach is directed by both understanding the mechanisms of change and the constant tuning into the dynamic system of the psychotherapy situation. It results in a process-oriented approach in which specific interventions are used at appropriate moments.

Gestalt therapists can share this basic attitude, in which they neither act solely intuitively nor strictly following a prescribed guideline. Manuals in this sense can serve as a supportive third party (Roubal, Gecele, & Francesetti, 2013) that helps orient the therapist in the therapy process, that helps to ground and settle the therapist, that helps the therapist attune to the client. This expands the therapist's capacity for meeting the client. This way the manual can support the therapeutic relationship in which the therapist's interventions are offered to the client.

Resources

Addis, M. E., Cardemil, E. V., Duncan, B. L., & Miller, S. D. (2006). Does Manualization Improve Therapy Outcomes? In: J. C. Norcross, L. E. Beutler, & R. F. Levant (eds.). *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions,* 131-160.

Addis, M. & Krasnow, A. (2000) A national survey of practicing psychotherapists' attitudes toward psychotherapy treatment manuals. *Journal of Consulting and Clinical Psychology,* 68(2), 331-339.

Carroll, Kathleen M.; Nuro, Kathryn F. One size cannot fit all: A stage model for psychotherapy manual development. *Clinical Psychology: Science and Practice,* 9(4), 396-406.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66, 7–18.* doi:10.1037/0022- 006X.66.1.7

Craske, M. G., Meadows, E., Barlow, D. H. (1994). *Therapist's guide for the mastery of your anxiety and panic II & agoraphobia supplement.* Albany, NY: Graywind Publications

Elliott, R., Watson, J., Greenberg, L. S., Timulak, L., & Freire, E. (2013), Research on humanistic-experiential psychotherapies. In: M. J. Lambert (Ed.), Bergin & Garfield's *Handbook of psychotherapy and behavior change, 6th ed.* New York: Wiley, 495-538.

Faust, J. (2018) *Reunification family therapy: A treatment manual.* Boston, MA, US: Hogrefe Publishing Reunification family therapy: A treatment manual.

Forbat, L., Robertson, J., & McNamee, P. (2016). Couple therapy following prostate cancer surgery: A manual to guide treatment. *Journal of Family Therapy.* Advance online publication.

Greenberg, L. S., Rice, L., & Elliott, R. (1993), *Facilitating Emotional Change: The Moment-by-Moment Process.* New York: Guilford Press.

Francesetti, G., Gecele, M., & Roubal, J. (2013). Gestalt Therapy Approach to Psychopathology. In: Francesetti G., Gecele M., & Roubal J. (eds.). *Gestalt Therapy in Clinical Practice. From Psychopathology to the Aesthetics of Contact,* Milano: FrancoAngeli, 59-76.

Klerman, G., Weissman, M., Rounsaville, B., Chevron, E. (1984). Interpersonal psychotherapy of depression. New York: Basic Books.

Luborsky, L. & DeRubeis, R. (1984) The use of psychotherapy treatment manuals: A small revolution in psychotherapy research style. *Clinical Psychology Review,* 4(1), 5-14.

Meneses, C. W., & Scuka, R. F. (2016). Empirically supported humanistic approaches to working with couples and families. In: D. J. Cain, K.

Keenan, & S. Rubin (eds.). Humanistic psychotherapies: Handbook of research and practice, 2nd ed. Washington, DC: American Psychological Association, 353-386

Morgan, R. D., Kroner, D. G., & Mills, J. F. (2018). *International perspectives on forensic mental health. A treatment manual for justice involved persons with mental illness: Changing lives and changing outcomes.* New York, NY, US: Routledge/Taylor & Francis Group

Newman, M. G., Castonguay, L. G., & Borkovec, T. D. (1999). New dimensions in the treatment of generalized anxiety disorder: Interpersonal focus and emotional deepening. Paper presented at the Society for the Exploration of Psychotherapy Integration, Miami, FL

Roubal, J., Gecele, M., & Francesetti, G. (2013). Gestalt Therapy Approach to Diagnosis. In: G. Francesetti, M. Gecele & J. Roubal (eds.). Gestalt Therapy in Clinical Practice. From Psychopathology to the Aesthetics of Contact. Milano: FrancoAngeli, 79-106

Stiles, W. B., Shapiro, D. A., & Elliott, R. (1986). "Are all psychotherapies equivalent?" *American Psychologist*, 41(2), 165-180.

Stinson, J. D., Becker, J. V., & McVay, L. A. (2017). Multimodal self-regulation theory of sexual offending. In D. P. Boer, A. R. Beech, T. Ward, L. A. Craig, M. Rettenberger, L. E. Marshall, & W. L. Marshall (Eds.), *The Wiley handbook on the theories, assessment, and treatment of sexual offending* (pp. 103-122). : Wiley-Blackwell.

Wampold, B. E. (2001). *The Great Psychotherapy Debate. Models, Methods, and Findings.* Mahwah: Lawrence Erlbaum Associates

Westen, D. (2002) Manualizing manual development: Commentary. *Clinical Psychology: Science and Practice*, 9(4), 416-418.

Wilson, G. T. (2007). Manual-based treatment: Evolution and evaluation. In T. A. Treat, R. R. Bootzin, & T. B. Baker (Eds.), *Modern pioneers in psychological science. Psychological clinical science: Papers in honor of Richard M. McFall* (pp. 105-132). New York, NY, US: Psychology Press.

CHAPTER SEVEN

A UNIFIED THEORY[1]

SYLVIA CROCKER

> ... we propose a theory to describe and explain the world or parts and processes in it. We do so partly to provide a basis for practical actions so that their order is least in conflict with the causal order of the world.
> Husain Sarkar

The Nature of Theory: Philosophical Assumptions

The truth of the commonplace "Every person is a philosopher" lies in the fact that everyday living requires at least a tacit set of beliefs about what kind of place the world is: what is possible or impossible, how change happens, what other people are like and how they are likely to behave, what is good or desirable and bad or undesirable, and so on. Similarly, every therapeutic approach is necessarily under girded by a certain set of assumptions: the nature of the human being, what constitutes health or functionality and disease or dysfunction, how therapeutic change happens, the nature and role of relationships, and so on.

All systems of belief–whether comprehensive or limited, whether consistent or contradictory, whether in everyday life, in science, or in psychotherapy–are *cognitive constructs* that go beyond what appears in sensory experience. Every theoretical system necessarily begins with a set of assumptions that cannot be established beyond all doubt. These assumptions are thought to be somehow "obvious" and to be borne out by some form of "experience." Since immediate experience itself does not reveal the connections between and among events, cognitive systems offer explanations of how things are related and how events happen. These regard the practical things we most wish to understand. Moreover, our desire to

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[1] This is the same chapter that appeared in the first edition of the Handbook, included here with Sylvia's permission.

know extends far beyond how events in the physical world happen; we also want to understand the vast range of personal, interpersonal, and social relationships, as well as the meaning of life.

Clearly, there is a wide range of opinion about what is and what is not *obvious* and what kind of *experience* is definitive, and there are no unassailable means for settling the issue. Nonetheless, all practical behavior–including the development of theories–must begin somewhere; otherwise, no one would know what to focus on as significant or how best to deal with any problem at all. Most people come to some kind of conclusions about the existential questions, often under the influence of systems of religious and philosophical belief, and these are notoriously incapable of rigorous proof.

Theories *explain* or *predict* the data of experience (Proctor and Capaldi, 2006) and *guide* practice. As Lewin famously remarked, "Nothing is so practical as a good theory" (1951, 169). Good theories guide us to the means by which we can achieve the ends we desire. They also help us to refine our understanding of those ends. And so we might add to Lewin's appraisal of theories the Socratic maxim that unless we know what the goal is we will not know whether we are moving toward it or away from it. Without knowing the direction in which we wish to go, we will not know how to select those means that will most effectively take us there. The function of theories, then, is to assist us in the practical endeavors of life, as we strive not only to survive but also to realize our hopes and dreams.

As a prelude to setting forth gestalt therapy's theory in as consistent a manner as is possible, I will begin by spelling out those assumptions that I believe underlie the thought and practice of gestalt therapy. Since gestalt therapy theory is still developing, I will, at several points, argue for certain principles that I believe are consistent with the gestalt approach, in the hope that this will help to push the limits of our theory as it continues to evolve.

I have argued elsewhere (Crocker, 1999) that there are two major philosophical paradigms in Western thought, the Platonic (1961, 1975) and the Aristotelian (1960, 1984), and that Gestalt therapy is primarily based upon the Aristotelian paradigm. The Platonic paradigm is concerned with the world of change *only* as a pathway for the rational discovery of pure, essential forms. According to this view, empirical investigations of the world cannot yield pure knowledge because the world is a realm of imperfect representations of these universal essences. *Nor can individual things be known, except as they embody a collection of essences.* For the Platonist the universal essence is ontologically prior and superior in value to the individual instance of it. This approach is essentially static, *favoring rest* over change as the fundamental condition of reality. The paradoxes of

Zeno, like Plato, the intellectual disciple of Parmenides, are intended to prove that motion and change are rationally unintelligible and therefore impossible.

The Aristotelian paradigm, in contrast, is dynamic, giving priority to *motion and change,* and thus focusing primarily on the actualities and potentialities of changing things in a comprehensive system of change. It is a field-theoretical approach to knowing, always considering the context in which an event occurs. It gives ontological priority to the individual, and views the mind as capable of understanding universal truths, patterns of interaction, and change by means of abstraction and synthetic generalization. *For Aristotle the individual can be known experientially through actual contact informed by an understanding that has been gained through reflection upon empirical experience.* I hope it will become increasingly clear that gestalt therapy employs the Aristotelian paradigm in its approach to human living and to the therapeutic task.

While gestalt therapists work within the limitations inherent in human knowing, most assume a position akin to Kant's (1958) *critical realism* concerning the relationship between the world that *appears* in experience and the world as the *source* of these appearances. Yet unlike Kant, who refused to assert any kind of similarity between these appearances and their source beyond experience, a more pragmatic position–and one that is more compatible with the gestalt approach–asserts that *there must be some analogous similarity* between what we immediately perceive and the objects they represent. If there were no analogous relationship, then we would have the (probably unsolvable) problem of understanding how the successful practical application of knowledge in the world of our experience is at all possible.

Idealism–the view that everything is nothing more than thoughts in a mind, in particular in the individual mind–is also pragmatically incompatible with the gestalt approach. If what-is is nothing more than our own percepts and ideas, then we would be stuck with the problem of explaining how it is that we meet with resistance when we try to act practically, and of explaining what prevents all of our dreams and strivings from coming true.

Further, materialistic reductionism is incompatible with gestalt therapy theory, in part, because so much of our experience is qualitatively not reducible to *matter in motion.* Moreover, we know from lived experience, that the hopes, desires, and plans that an individual person entertains, the actual choices he or she makes, and the overt behavior she or he performs, determine how the brain actually functions at a specific time. More specifically, materialism in and of itself seems entirely incapable of

explaining why the brain (or the gross movements of the body) functions precisely as it does at *a specific time* rather than functioning in any of the millions of other possibilities of which it is capable. Few of the goals that people pursue and the factors that are involved in discovering and evaluating the means to them are essentially bodily in nature. It is a person's hopes, dreams, and value-realizing pursuits that explain much of the body's actual behavior; the body itself and its abilities to function do not explain why a person pursues the non-physical goals he or she does. *Here the brain's processes are servant to the person's purposes.* The critical realism that tacitly under girds the thinking of most gestalt therapists is most compatible with their central focus on what amounts to the multi-dimensional events in a client's existential field.

What idealism and materialism have in common is the assumption that there is some kind of ultimate *stuff* of which reality is composed. But this is a necessary assumption *only* if one's ontological system is focused primarily on *nouns*, one that attempts to understand what real things are *made of* and their *composition* or *form*, rather than on *processes* and *interactions*. The Platonic paradigm is noun- and adjective-oriented (1961, 1975), while the Aristotelian paradigm (1960, 1984) is concerned primarily with verbs, adverbs, and dynamic relationships. Aristotle regarded "matter," "form," "substance," "actuality," and "potentiality" strictly as *analytical tools* that take on specific meanings only in specific contexts. While one of his assumptions was the etemality of the existing world of changing things, Aristotle was above all concerned with the processes of growth or change and interactions among things existing in a dynamic system, rather than with their qualitative or quantitative compositions (Randall, 1960). Similarly, gestalt therapy is primarily concerned with processes of interaction and change, and as such it tacitly assumes a verb-adverb-oriented ontology. This tacit assumption needs some elaboration.

A verb, or action ontology focuses more on time than on space, with *space* and *time* both being regarded not as existing entities in and of themselves, but rather in the relative sense of *where and when events of any kind happen.* When space is no longer reified, and when we think of *what-is as a nexus of many interpenetrating dimensions of possible events,* then "space" takes on many relative meanings: cognitive space, spiritual space, intimate space, physical space, market space, and so on. Analogously, time is when and at what rate the events in these spaces occur. Modem theories of space (Green 2004) do not really need to reify space (as they do), since what they are essentially attempting is to explain the possible directions in which dynamic events may occur in fields of influence with certain kinds of dynamic structures. From this point of view reality can thus be regarded

as a dynamic and ordered whole of many interpenetrating dimensions, in which events occurring in any dimension are capable–in principle and under certain conditions–of reciprocally influencing events occurring in any of the other dimensions.

This is not really a far-fetched notion, since even in physics *matter* is regarded as nothing more than a complex system of electrical *events*–and electricity has much more in common with *nothing*, with no-thing, than it does with solid things or an eternally existing and indestructible material *stuff*. There is no necessary inconsistency in holding that the physical system of actions and interactions gives rise to other kinds of realities that are not essentially physical. For example, in spite of the fact that the human brain has evolved as a physical fact, it is used in ways that have to do with and lead to real things that are not physical, such as the sacrificial striving to realize hopes and dreams, experiences of beauty and love, philosophical and scientific theories and so on. Given that physical things are ultimately patterns of electrical events, *physical things themselves are ultimately and fundamentally not physical!* Such a position makes the concept of holism–in which experience occurs in many dimensions–of greater explanatory value than is possible with an ontological position of materialism, idealism, or any form of dualism.

How then can we understand what we mean by "existence" or "being?" In an action system *to exist* means *to have actual (and potential) effects,* to make a difference in what-is and in what happens or can happen in time and circumstances. While all events occur in definite fields, there are varieties of fields, and influence is reciprocally exerted in a variety of ways. *Gestalt therapy takes into account any and all types of factors that significantly influence what happens in the events of a person's living.* Its first premise is that organisms can be understood *only* by focusing on them as they interact with others in the contexts in which they actually live (Perls, Hefferline and Goodman, 1951).

Gestalt therapy, therefore, can be seen as *beginning* with the holistic assumption, based on everyday, lived experience, that what-is is an individual whole of many dimensions in which emotions drive behavior, bodily states influence thoughts and moods, in which thinking influences bodily behavior, purposiveness guides thought and action, and so on. In other words, everyday living gives evidence that every event is, in principle, capable of reciprocally influencing and being influenced by nearly every other event, regardless of the dimension in which it originally occurs. In such a system cognitively generated problems of how things of different kinds, such as mind and body, can interact simply do not arise, since *the interactions are assumed at the outset.* From the gestalt viewpoint the

distinction between mind and body is strictly *a distinction of reason, not a real distinction.*

Contextual Assumptions

All living requires an environmental context, and contact–the interactions between the organism and others in its actual environmental setting–is absolutely central to every organism's life. Gestalt therapy is thus a *field-theoretical approach,* recognizing that any understanding of a person's life must take into account his interactions with those factors in his environment that influence him in significant ways. Further, since human beings are herd animals, and since no one can survive, let alone become fully human, without the influence of other human beings, every human being's environmental context is necessarily both social and interpersonal.

While field theory has come into prominence through the science of physics, the concept of "field" is not limited to the physical sciences. As a technical term "field" can be understood in two major ways. It can be an ontological, physical reality, as mentioned above, but it is not limited to that. Lewin (1951) pointed out that a given *interest* organizes a field; thus "field" here means a *domain of interest.* Such a field is always limited to those factors that reciprocally influence whatever the person's figure of interest happens to be.

Gestalt therapy is field-theoretical in both of these senses. It is important to keep in mind that a vast number of significant activities and their influences are not physical in nature, many of them occurring in "spatial" situations that are non-physical. For example, many problems that human beings address arise and are addressed in a kind of cognitive-affective environment: the novelist struggles within the story space, the musical composer works out how to express his own vision within–or beyond–a domain of musical norms, a theorist works within a domain of received knowledge and the judgment of his colleagues, the moral dilemma an individual struggles with occurs within a domain of values where two or more values are in irreducible conflict yet a decision must be made, and a couple seeking to work out their problems engage each other within the domain of interpersonal relating.

Because we are concerned with a person's many-faceted existential field we are, therefore, mindful of the fact that the wholeness of human living occurs (as indicated above) in the many simultaneous and interpenetrating dimensions: physically, mentally, emotionally, purposively, aesthetically, spiritually, and relationally with other individuals and as a member of society. These are not separable spheres of what-is; rather, what-is must be

seen as a *nexus* of many dimensions of possible experience or action; human living occurs within that nexus of dimensions. In many cases, if not most, what happens in one dimension of a person's life reverberates throughout other dimensions of her living, so that an emotional experience, for example, also involves cognitive and physical processes, and may also involve other dimensions of experience such as aesthetic, spiritual, and interpersonal relating.

The therapist must be sensitive to the kinds of environments that are relevant to the difficulties the client is dealing with, and she must attempt to discover the ways in which the interactions between the person's behavior and the events in those environments influence the client's present living–indeed, how certain aspects of many of these interactions during his lifetime have been internalized and are still "alive" in the present. Together, client and therapist explore and experiment with how the client reveals himself to the therapist within the therapeutic context, as well as his patterns of response to significant situations in his present life. In these ways client and therapist have "ever more intimate contact with the activities of the human organism as *lived* by the human organism" (Perls, Hefferline and Goodman, 1951, p. 21). As a result of this contact the organization of that living gradually emerges and becomes more and more available for change.

The Organism

In their interactions with environmental others, every organism constantly and ineluctably organizes the influences that come from these interactions, creating and re-creating itself as the *dynamic organismic whole that is its actual living.* With regard to the human organism, that aspect of one's living that involves awareness is a dynamic whole of memories, learnings and beliefs, habits, preferences, associations, emotional responses to interactions with important persons, and so on. Seen within an ontological framework where there is no ultimate indestructible "stuff," all existing things, including organisms, are *dynamic action systems* living reciprocally within a dynamic system of change. The ever-changing (within certain parameters) organization of each organism's living gives rise to–as well as limits–the possibilities for action, interaction, and change. Organisms, like all other existents, have only a transitory existence, yet it is possible to discern a kind of continuity in the changes that occur during the courses of their existence. When we speak of an organism's *identity through change,* from an *objective* standpoint, it is this discernible continuity to which we are referring.

Organisms, in contrast to inorganic things, have the power of *agency.* One of the major ways in which organisms show their capacity for agency is the fact that they are *self-regulating.* They are able to respond not simply passively to internal and external changes and to the impact on them of others' actions; they are also able to be selective in how they permit these actions to influence them. Perhaps most important of all is the fact that organisms can *initiate* processes of change, which they do in pursuit of the goals they need and/or desire, and to escape from factors that they perceive as threatening and hurtful. The behavior of organisms is clearly goal-seeking or *purposive, not random.*

Moreover, how the influence of others is sustained by an organism is rarely simply passive; rather, an organism usually responds according to some fairly definite preferences as it includes some aspects of that possible influence and excludes other aspects and as it then transforms what it includes in order to make it useful. The fact that organisms are not indifferent to what happens to them shows that how they function is informed by their intrinsic (positive and negative) *affectivity.* In most organisms these preferences are determined by their DNA, while preferences in the so-called higher animals are both innate and acquired through experience.

In the conscious living of human beings one of the major ways in which affectivity shows itself is in the *personhood of the person,* since persons both *originate* and *bestow value* upon certain things and events and actively strive to realize their desires for them. Human living is *personal.* Because their experience possesses a high degree of connectedness, human beings are able to range over the past through memory and into the future by means of imagination. Thus human living is marked by a complex of desires for and actions on behalf of goals that, in various ways, lie in the future. At some level and with varying degrees of awareness, every person likes some things but dislikes others, experiences wanting some things while rejecting others, and has (at least tacit) limits on what he will and won't put up with, or settle for. *The complexity of habitual patterns of behavior* that each person develops in pursuit of what seems good to him, and those other patterns by which he avoids or fights against what he dislikes or finds threatening, are usually what we mean when we speak of someone's *personality.*

Unlike other animals, every human being has a sense of an "I" that accompanies all of "My" experiences, and this gives rise to a sense of "Myself" as the *subject* to whom these experiences belong. This is the *subjective* basis of each person's sense of identity through change. Yet, many of the individuals who come to us for help do not know themselves

very well. Many of them feel confused about their desires and their own affective limits, and are often unaware or are only vaguely aware of their feelings when various interactions with others occur. Thus part of the work of therapy involves helping them become more clearly and vividly aware of how they really and fundamentally feel and what they really want, and then supporting them as they develop the necessary courage to act on behalf of and in accordance with these feelings and desires.

Everything that is characteristic of human nature and human living is manifested in the kinds of *contact* human beings have with *environmental and internal* others. Understanding the nature of contact is, therefore, fundamental to the work of the gestalt therapist.

The Centrality of Contact

Contact is central to all life, and it is central to the processes of gestalt therapy. The fundamental meaning of *contact* is that it is ***meeting with the other***. Growth of all kinds involves taking in what is "other" and assimilating it in ways that lead to some form of maintenance and/or growth, whether we are speaking of ingesting food or of learning, either *formally* or through *experience*. Since the concerns of gestalt therapy are psychological, the technical understanding of contact is *aware* ***meeting with the other***. Such contact is possible only where there is an awareness of difference, of what is not-me. We often speak of the *contact boundary* as the "place" of meeting. It is important, however, not to reify this boundary and regard it as a separately existing entity, but to understand it strictly as a function of the meeting itself. As a technical term "contact boundary" has only a relational meaning, the function of which is to call attention to the fact that in contact two or more "others" meet and mutually affect each other, *but they do not merge into each other, becoming a single entity.* As therapists we are concerned with the *quality* of those aware processes within a client's existential field, by which that person interacts with others in that field as he deals with the complex issues pertaining to survival and growth.

The Pragmatists rightly understood that most of the living of all organisms is devoted to solving a great variety of practical problems, and that these processes go on throughout the entire life of the organism. There are, of course, forms of contact that are not primarily practical, such as play, intimate relating, religious and sexual ecstasy, aesthetic experiences, and various forms of contemplation and meditation. While these are important to a whole life, they play a much smaller role in human living than practical endeavors do. Most of the time we are solving problems, large and small. The solution to one problem is always succeeded by new practical problems

that need to be attended to. Most people who seek the help of therapists experience less-than-satisfying attempts to solve their problems, and so it is important for a gestalt therapist to understand the nature of *functional* problem solving, as well as how it can become *dysfunctional.*

A contact episode occurs according to the following scheme. It begins as a person feels some excitement and interest in a situation, about which the person feels "something needs to be done." The figure of what that "something" is becomes increasingly clear as she looks around for an immediate solution. Finding none, she must then set about discovering what solutions are possible within the current field. She then evaluates these possibilities, selecting one and setting aside the rest. As she identifies with and then acts upon her decisions in favor of a given possible solution, the problem is usually satisfactorily solved and the figure is destroyed.

Two major analyses of the process of contact have been offered in Gestalt therapy. In the Perls, Hefferline and Goodman (1951) text Goodman analyzes it in four moments or phases. *Pre-contact* is that phase in the process in which the person feels some excitement and begins to form a figure of interest. The second phase is *Contacting,* the decision-making process, in which the person discovers possible solutions to the problem at hand, evaluates them, decides in favor of one of them, "alienating" the rest, as he progressively "identifies with" the one. *Final-Contacting* occurs as the person fully identifies with the solution as he engages in "a spontaneous unitary action of perception, motion, and feeling" (ibid., 403) on behalf of the brightened figure that originally prompted the process. Finally, *Post-contact* is the process by which the person assimilates the experience of contact into his ongoing living; this occurs largely out of awareness.

Joseph Zinker (1978) and others associated with the Gestalt Institute of Cleveland have developed an alternative analysis known as the *Cycle of Experience.* The context of this analysis is within the organismic cycle of contact and withdrawal, beginning with the individual in a "neutral" state of spontaneity, or creative indifference. Following that, the first stage in the cycle of experience is referred to as *Sensation.* Here the person is not practically concerned with anything in particular but is aware of what is going on around him and of sensations or proprioceptive perceptions within. The next moment in the process is *Awareness* as the person becomes focused on the emergence of some need that attracts his practical interest. The *Mobilization* phase involves a rise in physical and emotional energies as the figure brightens and the mind begins to discover and weigh possible means for effectively dealing with the figure of interest. This leads to *Action* as the person chooses and acts in what seems to be the "best" solution to the problem, followed by the experience of *Contact* in which the person actually

experiences the effectiveness of his action on the problem at hand. This is followed by the *Satisfaction* phase in which the person enjoys the sense of accomplishment and completion of the process as the figure recedes or is destroyed. At that point the person moves into a state of *Withdrawal.* In healthy individuals the person becomes available for contact again as the cycle starts over. Unlike the Perls, Hefferline and Goodman model, this analysis does not deal with the process of assimilation, a process that goes on primarily out of awareness.[2]

In psychotherapy a good theory not only helps the practitioner understand her therapeutic goals and experiences, it also gives practical directions for intervening in order to help the dysfunctional person become more functional as he lives through time and circumstances. In particular, given the centrality of contact to human life, a good theory should provide a kind of "map" to alert the therapist to points in the process where blockages can and do occur. Each of these models is intended to serve this purpose.

No matter which analysis a therapist employs she is always concerned with how the processes of interaction with others becomes blocked or distorted in ways that prevent the person from achieving satisfactory solutions to the problems of his life. This is the central issue in psychotherapy, and it gives rise to the following theoretical questions: "What inhibits or distorts these processes?" and "How are such processes of contact possible?" The first question gives rise to ways of understanding contact distortion, while the second raises issues about the nature of the self and of what kinds of capacities human beings possess that enable them to carry on processes of contact.

Historically, gestalt therapists have paid a great deal of both theoretical and practical attention to what are variously described as contact "interruptions," "disturbances," or "distortions." I prefer "distortions" rather than "interruptions" since dysfunctional contact is still contact even though its impact is at variance with what the person intends or desires.

In Perls, Hefferline and Goodman five contact distortions are given: projection, retroflection, introjection, confluence, and egotism. Since then two others have been proposed: deflection and proflection. But there are many more forms of contact distortions, not to mention the vast number of combinations such as confluent projection, or egotistical retroflection, and

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[2] Editor: Other gestalt theorists would assert that the cycle, or continuum of experience, does, indeed, include an assimilation phase that is sometimes known by other terms, such as "reflection" or "resolution"(see Woldt and Toman 2005, Melnick and Nevis 2005, 2000, Nevis 1987, and Scheinberg, Johannson, Stevens, and Conway-Hicks in chapter fourteen of the first edition of this volume.)

so on. Fully functional contact requires both a realistic appraisal of one's own strengths, limitations, and desires, as well as a realistic appraisal of the nature of the problematic situation, a practical grasp of the possibilities for effective action, and some degree of clarity about the likely impact of one's possible behavior. Each of these contact distortions involves some loss of clarity about either self or others, and thus leads to behavior that usually fails to achieve the intended effect and/or has unforeseen counterproductive or negative consequences. For example, a person who projects onto another person the power to bring about a change in their relationship will often resort to manipulation of the other person in order to get him to *change*. Usually the manipulated person feels resentment and the projecting person himself is left feeling frustrated, hurt, and angry. Direct communication and taking personal responsibility for helping change to happen is apt to have very different outcomes.

The Self

Because contact is central to living and to the processes of gestalt therapy, the theoretical question arises: "How is contact possible?" In other words, what functional capacities must a human being possess that enable him to carry on processes of contact? The theory of the self, first set forth in Perls, Hefferline and Goodman (1951), is an attempt to answer this question.

Paul Goodman, the principal author of the theoretical half of Perls, Hefferline and Goodman, adopted Freudian terminology–*id, ego,* and *personality* (rather than super-ego)–in his analysis of the nature of the self. Yet its meaning undergoes a transformation as these terms are seen within the context of gestalt therapy's holistic and field-theoretical approach.

In contrast to the reductionistic meaning of *Id* in psychoanalysis–where all *motivation* comes ultimately from bodily deficits and drives–in Goodman's analysis motivation is not limited to bodily impulses and states. In his attempt to make clear his understanding of the meaning of "Id" Goodman analyzes the hypothetical situation in which the person is merely relaxing, unconcerned about anything in particular. Fragments of sensations and thoughts pass in and out of the person's unfocused awareness, and "the body looms large" (Perls, Hefferline and Goodman, 381). In the cycle of experience this is the "sensation" phase. If no figure begins to form and brighten, then the person eventually falls asleep. However, let us imagine the following possibilities: the person may suddenly remember that he was to meet someone at that time, or he may have an inspiration for a passage in a poem he has been struggling with, or he feels the urge to urinate. In any

of these cases his state of rest is interrupted by a dawning figure that brightens and prompts the mobilization of his energies and his practical thought processes ("awareness" and "mobilization" phases in the cycle).

It is a mistake to take the statement "the body looms large" as an indication that Goodman thought of Id as a function of the body (Philippson, 2001). Goodman was concerned with developing a holistic theoretical structure for gestalt therapy, and it is clear throughout the theoretical part of the Perls, Hefferline and Goodman text that *motivation in this system can stem from any area of human concern and activity.*

In Goodman's understanding, as it was in Freud's, *Ego* is the self's practical function, the ability of the self to discover possible solutions to problems, and to weigh them in terms of such evaluating criteria as efficiency, costliness, elegance, side-effects, and so on. At the end of this process the self decides in favor of a given alternative, and finally moves beyond deliberation into an identification process that Goodman describes as relaxing into "a spontaneous unitary action of perception, motion, and feeling" (ibid., 403), ("action," "contact," and "satisfaction" in the cycle).

Personality, in contrast to Freud's Super Ego, is conceived of by Goodman as a set of habitual responses (that can be verbally replicated) that influence how a person responds to a variety of situations. This contrasts with Freud's concept of the Super Ego, the administrator of a set of exhortative and inhibiting principles.

In my opinion, there are several problems with the use of Freudian terminology in this theoretical analysis. First, Freudian language is not experience-near and thus it is not phenomenological. Second, the terminology is not clearly oriented toward dynamic actions, and thus it is not suggestive of the *self's functions or capacities to carry on certain kinds of processes.* Third, it tends to regard the self compartmentally, rather than seeing how the self is a whole in which every aspect mutually interacts with every other aspect. Fourth, as I will show, it is an *incomplete* analysis of the self's capacities to function in processes of contact. Finally, it is based on an ontology that is a form of materialistic reductionism. I will suggest an elaborated alternative analysis, which will not only employ phenomenological and process language, but will more clearly show where blockages in contact processes often occur, and which will provide the therapist with a more detailed "map" to guide therapeutic interventions.

I propose to understand the self's capacity for contact in terms of *six functions,* three of which have an overarching influence on how a person engages in contact, and three that deal specifically with moments or phases in a given contact episode (Crocker, 1999).

The *Contact* and *Withdrawal Function* is the self's ability to be available for contact or in a state of withdrawal from it. Contact with others within an individual's present field requires that the person be actually available for contact, and not in a state of withdrawal.

Whenever something rouses excitement during the course of a person's day he responds with *Interested Excitement,* which begins to mobilize his bodily energies and to engage his cognitive and evaluative processes.

The person engages in *Decision-making* as the figure of interest brightens and the person becomes more focused. The contact process continues to move forward because of the self's ability to look for readily available solutions and, finding none, to imagine possible solutions. He then weighs and evaluates these, and finally decides in favor of a given solution. These complex behaviors are possible because of the self's *Decision-making Function.*

The *Choosing Function* enables the person to move from decision, which is largely a cognitive process, to action, which involves a unity of mind, body, and emotions. This is what Goodman is referring to when he speaks of the process of "identifying" with a given solution, and alienating or dropping all concern about the other possibilities. No doubt Goodman's Aristotelian background (Stoehr, 1994) had impressed upon him the difference between deciding (thinking and evaluating) and choosing (overtly acting as a whole). However, Goodman inadequately developed what he meant by the process of "identification" that ends in action, making it appear to be the result of ego function when, in fact, it is a *holistic act* involving cognition, affirming motivation, and actual behavior. The result is that his treatment of *Full Contact* gave no hint of one of the major problems people deal with in therapy–the problem of translating thought into action, of intentional purpose languishing in inaction.

The *whole-making* or *synthesizing function,* together with the *contact function* and the *learning* or *habit-formation function* impact every phase of a contact episode. Human beings constantly *synthesize* wholes, whether digesting nutrients, making plans, telling stories, playing games, creating adaptive behavioral responses, working out theoretical explanations, developing a working "map" of the world, a sense of personal identity, and incessantly ordering and reordering their experiences into a living whole as life goes on. These are all accomplishments of the self's ability to synthesize many types of wholes, and these wholes clearly impact how problems are recognized, alternative solutions are selected and weighed, and how they affect the person's ability to translate thought into action.

The *Habit-formation* or *Learning Function* is the self's ability to practice skills and behaviors so that they become habitual, requiring only a

minimum of awareness. Many of these skills are simply part of normal human development, and others involve deliberation and practice, both in the process of acquisition of a given skill and of its modification or rejection. Without this capacity, ordinary life would be impossible, since each person would have to learn everything anew every day. This function becomes dysfunctional when someone employs habitual, often stereotypical, responses to situations that actually require careful evaluation and behaviors appropriate to the situation in question. Such dysfunctional contact often seems stale and all-too-predictable. It usually produces results that are unsatisfying. This group of learned responses is usually referred to as someone's *personality.* Here, however, personality is seen as the *product of a function;* it is not the function itself.

In a therapeutic approach a model of the self should be judged by two criteria: how well it reflects what people actually experience in their contact with others, and its value in guiding practice. A good model guides the clinician in discovering and assessing where the blockages are to healthy function in a client's living, and it suggests points and kinds of interventions that could be effectively employed. In my opinion, the model I have just described gives a more complete account of the self's functional abilities to engage in processes of contact than the one that is given in Perls, Hefferline and Goodman.

Moreover, this model clearly indicates where the blockages can occur in these processes. To take a few examples, there are many ways in which a person's availability for contact becomes dysfunctional, with some individuals being phobic about being close and exposed, while others are phobic about being separate from and unrecognized by others. Many of the contact distortions are employed to deal with these fears. With respect to excited interest, it is common for people who have lived with neglect or abuse not to notice either of these, or if they do notice, they fail to come to the conviction that something has to be (or can be) done to change the situation. Here the therapist's task is to help raise the client's awareness, and to give support as the client becomes determined to make a change. In decision-making some clients' impoverished maps of the world can blind them to important and viable solutions to problems, while others readily see a wide range of alternatives but get stuck in the evaluating process and/or cannot bring themselves to make a decision. The old saying, "the road to hell is paved with good intentions," points to the very common problem associated with moving from thought to action. Numerous factors, such as fear of consequences, lack of courage, lack of skill or confidence in performing certain behaviors, contribute to this. Each of these suggests to the therapist sets of interventions she can employ.

As gestalt therapy theorists have reflected on the nature of the self, they have divided roughly into two camps: those who see the self as persisting throughout the life of the person and as being the agent of contact and growth, and those who see the self as having an episodic existence, emerging only when the person engages in situations involving contact, otherwise receding into non-existence. The opposition between these two positions stems from the fact that Goodman himself was clearly of two minds on the subject when he wrote the theory part of Perls, Hefferline and Goodman–as a careful reading of the text shows (Crocker, 1999).

It is important to bear in mind that it is the person who endures through time and change. It is the person who is aware of himself as the subject to whom all of his experiences belong, who is able to act with awareness, and who endures through change. The human self in this context must be understood in terms of human processes and action. Every person possesses a *complex set of abilities to act with awareness* as he or she interacts with others in pursuit of goals, needs, and desires. In my opinion, *the self is this complex set of abilities.*

The self should never be understood as a kind of independent and indestructible "ghost in the machine." Every attempt to construe the self in those terms always involves answering the question "How do you know?" by referring to certain actions that make a difference in what-is. And yet one can only point to the actions of an individual person, never to the actual self. The self is revealed in how a person acts,[3] and the processes she or he carries on that lead him or her to act in certain ways. Indeed, the person is himself an action-system, interacting with other such systems in fields of change. Human beings, like most other organisms, possess a number of abilities to act that continue to exist as *potential powers* even when they are not being actively used. The power to see or to hear continues to be a *real potentiality, a real power,* even when no seeing or no hearing is actually happening. The self does not have an independent existence; the self exists only as a set of abilities in an existing human being. *When it is not being actively used, the self has only potential existence; the self overtly exists only when it is actually being used, but* the person whose self it is endures for a lifetime.

Theory of Practice

Most of the issues that bring people into therapy involve problems with how they habitually use their abilities to make contact with their world. The

[3] Editor: The reader may also find interesting the views of Karol Wojtyla (1979) on this point.

central characteristic of all gestalt therapy methods is that they *focus on contact,* the ultimate goal of which is to help client's *learn how* to have functional and satisfying contact with others. Gestalt processes thus aim at helping a client have lively contact between himself and what is happening nonverbally in his body and his feelings, with his needs and desires, with his environment, between the client and each side of a polarity, through the use of imagination to help him have expressive and illuminating contact with significant others in his life, as well as between the client and therapist herself. Early in my career as a gestalt therapist a colleague suggested a helpful rule of thumb that many gestalt therapists keep in mind in doing therapy. She referred to it as the "No Gossip Rule," the essence of which urges the therapist to remain alert to the opportunity to have the client move *away from talking about* significant persons and situations, and to ask him to *talk to* them or to suggest some way for him to have contact *with them.* The therapeutic situation, then, is a kind of laboratory in which the client can *re*-learn how to do business with his world in ways that bring him satisfaction and a sense of well-being.

Gestalt therapists *do not,* however, *aim directly at* either change, satisfaction, or at a sense of well-being. That is because intrinsic to the gestalt therapy approach is what is called *the paradoxical principle of change* (Beisser, 1970), which asserts that human change will not occur unless or until the person fully faces what-is, until he comes to a detailed and vivid grasp of how he *actually lives and typically behaves* in his current circumstances. Persons who look away from what-is as they wish for and futilely strain toward a different life usually remain stuck. The tactical aim of gestalt methods is thus the *letting-be-of-what-is.* Therefore, much of the work of gestalt therapy is the *here-and-now* exploration of and experimentation with how the person lives his everyday life, his involvements and habitual patterns of response in dealing with significant people and situations, as well as, ultimately, with the very organization of his living itself. In this way what-is gradually *stands-out-in-the-open.* Paradoxically, that is how human change happens.

In the gestalt approach the therapist herself *as a person* plays a central role. She comes to the meeting with a client with a ground of personal and professional experience, knowledge, and understanding. Every person wishing to become a gestalt therapist is encouraged to become a client herself in order to work through any unfinished business or other issues that function as a distorting screen in her contact with her own clients. Part of the work of the therapist is to function as a *sensing instrument* who is receptive to and curious about the verbal and nonverbal self-revelations of her clients. The gestalt therapist is (ideally) committed to being *clearly*

present to the client, welcoming and supporting the client's ability to reveal himself at increasingly deeper levels. Through her ability to listen actively to the client's story, she communicates her caring and her willingness not to judge or shame the client. And by helping the client tell his story in concrete and specific detail she is able to discover many fruitful points of intervention.

Ideally, a gestalt therapist will have internalized the theoretical principles elaborated above in such a way that they have become part of her present functioning, thus providing a set of lenses that inform her point of view and her understanding of the therapeutic task, and that sensitize her curiosity. They *do not*, however, provide any of the *answers* about the client or place him in neat therapeutic categories. Rather, her theoretical ground and experience help the therapist *notice*, as possibly significant, certain aspects of a client's self-revelation–such as voice quality, body language, the presence of certain assumptions about himself and/or other people, and so on. Her curiosity about these aspects suggests to her a series of working hypotheses, which in tum suggest a variety of possible experiments that deepen awareness and enliven the process. The unfolding experiences the therapist has with the client either tend to confirm some of the hypotheses or lead the therapist to reject or modify them.

The actual therapeutic practice of a gestalt therapist is guided and informed by three *practical* principles: *the paradoxical principle of change* (as discussed above), *the phenomenological method*, and *dialogue*. The phenomenological method and dialogic relationship are discussed elsewhere in this book, with an emphasis on method, but they will be discussed briefly below with regard to theory.

Just as gestalt therapy is not a "talking cure, neither is it a kind of "depth psychology," though in actual practice it is able to *discover and work with the* ground of a client's behavior as the organization of his living is progressively discovered. However, in the application of gestalt methods therapists focus on the *surface manifestations* of a client's living. We take as the *starting point* of gestalt therapeutic processes how the client reveals himself in the surface phenomena of his present verbal and nonverbal behavior. *The phenomenological method* involves the therapist's being open to the present self-revelations of the client, without *imposing upon* those revelations a meaning coming from the therapist herself, from gestalt theory, or from a diagnostic category. Rather, through the processes of becoming aware of, then exploring and experimenting with these self-revelations, therapist and client *together* track the *personal logic* of the revelations in order to discover the unique meaning they have in the client's living.

In gestalt therapy *meaning resides in the relation of figure to its ground.* In practical terms this means that, as the therapist explores and experiments with the client's present phenomena, she is actually tracking that person's *unique logic* in order to discover how the client relates figure to ground, or how the ground gives meaning to the figure. For example, if someone tells us about those feelings that come over him when he deals with a present authority figure, we may well discover, through the therapeutic process, one or more unresolved difficulties the client has had with authority figures in the past. Finding a way to resolve these old difficulties in therapy may open up for the client new behaviors he can begin to practice in his current situation involving an authority figure.

As the work of therapy goes on over time, and as the therapist forms a succession of working hypotheses about the meaning of what the client is presently presenting, the therapist remains open to how the person's self-revelations evolve. Whatever hypotheses she entertains are held only lightly, being modified or discarded in the light of the client's subsequent revelations. *A cardinal principle of the phenomenological method is that the client's own experience and how he actually reveals himself always takes precedence over any theories the therapist may have about him.* The method itself *never* produces the answers, but it permits therapist and client together to engage in processes out of which the meaning of the client's experiences emerge.

Central to the entire therapeutic process is the *dialogic relationship* between therapist and client. Gestalt therapy is *dialogic* in two ways. Gestalt therapists regard gestalt processes as clearly collaborative, with therapist and client engaging in ways that result in the progressive revelation of the patterns and organization of the client's living. The therapist must be open to, interested in, and curious about what-ever and how-ever the client reveals himself. The therapist's task is to facilitate the process and to give support to the client as he learns how to support himself in his new ways of living. A second way in which gestalt therapy is dialogic is that the interactions between therapist and client are sometimes the venue for therapeutic work, as a client's old patterns of response are re-enacted in relation to the therapist. One of the important principles of the work of a gestalt therapist is the commitment to deal with the client as a *real person,* not as a blank screen or as someone playing the "therapist role." Therefore, the relationship between client and therapist is a *real* relationship. It is a widely held opinion among gestalt therapists that an effective therapist is committed to *interacting with* the client, to *affecting and being affected by* the client in *truthful* ways. The presence of the therapist who is, within

limits, self-revealing and openly interested in the client as a person works against projective and retroflective processes.

The persons who come for help have usually developed *adaptive patterns of response* to inhospitable situations in which they found themselves earlier in life. While these had survival value at the time, they are anachronistic and counterproductive in their present lives. Yet because these patterns have become "second nature," i.e. habitual and quasi-automatic–therefore requiring only minimal awareness–the person does not understand how he is contributing to what continues going wrong in his current life. Or if he does understand, he feels incapable of changing. By finding ways to make contact with the living ground of a person's present behavior, by discovering with the client those dysfunctional patterns of response–thus bringing them into awareness where they can be explored and experimented with–a gestalt therapist can aid the person in *undermining* how these patterns "live" in his existential ground. When the negative influences from the person's past experiences no longer exist in his present living, they are either forgotten or live only as distant memories.

Gestalt therapy theory is unified by constructs that endure across its four main tenets and mold them into a framework that is both solid and dynamic. Theories of the self, contact, and action, as well as theories of health and change abide whether one is focused primarily on the phenomenological method, dialogic relationship, field theoretical strategies, or therapeutic experiments. Every time there is a phenomenological inquiry it takes place between people, in the context of a relationship, and involves contact. Because the meeting between therapist and client is alive, it is therefore to some extent unpredictable and experimental. The therapeutic situation thus provides both therapist and client opportunities to practice behaviors that are improvised to fit *this here-now* situation–a skill that is essential to living authentically and well in the everyday situations of life.

To summarize, in contrast to a number of other therapeutic approaches that seek to discover the category into which a client's behavior places him, gestalt therapy aims at the discovery of the *uniquely personal meaning* of what a client reveals about himself in the here and now. *The point of gestalt therapeutic processes is to enable both client and therapist to have contact with the living organization of the situated client's life,* how the influences in his life have been assimilated or accommodated, and how some of them continue to "live" and to exert their influence on his present living. The very processes by which client and therapist come to grasp the unique truth of a client's living begin to open the door to change. And, further, as a person comes to a deepening understanding of himself, he becomes clearer about the life he *wants to live and how he wants to be.* The therapeutic processes

themselves, together with his relationship with the therapist, also produce in him *the courage to step out further into that life.*

Existential Assumptions: Health and Fulfillment

The *paradoxical principle of change,* in effect, states one of the principles of a healthy and well-functioning human life: the processes of growthful change begin with discovering and taking seriously *what-is* and *how-it-is.* In human terms this becomes: *"Who am I?"* and *"How do I live?"* When we ask the question "What is the truth about being a human being and how does truthful human living go on?" we find that the answer is two-fold. *Each person is both a unique individual as well as a member of the human family.* Each is programmed by his DNA and by family and society to grow to human maturity, both as an individual and as a member of society. However, what constitutes mature, healthy, and functional living for an individual is sometimes in conflict with what constitutes living well as a member of society. The resolutions of such conflicts most often come from the responsible person's improvising solutions that fit the peculiarities of the situation itself, sometimes with his having to choose "the least of the evils." In general, these two identifications must be *held in tension,* without favoring one or the other. Each domain of living must be seen as providing a *set of limiting conditions* for the other domain.

Martin Buber's concept of *I and Thou* (Buber 1958) provides one of the assumptions that informs gestalt therapy's fundamental humanism and sheds light upon how the two domains in which human beings live serve as limiting conditions for each other. Buber distinguishes between *I-It* and *I-Thou,* where things that are *It* are valuable primarily because of their *usefulness,* whereas a *Thou* is something that is *intrinsically* valuable, something that is an *end in itself.* Things that are *It* have value *bestowed upon them as means to ends,* while *Thou's originate and actually bestow value.* From this perspective, every person must be regarded and treated in ways that unfailingly honor the fact that that person is an end with intrinsic value, a *Thou,* and must *never* be treated as *only* a means, as an *It* whose value is that of utility. Everyday living involves both the practical pursuit of relative ends that in tum become means to further ends. It is often the case that our interactions with other people involve treating them as means that serve the ends we are pursuing. And yet our behavior toward them must reflect the fact that we are mindful of the fact that they are *never* merely means but are Thou's. Or as Heidegger (1962) has asserted, given the nature of what it is to be a human being, the appropriate way for human beings to deal with each is with *care.*

Therefore, an individual person should not "do his thing" *at the expense of other people,* dealing with them strictly and solely as means to his private ends. How a person "does his thing" is properly limited by the intrinsic value of other people as ends and as bestowers of value. To live as though "I alone am an end with intrinsic value" and "My desires and needs are superior to everyone else's" is to *live a lie.* Similarly, the *reality of the intrinsic worth of the individual persons who are citizens* limits the kinds of laws and institutions that are politically legitimate: these must all respect the intrinsic worth of society's individuals. This means, among other things, that laws and institutions must not reduce one segment of society to the level merely of means for an elite group to secure privilege or wealth. Moreover, institutions should not be structured so as to produce Procrustean uniformity, but to encourage the diversity that comes from the development of both the uniquely personal *and* the social aspects of human living.

Within these limiting conditions, then, what does a well-lived life look like? A healthy person is realistic about his own strengths and limitations, has a realistic view of the world in which he finds himself, and interacts with other persons with realism, openness, and respect. He also commits himself and actively pursues goals he views as worthwhile. Further, human beings both need and want to be with other human beings, for cooperation, support, and companionship. Human development itself absolutely requires interactions with parental figures, teachers, and friends who are peers. Indeed, the humanity of people who have no peers becomes grossly distorted and sometimes even monstrous. We learn how to be human through our interactions with other people with whom we share our world and who both support and limit what we can do.

Human beings inevitably reveal themselves verbally and nonverbally in everyday life, and yet the most inward truths (Latin: *intimatus*) remain concealed until and unless they are welcomed and supported to stand-out-in-the-open (Latin: *exsistere*). Human beings are made for intimacy, for relationships in which each person is free to reveal herself and can be known and affirmed as the unique person she is. This most often happens between close friends, lovers, and with therapists. Ideally, these relationships provide the necessary conditions of welcoming, openness, and caring that encourage a person to reveal what is innermost. A gestalt therapist is consciously committed to providing these conditions so that client and therapist together can discover the client's deepest truths.

Since all human beings are *goal-seeking,* or *purposive,* a healthy person is sensitive to the opportunities for pursuing certain goals that are open to him, and realistic in appraising the possible means by which they can be achieved. He has the courage to take risks and does not have "control

issues," since he is convinced that whatever happens he will "figure something out" to cope with it. An authentic person *lives improvisationally*, not stereotypically, tailoring his responses to fit the particulars of a given situation. Yet even though he does not live with rigid and predictable patterns of response, he inspires trust since he is known as a responsible person who can be counted on to do "the right thing." A person who lives fully and well takes seriously the tasks of making his life mean something, and the meaning he gives it focuses not on himself alone but includes his interactions and participations with others, as a friend and a citizen.

One of the unique features of being human is a person's ability to discover and choose a *unique path* within the concrete situations in which he finds himself. This is not limited to the so-called "hero in history" but is characteristic of every well-lived life. My commitment to do "the right thing," to do what is appropriate *for me in this particular situation,* requires of me not only a sense of responsibility but an ability to perceive what is *uniquely called for* in this here-now state of affairs. This in turn requires a combination of self-knowledge and an openness to how the situation, as it reveals itself, *uniquely calls out* to me for action. And so; we sometimes find an otherwise undistinguished person standing up for a cause with little or no support from others.

One often describes the quality of this life as "authentic." The Greek root of this term is *autos,* meaning *the same,* or *self* (in the self-referential sense). The term "authentic" means that something is the "real thing," it is what it purports to be. An "author" is the source of something such as a story or a theory, and an "authority" is someone who holds the power to decide or control in some domain. In general *autos* pertains to those things or persons who are ultimately referred to in order to explain why something is as it is. An authentic person, then, is someone whose behavior truthfully expresses who he understands and affirms himself to be. In order to understand his behavior we must have an understanding of how he thinks and the values he lives by. He does not live by the authority of other persons or organizations. Within the limiting conditions of the reality of himself and other people as *Thou's*–those who can never be treated strictly as means to ends–and his life as a *member of the human family,* he has become his own authority. He has internalized and incarnated the values he lives by in such a way that they inform, characterize, and explain how he actually lives.

What is it that makes this kind of living possible? I believe that the tasks of living well personally and in relationships with others, as well as the ability to be an effective gestalt therapist, require the functioning of a person's *spirituality.* In my opinion this is a tacit assumption that operates–usually without being named–in gestalt notions about effective living and

effective therapy. The truth of this statement hinges, of course, on what is meant by "human spirituality." Just as physicality, sexuality, and mentality refer to human beings' abilities to have certain kinds of experiences, spirituality also refers to the ability to have experiences of a certain kind. In this context I take spirituality to refer to *the ability of a person to interact with a significant mystery, and to do so in ways that honor the fact that it is intrinsically mysterious.*

Whatever is unique is not shared, and in most cases it cannot be spoken about intelligibly since words have to do with what is shared. Perceiving "my calling" sometimes requires me to go beyond "what everybody sees" and "what everybody does" so that I can grasp what "I alone can see and feel *called* to do." Similarly, really to know another person requires that I give that person the space to reveal himself as he *is* and not as I *wish, expect, or demand him to be.* Even though a gestalt therapist meets each client with a ground of experience and learning that lead her to develop working hypotheses about the client as the work goes on, she is concerned *above all* to receive the client's revelations as he uniquely reveals himself to her. And this means that all of her cognitions are tested against her experience of the client's revelations, and modified or set aside if they do not fit these experiences. Working spiritually–with patience and with the understanding that no one will ever fully plumb his own or any else's depths–client and therapist can come to a measure of understanding of *how the client's living is organized and what it affirms.* Even though this shared knowledge cannot be spoken, since it is unique, client and therapist are able to work together with the client's living in ways that encourage and support change in how the client lives through time and circumstances.

In an earlier section I mentioned the fact that human beings share with all other organisms several characteristics that in human beings are foundational for a person's sense of self. These are: *agency, organic wholeness, identity through time,* and *affectivity.* In addition, every human being has a sense of an "*I*" that accompanies all of his experiences, and an inescapable feeling that "these are *my* experiences, they belong to *me.*" An authentic and fulfilled human life reveals the *mature form* of these characteristics. In such a life *agency* has become *authentic power,* as the person–while respecting the rights of others–has developed the power to act in accordance with the principles he gives himself, is open to what is novel and unique in his experience, and to how it might call out to him for action. *Organic wholeness* has become *full integrity* since as a result of having nurtured and integrated all aspects of his human nature–the person has developed the kind of *self-possession* that allows him to translate his intentions into action: he does what he says he will do. Such a person

inspires trust in other people. *Identity* or *continuity through time* has become transformed into a *meaningful history* by how he has lived through the events of his life. *Affectivity* in its mature form shows itself in the *full personhood* of the person, whose life incarnates and testifies to the values he has affirmed and the ends he has pursued. Such a person is willing to expose himself to ridicule and danger on behalf of these values when they appear to be at risk. Finally, in maturity the subjective sense of the "I" that accompanies all of *my* experiences becomes the sense of *ownership* and *responsibility* for the life the person has lived in a spirit of *responsive self-transcendence.*

The by-products of such a well-lived life are full measures not only of self-respect, but of happiness as well. These are the ultimate aims of gestalt theory and practice.

Resources

Aristotle. (1960). *Metaphysics.* Translated by Richard Hope. Ann Arbor: University of Michigan Press.

—. (1980). *The Complete Works of Aristotle,* Volumes I & II, Jonathan Barnes, ed. New York: Random House.

Beisser, A. (1970). The paradoxical theory of change. In J. Fagan & I. Shepherd (Eds) *Gestalt therapy now.* Palo Alto: Science and Behavior Books.

Buber, M. 1950. *I and Thou.* Translated by Ronald Gregor Smith. New York: Macmilllan.

Crocker, S.F. (1999). *A well-lived life: Essays in gestalt therapy.* Cambridge: The GIC Press.

Green, B. (2005). *The fabric of the cosmos.* New York: Vintage Books.

Heidegger, M. (1962). *Being and time.* Translated by John Macquarrie & Edward Robinson. London: SCM Press, LTD.

Kant, I. (1958). *The critique of pure reason.* Translated by Norman Kemp Smith. London: Macmillan & Co., LTD.

Lewin, K. (1951). *Field theory in social science.* New York: Harper Torchbook.

Melnick, J. & March Nevis, S. (2005). Gestalt therapy theory of change. In *Gestalt therapy, history, theory, and practice*, Ansel Woldt and Sarah Toman, eds. 101-116. Thousand Oaks, London and New Delhi: Sage Publications

—. (2000.) Diagnosis: A struggle for a meaningful paradigm. In E. Nevis (Ed.) *Gestalt therapy: Perspectives and applications*, pp.57-78. Cambridge: GestaltPress.

Nevis, E. (1987). *Organizational consulting: A gestalt approach.* Cleveland: Gestalt Institute of Cleveland Press

Perls, F., Hefferline, R., Goodman, P. (1951). *Gestalt therapy: Excitement and growth in the human personality.* New York: Dell Publishing Company.

Philippson, P (2001). *Self in relation.* Highland: The Gestalt Journal Press.

Plato. (1961). *The Collected Works of Plato.* Edith Hamilton and Huntington Cairns, eds. New York: Pantheon Books.

Proctor, R. and E.J. Capaldi. (2006). *Why science matters: Understanding the methods of psychological research.* Oxford: Blackwell Publishing

Randall, J.H., Jr., translator. *Aristotle.* (1960). New York: Columbia University Press.

Sarkar, H. (1983). *A theory of method.* Berkeley, Los Angeles, London: University of California Press.

Stoehr, Taylor. (1994). *Here now next: Paul Goodman and the origins of gestalt therapy.* San Francisco: Jossey-Bass.

Wojtyla, Karol. (1979). *The acting person: Analecta Husserliana the yearbook of phenomenological research–volume X.* Dordrecht, Boston, London: D. Reidel Publishing Company.

Woldt, A. & Toman, S. (2005). Prologue-foreword. In A. Woldt & S. Toman, (Eds.). In *Gestalt therapy, history, theory, and practice,*), xi-iv. Thousand Oaks, London and New Delhi: Sage Publications

Zinker, Joseph. (1994). *In search of good form.* San Francisco: Jossey-Bass.

CHAPTER EIGHT

GESTALT THERAPY AND PHENOMENOLOGY: THE INTERSECTING OF PARALLEL LINES[1]

DAN BLOOM

"In any case, I hate everything that merely instructs me without augmenting or directly invigorating my activity."
W. Goethe in F. Nietzsche, (1997)

George: is lonely and chronically sad. He lives with a close friend. He is in his late 60's. George is always somewhat fearful. He sings in a famous chorus and gets anxious when he sings solo, although he has a beautiful voice. He says he is afraid of change.

Gestalt therapy is a psychotherapy that attends to the whole, embodied experiences of suffering patients. Our clinical work is oriented toward a person's distress understood in terms of field-emergence, gestalt process, contacting, creativity, relationality, aesthetic criterion and so on (Perls et al. 1951, Spagnuolo Lobb, 2013, Francesetti, D, Gecele, G, Roubal, J., 2013). We attend to contacting, emergent at the contact-boundary of the organism/environment field, which is neither empirically measurable, mappable, nor quantifiable (Perls et al., 1951). In other words, we pay attention to *phenomena* "that which appears or is seen," (*Online Etymology Dictionary*, https://www.etymonline.com/word/phenomenon). Put in terms of psychotherapy, we pay attention to what develops and appears from within the therapy process and, indeed, our attention is itself intrinsic in the process itself. Our approach to psychotherapy is phenomenological, the inquiry into phenomena in our own particular way.

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[1] I am grateful to Prof. David Carr, professor emeritus, Emory University, adjunct faculty, department of philosophy, New School for Social Research, for reading a draft of this chapter and offering his comments. Likewise, I thank John Noras, doctoral candidate in philosophy at the New School for his consultation.

Whether we know it or not, we gestalt therapists who focus on contacting and the structure of experience of the figure/ground process practice a form of clinical phenomenology. This chapter begins by laying out the parallel and crossing lines of gestalt therapy and phenomenological philosophy in some detail, then turns to actual clinical cases to show how this is relevant to our work

Of course, crossing of parallel lines violates basic rules of Euclidian geometry.[2] This paradox is actually a metaphor that shapes this chapter. Various parallels between gestalt therapy and phenomenology such as bracketing and intentionality have inspired our theory/practice (Bloom, 2010; Crocker, 2009; Mann, 2010; McConville, 2001; Robine, 2003; Spagnuolo Lobb, 2013a & b; Yontef, 1993). The limitations of phenomenology have also been noted (Mann, 2010).

I will take this inspiration from these parallels further and by drawing on different concepts from phenomenology, I will coax parallel lines to cross. Gestalt therapy and phenomenology can overlap in terms of the "attitudes," "reductions," and the "lived-world" or "life-world," specialized terms which I will explain. I will hone critical aspects of gestalt therapy theory and practice in order to sharpen their effectiveness in terms of those areas where the lines of gestalt therapy and phenomenology are parallel– and intersect. These intersections allow me to reformulate the organism/environment field in a more phenomenological way, which more fully accounts for our actual clinical practice. From this new perspective, our attention to what is emergent of the contact-boundary sharpens and widens. Contacting itself within the clinical situation–the therapist-patient relationship–appears in a new light.

By "linking" these parallel lines, gestalt therapy and phenomenology will as if breathe the same air. In this shared atmosphere, new and useful ways to apply our theory to our clinical practice become apparent. I will show this with the concrete clinical example of George, who made his appearance above.

For the most part, Edmund Husserl (1859 - 1938) structures my discussion since much of what followed in phenomenology developed from his work, and many of the parallels noted by gestalt therapists have been with his ideas. Husserl is universally acknowledged as the philosopher responsible for the phenomenological movement even though his own work began as a continuation of his Franz Brentano's 1838 - 1917). Husserl was

[2] Parallel lines do cross in hyperbolic geometry, but for the purposes of this paper, such a detail need not be considered.

a systematic thinker, like Aristotle, but[3] like the latter, he was not a system builder. That is, he was a systematically open-ended thinker. He constantly rethought his ideas. It is important to remember that he was first a mathematician and continued to think along the lines of a mathematician who repeatedly reviewed difficult problems. Some of his work contains inconsistencies. He developed not one, but several "phenomenologies" – such as static (i.e. descriptive or constitutive, concerning consciousness) and genetic (concerning the experience of time) (Zahavi, 2003). His philosophy appears in works published during his life, those published posthumously, and in the few remaining to be published but still studied by scholars. Some inconsistences or differences within his ideas opened gaps in his philosophy that provided opportunities for creative Husserl scholarship. Every emphatic claim about him, even those perhaps made below, ought to be held as lightly as possible as we consider them within the totality of this chapter. To write of Husserl, then, is to write of a particular and not of a definitive Husserl or, indeed, of phenomenology as if it were a fixed philosophical discipline. This is an important caveat.

What goes without saying must be said. We are psychotherapists, not philosophers. This distinction matters. The philosophical project of phenomenology is to use its method in order to describe *and* study (*-ology*) first person experience as such *in a particular way* (Carman, 2008; Zahavi, 2003). As gestalt therapists, we approach the phenomena of each clinical situation not by studying or analyzing them, but by paying attention to them *in our own* particular way. That is, we actively engage with the experience as concrete and current actualities of a suffering person. We never step away from our living practical engagement with the world (Crocker, 2009 Carman, 2008; Gurwitsch, 1974). Yet both phenomenology as a philosophy and gestalt therapy as a psychotherapy have one essential common denominator. They both are concerned with first person experience – the very process of personal experiencing itself. This is not a trivial commonality.

Most significantly, we and our patients are "doing" psychotherapy – not philosophy. Our mission is to relieve our patients' personal distress – and, as gestalt therapists, to free them from the fixed repeating gestalts that diminish their capacities. To the extent we use insights of philosophy, we do so in the service of lightening the suffering of patients. Of course, philosophy is not imposed as an extrinsic doctrine to the therapy itself, but it may be an aspect of the support each of us needs to maintain our

[3] Unlike such philosophers as Immanuel Kant (1724 - 1804) and Georg Wilhelm Hegel 1770- 1831)

equilibrium during the therapy itself. As presented here, phenomenological philosophy is part of the scaffolding of our clinical method. What follows, then, is a discussion of gestalt psychotherapy, informed by insights from a companion discipline, phenomenological philosophy.

Part One: Two Beginnings–The "Here and the Now"

Gestalt therapy has always been closely identified with the words "here and now." With them Fritz Perls introduced what he called the "Gestalt outlook --- the original, undistorted natural approach to life, to thinking, acting, feeling." (Perls et al, 1951) In *Gestalt Therapy, Excitement and Growth in the Human Personality*, by Fritz Perls, Ralph Hefferline, and Paul Goodman, (hereinafter referred to as PHG, the book that introduced gestalt therapy itself in 1951), the reader is directed to enter this particular attitude toward the world:

> Try for a few minutes to make up a sentence stating what you are at this moment aware of. Begin each sentence with the words 'now' or 'at this moment' or 'here and now.' PHG, p. 31

This leads to a way of being open to experience itself now free of "about-isms," "should-isms" and other opinions that obscure a clear and direct experience of "what is" (PHG 1951, p.32).

This outlook, or approach (Perls, F., 1973), changes the simple commonplace chit-chat of everyday encounters in which the therapist and the patient negotiate the mundane mechanics of the start of the hour into a different kind of experience, which is the gestalt therapy experience proper itself. A gestalt therapy session, then, is within this changed "outlook" or "attitude" on experience changed from its original perspective, now cleared of pre-conceptions, or, at least with those pre-conceptions identified and consequently altered.

With that nearly trivial yet deceptively radical phrase[4], "here and now," Perls flips from a chit-chat attitude to a different way in which a person now views the immediate world of the therapy milieu itself. In an instant, assumptions and expectations about "here" are changed; notions of what is "now" are changed. The room defined by 4 walls, a ceiling and a floor becomes an as if new "place." A person is no longer at *this* street address and no longer in an hour measured by *that* clock. This "now" of the gestalt attitude is an "experiential now." It is a "passage," not the "now" of colloquial

[4] That is, if it is taken seriously and not as a cliché. When the phrase became gestalt therapy's calling card, it lost the power of its original intention.

language. This "here" is what is presented in a flowing now, transformed into a stream of experience along the "awareness-consciousness continuum." (Bloom, 2017) The office is no longer a Cartesian box, the therapy hour no longer the time ticked-off in minutes by the hands of a Cartesian clock. This now-and-here, this-now-and-here-with-the-therapist, is the situation of therapy set off from the ordinary or mundane and which has its own kind of sounds and light and sense –its own aesthetic of contacting (Bloom, 2003; Francesetti & Gecele, 2002, 2009). This is the aesthetic of the sensed, felt, relational atmosphere as the very plenum, the space of all space, of a gestalt psychotherapy session.

Yet, the actual or natural world in which the patient lives, breathes, functions, loves, and suffers has not been left behind. But the commonplace notions of that world are set aside, parenthesized, bracketed–not excluded–but importantly engaged within this new gestalt attitude. This new attitude is a modification of phenomenology's "natural attitude," as I will describe, below.

It is actually a misinterpretation of how gestalt therapy employs bracketing to assume that the bracket keeps the everyday world out of the therapy process and its appearance an "intrusion" on the work (for example, Mann, 2010). The organism/environment field, central to gestalt therapy, is indivisible. The very assumptions that are bracketed–or marked–are included in the contacting process, but payed attention to within this new, *gestalt attitude*. This has implications I will address below.

Gestalt therapy begins simply, as simply as the gesture of taking a moment to catch one's breath. A person crosses from one plane to another, from that of everyday natural life to that of special orientation of the therapy session, and in that second plane of the *gestalt therapy attitude* a person and the therapist meet at the contact-boundary. The ordinary and commonplace become a field of possibilities in which therapist and patient are co-engaged at the contact-boundary in the process of contacting. This world seen within a gestalt therapy attitude is one ripe with the potential clarity of extending moments of novelty and discovery–and for the surprise and wonder implicit in the process of contacting.

In this sense, whether they know it or not, all gestalt therapists practice some form of phenomenological psychotherapy. One way or another, it starts this way by entering of the *gestalt attitude* through the *gestalt therapy epoché*, a parallel, different, approach to Husserl's. I will explain.

Husserl's Phenomenology: Epoché, Bracketing, Reduction

If gestalt therapy proper begins at this moment, attention is directed away from the commonplace and to the experience of the phenomenal "here and now;" then, very simply and even more roughly, this also is the beginning of another parallel discipline.

Consider if following Fritz Perls's instruction to attend to the here and now, we

> .. begin our considerations with how human beings naturally live... in a *natural attitude*. I am conscious of a world spread out in space, endlessly becoming in time. [In]every moment of waking consciousness, I findmyself in relation to one and the same world though it is constantly changing... It is continuously on hand for me." *Ideas I* (Husserl, 2014, p 48. *emphasis added*)

This is the starting point of Edmund Husserl's phenomenology, which he begins with his famous *epoché.* It is crucial to note that Husserl also begins with what he calls the "world" or "natural world." (Husserl, 2014, pp.9 - 10,1913)

The epoché is an act that initiates bracketing and the *reduction* of this natural attitude to the *phenomenological attitude*. Each reduction is a turn away from experience and then a return to it with a new point of view or attitude. "Reduction" is derived from the Latin, "*reducere,* to return."

> The entire world posited in the *natural attitude*, the world actually found from the outset in experience, taken up perfectly in a "theory-free" way as it is actually experienced and clearly manifests itself in an experiential context, counts for us now is nothing. It is to be bracketed, untested but also uncontested.[5] Husserl 2014, p. 56 (*emphasis added*)

The beliefs laden contents of *natural attitude*, then, of bracketed, "put out of action." (Husserl, 2014. p. 55) We are now in what Husserl refers to as the "phenomenological attitude" within which we have adopted a phenomenological point of view. By bracketing, the natural attitude has been stripped off or "cleansed" of opinions, theories, assumptions and beliefs about the world. Likewise, perceptions and somatic experiences are consequently stripped off of judgments and beliefs about them. The embodied world of the senses and perception, kinesthetic and kinetic

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[5] It is misunderstanding to think that Husserl's method ever splits the phenomenal from the material or physical world. To be conscious is to be conscious of some *thing.* To perceive is to perceive some *thing.*

resonances (Frank, 2016) are here, of course, but importantly separated from presumptions about them. The body-as-object is now the body-as-lived. The phenomenological attitude is kept pure of all interest in the objective world. Yet it remains in the world. "We stress again and again. ...As an actuality, 'the' world is always there." (Husserl, 2014, p. 52.) This latter point is important since many mistakenly think that Husserl's method annihilates the concrete actual natural world.

There now are two follow moves in Husserl's method. The first is characteristic of "descriptive phenomenology." Free from interest in the objective world, the "ego" or "I" can reflectively observe and describe what remains as concrete contents of consciousness. From within this *phenomenological attitude*, the phenomenologist makes an additional move and turns away from the particulars of what is observed and by the technique of imaginative variation, contemplates ideal or pure forms derived from what had been described. This is the *eidetic attitude*. The phenomenologist freely contemplates various pure "possible matters of givenness" in order for their essential *universal* structures to emerge. Pure consciousness is thus explored and analyzed–yet, importantly, in the manner it is correlated to its objects. Within this attitude, the phenomenologist studies the transcendental ego, intentionalities, essences and so on. These are his reductions, his reflections back to bracketed experience from within different attitudes. This is obviously a compression of one version of Husserl's approach.

Gestalt Therapy and Husserl's Phenomenology: Reduction and Induction

There are parallels here with the "gestalt approach"; obviously, these parallel lines do not touch. Yet, they are so close they could be said to brush against each other. Psychology, a *science*, studied human behavior and the particular human psyche in the objective world. Time and again, Husserl underscored that as a *philosophy*, phenomenology was concerned with pure and universal forms of consciousness. Importantly, for Husserl these forms of pure consciousness were not disconnected from the objective world. Nevertheless, we gestalt therapists clearly have an importantly different focus. We practice psychotherapy. We deal with contacting–concrete actualities of our patients as experienced activities in the world, and not at all the ideal forms of pure consciousness.

Let me take this even further. By entering our *gestalt attitude*, we do not actually suspend the everyday world or even the bracketed commonplace aspects of that world itself, containing our beliefs, assumptions and pre-judgments, but *include* them within our "new way" of seeing. While we

enter the temporal passage of contacting as the phenomenal time of the therapy session, we are still within the concrete actuality of the therapy hour[6].

The *gestalt therapy attitude* parenthesizes, brackets, but does not, cannot, ignore or exclude everyday life. Instead of pure exploring experience "cleansed" of the assumptions that are part of the ordinary world while bracketed in our particular way, these assumptions are present, within the gestalt attitude, which is a "modified natural attitude" (Bloom, 2010). These assumptions are sometimes implicated in a person's suffering. Within the gestalt attitude, they become part of the contacting process and experienced differently. These are not only assumptions, or understandings or fixed patterns or gestalts. They are embodied or postural habits. They are styles of movement. The brackets of the *gestalt epoché* are like the parentheses in a mathematical equation that do not take that which they bracket out of play but organize them for new functions within the equation itself. Our clinical method, then, creates an opening to the structure of a person's embodied actual, engaged, and practical experiences in such a particular way that fixed gestalts disrupting the flow of experience and causing a person's distress may emerge or become apparent–and resolved.

In short, by bracketing the everyday and commonplace, we as if mark them for consideration in a new way. The mundane and fixed attitudes are not left behind and then returned to as in the phenomenological reduction but are included as part of the emerging figure. Rather, by what is better called the *gestalt therapy induction,*[7] not reduction, a "leading *into*" rather than a "returning to," our attention opens to the contact-boundary of the wide horizon of the organism/environment field and the possibilities of the emerging figures of contacting. New figures can then emerge with renewed clarity and fluidity as possibilities spread out and drawn forward from a past to a future. Dramatically, the gestalt therapy epoché excludes nothing from the gestalt attitude. Patient and therapist are co-participants as well. Fritz

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[6] A clear sense that the session will begin and end at a time-certain is part of the concrete structure that supports the therapy itself.

[7] Martin Heidegger was Husserl's most important student. In an early criticism of his mentor, he argued that since it is impossible to separate oneself from the world, bracketing actually bracketed nothing at all. The reduction as a "return" to what remains after bracketing is meaningless since one cannot return to what one never left. In his unpublished draft for Husserl's 1927 *Encyclopedia Britannica* entry, he proposed that rather than a "reduction," the phenomenologist exercises an "induction." Then the phenomenologist remains close to experience and in-the-world. The "induction" is a radical opening to what already is and, further to "immanent possibilities." (Sheehan, p. 70)

Perl's famous instruction to turn attention to the "here and now" as if conjures up the gestalt attitude as a different orientation to what is, was, and will be. In this way, gestalt therapy is a therapy of the ordinary (I. From, personal communication) transformed into the extraordinary. This ordinary is turned extraordinary by a process that *leads to* the structure of experience in contacting, the gestalt therapy induction.[8]

Husserl's Phenomenology: The Life-World

Although not generally paid attention to by gestalt therapy, Husserl was also concerned with embodiment, empathy, intersubjectivity, time, and history. He took up and developed a concept from the German *life-philos*ophy of Wilhelm Dilthey (1833-1911), the *Lebenswelt*, the life-world. I will draw this into my discussion of intersecting parallel lines.

As Husserl describes it,

> The life-world is the natural world in the attitude of natural life we are living functioning subjects together in an open circle of other functioning subjects. Everything Objective about the life-world is subjective givenness, our possession, mine, the other's, and everyone's together. ... [W]hat is lived is lived experience of the surrounding world, and that holds also for what is seen and thought, etc. (Husserl, 1989, p. 385)

The life-world is the actuality of life, the world in which we are already living. It is the "*founding*" pre-given and given world, which constitutes the absolute horizon or background of a person's lived-experience, the horizon of all horizons upon which all else is "*founded*" (Husserl, 1970). It is the world that is left behind after *epoché*. His student, Aron Gurwitsch (1901-1973), writes that it is

> the universal scene of our life. The soil, so to speak, upon which all human activities, productions and creations take place, the world of common experience., G 35... our cultural world, which is our life-world, a world apperceived, [perceived and assimilated] apprehended, and interpreted in a specific way. (Gurwitsch, 1970, p.52)

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[8] Whereas, at least insofar as Husserlian phenomenology is concerned, in phenomenology is *selbstverständlich* (self-understandable) is rendered *verständlisch* (understandable). Gestalt therapy's understanding is emergent of contacting and, as such, implicitly has the halo of the extraordinary surrounding it.

It consists of history, culture, society and so on– and all the concrete, including natural things upon which life depends and which structure our sociality, subjectivity, and intersubjectivity (Steinbock, 1995).

Husserl refers to the life-world as the totality of our subjective world and the all-encompassing we-world, stretching backwards in time to our shared culture and history, laterally as our societies, and forward in our experiences of the future. It includes the natural world as well. It is the sphere of humanness.

Life-world and attitude. As seem above, the natural and phenomenological attitudes are important to the gestalt and phenomenological approaches. There are other important attitudes, which, I propose, may illuminate the theory/practice of gestalt therapy.

"Attitudes" are ways our interests are organized in our particular approaches to the life-world (Luft, 1998; Husserl, 1998).

> We constantly find ourselves as persons living in the personal world, [of the life-world] and so do the natural scientists, even in the very activity of natural science" it is just that their focus is directed exclusively to physical or zoological nature. (Husserl, 1989, p. 302 n 1)

The sciences, including empirical psychology and non-experiential psychotherapy, are of the life-world, yet their interests have a particular organization. They are aspects of the "natural*istic* attitude" (Husserl, 2000, p.190 (*emphasis added*), and this actually is a limited point of view.

> Even the most subtle theory in natural science does not touch the life-world because the scientist follows a theoretical path ***away from the actuality of life***, leaving it behind right at the beginning, and only reverting back to it in the form of technology. (Husserl, 1989, p.384 *emphasis added)*

This is the attitude within which the life-world is "measured," "mathematized," and "thematized." This is also known as the "scientistic attitude."

Husserl proposed other attitudes from which we "see" or organize our interest in the world. They are "vocational attitudes." For example, accountants view the life-world from with the "accountant attitude," carpenters view the life-world in the carpenter's attitude, psychologists have the "psychological attitude" (Husserl 1970; Husserl 1989). Neuroscientists would have the neuroscientific attitude. Writers of chapters for books have a writer attitude and so on.

These are all "paths away from the actuality of life" to study them in particular ways. This is necessary. Their danger is in losing that very actuality of the life-world. Husserl proposed another attitude, the

"personalistic attitude" as the approach that remains close to this actuality. In this attitude, we view the life-world from *within it*, from within our very own subjectivity. This is "the attitude we are always in when we live with one another, talk to one another, shake hands with one another" (Husserl, 1989, p. 192). We are persons who see others as persons and our self as a person among persons, selves among selves.

The gestalt therapy attitude is a personalistic attitude par excellence.[9] It is within the gestalt attitude as a personalistic attitude that we, *therapist and patient,* organize our interests as persons with heightened attention to the contact-boundary–a phenomenal location impossible to measure. This contact-boundary is where we are open to the developing figure/ground process, experienceable as emergent of the otherwise unnoticed "actuality of life." This is a process of the organism/environment field.

Expanding Gestalt Therapy at the Crossing: Environment as Life-World

Yet is "environment," of the organism/environment field, sufficient home for this actuality of life, of what is to be a whole person oriented within the personalistic? Or is it a better descriptor for the naturalistic attitude?

Each of us is a biological organism sustained by the resources of our environment. Air, food, shelter. The hard, actual ground supports our stride from here to there and allows us to maintain our balance against gravity. It is the climate--hot, cold, dry, wet. It is the natural surround that sustains all living species. The environment in this regard is inextricably linked to the survival of organisms. While this is an environment common to human others, it is nevertheless uniquely each of ours. We cannot taste the food in another's mouth or be nourished by what another eats or rested by another's sleep. We bite and chew (Perls, 1992). We aggress the environment and destroy in order to meet our particular biological and material needs.[10] As Perls and Goodman put it, we are animals "freely roaming in the environment" (Perls et al, 1951, p.262).

Obviously, this is not all we are. We human beings are affected by gravity and immutable hard facts of the material world. There is more. There is the human other: we love and are loved, touch and are touched, hate and are hated. We are warmed by the sun and also weep at the beauty of a sunset.

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[9] It is by no means the only psychotherapy within the personalistic attitude. Gestalt therapy exceptionalism is loathsome.

[10] We also cooperate in finding food, shelter and so on for one another.

We are born into families and live in societies. We are organisms and also human persons in communities, sharing histories, cultures, memories, dreams, hopes, and plans for the future. Insofar as gestalt therapy has been concerned, the term "environment" has been sufficient to describe this world. But, does the term that describes the milieu of the hungry animal satisfying individual needs mean the same as persons-in-relationship or contacting itself in its most enchanting and fulfilling sense? By crossing another line of phenomenology with gestalt therapy, I will suggest an alternative–the environment as life-world.

The life-world is subjective and at the same time is the objective, actual world of living where persons know persons, empathically, relationally, and within communities. We approach each person from a felt sense of presence as co-dwellers of the same human world, not only as animals sharing a physical environment.

We are organisms functioning within the environmental conditions that shapes and sustain life. We are *living beings* among *material things.* Contacting is of the organism/environment field. Yet human beings are more than this. We are sensing animals-thinking persons. Human beings as persons live and experience one another in the life-world, organized and co-constructed in contacting, which has an historical, social, and inter-personal fabric. The life-world includes whatever else is meant by "environment." The environment as life-world is where we dwell as persons, not only survive as organisms. Gestalt therapy, then, is a psychotherapy of the *organism/environment-life-world field.* By transposing the organism/environment field into a phenomenological key, as we practice within the personalistic gestalt attitude, gestalt therapy is vaccinated against any possibility of biological or physicalist reductionism.

But this does not mean that as clinical phenomenologists we are at sea in an ocean of untethered phenomena. The phenomenal figures emerging forth from the contact-boundary of the life-world are those of actual living. Contacting is engaging with the world. Contacting is contacting some-thing. As animal organisms we contact that which supports our life–the air we breathe, the nutrients that nourish us. Sentient, we contact our surroundings; we are sensorically and kinesthetically alert to our situation (Robine, 2011). And as sapient, knowing persons, we are present as the whole contacting process (Bloom, 2017).

Yet each of us is an experiencing "subject" in a phenomenal world that cannot be simply organized as "subject" and "object." We are implicated in the experience of the other–these phenomenal qualities of the contact-boundary. All of this has implications for gestalt therapy and phenomenological research, addressed elsewhere in this volume.

Staying within the Husserlian frame of this chapter, the observers or researchers need to be sensitive to the difference between "nature," which is customarily ensnared by the themes and presumptions of the scientists' "naturalistic attitude," and the life-world where life is actually lived. That is, scientists need to recognize that their work in their "scientistic attitude" is itself founded on the life-world. Their interest, their attitude, needs to be organized in such a way as to gain ever more precise understanding of life as it is actually lived rather than continuing the development of their experience-distant abstractions (Husserl, 1970). To the extent that modern science embraces "falsification," and even declares itself post-positivist, it already shows evidence of this. Husserl's repeated support for the development of phenomenological psychology supports the serious scientific study of human experience. This chapter's focus is on gestalt therapy as a phenomenological psychotherapy practice that attends to emerging figures of contact and their qualities in the material, actual, world.

At the intersections with phenomenology I described, gestalt therapy's lens has a new optics.

> *The phenomenological world is ...the sense that shines forth at the intersection of my experiences and at the intersection of my experiences with those of others..*
>
> Merleau-Ponty (2012, xxiv)

Part Two: Clinical Application and Discussion

Let me briefly summarize the gestalt phenomenological approach presented above.

A clinical hour begins as the therapist and patient greet one another, perhaps comment about the day, or address practical concerns relating to the session. This is average everydayness of ordinary life, unavoidable, inevitable, and necessary.

The gestalt therapy session proper begins:

1. The *gestalt epoché*: bracketing

The everyday world is bracketed whether introduced by glance, silence, or the therapist's comment/question, these everyday interactions stop and their attention turns to the moment.

This is the *gestalt attitude,* a personalistic attitude

The office as everyday place becomes the phenomenal open experiential "terrain" of the life-world.

2. *Gestalt epoché*: gestalt induction

By experiment, suggestion, dialogue, and so on, attention is directed to lived-experience–the contact-boundary and therefore the "extraordinary" process of the sequence of contacting of the organism/environment-life-world field. This is the core of gestalt therapy.

George, The Muffled Song of Terror

A friend of his with whom I had been working referred George to me. He is in his late 60's. George was lonely and chronically sad. He lives with a friend who once was a romantic partner many years ago. George is always somewhat fearful. He is a classical singer in a famous chorus. He gets frightened when he sings solo or notes at the top of his range. He says he is frightened of change or of doing anything different.

He is usually dressed for colder weather than it is, wears a scarf with every jacket, carries an umbrella whenever it was cloudy. I've worked with him for 2 years.

He is always early. Sometimes he buzzes to let himself in some 20 minutes before the last session has ended. He says he likes to be early to sit in my waiting room.

When he comes into my office proper, he asks me, "Are you ok?" as always and smiles when I say "yes," as always.

He sits down, adjusts himself on the couch, looks around as I make sure my phone is on mute. These are the ordinary tasks of everydayness that are the start of an office visit.

"Go to any operas?" He knows I go to the opera. He asks because he sings in the opera chorus. This is part of our greeting, part of the ritual everydayness.

3. *Gestalt epoché: bracketing and the gestalt attitude*

I take a breath. He notices and takes a breath. Silence and time.

"How are you, George?" He recognizes this as my punctuation that separates the everyday greeting from the deeper how of this moment.

"I don't know. I feel kind of sad now."

In the sequence of contacting model, this is, roughly, fore contacting as the felt sense of the situation comes into awareness. This experience is only apparent in the gestalt attitude.

4. *Gestalt epoché: induction and life-world*

"What is it like for you to be sad, George? Can you pay attention to just how and where you experience that feeling? What you are sensing?"

He is quiet. I see his eyes twitch.

"Can you pay some attention to your eyes... ?"

"Um... " He moves in the chair.

"I am getting scared."

"Let's take a moment and sense if your feet are on the floor? Now if your butt is on the chair. How your weight is supported. And now, let's both look around the room and get a sense of this place."

"Okay, now I feel less scared, but I am still uneasy."

"Would you be willing try something out?"

"Maybe, what is it?"

"If you're ok with it, I'd like you to close your eyes and pay close attention to what you might be sensing.... feeling. And if you notice that fear, allow yourself to pay more attention to it."

"Ok..."

The soft sound of breathing and then shorter breaths.

"I feel really scared, Dan,"

"Can you let your fear talk? What would it say, out loud?

"BE CAREFUL, GEORGE, IT'S DANGEROUS... I feel like a little boy now." He opens his eyes. "That's what mama always said to me. She said it was dangerous. She always double locked the door. She was scared. I remember her crying...."

"She grew up in Poland. She said the women could be raped. She heard of it. She said we lived in a dangerous neighborhood, and I could get hurt. They all hated Jews. I don't even think she left the house much after papa died."

He has tears in his eyes.

"She was always scared... Could she have made me scared?"

Silence.

He catches his breath.

"So, I am scared, and she is terrified..."

"You live in New York and she lives as if she is still in Poland?"

George shudders.

"Poor mama," he says sadly. "But she is gone now."

In the gestalt induction George's and my attention were directed to what emerged within the gestalt attitude. I immediately directed his attention to what he called "sadness," which in this attitude we no longer take for granted. Sadness develops into fear.

When I ask George to experience his weight on the floor and chair, to look around the room now, within the gestalt attitude, I am proposing he experience the *life-world*, the world of his lived experience. His experienced body and the life-world are the very framework of support for contacting that might enable him to tolerate this fear.

It is easy to track the developing sequence of contacting in the session from fore contacting to contacting to final contact. It is straightforward to observe self-process, as well, as self develops the "id," or it, of the situation (Robine, 2011) through the agency of "ego" or "I functioning" in which George identifies, chooses, rejects, understands, comes clearer and clearer into awareness-consciousness, and personality functioning, as the larger personal sense of who he is and what things mean to him contextualize his experience, and relational function as he further organizes towards and with the other (Perls, et al., 1951; Spagnuolo Lobb, 2013, 2016; Bloom, 2016). These are traditionally understood in terms of the organism/environment field.

George's mother could be understood to be part of this field–the social field, part of the environment. Or George's mother could be understood phenomenologically as being of the life-world, the very experiential surround that sustains George and is the domain for the actuality of life. As I described above, the life-world is peopled by our past, filled with culture and history wound together in a fabric of (inter)personhood. In our clinical work, we gain access to the life-world in the gestalt attitude and explore its landscape through the induction. George lives in New York City. Yet his life-world includes the time-distant Poland of his mother. He lives in the safety of a modern urban environment, but also in the life-world endangered by murderous anti-Semites. He is able to contact this within the gestalt therapy attitude.

In a more widely followed gestalt therapy understanding, George might be understood to have introjected his mother's terror or some aspects of her. His contacting would be from within the shadow of the introjecting, with a repeating fixed gestalt preserving his unaware relationship to his childhood mother. Further, his habit of asking me if I am ok suggests the wide expanse of confluence which gathers into his frightened orbit everything around him. Or it may suggest a projection onto me of his own fragile-boyhood, which then brings forth his maternal caretaking of me.[11] After all, he and I are co-domiciled of the life-world. He asks and then is comforted that I am ok. Yet I experience his question as genuine; his eyes are warm, the smile on his face gentle, as our gazes touch. This leads me to wonder if the confluence/introjection model in this instance is incomplete.

To think of George's fear as an introjection of his mother's terror is to extract George and his mother from the life-world. George and his mother, New York of today, New York of his childhood, Poland of his mother's

[11] Or it may suggest a reaction formation of his rage at being infantilized by his mother now turned into an excess of caring. There are many possibilities.

childhood are overlapping temporal dimensions of the life-world. George dwells in this life-world insofar as it sustains his personhood, much as the physical environment maintains his life. The structure of the life-world becomes clear in the gestalt attitude.

The example above is an extended moment of one session. The themes that were emergent returned over a number of sessions. George's fears diminished. Eventually, his mother's terror receded from his experience and he could sing the fullest extension of his range, hitting the highest note he cared to make. That is, he could take a stand on the terrain of the life-world unshadowed by terrors not his own. His highest notes broke through the low roofs of the village where his mother once lived and that he carried along with him, unaware, wherever he travelled.

Conclusion

Gestalt approach, epoché, bracketing, induction, organism/environment-life-world are new ways to look at our work. Yet it is work we already do. When all is said and done, we gestalt therapists gather to ourselves the best of our training, best of our clinical wisdom, the best of our thoughtful understanding, and fold these into our sense of ourselves–our values, knowledge, personhood–and engage our patients with us in a therapy process that we have confidence will do good. That said, there are differences in our approaches, differences in how and what we see when we meet our patients. Bundled together, our approaches constitute the diverse practices of gestalt therapy. Whether we know it or not, to the extent we are concerned with contacting and, accordingly, with the structure and process of experience, each of us practices a phenomenological psychotherapy; whether we know it or not, our work parallels and crosses parallels with some useful concepts from phenomenology.

I hope by making some of this explicit, I have brought our own particular phenomenological approach to the foreground. How we remain committed to contacting and, as such, to disclosing the structure of experience, in all its creative-adjustings, aesthetic qualities and wonder, are the measure of how we maintain our identity–and effectiveness–as a psychotherapy. This chapter emerged from this commitment.

References

Bloom, D, (2003), "Tiger! Tiger! Burning bright"–Aesthetic values as clinical values. In M. Spagnuolo Lobb & N. Amendt-Lyon (Eds.) *Creative license: The art of gestalt therapy.* (pp. 63-78). New York, Vienna: Springer-Verlag.

Bloom D. (2010). The phenomenological method of gestalt therapy: Revisiting Husserl to find the essence of gestalt therapy, "*Gestalt Review*, 13(2), 277-295.

Bloom, D. (2011). "One good turn deserves another." *Gestalt Review*. 15(3).

Bloom, D. (2013). "Reflection: In dialogue with Philip Lichtenberg's 'inclusive and exclusive aggression:' A window to the next resistance." *Gestalt Review*, 17(3), 284–288.

Bloom, D, (2017) The relational function of self: Self on the most human plane. In J-M Robine (Ed.), *Self, a polyphony of contemporary gestalt therapists*, pp 65-84. St Romain La Virvée, Fr: L'Exprimerie.

Carman, T, (2008) *Merleau-Ponty*. Routledge: London and NY.

Crocker S. (2009), Phenomenology in Husserl and in gestalt therapy. *British Gestalt Journal*, 18(1), 18-28.

Francesetti, G. & Gecele, M., (2002). Psychopathology and diagnosis." In *British Gestalt Journa*l, 18(2), 5-20.

Francesetti, G., & Gecele, M. (2009). A gestalt therapy perspective on psychopathology and diagnosis. *British Gestalt Journal, 18*(2), 5 - 20.

Francesetti, G., Gecele M., Roubal, J. (2013) (Eds.) *Gestalt therapy in clinical practice: from psychopathology to the aesthetics of contact.* (pp. 131-145). Milan, It: FrancoAngeli.

Frank, R. (2016). Self in motion. In J-M Robine (Ed.) *Self, a polyphony of contemporary Gestalt Therapists,* pp. 371-387. St Romaine de Virvée, France: L'Exprimerie.

Gurwitsch, A. (1970). Problems of the life-world. In M. Natanson (Ed.) *Phenomenology and social reality, essays in memory of Alfred Schutz,* pp. 35-61. The Hague: Martinus NijHoff

Gurwitsch, A. (1974), The lifeworld and the phenomenological theory of science. In L. Embray (Ed.) *Phenomenology and the theory of the social sciences*, pp. 3-32. Evanston, IL: Northwestern University Press.

Heidegger, M., Macquarrie & Robinson, (Trans) (1927/1962). *Being and time.* New York: Harper & Row

Husserl E. (2014), (Dahlstrom, D. Trans.) *Ideas for a pure phenomenology and phenomenological philosophy*
Indianapolis, Ind: Hackett.

Husserl. E, (Carr, D, trans) (1970) *The crisis of European sciences and transcendental phenomenology.* Evanston, IL: Northwestern University Press.

Husserl, E. (Rojcewicz & Schuwer Trans) (1989) *Ideas pertaining to a pure phenomenology and to a phenomenological philosophy, second book.* Dordrechct, NE: Klewer Academic Publ.

Luft, S. (1998), Husserl's philosophy discovery of the natural attitude. Continental Philosophy Review 21, 153-170

Mann, D. (2010) *Gestalt therapy, 10 key points and techniques.* London: Routledge.

Merleau-Ponty, M. (Landes, D. trans) (2012). *Phenomenology of perception.* New York: Routledge.

McConville, M. (2001). Let the straw man speak: Husserl's phenomenology in context. *Gestalt Review,* 5(3), 195-205.

Nietzsche, F. (1997) Untimely Meditations II. In D. Breaseale & RJ Hollingdale (Eds.) *The uses and disadvantage of history,* p, 57. Cambridge, UK: Cambridge University Press.

Perls, F. (1947/1992) *Ego, hunger, and aggression.* Goldsboro, ME: Gestalt Journal Press.

Perls, F. S. (1973). *The gestalt approach & eye witness to therapy.* Palo Alto, CA: Science & Behavior

Perls F., Hefferline R.F., Goodman P. (1951), *Gestalt therapy: excitement and growth in the human personality.* Goldsboro, ME: Gestalt Journal Press.

Yontef, G. (1993). *Awareness, dialogue and process: Essays on gestalt therapy.* Highland, NY, Gestalt Journal Press.

Sheehan, T, (1997) Introduction. In *Psychological and transcendental phenomenology and the confrontation with Heidegger,* (1927-1931). New York, NY: Springer.

Robine, J.-M. (2003). Intentionality in flesh and blood: Toward a psychopathology of fore-contacting. *International Gestalt Journal,* 26(2), 85-110.

Robine, J-M, (2011) From field to situation. In *On the occasion of the other,* pp. 103-121. Goldsboro, ME: Gestalt Journal Press.

Spagnuolo Lobb M. (2003) (tr. it. 2007). Therapeutic meeting as improvisational co-creation. In M. Spagnuolo Lobb & N. Amendt-Lyon (Eds.). *Creative license: The art of gestalt therapy,*), pp. 37-49. Vienna and New York: Springer.

Spagnuolo Lobb, M. (2010). The therapeutic relationship in gestalt therapy. In R. Hycner & L. Jacobs (Eds), *Relational approaches in gestalt*

*th*erapy, pp. 111-129. New York, NY: Gestalt Press/Routledge, Taylor and Francis Group.

Spagnuolo-Lobb, M. (2013a) *The now-for-next gestalt therapy recounted in post-modern society*. Milano, IT: FrancoAngeli

Spagnuolo-Lobb, M. (2013b) Fundamentals and development of gestalt therapy in the contemporary context. In G. Francesetti, M. Gecele, & J. Roubal (Eds.) *Gestalt therapy in clinical practice: From psychopathology to the aesthetics of contact, pp. 27-55.* Milano, IT: FrancoAngeli

Spagnuolo-Lobb, M. (2016). Self as contact, contact as self. A contribution to ground experience in gestalt therapy theory of self. In J-M Robine (Ed.) *Self: A polyphony of contemporary gestalt therapists,* pp. 261-289. St. Romain la Virvée, France: L'Exprimerie.

Steinbock, A. (1995) *Home and beyond: Generative phenomenology after Husserl.* Evanston, IL: Northwestern University Press.

Yontef, G. (1993). *Awareness, dialogue and process: Essays on gestalt therapy.* Highland, NY: Gestalt Journal Press.

Zahavi, D. (2003). *Husserl's phenomenology.* Stanford, CA: Stanford Univeristy Press.

CHAPTER NINE

RELATIONALITY AND RELATIONAL PROCESS IN GESTALT THERAPY

LYNNE JACOBS, PH.D.

> The point is to travel the way which lies between us. The obstacles from here and from there are the same, the distance is the same from me to him, as from him to me.
>
> Letter from Hans Trub to Martin Buber, 1926 (Agassi, 1999: 163)

It all began for me in 1970. Or was it 1971? I was in college, a paraprofessional volunteer at a local free clinic. I was co-leading group therapy alongside a volunteer psychiatrist. I picked up a copy of the book, *Gestalt Therapy Verbatim*, and my long love affair with Gestalt therapy began. What attracted me viscerally was the focus on immediate experience, contact and the therapist's presence. Those three elements, especially the therapist's presence and willingness to meet and be met, person-to-person, shown guiding lights into the darkness that was my isolation.

Gestalt Therapy is a Relational Process

I am one among many therapists who have focused on elaborating on the foundational relationality of our theory and on its implications for the practice of gestalt therapy. Considerations of the relational perspective on gestalt therapy have three major dimensions. The first is the foundational relationality of gestalt therapy (among many other contemporary psychotherapy theories). The second dimension is that of the ethical implications of a relational perspective. The third dimension is an elaboration of relational processes and their significance as they occur in Gestalt therapy.

I shall write about all three dimensions, starting with the most abstract: the foundational relationality of gestalt therapy. I shall then move on to the other two dimensions, both of which are "closer to the ground." They address more directly the therapeutic process. Readers who prefer more

direct experience before contextualizing the experience in the more abstract theory might want to skim the first section lightly, and then return to it after reading the later section of the chapter.

Foundational Relationality

Frank-M. Staemmler (2016) traced the arc of the movement from our original individualistic ethos to the relational ethos of today, and then the movement from a "weak relationality," (self-in-relation), to more radical, or "strong relationality" (relationship as constitutive) (ibid pp. 8-9). Despite some remarkable–for their time–post-Cartesian ideas in our founding text, *Gestalt Therapy* (Perls, Hefferline, & Goodman, 1994), Fritz Perls' individualistic style of clinical demonstration, which popularized gestalt therapy, dominated the scene in the early years, eclipsing the more subtle relational style that Laura Perls, her students, and the Polsters and some of their colleagues from a Cleveland study group preferred. Fritz Perls' style was not an inevitable outgrowth of the theory that he, Laura, Paul Goodman and others were developing, but it fit the *zeitgeist* of the time (Ibid p. 4; Bowman, 2005).

In fact, the evidence of radical relationality in the founding text, *Gestalt Therapy*, is shown in the following quotes:

> It is the contact that is the simplest and first reality. (Perls et al., p. 227) …the definition of an animal involves its environment: it is meaningless to define a breather without air, a walker with-out gravity and ground, and so on, for every animal function. The definition of an organism is the definition of an organism/environment field. (*ibid*., pp. 258f.) …Social relations, like dependency, communication, imitation, object-love, are original in any human field, long prior to one's recognizing oneself as an idiosyncratic person. (Ibid p. 320).

In the '80's and '90's, publications by Rich Hycner and myself (1995), and Gary Yontef (1998), among others, initiated a more concerted focus on the therapy relationship and its essential role in gestalt therapy. Since that relational turn–which began for Hycner, Yontef and myself with an integration of Martin Buber's philosophy of dialogue into gestalt therapy–other explorations of the relationality of gestalt therapy (and the implications of the inherent relationality of human existence) have held a central place in gestalt therapy theory development. Some of the theorists who have tackled the subject are Bloom (2016), Brownell (2010), Fairfield and O'Shea (2008), Francessetti *et al (2014)*, Phillipson (2001), Robine (2016), Spagnuolo-Lobb (2013), Staemmler (2016), and Wheeler (2000).

Some of the explorations have drawn centrally on our field theory roots, others on contacting and our roots in phenomenology.[1] Of course, many other therapy modalities have made a relational turn as well, and insights from many other sources have informed some of the thinking of many gestalt therapists, for instance, Jacobs, (1992) Zahm and Breshgold (1992), and Taylor (2014) among many others.

No matter what influences extend our understanding of the radical relationality put forward by the theories of self and of contact, the embeddedness of gestalt theory in concepts of phenomenology and holism and field theory put forward by PHG, be they; the philosophy of Buber and others of 'dialogicality,'[2] attachment theory, neurobiology, non-linear dynamic systems theory, psychoanalytic intersubjective system theory, etc., all the approaches to relationality share some common precepts (some of what follows is taken from Jacobs, 2009):

1. First and foremost, our relationality is irreducible. Our relatedness in our environment and with each other does not begin with us as separate selves, with relatedness being an "add-on." This is the "strong relationality." Our very existence is utterly, thoroughly context-dependent, and our worlds of experience are emergent from our contexts. We have no experience that is prior to relatedness. As Merleau-Ponty has demonstrated is his writings on corporeality, we are born into a world "always already there" (Taylor, 1989). I am reminded of Peter Philippson's invocation of the Escher drawing in which who is drawing whom cannot be discerned (2001). Every experience we have is co-emergent from what I bring and what you bring, along with our setting, our task, and other aspects that go into comprising our situation. Your world of experience and action and mine are utterly interdependent. We constitute each other.
2. We are all more alike than not. We come into being in the shared context of being human: of using meaningful language, of physicality, of a neuronal readiness and capacity to resonate and respond to each other and to new emotional experiences.

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[1] While the many authors explore the inherent relationality of self-as-emergent, each author has a slightly different approach to understanding the significance of a contextually emergent, as opposed to a Cartesian, self. For instance, Robine does not focus on relationality, *per se*, but rather on moments of contact.

[2] For a description of "dialogicality" as an ontological foundation, which includes the thinking of the American Pragmatists who influenced Paul Goodman, see Staemmler, 2016.)

3. While our commonalities make connection possible, our individuality (or individual expressiveness in a given situation) makes connecting interesting, novel and provides us a chance to learn something new, to develop, to expand our experiential horizons. This is the essence of contacting. Contacting and growth are inescapably intertwined. There is not one without the other. All contacting is growth. We might better say, contacting is constitutive. We are called into contact, and we call others into contact. We are called into being, and call others into being.
4. And paradoxically, *our uniqueness is also an emergent configuration that points to our shared humanity.* On the one hand our mutually shared human situation puts us in a more common position than otherwise, despite whatever differences of language, culture and personal narratives we have. On the other hand, each person carries a way of being that emphasizes a different aspect of our humanity, and thus anyone with whom we come into contact gives us the gift of enriching our ground. They broaden our own human possibilities as well.
5. Our sense of self, including such dimensions as: sense of agency, emotional capacities, even individuation and differentiation, our capacity for intimacy, is contingent, dependent on our developmental and our immediate emotional contexts. This means not just that we are all interrelated, but that the quality of our self-functioning, and most importantly, our developmental possibilities, depends on our relational/contextual supports.
6. We are always reacting and responding to each other. This is inescapable, unavoidable. Every act we initiate is always also a response or reaction to our situation.
7. Mutual co-regulation is an on-going and unavoidable phenomenon. In all contacting there is a reconfiguration of the person/environment field, and that reconfiguration is mutual. That is, we who are "environment" for each other are reconfiguring/being reconfigured with each other. This is happening in the smallest of moments, as when two people shift slightly, perhaps without awareness, to accommodate each other on a sidewalk. Gestalt therapists pay close attention to their body sensations, in part based on the recognition that our bodies are coordinating with each other all the time. When my patient tightens his breathing, I notice I do as well. When I consciously attend to deepening my breathing, my patient's breathing undergoes a change.

8. When we are in relationships, in the repeated contacting patterns, we constitute *identities* with each other:
   "we... *become* somebody. That is, we come to play a certain part or adopt a certain identity. With my mother, I come into being as a child; with my children I come into being as a parent, and so on. Each relationship will bring me into being as a certain sort of person, and the actions that I acquire will enter the repository of potentials for future use" (Gergen, 2009, p. 136).
9. Finally, the co-regulation and co-emergence, and even co-constitution come together (the simultaneity of the strong and weak relationality) *intentionally* in dialogue, for example, when Hans Georg Gadamer asserts,
   "To reach an understanding in a dialogue is not merely a matter of putting oneself forward and successfully asserting one's own point of view, but being transformed into a communion in which we do not remain what we were" (1989, p. 379)

Ethical Implications of a Relational Perspective

The premises of co-regulation and co-emergence, that we are all emergent within our world of both human and nonhuman contacting and relatedness, (the premises of strong relationality) begs the question of our ethical responsibility to each other. Clinically, the premise of strong relationality places the therapeutic relationship into an inescapably ethical context. We are intimately involved in the experiential world of other vulnerable people who entrust themselves to us.

I draw inspiration–as did Laura Perls (see Amendt-Lyon, 2016)–from Martin Buber's philosophy of dialogue, in which he emphasizes that:

> Man wishes to be confirmed in his being by man, and wishes to have a presence in the being of the other. The human person needs confirmation because man as Man needs it...secretly and bashfully [man] watches for a Yes which allows him to be and which can come to him only from one human person to another. It is from one man to another that the heavenly bread of self-being is passed. (Buber 1965b, p.71)

> Buber describes such things as a "surrender" to what emerges between us, to a "full-bodied turning towards the other," and to "courting surprise." (Agassi, 1999, pp 3-21)

My ethical responsibility as a therapist is to adopt a dialogic attitude. In this attitude, I recognize that my patient and I can further develop our creativity and spontaneity and expand our range of contacting and new

relational possibilities, if we do so together. Whatever problems inhere in our relationship are *our* problems, not the patient's problem nor my problem, but ours together.

Hans Georg Gadamer (1989) noted that in genuine dialogue, even the most absurd utterance that a person may make requires us to strive to understand how that utterance makes perfect sense from the perspective of the speaker. He refers to "under-going the situation" together. He recommends that we take the most absurd utterances and try to understand them as the speech of a reasonable person. From a relational perspective I suggest that the utterance emerges from our shared world. That is, in the clinical situation every utterance, every thought, feeling, sensation, every movement that happens in our consulting rooms is variably mutually influenced (and influencing).

Engaging another in dialogue accords the other a respect and dignity that confirms him. Buber asserted that psychological suffering was a direct result of being alienated from dialogic relations. In writing about psychological problems, he said, "sicknesses of the soul are sicknesses of relationship" (1969, p. 150).

These assertions linking dialogue with human dignity match nicely with the therapeutic orientation that Arnie Beisser introduced us to after some years of friendship and colleagueship with Fritz Perls, "the paradoxical theory of change" (2004). Beisser's simple assertion is that change occurs not by trying to become different, but rather by contact with your present existence. Your existence is always moving and changing, and the principle of pragnanz suggests that you are always solving your problems, resolving your Gestalten with the best form possible given the resources that are available. Thus, identifying with your existence as it is–moving and changing–allows the growth and development that is possible.

As therapists, we are one of the resources for the patient. Our presence and our willingness to meet the patient without aiming at changing them, are crucial supports, however challenging it may also be for both of us. Zinker, an early gestalt therapist, wrote of presence in a way that clearly intertwines presence as ethic and practice. He described deep, full breathing, a sense of being grounded, diffuse attentiveness and readiness to respond, lack of judgment and evaluation (1987). This is an aspect of a dialogic attitude and the paradoxical theory of change. It supports the therapist to meet the patient without trying to move the patient.

In the paradoxical theory of change, ethical implications and clinical implications of our foundational relationality come together. By surrendering to emergence and dialogue–by letting go of trying to aim at an outcome and by letting ourselves be affected by the dialogue–I believe we are confirming

the patient's dignity while at the same time supporting therapeutic conditions that facilitate contacting in the service of the now-for-next that is the moment-by-moment developmental process.

With Relationality in Mind: What Does It Mean to Practice with a Relational Perspective on Gestalt Therapy?

This will involve a consideration of the basic orientation, the adoption of a dialogic attitude, the use of embodied dialogue, and the provision of support.

Basic Orientation

My starting place for practicing with relationality in mind is to pay attention to my participation in the relationship that exists between me and my patient. The following questions hover; is my presence in this moment facilitating the dialogue with the patient (facilitating the development of presence, of contacting and awareness)? Is my engagement facilitating the patient gaining access to their experience? Or is my engagement inhibiting the patient's flow of their emotional life and access to their experience? Am I inhibiting dialogue with the patient? Much of time my questions are self-reflections. Occasionally they become conversational fodder, most especially when I think that my way of being with the patient is inhibiting our dialogue, and I want to explore together how I am contributing to our difficulty.

There are two corollaries to my attention to my participation in the relationship. The first is that practicing from a relational perspective does not mean that the patient has to pay attention to our relationship. I keep our relationship in mind so that I can make my best guess as to how my patient can make good use of me. But often, patients make good use of my presence as a background to their stories and explorations. They may develop a confident expectation that they will be well heard and generally well understood, without ever paying explicit attention to how I am being with them. Obviously, there are times in the therapy process when paying attention to our relationship can be quite useful to the patient. My point here however, is that working relationally does not mean that therapist and patient together must always be focused on the relationship between them.

Dialogic Attitude

The second corollary that goes along with a relational perspective, is a dialogical orientation. As I mentioned earlier in this chapter, some of us draw, as Laura did, on Martin Buber for our inspiration.[3] Buber's phenomenological approach emphasized that humans are inevitably interrelated. They come into being in relationship. He described two modes of relating, commonly known as It-IT and I-Thou. We live primarily in the I-IT mode of managing and moving about in our world. But moments of I-Thou are necessary in order to feel human.

> Whilst the I-It stance is concerned with doing and achieving in the relationship, the I-Thou is a state of *being* in relationship. The I-Thou relation trusts the between and is therefore willing to surrender to that between and in that surrender the other's humanness is affirmed. An I-Thou meeting can only take place when both parties are willing to surrender to the between, it cannot be forced or coaxed, as Buber states it comes through grace. Many clients that walk through our doors have been starved of such relating, they are not in a position to surrender to the between of a relationship, to gain the nourishment they yearn. It is through the therapist's willingness to hold an I-Thou attitude during I-It relating, to reach out and be available to the client without the expectation of being met that creates the ground for profound relational healing (Mann, 2010, p. 218).

Buber described three "elements of dialogue" that inhere in dialogue that supports one's coming-into-being. The three elements are presence, inclusion, and commitment to dialogue. The three elements come together in what I call, a dialogic attitude (Jacobs, 1989). In simplest terms the dialogic attitude is a specific attitude of welcome.

About inclusion Buber wrote, "... for in its essential being this gift is not looking at the other, but a bold swinging–demanding the most intensive stirring of one's being–into the life of the other" (Buber, 1999, pp. 81, 82). For a therapist this translates into a recommendation to feel an approximation of what the patient feels–an approximation so close that the therapist feels it in his or her own body. Inclusion requires authentic presence, which means that the therapist must be present as a person, discriminately revealing him or herself: "...if genuine dialogue is to arise,

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[3] More recently, a Buber contemporary, Hans Georg Gadamer, who also focused on dialogical conversation, has also been a resource. See, for instance, Staemmler, F.-M. (2004). "Dialogue and interpretation in gestalt therapy: Making sense together." International Gestalt Journal 27(2): 33-58.

everyone who takes part in it must bring himself into it" (Buber, 1999, p. 86). Therapeutic presence is the disciplined and discriminating use of the therapist's aware experience in the service of the therapy. The third characteristic of the dialogic method is a commitment or surrender to dialogue. The therapist practices inclusion and presence, and something emerges out of this relationship that the therapist does not aim for or control. The therapist stays engaged in the therapeutic process and by surrendering to what arises from the therapeutic dialogue, is him or herself changed (Yontef and Schulz, 2016, p. 20, footnote 3).

With presence, the therapist brings a willingness to be seen by the patient without hiding behind a wall of therapeutic authority. It means a willingness to be seen even in ways that do not flatter us. We also bring a willingness to be touched, moved, changed by the patient. We try to understand, bodily as well as with words, our patient's experiential world, from within the patient's perspective. WE feel our way into how what they are bringing makes sense, given their world view. With inclusion, our task is to feel our way into its rightness. This practice of inclusion is especially important when the patient is speaking of their experience of being in the relationship with us. It is not easy to hear our effect described as deleterious or hurtful, or grossly mistaken, for instance. It is in such times that an attitude of welcome is difficult to sustain, and yet vitally important. The third element, the commitment to dialogue means we are willing to say what begs to be said, even if difficult, perhaps even anxiety-evoking. Or perhaps something that might make us feel some shame.

Taken together, all these elements comprise the dialogic attitude, which calls us to include the otherness of the other as fully as possible while being present to the other–a kind of porous, vulnerable nakedness. It calls on us to recognize that, while we practice inclusion, and stand revealed in our presence, we are humbled in the poignant yet expansive awareness that my understanding, my recognition, of this other before me, is inescapably incomplete. This person before me is always more than I can know of him, her or they. And my knowing of myself has become slippery, fluid, a soft-assembly. This is a form of contacting that risks our very sense of who we are, risks our very sense of self. And yet, as we move along, it is also felt as our fullest sense of ourselves!

Embodied Dialogue

This basic orientation, with is first questions and dialogic attitude, also calls on us to pay attention to our "sense of things," what our sensations, our viscera, our movements and our breathing are telling us about being

with this other person. We also try to sense what our patients' sensations, their viscera, their movements and breathing, are saying about being in this situation with us.

Margherita Spagnuolo-Lobb calls this aesthetic relational knowing. "*Aesthetic relational knowledge* allows the Gestalt therapist to grasp the *now-for-next*, the client's intentionality for contact implied in their habitual and desensitized way of experiencing the contact boundary" (2013).

Dawn Gwilt, writing in the first edition of New Gestalt Voices, described a process of meeting being guided by aesthetic relational knowing (or, perhaps better stated, "aesthetic relational sensing-my-way-along"). The process was a moment in time in her work with a patient who tentatively began to describe his interest in sexual bondage.

> I felt an opening up to curiosity, a heart opening. I felt honoured and respectful, like I was engaging a different gear of sensitivity - more sensitised, alive, alert. Much background support kicked in automatically. Some of this background support was in the form of intentions. My intention was to bring safety to this space, to protect the tender shoots emerging, to go slow enough, to engage fully. This intention of protection made the space safer. In this moment, I am remembering the feeling of safety growing and surrounding us, with judgments cleared away to create an open invitation. I wasn't speaking aloud, but my intention was saying, "Give him space. This is important. This is a voice that needs to be heard." I felt quite vigilant about pushing to one side anything extraneous for now, to allow this new voice to be heard. At the same time I was aware of protecting him from the glare of the spotlight; protecting against anything in me that might push too hard or be too inquisitive. My intention was to follow and support his pace to meet him where he was in terms of pace and energy, as well as content. This was a minute- by-minute gauging of how much curiosity was the right amount like constantly adjusting the tension on a guide rope slightly tighter, slightly looser and all the while looking at, feeling into, and sensing his responses to this mostly in the energetic flow between us, not verbally. I checked for any response in me of fear, disgust, or needing to put on the brakes. I also checked into my sense of his experience. What I felt was a sense of heightened engagement from both of us. It's not so much what I did externally, as the intentional and implicit boundaries that I engaged with that provided a safe enough space to continue. (2017, p.7, British spelling retained)

In her process with the patient, Dawn could sense her way into a mode of being-with that facilitated sensitive, meaningful dialogue. It was built on what had come between them, and Dawn grasped and supported the now-for-next of the patient's wish to be known in a particular way and be welcomed.

One of my patients has been depressed for several years. He laments that he feels locked away and unable to participate with others in social situations and in learning situations. He feels too afraid of embarrassing himself by sounding stupid. We would have long stretches of silence in our sessions. He told me he would like me to reach for him yet when I did so he rebuffed me and retreated into further silence. My own feelings in response to him didn't seem to match his description of himself as afraid of sounding stupid. I found myself tempted to be provocative and a bit confrontive with him. I told him I thought of him as stubbornly, perhaps defiantly, withholding himself from engaging with me. He agreed and told stories about life in his family that seemed to corroborate the idea that to preserve himself he had to withhold himself from being taken over by others.

Our discussions did not shift the dynamic. In fact, both of us seemed to be hardening in our positions. He would continue to tempt me to engage him to help him explore, and then rebuff me and retreat into a resentful silence. I would perhaps ask a question or make an observation, and then in the face of his rebuff I would retreat into a righteous, resentful silence as well. I was so frustrated I was unable to consider the possibility that my way of approaching him might not be well attuned to his anxieties. After some weeks of the increasing intensity of our mutual implosive power struggle, I said, "I feel at a loss as to how to be of use to you. What I know is that I don't like how I am treating you. I am being defensively reactive. And I don't like how I feel about myself when I sit in silence having angry thoughts about you."

In the following session, my patient said that was the first glimmer he got that I was fumbling along just as he was, that I was not a master puppeteer who knew exactly what I was doing and wanted to control him. That was the beginning of a long process of making our way out of what could have become an impasse. Subsequently, he has become much more able and willing to identify with his desires for engagement with others, our conversations are more free-wheeling, and his depression has lifted. We enjoy enjoying each other.

One implication of our inescapable relationality is that all experience in the therapy situation is co-emergent. The words one chooses, body movements, even the smallest shifts in attention or emotion emerge from the situation. While it is true that we enter new situations with pre-formed habits and styles of engagement, the manner and timing with which the habits and styles are present reflects the unique system created by the particular therapist-patient pair. Therapist and patient are involved in reciprocal mutual influence, as illustrated in the vignettes above.

Our patients' suffering originated in relationships. It has been maintained in relationships. The creative-adjusting they have learned occurred in difficult environments. In social situations, we tend to fall in line with the messages we get from others about how to engage with them, and they do the same for us. In therapy, if we pay attention to our bodies, we can discern–based on our bodily reactions–how the patient generally wants to be treated, at least superficially.

Yet, if we only relate to the patient in response to their habitual modes of engagement, no expansion of contacting occurs. The therapeutic relationship balances between a sense of safety and a sense of risk. Any new moment, calling for a creative now-for-next engagement, poses a risk. This is therapeutic art. The unusual relationship of psychotherapy affords the possibility of new creative adjusting and new, more nourishing relational experiences. This requires attending to the relationship as it forms over time (whether it be 6 weeks or 6 years), rather than attending merely to what is happening in the current moment. What is happening in the current moment takes place against the backdrop of what has come before and the implied directionality of our intentions as we move into the next moment. So, although we have many opportunities to disconfirm a patient's expectations, useable disconfirmation takes place within a complex relationship that also repeats, to some degree, what is familiar to the patient and the therapist. In the vignette above, one of the disconfirmations that was quite powerful was that I was able to reflect on my own participation in what was a repetitive relational pattern. I was not able to avoid the pattern, but I could address it with humility. My commitment to dialogue supported me, despite some shame and some anxiety, to speak of my angry thoughts, and call attention to my resentful withdrawal. Not a very flattering self-portrait, but it proved useful for interrupting our slide into impasse.

My reflection supported the patient to dare to risk greater spontaneity with me. Malcolm Parlett, discussing "support" in gestalt therapy noted:

> The closer people come to their wounds or scars, the more they tend to veer off into habitual modes of protection. In my view, creating a field which contradicts 'expectations of danger' is often the key function for the therapist: the fixed gestalt wobbles and finally collapses if the environment proves to be different from what's expected. *Support is often seen as the opposite of challenge: but supporting someone can often challenge them greatly* (BGJ 2016, p. 47) (italics mine)

Supporting contacting, especially the dialogical contacting so vital to a sense of being human, does not come easily. Over time, the gravitational pull of our embodied habits and the patient's embodied habits militate against fresh creative adjustments. The adjustments become an admixture

of newness and habit. With the patient above, our first few sessions had more newness for both of us, and then the pull of the dynamic that had brought him to therapy in the first place, and the pull of my habit of reacting defensively in the face of withholding resentment, gained more and more prominence in our process. My defensive retreats or provocations confirmed, rather than disconfirmed, his worst fears. My exposure of my humility *dis*confirmed his worst fears and opened a new path for us.

Support

I don't think it is a bad idea that there is a tension between the old and the new. Patients come to therapy with both hope and dread. The hope is for an experience in therapy that can open a wider range of possibilities for living. The dread is that therapy will merely reconfirm that they are doomed to the painfully narrow and rigid way of life that they currently suffer. But they also dread they will be ridiculed for the adaptations they have made and cling to, or that they will be pushed too fast to change. The old modes of engagement, however painfully narrow and rigid, are also their safety. One of the problems in early gestalt therapy is that there was often not sufficient attention paid to developing a relationship with the patient that could become safe enough to allow the patient to experiment with new modes of being-together.

Gestalt therapy prizes leaning into one's coming solutions with as much spontaneity and flexibility as your resources (including those of the situation/relationship) allow. But it may take some time together to acquire the competencies for new contacting. We need to keep our eye on the patient's intentionality–what new contacting they seek–but we also need to be sensitive to the presence or lack of supports in the relationship.

Laura Perls considered support a bedrock gestalt therapy concept. In her workshops and teaching, she frequently stated that in therapy she wanted to "provide as much support as possible, and as little as is needed". Support is bedrock because without it, contacting is not possible. More precisely, the contacting that is possible in any given moment is that for which there are supports.

Supports come in many sizes and shapes. For instance, breathing into one's diaphragm is a support for remaining open and present. It is also a support for speech that can reach to another person. All of our senses can be used as supports. Aspects of our history are called upon as supports as they are relevant to the current situation. Knowledge and various skills are supports. Receptivity and the capacity to use the supports available in our environment are perhaps the most fundamental supports. For instance,

without air I cannot breathe. But if I tighten my throat and chest I am not receptive to all that the air can offer.

Aspects of the therapeutic relationship can be experienced as a support for contacting in different ways at different times. In the example above of Dawn's attention to her patient, calibrating her intensity and her curiosity to be in tune with the patient's delicate revelations, was a support for him to reveal himself more fully. With my patient, my emotionally tinged self-disclosure was a support for expanding our range of contacting possibilities. In another instance, the offer of an experiment that offers a chance to play with new experience is the support (Yontef and Schulz, 2016). Sometimes laughing together is a support for taking the next step of plunging into vulnerable explorations.

Sometimes a fight supports new contacting. For example, a patient and I used to get caught up in a fight over whether or not her anxieties should be met with tender loving kindness or with a heartier, "you can handle it," response from me. Our disagreement was a thread in our relationship for several months. Ultimately, she used her experience of fighting with me as a spur to standing up for herself in other arenas of her life. This enabled her to enter into a romantic relationship for the first time in over 30 years (her first relationship had been disastrous for her in part because she never spoke up for herself). Interestingly, even after our disagreements have been resolved, the experience had proved useful to her in another way; our relationship had shown her not only that she had the strength to stand up for herself, but that a relationship could actually become stronger by allowing disagreements and working them through, as ours had. Our successful and useful resolution occurred, in part, because I was willing to see myself as a problem for her, while at the same time, I believed I had something useful to offer to her.

My commitment to dialogue was crucially important in this process. We see many patients, who in one way or another, are seen, and experience themselves, as "a problem," first, a person second. To work with them, requires that I recognize that I, too, am a problem. Recognizing that my patient had every reason to experience *me* as a problem, meant my self-identity was not always as important as I might wish it to be, and this can feel like a form of dispossession or annihilation, which is sometimes a necessary suffering.

The possibilities of what might support contacting are endless. The thing to remember is that something is a support only if it can be used for contacting. That is, something I say or do, that I intend as a support, is not necessarily support. It stands to reason that something can only be judged as a support based on whether or not it is of use to the patient.

A final note on support: I find that paying attention to how my presence is or is not a support for expanding contacting, functions on two levels that are mutually reinforcing. The first level as in the example above of our fights, is how expanded contacting possibilities occur as a consequence of various kinds of supports that the therapist's participation brings. The second level is that the therapist's willing participation in experimenting until the most usable supports are found, builds the patient's confidence that the therapeutic relationship can be counted on to welcomethe patient's most vulnerable and shameful experiences. This happens in part because the therapist is willing to be fallible and to be corrected by the patient, while still trusting in their own expertise, as the patient and therapist together find the useable supports as they muddle along together.

Presence

By way of ending this chapter, I want to circle back to one of the aspects of gestalt therapy that is unique. I think no other therapy I know of places as much value of the therapist's presence as does gestalt therapy.

I know that for many people their first acquaintance with gestalt therapy was a form of grand activity and show. But my first acquaintance was with subtle musical, dance-like interplay between therapist and patient. The experience of "truth-telling" is a sensory experience that one feels in the muscles of one's face, in one's breathing, in the expansion in one's diaphragm, in one's growing freedom of movement in the moment. Therapeutic communication, even when profound suffering enshrouds us, has a beauty that transcends pain without obliterating the pain. So, what first drew me to gestalt therapy was the beauty of meaningful dialogue, the "being-with." It remains one of the strongest supports for putting my heart at risk in our encounter with suffering.

A life-blood of meaningful dialogue is presence. As I mentioned earlier, Joseph Zinker wrote a lovely essay in the first year of the publication of the *Gestalt Review* entitled, "Presence As Evocative Power in Therapy" (1987). Zinker says of presence that it "stimulates unknown parts of oneself, parts not yet fully sensed, described or named as awarenesses. Another's presence makes me feel my own being-here, my own validity. Presence is generally empowering." He describes qualities of presence in sensate terms: deep full and even breathing, a sense of being grounded, diffuse attentiveness, readiness to respond. Sitting with someone's presence, as Zinker writes: "I feel free to express myself, to be myself, to reveal any tender, vulnerable parts, to trust that I will be received without judgment or evaluation."

Being in the presence of presence is, dare I say, healing in itself.

References

Agassi, J. (1999). *Martin Buber on Psychology and Psychotherapy*, Syracuse, NY: Syracuse University Press.

Amendt-Lyon, N. (2016). *Timeless Experience: Laura Perls's Unpublished Notebooks and Literary Texts 1946-1985 (The World of Contemporary Gestalt Therapy)*. Newcastle Upon Tyne, UK: Cambridge Scholars Publishing.

Beisser, A. (2004). The paradoxical theory of change. *International Gestalt Journal, 27*(2), 103-108.

Bowman, C. (2005). The history and development of gestalt therapy. In A.Woldt & S. Toman (Eds) *Gestalt therapy: History, theory, and practice, pp. 1-20.* Thousand Oaks, CA:Sage Publications.

Breshgold, E., & Zahm, S. (1992). A case for the integration of self psychology developmental theory into the practice of Gestalt therapy. *Gestalt, 15*(1), 61-93.

Brownell, P. (2010). *Gestalt Therapy: A Guide to Contemporary Practice.* New York, NY: Springer Pub Co.

Buber, M. 1965b. *The knowledge of man.* New York: Harper and Row.

Buber, M. 1969. In R. Anshen (Ed.), *A believing humanism: Gleanings by Martin Buber.* New York: Simon and Schuster

Fairfield, M., & O'Shea, L. (2008). Getting 'Beyond Individualism'. *British GestaltJournal, 17*(2), 24-38.

Francesetti, G., Gecele, M., & Roubal, J. (2014). *Gestalt Therapy in Clinic Practice. From Psychopathology to the Aesthetics of Contact.* Milano: FrancoAngeli.

Gwilt, D. (2017) Experiences at the relational growing edge. *New Gestalt Voices,* vol.1, 7-14. Downloaded from www.newgestaltvoices.org.

Hycner, R., & Jacobs, L. (1995). *The Healing Relationship in Gestalt Therapy: A Dialogic/Self-psychological Approach.* Highland, NY: Gestalt Journal Press.

Jacobs, L. (1989). Dialogue in Gestalt theory and therapy. *GestaltJournal, 12*(1), 25-67.

Jacobs, L. (1992). Insights from psychoanalytic self psychology and intersubjectivity theory for Gestalt therapists. *Gestalt Journal, 15*(2), 25-60.

Jacobs, L. (2009). Relationality: Foundational assumptions. In D. a. W. Ullman, G. (Ed.), *Cocreating the field: Intention and practice in the age of complexity* (pp. 45-72). New York: Gestalt Press/Routledge.

Mann, D. (2010). *Gestalt therapy: 100 key points and techniques.* New York, NY: Routledge.

Perls, F., Hefferline, R., & Goodman, P. (1951/1994). *Gestalt Therapy: Excitement and Growth in Human Personality.* Highland, NY: Gestalt Journal Press.

Philippson, P. (2001). *Self in Relation.* Highland, New York: The Gestalt Journal Press.

Spagnuolo Lobb, M. (2013). *The Now-for-Next in Psychotherapy. Gestalt Therapy Recounted in Post-Modern Society.* Milano, IT: Franco Angeli.

Staemmler, F.-M. (2016). Taking another turn: the relational turn in Gestalt therapy. *British Gestalt Journal*, 25:2, 3-19.

Stevens, C. (2016). An interview with Malcolm Parlett, 31 January 2015. *British Gestalt Journal* 25:1, 42–48

Taylor, M. (2014). *Trauma therapy and clinical practice: Neuroscience, gestalt and the body* UK: McGraw-Hill Education.

Wheeler, G. (2000). *Beyond individualism: Toward an understanding of self, relationship, & experience*. Hillsdale, NJ: The Analytic Press.

Yontef, G. (1998). Dialogic gestalt therapy. *Handbook of experiential psychotherapy,* 82-102.

Yontef, G., and Schulz, F. (2016). Dialogue and experiment. *British Gestalt Journal, 25*(1), 9-21.

Zinker, J. (1987). Presence as evocative power in therapy. *Gestalt Review, 1*(2).

CHAPTER TEN

AN EXPERIMENTAL APPROACH: FOLLOW BY LEADING

JAN ROUBAL

"Gestalt therapy? Yes, the empty chair..." The usual first association for people outside Gestalt therapy circles. Gestalt therapists have invested a lot of effort, with some effect, to change this image. However, the chair(s) experiment remains the best-known Gestalt therapy intervention. Accepting that, we should rather explain more carefully how we understand it and how we use it in practice. We should explain it more carefully also for our own benefit. We often "just do an experiment" with our clients, without reflecting on the methodology behind using it: how was the experiment built, based on what intention was it introduced, how was the result of the experiment meaningfully included into the psychotherapy process?

When I was asked to write this chapter as a way of introducing a manual for the use of experiment in the practice of Gestalt therapists, I welcomed the challenge. I would also like to ask you, readers of this chapter, to invest some effort into the idea of opening up the concept of a psychotherapy manual that can be compatible and hopefully even profitable to the Gestalt therapy approach. I am convinced that manuals for different aspects of Gestalt therapy can not only provide an opportunity to explore our work through research, but they can also help us to become aware of the in-session micro-processes related to the particular interventions that we naturally use in an implicit and intuitive way. This would provide many learning possibilities as well as opportunities for improving our practice and for advocating it better.

Of course, there is always the very important question of the unique here-and-now situational process, which cannot be prescribed, the question of the artistic nature of our work. Creativity is at the core of Gestalt therapy, it has even become almost synonymous with our approach (Melnick, 2001). We, Gestalt therapists, value our creativity highly, but we are not only artists in our practice, in fact, most of the time with our clients, we are craftsmen,

who repeat and adjust the usual, practice approved procedures. Based on the fair craft, the unique moments of artistic creativity can flourish and bring fruits, as in any other kind of art. I see psychotherapy as a mixture of art, craft, and science. Manuals can cultivate the craft aspect of our work, so they can serve us as a way of supporting the artistic creativity on one side, and also, through research, as a way of developing the scientific aspect of Gestalt therapy on the other side.

Experiment as an Integral Part of Gestalt Therapy

In their daily lives, people again and again find themselves in situations that invite or even push them to try something new and unexplored, to try stepping into a process that is unpredictable and cannot be planned in advance. The risky step they need to make in such situations seems necessary for their growth, sometimes even for their survival. They need to "step outside of one's self" to discover a clear and fresh perspective (Yontef, 1993).

Gestalt therapy offers a support in this natural process of growth necessary for the instantly evolving, creatively adjusting contact with the environment. Moreover, Gestalt therapy uses the natural human urge for actualization on which to build one of its basic tenets. It actively invites clients to adopt the experimental attitude towards life to try out new behaviours and learn from what happens (Perls, Hefferline & Goodman, 1951). For that, an experiment as a specific intervention in Gestalt therapy is used as a challenge, is actively introduced by the therapist and is embedded in the safe and supportive therapeutic relationship.

The experimental dimension lies in the very foundations of Gestalt therapy. According to Laura Perls (in Amendt-Lyon, 2003a), Gestalt therapists may include a tremendous variety of therapeutic interventions in their work, as long as these are existential-phenomenological, experiential and experimental. Miriam Polster (Polster, 2005) perceives awareness, contact, and experiment as the three fundamental therapeutic instruments of the Gestalt therapy approach. Malcolm Parlett (2003) describes five creative abilities: responding, inter-relating, self-recognising, embodying, and experimenting. Melnick (2001) considers the concept of experiment as an essential ingredient of both creativity and the Gestalt therapy method. Also, Robine (2013) finds the concept of experiment at the heart of the Gestalt therapy method. Amendt-Lyon (2001a) sees the search for novelty using creativity, especially artistic methods, as fundamental to the Gestalt approach. Many others could be quoted.

On the other side, there was also a significant move away from using experiments in the development of Gestalt therapy. Burley, Resnick & Resnick (2005), do not consider experiment to be a part of Gestalt therapy's philosophical foundations, rather just one of many possible interventions used in the service of raising awareness, which is dispensable and replaceable. Resnick[1] differentiates the general "strategy" of Gestalt therapy, which is the restoration of self-regulation within the organismic/environmental field, from "tactical ways," technologies that create a difference. The difference allows awareness, which presents for Gestalt therapy the main methodology used in the service of the general strategy. There are many such "tactical ways" besides experiment as dialogically relating techniques, polarities, breathing, voice, dreams, fantasy, imagery, etc. Experiments can be congruent with and supportive of Gestalt therapy but they are not seen as one of the basic tenets of this approach.

Regardless of the differences in the theoretical conceptualization of Gestalt therapy, experiments are clearly observable in the everyday practice of Gestalt therapists in general. Experiment is described as one of the key interventions in the Specific Competencies for Gestalt Therapists developed by the European Association for Gestalt Therapy (Vidakovic, Zeleskov-Djoric, Roubal, Baalen, Francesetti, Wimmer, 2015). Experiment was also identified by international expert consensus as one of the eight key concepts (together with the therapist behaviours that reflect those concepts) that characterize Gestalt therapy and can be used in a fidelity scale to identify the application of the Gestalt approach for research purposes (Fogarty, Bhar, Theiler, O'Shea, 2016). The use of experiment represents a distinct feature which differentiates Gestalt therapists´ working style from some approaches like psychoanalysis or the person-centred approach and it also served as an inspiration to some other approaches like emotion-focused therapy.

During the sixties and seventies of the last century, when Gestalt therapy was becoming popularised and codified, the original creative expression of Fritz Perls' momentary insight (e.g. empty chair, two chairs, top dog/under dog) became applied rigidly as techniques. Fritz Perls was later criticized for his contribution to this distortion of the Gestalt approach (e.g. Melnick, 1980; Yontef, 1993; Greenberg, 1997; Spagnuolo Lobb, Amendt-Lyon, 2003; Bowman, Nevis, 2005; and others). In the last decades there has been a focus on the dialogical approach in Gestalt therapy, which can be considered as a necessary pendulum reaction to the risk of the over-use of techniques. However, the pendulum may have swung too far. The dialogical

[1] Personal communication, September 2017.

approach becomes honoured and the experimental approach is sometimes shrugged off by saying that everything is an experiment. Such an approach would disable the opportunity to systematically explore and develop experiment as a specific intervention within the Gestalt approach.

This chapter is presented as an attempt at a methodological elaboration of experiment as a specific intervention in Gestalt therapy and as such it is based on an existing wide literature base focusing on the creative aspects of Gestalt therapy in general and on potentials, limits, and general rules for the use of experiment in particular (e.g. Zinker, 1977; Melnick, 1980; Mackewn 1999; Philippson, 2001; Amendt-Lyon, 2001a, 2003a, 2003b; Melnick, Nevis, Shub, 2005; Joyce, Sills, 2006; Frank, 2003; Roubal, 2009; Yontef, Schulz, 2016; and many others). This chapter complements the existing literature with a pragmatic and practical attempt to explore and cultivate experiment as a specific intervention, which is often used in the daily practice of Gestalt therapists. Hopefully, it can help Gestalt therapists to use this kind of intervention with more awareness of its benefit, limitations, and can also enable them to integrate it meaningfully into the whole of the therapy process. I believe that this way experiment can then be used more congruently with our epistemological foundations.

Experiment as a Specific Intervention

The general experimental dimension of Gestalt therapy with its systematic curiosity and openness to the unique responses of each client in each moment is part of the phenomenological approach (Joyce, Sills, 2006; Yontef, Schulz, 2015) and so it constitutes one of the basic resources in Gestalt therapy. However, the general experimental dimension of a Gestalt approach needs to be distinguished from the experimental methodological approach (Melnick, 1980). If we were to stay with the general experimental attitude, assuming that every psychotherapist's intervention is in a way experimental, we would miss the chance to develop the methodology of experiment as a specific intervention. By identifying clearly the intentions, indications, procedure and also the risks and limits of experiment we create a basis for a systematic use and research-based evaluation of this specific aspect of the Gestalt therapy approach.

An experiment in Gestalt therapy is an active intervention that furthers the collaborative exploration of a client's experience (Yontef, Schulz, 2015). It is a systematically and appropriately used intervention, which can offer a chance to unblock rigid processes and enhance the client's sense of choice (Joyce, Sills, 2006). Experiment is integrated in the whole of the psychotherapy process and can effectively be used only when based on a

safe, supportive and trustful therapeutic relationship. The basic procedure when using experiment is exploring and learning through doing, the basic starting point when creating an experiment is to be process-oriented. Metaphorically, experiment can be seen as an adventurous common journey for both the client and the therapist, starting in the here and now situation, continuing through a creative indifference and aiming towards an unplanned discovery.

From the perspective of other psychotherapeutic approaches, Gestalt therapy still has the reputation of a therapeutic approach based, to a substantial degree, on the use of techniques. This is a misunderstanding as creatively discovered experiments are mistaken for behaviour modification procedures. The process of creating experiments within the field of a therapeutic relationship may be difficult for therapists from other psychotherapeutic approaches to understand. They may view the work of a Gestalt therapist through the lenses of the medical model, in which a technique is prescribed to cure a symptom. However, they also point to an important point for us, Gestalt therapists, because the danger of an experiment being "frozen into a technique" (Melnick, 1980) is always present in our work, if the experiment is seen as a cure in itself (Stevens, 2004). It is essential to our approach to differentiate between routine and creative style, between technique and experiment (Amendt-Lyon, 2001b).

Distinguishing between technique and experiment is necessary in elaborating the specific methodology of experiment. Technique is an exercise prepared in advance that therapists can employ if they want to induce a particular state, or to direct the client to a particular aim. For example, a relaxation exercise at the beginning of a group therapeutic session aiming to physically relax the clients and focus them on the present experience.

Contrary to this, experiment is a creative adventure. The therapist suggests to the client, "Do this, to see what you experience," and not, "Do this in order to change." (Greenberg, 1997). Experiment is not applied as a healing procedure for the client. Although there are general intentions such as raising awareness and activating unused resources, the concrete content of such new awareness and the specific kinds of activated resources remain unknown and can only be discovered during the process of the experiment. Our basic attitude is to embrace uncertainty, and to be unendingly curious (Melnick, 1980). The fundamental ability of the therapist when using an experiment is to abandon efforts to bring the experiment to a particular, desired outcome, because the experiment essentially aims at process goals (Joyce, Sills, 2006) that cannot be planned. The therapist allows what emerges between client and therapist to guide the therapy process (Yontef,

Schulz, 2015). Gestalt therapists´ creativity is not embedded in the client, or the therapist, rather it presents a novel, daring, courageous, and intuitive process, it is a field phenomenon (Amendt-Lyon, 2001a). Both the therapist and the client together make a courageous step as an attempt to expand contact possibilities and awareness, to actively bring something novel, to focus on something which attracts them both and creates something that transcends them, this step is called an experiment (Spagnuolo Lobb, 2017).

Here yet another substantial feature that differentiates experiment from technique appears. Technique is usually prepared by the therapist in advance, whereas an experiment is co-created by both the therapist and the client in the here and now situation. Although the therapist actively structures the therapy process and offers the client a particular task, the gradual development of the experiment is flexible and is not controlled by either the client or the therapist (Mackewn, 1999). An experiment is born out of the process of the therapeutic relationship (Amendt-Lyon, 2003a), the mutual relationship becomes a laboratory in which experiment forms organically.

A creative experiment emerges from the therapist´s contact with the client and is not selected from a set of standardized interventions, known to produce a standard reaction (Philippson, 2001), techniques however can be used as an inspiration for experiment. A therapist can store for themselves a pool of useful techniques, such as externalizing inner dialogue through two chairs, repeating a deflecting sentence again with "I" in the beginning, or many others. When the therapist is not applying a pre-prepared technique to solve a problem, but stays open in the here-and-now therapy situation with the client and the idea of a technique arrives as an inspiration, a "frozen" technique can be "warmed up" again into a creative experiment.

Existential Nature of Experiment

Thanks to an experiment, the client experiences themselves in a new, exciting, but often also fearful and shameful way. This kind of experience evolves while in the accepting and supportive presence of the other, thus opening a new way of being in the world for the client. Experimenting opens new possibilities and the safe relationship enables the client to try them out. A very new way of existing can be born for the first time in the presence of the therapist. Co-creating and witnessing together how this new way starts to blossom, creates a touching human closeness. Use of experiments contributes thus to creating a ground for an existential "I-Thou" encounter between the client and the therapist.

The therapist accepts the uniqueness of the client's creative adjustment in the context of their life story. The creative adjustment presents a starting point for developing an experiment. At the same time, the therapist invites the unused potential of the client and challenges it. There is an existential tension in the client between the polarity "I want to change myself, because I am not satisfied with the way I live" and the other polarity "I do not want to change myself, because the way I live is the only one I know". The therapist is able to stand this tension, they do not identify themselves with any of the two polarities. They simply stay available and by introducing the experiment, they express both their respect for the unique life experience of the client and their trust in the client's ability to find new, more satisfying ways of living. Experiment enhances the opportunity for developing the existential "non-dual awareness" (Williams, 2006).

The existential offer of the experiment is: "Accept your experience" (Greenberg, 1996), which counts for both the client and the therapist who find themselves together in the therapy situation. The experiment is situational, which means it is controlled neither by the therapist nor by the client. It is the intentionality of the situation that drives the dynamics of the experiment and the therapist is sometimes supporting it and sometimes simply trying not to get in the way. Trusting the process, which naturally evolves during the experiment, includes also experiencing the existential anxiety connected with the disturbing awareness that we ourselves are part of the flow of the situation, we are a function of it. This existential anxiety is a natural part of using experiment, it is experienced by both the client and the therapist, and the specific therapeutic skill when using experiment is not to calm the anxiety, rather to transform it into excitement. The therapist supports the process of Gestalt formation to allow the blocked excitement producing the anxiety to become active excitement (Robine, 2013).

Experiment and Dialogue

Gestalt therapy builds upon Martin Buber's (1958) synthetic thesis of dialogical existence, and uses Buber's principles of the dialogical relationship within therapy (e.g. Yontef, 1993, Jacobs, 1995). At the same time, Gestalt therapy works with more directive, task-oriented and risk-taking interventions, when the therapist offers the client a particular, more or less structured task and leaves the outcome open. It is this delicate, creative balance that is characteristic of the Gestalt therapy approach. A balance between the dialogical meeting of two unique human beings, and the more active, task-oriented and risk-taking style through which the therapist influences the process more directly. Such an approach can even

help to transcend the historical/theoretical dichotomy between relational and behavioural approaches (Yontef, Schulz, 2015). Although Gestalt therapy has developed this approach in a specific way, generally it is not alone in adopting it. Currently, an entire group of experiential therapies are being characterized this way (Elliott, Greenberg, Lietaer, 2004).

The dialogic and experimental dimensions can be seen as polarities in the Gestalt approach. At a certain moment, one polarity can be more in the foreground and the other more in the background, in the next moment they can change their positions within the ongoing process of the therapeutic relationship. The unique contribution of the Gestalt approach lies in the therapist's flexibility in the differentiated use of both the dialogical and the task-oriented polarities, in the continuous creative movement between them depending on the situation here and now in the therapeutic relationship. Both the polarities are always present in the Gestalt therapy approach creating a lively tension between "is-ness and doing" (Greenberg, 1997), between the Eastern focus on awareness of being in the here and now and the Western emphasis on action and doing (Melnick, 2005).

Joseph Zinker (1977) speaks about stretching the self-concept during the individual development. When the one polarity is accepted and honoured, it also enables the exploration and full development of the other polarity. We can expand this concept to the development of Gestalt therapy as a whole. The dialogical and experimental approaches do not rule each other out, on the contrary, they strengthen each other. The use of experiments can even be seen as a specific Gestalt therapy competency for working with the psychotherapy relationship, when the therapist is able to support the intentionality of contact by custom-tailored and creative experiments (Vidakovic, Zeleskov-Djoric, Roubal, Baalen, Francesetti, Wimmer, 2015).

In the whole Gestalt of the psychotherapy process, the dialogical and experimental attitudes complement each other like two hands working together. In the dialogical approach, the process of change is based on the transformation of "selfing" (Parlett, 2005) through safe and accepting contact with the therapist, through being together without aiming (Yontef, 1993). At the moment when the experiment is suggested, the dialogical dimension of the meeting moves to the background. Instead, the experimental, task-oriented and risk-taking dimension comes to the foreground. The task of the therapist also changes. For the limited time of the experiment, they take more responsibility for directing the therapy process by structuring actively the present situation. The (ever present) asymmetry of the roles of therapist and client becomes more visible for the moment. The risk-taking component is of course present in every therapy meeting, but in Gestalt therapy it is stressed with specific intentions at

certain moments in the therapy process. The challenging and exciting task for the Gestalt therapist is to use such changes in attitude with awareness and for the benefit of the client.

An honest interest in the client as a unique human being, combined with the building of authentic contact with them, creates the necessary foundation for using experiments that direct the therapeutic process towards the client's new, fresh experience. Such an experience offers yet another opportunity for a genuine personal encounter within the therapeutic relationship, because it appears in the presence of the therapist and is co-created by both the client and the therapist. The client can feel that they are accepted and so learns to accept themselves with the new, often surprising experience that was discovered through the experiment.

This chapter is dedicated to the experiment and so it intentionally focuses on one polarity. However, it needs to be read with the awareness that the dialogical dimension is an ever-present component of the Gestalt therapeutic approach too, although at the time of using an experiment it withdraws into the background.

Research on Experiment

Taking into account the overall shortage of research in Gestalt therapy, experiment has been relatively extensively researched. However, it was mainly studied as a separated intervention not integrated into the whole of the Gestalt therapy process. Often it was researched as an additional enrichment to other approaches and so a question arises, to what extent was a pre-selected kind of experiment applied more as a technique. The existing research offers valuable information not only about the process and outcome aspects of using experiment, but also about where future research on experiment in Gestalt approach needs to be focused.

Research on experiment-based interventions was systematically conducted by Greenberg (and colleagues), who started his career as a Gestalt therapist and integrated experiments into Emotion Focused Therapy. Two specific interventions used for special tasks in therapy were studied: the "Two chair dialogue" for conflict splits and the "Empty chair dialogue" for unfinished business. They were compared to client-centred empathy, cognitive-behavioural problem solving, and experiential focusing.

Research showed that the two-chair dialogue was more effective than the comparative interventions for working with conflict splits and led clients to deeper levels of experiencing and greater awareness (Greenberg & Clarke, 1979; Greenberg & Dompierre, 1981; Greenberg & Higgins, 1980; Greenberg & Rice, 1981; Greenberg & Webster, 1982). Client performances in

successful episodes of conflict resolution were compared to unsuccessful episodes to identify how the change takes place, which led to the construction of a model of intrapsychic conflict resolution (Greenberg, 1983, 1984; McKee, 1995) and to the description of self-critical processes (Whelton, Greenberg, 2000). Research on the relationship between resolution processes and outcome (Greenberg, Webster, 1982) provided support for the validity and clinical utility of the proposed model of conflict resolution.

Further study on emotional processing (Stiegler, 2017) contributed to differentiating the specified use of the two-chair intervention at different times for different clients. Similarly, the empty chair dialogue was studied (King, 1988; Maslove, 1989) with a special focus on the micro-processes involved in change. In comparing successful and unsuccessful resolution of unfinished business by a task-analytic research program (Greenberg & Foerster, 1996) a model of the change processes in the empty chair intervention was developed.

Gestalt experimental interventions were also researched in contexts outside individual psychotherapy. Hatcher (1978) noted them as a valuable short-term tool and he demonstrated their enhancing effect in family therapy. Experimental work within the 4-stage model of a Gestalt therapy session (Fiebert, 2012) was viewed as an effective vehicle for integrating intra-marital polarities in couple work (Olivieri, Fiebert, 2013).

The "chair work" dialogues are probably the most influential interventions outside Gestalt therapy. The way they are used in different approaches (Gestalt therapy, Emotion focused therapy, Redecision therapy, Cognitive–behavioural therapy, and Schema therapy) was explored (Kellogg, 2004). Each approach uses them in accordance with its own epistemology, which presents a challenge for Gestalt therapy to clarify more precisely and systematically its own theoretical understanding and the practical clinical implications of the use of experiments and, most important, to ground it in research.

Gestalt therapists might encounter difficulties when starting a research on the experiment as a specific intervention. With justification, they can feel the invaluable complexity and the spontaneity of the involved processes of the approach as an integrated whole could be lost. However, bearing in mind that every research is unavoidably a simplification, we can explore some specific aspect of our work and then include the research-based feedback back into the holistic approach. This way our work can be more grounded in the real practice evidence.

Currently, there is a trend in psychotherapy research to identify which specific therapy procedure and under what conditions it is helpful and which is without an effect or even harmful to clients (Chambless & Hollon, 2012).

In Gestalt therapy experiment could easily be the subject of such exploration. The Gestalt therapist can meet yet another obstacle here, because research showing the proven effectiveness of psychotherapeutic procedures leads to a manualisation (see chapter six).

Suggested Guidelines for Using Experiment

The following section presents a "mission impossible," because it tries to construct a manual for a creative, intuition-driven improvisation which grows from the ever-changing here and now situation. In a way, the following section is an experiment itself. Guidelines suggested here are offered as an inspiration to free and creative Gestalt therapists, keeping results open. They present a working process model grounded in my own experiences and knowledge gained from my Gestalt therapy teachers and from the Gestalt therapy literature I am familiar with. The model was discussed thoroughly in two focus groups of experienced Gestalt therapists and their feedback was included in the version presented here. It is not a prescriptive model of how the therapist should work, rather a descriptive one trying to categorize and name explicitly what Gestalt therapists usually do in their practice. It is intended to support therapists in their creative work in the unique here and now situation with the client.

First, there is an introduction into when and why experiment can be used. Second, there is an explanation of how therapists need to consciously change their working approach to be able to create and develop an experiment. Third, a sequence of steps in the procedure of an experiment will be presented. The guidelines are introduced here for more comprehensive experiments, which include for example a creative use of empty chair(s), body enactment, etc. However, elements of the same procedures can be recognized also in brief, limited experiments. A detailed description and process analysis of one case study from my own practice follows the guidelines to illustrate the model.

Intentions for Using Experiment

How can experiment be useful for a client? When is it useful and when not? As therapists, we are in a paradoxical situation. On the one hand, we do not push an experiment towards a pre-conceived outcome, on the other hand, we do not use experiment just incidentally, rather with our aware intention. We do not direct the experiment towards a particular content (what the client should discover), but we aim the experiment at process

goals discovering new ways which can open themselves through the experiment.

The research into the common factors approach to psychotherapy (Rosenzweig, 1936/2002; Frank & Frank, 1993; Garfield, 1995; Goldfried, 1980; Grawe, 2004; Lampropoulos, 2001a; Prochaska & Norcross, 1999; Wampold, 2012) helped to identify factors that can be intentionally utilized by therapists as general clinical strategies (Goldfried, 1980). Lampropoulos (2001b) summarized the strategies in eight categories: (1) therapeutic relationship, (2) catharsis and relief from stress, (3) instillation of hope, (4) self-exploration, awareness, and insight into problems, (5) provision of a theoretical explanation, (6) problem confrontation, (7) acquisition and testing of new learning, and (8) achievement of control and mastery. Except for points 1 and 5, experiment can be used directly for all these general strategies.

Raising awareness. Experiment in Gestalt therapy is a therapeutic intervention where the therapist actively transforms the therapeutic situation. Experiment is used in the service of a general intention in the Gestalt therapy approach to raise awareness and broaden the client´s freedom of choice. Using an experiment, the therapist accelerates the process of raising awareness and enables the client to gain the new awareness in a holistic way, which includes not only their thoughts, but also their feelings and embodied experiences.

Each person's unique way of contacting is regulated by a combination of habit/implicit awareness and focal awareness (Yontef, 1993). The habitual ways become actualized in the present therapy situation. By the use of an experiment they become more distinct and both their values and their limitations stand out more clearly for the client. Gestalt therapy focuses on the immediacy of experience, which is brought into awareness to challenge pre-existing patterns (Yontef, 1993) and uses experiments to support this process. Simply raising awareness of the ways client´s habits are imprisoning them, together with the support and the safety of the therapeutic relationship, already opens a challenging situation for discovering new ways. A choice opens for the client to step out of their fixed patterns through which they perceive and relate to themselves and their surroundings. By raising awareness through a holistically felt experience, an experiment creates a chance to step out of these fixed patterns and to enhance the client's sense of choice.

Acting differently. Raising awareness is not the only intention of using experiments. Through an experiment the client also encounters an opportunity to get in touch with their neglected potentials and to start learning how to use them. This second intention of experiment is to create

a safe place where the client can accept their anxiety around moving out of the familiar and risk acting differently (Philippson, 2001). When using experiment, the implicit message from the therapist to the client is: "Try something new, when you have the support for it" (Greenberg, 1997).

Experiment in Gestalt therapy can be seen as an integration of phenomenology and behaviourism (Zinker, 1977), which uses experiential learning in the here-and-now therapy situation for a behavioural change. The change will not happen on the level of an explicit memory when only a content is discussed in therapy (Staemmler, 2002). The therapist focuses on the actually present experience, because the repeated pattern can be changed only when it is activated in the implicit, procedural memory. Thanks to the support of the therapist, the client can dare to step out of their fixed behaviour. Through experiment, their own creativity is vitalized and becomes a resource for trying out new ways.

Enhancing agency. Besides raising awareness and acting differently than usual, the experiment also offers the client a direct experience of being capable of making the change themselves, from their own resources. Clients are not subjects of change, they are "active agents" (Bohart, 2000) who, thanks to therapy, mobilize their agency, their own ability to act differently than usual, their capacity to find their own way. In their research on how therapists conceptualize agency within the process of change, Williams and Levitt (2007) described several principles across orientations designed to guide the therapist's moment-by-moment decision making process for enhancing the client's agency. One of them, "challenging and confronting to enhance awareness, reflection, and agency", when applied to Gestalt therapy, identifies how experiment contributes to the process of change. Through the experience "I can make the change" the client is encouraged and more self-supported. Their sense of "my life is in my hands" is increased, their agency is enhanced through the challenging work in an experiment.

Mind-Set for Using Experiment

Experiment is born out of the process of the therapeutic relationship (Amendt-Lyon, 2003a) and is not controlled by either the client or the therapist (Mackewn, 1999). The mutual relationship becomes a laboratory in which experiment forms organically. This way the creativity used for an experiment is a relational process (Zinker, 2003). It is important that the therapist consciously prepares their mind for such an approach. It gives them a clear vision of their tasks and strategies for introducing an experiment. This then provides the safety and stability necessary to the

psychotherapy relationship as a ground for the challenging experience discovered through experiment.

Before actually offering an experiment to the client, the therapist focuses first on themselves and prepares by adjusting their mind to an "experimental mode", which they will keep for the duration of an experiment. It is similar to driving a car. Before actually starting to drive, the driver prepares themselves for this new activity, first with full consciousness, later as an automatic habit. For a beginning therapist, it is useful to make the change to an experimental mind-set deliberately and consciously. Later, it becomes an automatic switch.

For creating, developing and concluding an experiment, the therapist temporarily and consciously switches to an attitude which differs from the dialogical one in some distinctive points. Making this change in attitude and thereby bringing the experimental polarity into the foreground with full awareness enables the therapist to stay well grounded. When the therapist knows what they is doing it brings clarity and safety for the client as well. A safe and clearly understood therapy situation with a well-established working alliance provides the necessary ground for creative, intuitive and often quite "crazy" work in an experiment.

Grounding in here-and-now. In using an experiment, the therapist intends to explore what has already been present in the therapy situation. They do not bring their own agenda to change the situation, do not try to persuade the client. They stay grounded in the awareness of what is happening here-and-now in the therapy. From this starting point, they search for creative ways to "outline" the figure that is just arising. Experiment is used to bring new awareness and new meaning to the phenomena, which are in some way, often implicitly, already present in the therapy situation.

Active suggesting. Experiment is a kind of therapist-imposed structure (Melnick, 1980) in the flow of a therapist-client dialogue. The therapist consciously takes a leading position towards the client by actively suggesting a specific task, encouraging the client to 'try out', and 'discover'. The task is often offered as optional and collaborative ("Would you like that we explore this a bit more?"). However, the therapist uses their professional authority to structure and direct the situation to some extent. The therapist actively and with awareness switches their role from a companion to a guide.

Openness to discoveries. The therapist moderates the process of experiment as an open-ended adventure. They are facilitating it to be unpredictable even to himself (Philippson, 2001). They need to resign their ambition to direct the process towards a particular, desired result. Together with the client, they set out on a common adventurous expedition into an

unknown territory. The process of an experiment can take surprising turns when the therapist maintains a non-judgmental attitude (Joyce, Sills,2006) and follows the development of an experiment with curiosity. In this sense, an experiment in fact cannot go wrong, cannot be evaluated as successful or unsuccessful, because the therapist collaboratively elaborates the experiment with the client and phenomenologically explores what it brings.

Courage to creativity. The therapist becomes an artist, who creatively uses what is available at a present moment in contact with the client, "a material" that grows from their encounter. Often the paradoxical theory of change guides the therapist to interact with the client (Yontef, Schulz, 2015). A creative idea comes in an intuitive way and the therapist often labels it for themselves as non-sense, strange, or crazy. At this point the therapist puts aside their preconceptions and introjects. The therapist can give themselves permission to use any creative intervention which meets the following conditions: it aims to enhance awareness, it arises from both dialogue and phenomenological work, and it remains within the ethical boundaries (Yontef, 1993). This way the therapist is modelling courage for the client. If the client is encouraged to risk a step out of their safe, comfortable zone, the therapist can support them by modelling it by doing it themselves.

Strategic leadership. The process of creating and developing an experiment is a relational interaction in which the client takes an active part. The therapist suggests tasks and leads the process during an experiment, but this leadership is of a paradoxical nature, a humble one, the least visible as possible. The therapist is sensitive to the resources, risks and needs of the situation, always ready to give space to the naturally maybe even surprisingly evolving process. They continuously monitor that they are pacing together through the adventurous journey of the experiment.

The leadership includes a strategic thinking about the overall timing. The therapist suggests an experiment when there is enough time to develop and integrate it. Generally, it is not recommended to suggest an experiment when there is less than 10-15 minutes left before the end of the session, because it is not clear in advance how intense the experiment might be and how much time it might need for safe integration.

At certain points, the therapist turns their attention from the process of experiment to the client as a partner working with them on a common task. The therapist uses the moments when the client´s experiencing becomes naturally less intense and the client can temporarily step out of the flow of experiment. Together they assess how the experiment is going and what are the capacities for possible next steps, and then they plan what such steps might be. The therapist needs to be ready to grade down or finish the

experiment if the client does not have enough support for a next step. The new discovery needs to be small enough for the client so they can integrate it.

Procedure

The following steps are suggested to support the therapist through the procedure of experiment. These steps present an attempt to distinguish the phases of the therapist´s activity during the process, phases which however can overlap and repeat in the natural creative flow of the therapy session. The description is focused on the therapist´s part in the therapy situation, on their contribution (observations, conceptualisations, actions, attunement, self-management, etc.) to the process of experiment. In practice, the steps often follow each other in an implicit way as a natural part of the flow of the psychotherapy process. Using them as a prescription during the work would block the flow. The following procedure is thus meant to serve as a reflection and a cultivation of the use of experiment.

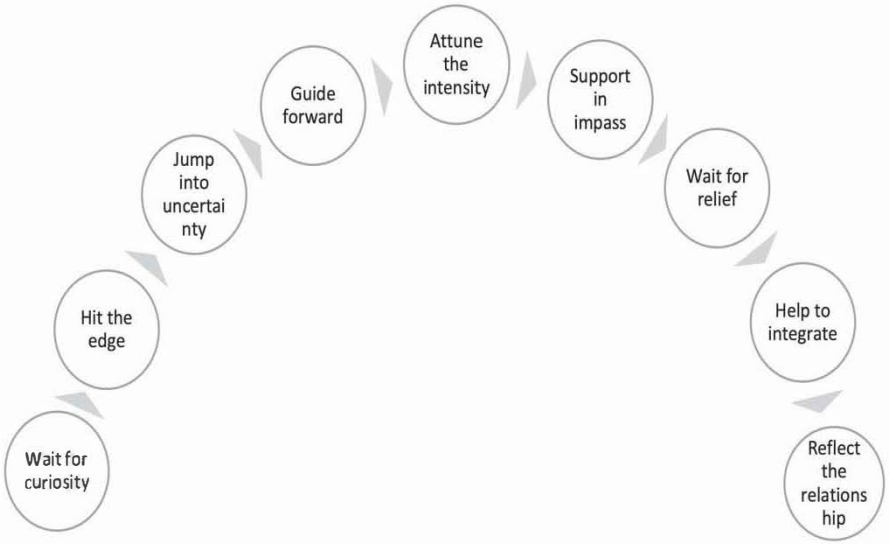

Figure 1: Sequence of steps the therapist makes during an experiment

Wait for curiosity. When does the therapist suggest an experiment? The timing is crucial. The aesthetic sensing of the situation helps the therapist to recognize a suitable moment for a productive experiment. It is important that the therapist is able to bear their own feelings at that moment, and that they are well-grounded with a capacity to contain the strong experience the experiment might bring. The therapist suggests an experiment from their genuine curiosity, which has a kind of a "childish" quality of "Hmm, what is this? How does this work? Let's explore it...".

On the contrary, the therapist does not suggest an experiment when they are in tension, confused or overwhelmed. An experiment brought at such a moment would serve to save the therapist and would not be safe enough for the client. The therapist needs to be a well self-supported guide for the client, who is invited to discover unknown territory.

The therapist also checks the client's readiness for an experiment. A good timing is when the client has enough capacity for discovering and processing something new, but is at the same time missing an impulse for that. The therapist does not suggest an experiment when there are many impulses already present for the client. The impulses can be from outside, when many new things are happening to the client, or from inside, when the client is experiencing many feelings new for them. A safe space for integration through dialogue is needed first, before possibly introducing new interesting impulses through experiment.

The therapist can attune himself to the intentionality of the situation and can use the aesthetic criteria for deciding whether the time is suitable for an experiment or not. They can for example envisage if the situation needs more opening-up (a good time for an experiment), or if it needs more closing-down (a good time for integration in a dialogue). The therapist can check for themselves at a certain point, if their own hand wants to push the client a bit (a good time for an experiment), or if they want to stroke the client (a good time for active empathic listening).

The curiosity needed for the start of the experiment is often preceded by a feeling of frustration, of getting stuck, as if the client was saying at that point: "OK, so I have told you all this and what? It is nothing new for me..." The client himself is frustrated by their own fixed Gestalt. When the client is frustrated by their own "conservative polarity", the therapist can support the client's "revolutionary polarity" (Zinker, 1977) by an experiment. However, the therapist does not suggest an experiment straight from this frustration. They first rouse a curiosity in themselves and then in the client: "Well, this is interesting. Would you like to explore this a bit more?" The experiment often starts paradoxically by exploring the "stuckness", not by pushing for a new discovery.

By staying with the present experience, the therapist is using the actual emergency of the situation, or they even create higher-intensity experimental emergency *in situ* (Robine, 2013). It is a kind of safe emergency (Goodman, 2003), when the client can experience high intensity feelings connected to stepping out of the safe habitual way of contacting and at the same time to feel that they are safe because they can cope with the situation (Perls, Hefferline and Goodman, 1951), feeling that they are protected by the therapeutic relationship.

Hit the edge. The therapist tries to estimate the edge between the safe and supportive well-known territory of the client's awareness and the area of exciting, promising new discoveries for the client. The grading of an experiment is important, because when the therapist stays on the safe side nothing new appears. The client then stops investing their hope, a crucially important "placebo" part of our work, in the use of experiments. On the other hand, when the therapist overloads the experiment and makes it too demanding, the too highly provoked anxiety blocks reception in the client. Nothing new can then be integrated and made available as useful for the client. Using or even creating the emergency (Robine, 2013) is essential for an experiment. The therapist needs to calibrate the emergency "just enough".

The therapist attunes the intensity during the whole process of the experiment (see below), however, the initial suggestion and negotiation with the client is crucial for the collaborative nature of experiment. The therapist assesses the capacity of the client, which depends on the safety of the situation, on the client´s trust in the therapist, on the intellectual capacity of the client, on their ability for symbolic thinking or for body work, on their visual, acoustic, and spatial-movement sensory strengths, etc. They also assess their own capacity, as well as the capacity of the whole situation including the time and space context. Then the therapist suggests an experiment trying to hit the edge. In the case of bigger experiments (like an empty chair) they discuss the suggested experiment together with the client and they come to an agreement. In the case of smaller experiments (like starting a sentence with "I") the therapist just monitors the client´s non-verbal reaction and adjusts the grading to it.

Jump into uncertainty. The therapist creates a space for something new, unknown, not yet tried, to appear. To leave the safe, well-known territory it is necessary to pass through a "gate of shame" (Evans, 1994) and the therapist does that first to encourage the client. The therapist´s own creative daring can then become a model for the client (Amendt-Lyon, 2001a). The therapist modulates their presence, and in this way the co-created field is changed, allowing a new experience to come (Francesetti,

2015). The therapist risks the uncertainty and exposes themselves to the feeling of shame. Moreover, feeling ashamed oneself brings a valuable diagnostic information, it indicates to the therapist that a way of discovering something new is just opening.

The therapist needs the courage to be awkward (Amendt-Lyon, 2001b) and to go into the shame first: "Some kind of a crazy idea came to me. Would you like to hear it?" or "What about trying something new?". And then, being aware that an experiment is learning through doing, they suggest doing it: "OK, let's try it now." They risk making a first step without having a clear plan for the next ones. They are willing to be surprised, they trust their intuition in cooperation with the theoretical foundation (Amendt-Lyon, 2001b). The therapist makes their "creative jump" by, for example, offering an empty chair or by suggesting making some body movement or by giving any other kind of an instruction for an activity.

Guide forward. Once the therapist is set on the trip, they stay in the "experimental" state of mind and use everything that appears. The clear intention of the therapist and their self-support bring a feeling of safety into the whole situation and support the client in making courageous steps. The therapist stays curious, even playful and they "contaminate" the client with this attitude. They guide and encourage the client through the process of experiment keeping a basic trust that it cannot go wrong, because there is no one right result, just an interesting discovery. An experiment is a piece of art and as such, it is not merely created by the artist. Rather the piece of art "uses" the artist to be created. The therapist finds themselves led by the flow of the intentionality of the situation.

When new, strong and unexpected experiences appear, the therapist grounds themselves well to contain them and they maintain the position of active guide for the client. They do not stop the development of the experiment with empathic sharing at that moment, like: "Oh, it must be really hard for you now". The therapist also does not cancel the experiment when facing a difficulty: "Well, it seems it does not work, let's stop it." Rather they keep the active suggesting attitude guiding the client forward and at the same time providing support. In a collaborative way, the therapist explores with curiosity the unexpected phenomena and searches for new ways to move forward: "Hmm, it seems really difficult for you to do what I'm suggesting to you. Could we explore what would help you to try it? Could you do it in your own way?"

The therapist intentionally and with awareness does not explicitly focus on the therapeutic relationship temporarily for the duration of the experiment. Their task is to support the collaborative work on a challenging task. It can be clearly illustrated by an example of using an empty chair. The

therapist is looking at the empty chair together with the client, or they moderate the dialogue between the client and the empty chair, but they do not get involved in a personal dialogue between themselves and the client, they might even avoid direct eye contact with the client during the experiment.

The therapist not only supports the figuring process of the experiment. They are, at the same time, monitoring the background support resources which enable the client to move on. The therapist monitors especially carefully the client's feeling of shame and, where necessary, they again go through the "gate of shame" first. It is very important that the client does not feel alone and left without support when feeling ashamed during the experiment. Such an experience would present a big risk of repeating a client's harmful or even traumatic past experience. Keeping a clear leading position during the emotionally intensive part of the experiment provides safety for the client and enables them to meet fully the new experience and to find a new sense of their own agency: "I have managed it".

Attune the intensity. The intensity of the experience changes during the experiment. The therapist grades the intensity "just enough" and balances it with support. Laura Perls' (Perls, Rosenfeld, 1978) advice to give as much support as needed and as little as necessary seems very appropriate here. When the grading is too low and the task is not challenging for the client, the experiment does not bring anything new, the client does the experiment mechanically just to satisfy the therapist. Grading the experiment up brings uncertainty, excitement and curiosity.

The well-known empty chair experiment is in fact one at a high-level grade. The therapist can start lower and gradually make the experiment more challenging to reach the right level of excitement. For example, the following dialogue in a situation offers an opportunity to introduce an experiment:

Client: "My mother always told me I am not clever enough to study at university, so I started to work very young."

Therapist: "How was it for you to hear this from your mother?"

Client: "Well, I think she was right. But sometimes I think she spoke more about herself then about me. She did not make it to university herself. It's not about me. This makes me angry."

Now, the therapist can introduce an experiment and grade the challenge up to the growing edge for the client. Here are some examples of interventions from low-grade ones up to the most challenging ones:

"Do you think it would be possible to say this to her now? Maybe just for yourself, in your mind?"

"Could you tell me, what you might want to say to her?"

"Could you imagine your mother somewhere here in the room? How would it be to speak to her image?"

"Could you choose an object in this room as a symbol of your mother? Could you tell her, how it was for you?"

"Could you put an image of your mother in front of you into the empty chair? Can you describe, how she looks there? And now, can you tell her, how it was for you?"

When grading too high, the challenge exceeds the client's momentary capacity and the excitement changes into anxiety. The experiment then stops being productive and useful for the client. Grading it down can brings the excitement and curiosity back: "I was maybe too fast now, we do not have to make this step. And I am really curious, what was the most interesting part for you up to now? ... Would you like to explore this a bit more?" The therapist uses the collaboration with the client to attune the intensity of experiment to the support resources of the momentary situation. If the experiment is graded too high or too low it is not a mistake, rather just another opportunity for a collaborative search for a better fitting task.

Support in impasse. There is usually a moment during an experiment when it seems the process has stopped. Nothing observable happens, however the level of excitement is high. The therapist can find themselves holding their breath and can feel a tension in their body. Fear often appears on the side of the client. This moment of impasse is a very important part of an experiment and in bigger experiments it is inevitable, because it opens a possibility for an unexpected discovery. The task of the therapist is to stay present and to support.

The therapist supports the uncertainty that comes with creativity (Yontef, Schulz, 2015). They ground themselves in their own aesthetic sensing of the situation. In contrast to the case of grading the experiment too high, when the awareness of the therapist is "I am losing the connection with the client", the experience in impasse is different. The therapist feels, "We are together in a hard moment." There is no clear way forward and the way back does not make sense. In this moment, the therapist does not push the experiment forward, rather they trust the process and wait to see what happens. They support the client mainly just by being present, grounded, attuned, trustful. Besides that, they can simply encourage the client ("It's fine, you are doing fine...", "Stay with it and breathe...", "Just try to describe to me, what is happening..."), but does not solve the situation for the client.

Wait for relief. When to stop developing an experiment and come to a closure? Again, the leading position of the therapist brings safety and support for the client. It is the task of the therapist to estimate that there is enough time for closing an experiment and for suggesting it to the client. It

is important to proceed towards closing an experiment in the moment of the client's saturation. Not before when the experience is not perceived as meaningful yet and also not later when the experiment starts to be mechanical and boring. There are several indications for a good time to suggest finishing an experiment: the general level of arousal is going down, the client starts to feel relief, they turn from emotions to thoughts and they themselves start to reflect spontaneously on the process of the experiment.

At the same time, the strategic leadership is again required: the therapist needs to initiate the closing of an experiment at least ten minutes before the end of the session to leave time for integration. Sometimes the therapist needs to sacrifice a very promising development of an experiment to allow time for the client to ground well before the end of the session. The experiment is useful if the new discovery is small enough to be integrated. The fire should not be bigger than the fireplace. When there is not much time for integration the therapist needs to give up on their own desire and to stay on the safe side. Some of the excitement of the situation hopefully can still be preserved for future work. The therapist can frame it: "It's wonderful what you have discovered so far. I appreciate your courage very much. Now, we need to close this experiment because of time. And I would very much like to return later to where we got to now."

Sometimes, stopping an experiment can look like a missed opportunity. However, from a broader perspective, finishing an experiment in a safe and well-grounded way presents an investment in future work. The client becomes unafraid of using experiments, learns to work this way and trusts the therapist when using this powerful tool.

Help to integrate. At this point, the therapist gradually changes his mind-set from the experimental to the dialogical one. The mutual position of the client and the therapist changes. From the collaborative focusing on a common task, they turn to each other in a dialogue again. The therapist is an active initiator of this change and they adjust the way of integrating the experience according to each client's habitual way of integration and assimilation.

The therapist can help the client to give words to the new experience gained during the experiment. This enables the client to grasp the experience and integrate it in a meaningful way for themselves. The therapist can also help the client to ground the new experience in their body and to give enough time for the body to feel self-support and relief. The therapist can support the client to look for a way of integrating the new experience meaningfully into their life narrative. Or, the therapist can explore with the client how the new experience can be of practical use in the client's life. It is important to use the same way the client usually uses to ground and

stabilize themselves. It is also important that the integration itself is not too demanding. The client is usually quite tired after the experiment, the integration needs to be adjusted to their remaining capacity. The intention of the integration at this point is to have some kind of a simple "handle" by which they can grasp the experience. It can be a key word, image, body feeling or a summarizing statement. The natural process of a more complex integration will take place later. Usually, the experience needs more time to make sense, sometimes the client needs to stop thinking about it for a while, or have a chance to dream about it at night and so on.

During the experiment, the client is in a slightly altered state of consciousness and it would be potentially dangerous for them to leave the consultation room in such a state. Not only would they lack the protection of the usual fixed Gestalts in the psychological sense, but also on a very practical level, the client cannot fully rely on their automatic skills, it could for example be dangerous for them to drive a car immediately after the session. The therapist holds their strategic leading position also at this point if necessary: "It was a very intense session today and it will take some time for you to become well-grounded after it. I would like to ask you to take some time before you drive your car. You can sit in the nearby park for a while, or drink a coffee in the cafe around the corner... OK?"

Reflect the relationship. Now, the client and the therapist can share what it was like to go through the experiment together. The therapist focuses now on the relational aspect, which was in the background during the experiment: how was it for the client that the therapist suggested such a challenging task and guided them through it? The focus is more on sharing then on exploring: "I am aware it was quite unusual in our work, I was giving some instructions to you, I was quite demanding sometimes... I would like to hear, how that was for you?" The intention of this step is to make it more understandable and meaningful for the client why the therapist was so actively suggesting and leading during the experiment, and why they now leave more responsibility for the process to the client.

This step can be made at the end of the experiment but often it comes at some interval from the experiment, usually during some of the following sessions. It can be quite short with some clients who are not so ready for here-and-now relational work, but for others, such a personal relational reflection can be as valuable as the experiment itself. They might appreciate when the therapist too shares their own experience from the experiment. The interpersonal dynamics could become richer and reveal new dimensions, thanks to the new roles they both experienced during the experiment. Usually, the issue of a relationship to an authority with its transferential potential becomes more visible.

Small Experiments

Some experiments can take just a few minutes. They can serve just as small "accelerators" in the therapy process, and they can also present a test to gauge if a bigger experiment could be useful in a certain situation. Basically, the same intentions, therapist mind-set and procedure for bigger experiments can serve as guidelines here as well, they are however often present only in an implicit, condensed way. Small experiments are often used as momentary intuitive interventions, seeds dropped by a therapist, which may or may not get planted and grow from the present field.

- *Client: "Everyone needs to fight for his rights". Therapist: "Could you say this sentence once more starting it with "I"?". The therapist uses the language to help the client formulate clearly their own stance and to take responsibility for it.*
- *Client (while looking to the side): "I realize I have to be careful and not trust everyone". Therapist: "How would it be to say this directly to me?" The therapist uses the content the client naturally speaks about and explores the relational aspect of it in the here and now situation.*
- *Client folds their arms across their chest, holding their shoulders. Therapist: "Could you hold this body position with a bit more power? And even a little bit more? Could you make the movement your body wants to do now?" The therapist actively focuses on the body, increases the experience and gives an opportunity for a bodily felt polar feeling to become more present.*
- *Client tells a story about a disappointing experience with their children. Therapist: "Could you stay with the feeling that comes up as you are telling the story now? Could you tell me what happens in your body when you stay with this feeling?" The therapist switches from the content (speaking about) to the process here-and-now and through body awareness they explore the immediate experience as it appears. It often brings awareness of less accessible feelings that were already present in the situation.*
- *Client: "I feel hopeless in my life situation. There is no way forward. I feel like there is a wall in front of me." Therapist: "Could you describe the wall to me? What is it made of, how wide is it, how high is it? What might be behind it?"*

The therapist uses the metaphor the client naturally uses as a switching from a disabling, passive generalisation to a creative, active focusing on details.

These are just a few examples, many more can be found in the relevant literature (e.g. Zinker, 1977; Melnick, 1980; Mackewn 1999; Philippson, 2001; Amendt-Lyon, 2001a, 2003a, 2003b; Melnick, Nevis, Shub, 2005; Joyce, Sills, 2006; Frank, 2003; Mann, 2010; Yontef, Schulz, 2015; and others) or just observed in the natural daily work of Gestalt therapists. Often also other media then words are involved in an experiment, such as artistic materials or musical instruments, or movement, gestures, and use of space in the room (Amendt-Lyon, 2003b). Also in the case of "smaller" experiments, it can be useful to reflect on them with the help of guidelines described above to make more explicit why and how they are used.

Experiments Outside the Therapy Room

Experiments can be used as creative homework too. A very important part of the psychotherapy process is happening between the therapy sessions and we can support it by inviting the client to practice experiments also outside the therapy room. In this case, it is important to differentiate between a technique, which is prepared in advance and applied to achieve a certain goal, and an experiment, which emerges creatively from the therapy process and is co-created by both the therapist and the client. Together with the client, an experiment can be created which fits their daily life situation. Then, at the next session, the therapist helps the client to explore the experience from the experiment.

The client arrived at a session just in time and fell heavily into a chair. For a few moments she stayed sitting silently, red in the face and breathing heavily. "I had to run to be here on time...", she mumbled finally. It took a few more minutes before she was able to become present in the therapy. We discussed what was happening and she explained to me that she always has to arrive at meetings exactly on time: "I need to be perfect".

"How is it for you to say this?"

"I do not like it. I do not want to be a superwoman! It would be unbearable for me and also for others."

"And how would you like to be?"

"To be in peace with myself, to feel good with myself."

We explored that this meant for her to respect her own pace and capacity, which is however very unusual for her. She lives in constant fear that others will leave her if she does not fulfil their expectations. We talked

about her life experiences which formed this fear of hers and also about her needs and wishes for the future. She becomes calmer during our talk, there were a few minutes left of the session. "How do you feel now? Are you at peace with yourself?"

"It's quite good now... I feel calm, respecting my own pace. I am not used to experiencing myself this way. It would be a relief to be more often like this."

"Would you like to try it the next time you come to our session?"

We then came to an agreement, that the client would try to recall this body feeling next time when on the way to therapy, and walk according to it. I promised to wait for the client, even when she arrives late, and explore this new experience together.

There are many possible ways to use experiments between the sessions. Generally, it seems most useful to introduce experiments that build on new skills the client has already discovered in the session. The client tries to bring these skills into their natural, daily life situations and shares with the therapist at the next session what they have discovered. For example, a man who came to therapy because of his impulsive violent behaviour can practice what he discovered in the therapy: before acting-out the impulse, he can stop himself for a little while to become aware of his feelings, body, and thoughts. Together with the therapist they can then explore at the next session how it was for the client and what he has discovered. It is important to distinguish such practice from a rehearsal technique. The therapist needs to keep the basic feature of an experiment in mind and introduce it to the client, too: there is no one right result, just an opportunity for discoveries.

Risks of Using Experiment

An experiment needs to grow from a safe and stable ground. When such a ground is missing the use of experiment is not only unproductive but also risky. The safety and stability of the ground depends on the therapist, on the client, and on their relationship. In general, there is a risk of re-traumatising the client, when the therapist takes an individualistic perspective (Francesetti, 2015) and builds the experiment on the feeling of 'having understood', or 'knowing'. Being well grounded and staying open to what comes, reduces the risk, because the creativity can then appear as a field phenomenon, and the therapist can let their interventions be led by their aesthetically informed intuition.

On the side of the therapist, the main risk is when the therapist suggests an experiment as a way of escaping from their own anxiety, helpfulness or feeling of urgency. "I do not know what to do now with the client! Maybe

some good experiment would help..." The safe and effective use of experiment depends on where the impulse originates from in the therapist. The therapist needs first to ground themselves well through their body position, breathing and/or a conceptual understanding of the situation. They also need to establish good contact with the client through a dialogue about the details of the client's situation or story. Only then can an experiment emerge creatively and freely and as a way of exploration and not as a solution. There is a useful general rule: when you do not have anything to say, don't say anything. It is most valid for the use of experiment as well. When no idea of a possible kind of experiment presents itself to the therapist they should not introduce any experiment for the moment.

The therapeutic relationship needs to become established almost as a routine before introducing some bigger experiment. I still remember how, being an eager Gestalt therapy student, I lost my first client after introducing a powerful experiment right at our second meeting. When there is a lot of novelty and discovery in the relationship itself, there is no point in bringing even more uncertainty by introducing an experiment. The therapist can just follow the natural figure/ground dynamics. Until the dialogical aspect of the work is figural and vivid, an experiment is not needed and could possibly only serve as a way of avoiding some challenging relational issues.

There are some clients, typically the ones with traumatic, psychotic or borderline experiences, who come to therapy with a basic lack of a safe ground. Special attention needs to be paid to the risks of using experiment with them. The role of the therapist´s ***Strategic leadership*** becomes much more important in such cases. Experiments can be used but much more attention needs to be paid to evaluating the situation and planning the experiment. The therapist needs to have a clear intention for introducing an experiment based on a case formulation. The process (not the result) of an experiment needs to be more controlled by the therapist.

Work with clients with traumatic experiences, where there is a high risk of re-traumatisation by an experiment, can serve as an example here. The client can meet the traumatic experience again in the experiment. The risk of re-traumatisation lies in repeating the experience of losing control and of being abandoned. It is crucial that the therapist slows down the process of experiment and moderates the intensity of the experience, so the client has a chance to control the process of the experiment and finish it, when they want. This already presents a new, healing experience for the client. A verbal description of experiences (either by the client, or by the therapist) helps to slow down the process, include cognitive processing and to grade down the intensity of the experience. It also enables the client to feel the

supportive presence of the therapist in the "safe emergency" experimental situation.

Example of a small experiment. *The client was a young woman with a traumatic childhood experience with a highly emotionally unstable mother, who many times claimed and intended to commit suicide in front of her little daughter. The client remembers vividly, how, for example, she as a five-year-old girl was begging her mother desperately and holding her balancing on the parapet of a window high above a street. During two years of therapy, the client slowly started to step out of the role of a victim, which has caused her a lot of difficulties in her life, into the position of actively creating her life. There were very important markers of these two positions, which we often used for monitoring which position she found herself in here-and-now. She either spoke with a high, squeezed voice when being in the victim position, or with a low, calmer voice in her newly found position.*

At the present session, the client reported on how her mother came to her recently and urgently started to share with her how she herself was sexually abused as a child. The client did not want to hear it, she did not want to be the one again who is at the disposal of others and neglecting her own needs. She felt a great anger because her mother always managed to put her into the position of her saviour. She felt hopeless and helpless.

The therapist noticed that she was describing the whole situation with a high, squeezed voice. So, he suggested to her that she try to describe the whole situation again with the other, lower and calmer voice, the one she knew already from her newly discovered position of an active creator of her life. The client reacted reluctantly, with a high voice: "Well, I don't like to come back to it again.... I see, I am saying this as a victim again, right?" Therapist: "Maybe you can try just one or two sentences, something about your mother and about you two together...?"

The client was silent for a while, mobilizing her energy, then she started with a lower voice: "In fact, I am realizing how similar to each other we are. She has a hard life and I do not want to refuse her. I want to listen to her, when she needs it. And at the same time, I do not want to get hurt myself. Well, now I can feel very close to her, I have not felt this for a very long time."

The experiment led to two important discoveries: the client found she can consciously, on purpose, change her perspective on a stressful life situation using the change in her voice (***Acting differently, enhancing agency***); she also discovered that leaving a victim position enables her to feel proximity with her mother (***Raising awareness***).

An example of a bigger experiment. *A 35-year-old client had referred in the last session to a traumatic experience of sexual abuse in early*

adolescence. At the next session, she shares: "I felt so much anger last time here... And I kept it for myself. I always do that, I understand the reasons, why others are rude to me. I can explain everything to myself, I do not bother others by my feelings. It's my old habit.... When I was a little girl, I promised to myself: "I will never cry!" Therapist: "What happened?" Client: "I was a very emotional child and when I was angry, I cried. My parents always stopped me immediately saying that I had no reasons to cry. I had to go to my room in such cases. I felt so alone there!" Therapist: "How is it for you to speak about it now?" Client: "I feel so helpless, I can't do anything with it. I am powerless."

The therapist suggested an experiment to her: "Could you imagine here, in front of you, this little girl you once were, the one alone in her room? What would you say to her as the adult woman you are now?" Client (to the little girl): "You can cry, it's all right. You need to take care of yourself when taking care of others. You can go closer to others."

The experiment had the clear intention of building self-support, however there was still a lot of space left for a creative discovery of the client's own ways of self-supporting. One of them, the final sentence: "You can go closer to others", became a key impulse for further work together and for the changes the client started to make in her life.

Including Experiment into the Whole of a Therapy Process

An experiment was described above as a specific kind of intervention that is used by the therapist with special intentions, mind-set and procedure. However, an experiment is obviously not an isolated event in the psychotherapy process. It remains a collaborative event co-created within the dialogic relationship. Moreover, experiment itself is a function of the field of the present therapy situation. It emerges from this field, is formed by it and influences it in return. Experiment can be seen as formed by the intentionality of the situation. Both the client and the therapist can find themselves being led by the flow of the process, which follows its own meaningful way, often hidden to the involved parties at the moment. The process of the experiment itself can be seen as directed by the 'law of Prägnanz'.

The therapist explores their own awareness during different phases of the process of the experiment with respect to the dynamics of the relational field. A supervision specifically focused on the use of experiment is useful here. The therapist can explore *how the experiment started*, how the experiment gradually grew from the therapy situation and what relational

phenomena were present: what was the therapist's awareness of the situation when they suggested the experiment? The therapist reflects on when and for what purpose they might have suggested the experiment and what role the experiment could play in the dynamics of the therapeutic relationship. It can happen that by suggesting an experiment the therapist is taking care of their own needs.

Was the therapist for example avoiding their more personal involvement in the relationship with the client by suggesting the experiment? If this is the case, it is not something to be criticised. On the contrary, such awareness could be valuable information suggesting that the dialogical aspect of therapy needs to become more figural (with the experimental withdrawing to the background) in this phase of the therapy process.

Or, has the therapist suggested the experiment when they themselves were anxious about not knowing what to do with the client? From the field perspective, the anxiety does not belong solely to the therapist, rather it is a function of the present field. Such awareness can again be used as important information suggesting that the ground of the relationship needs more support, because it is still not safe enough for challenging new discoveries (through the use of experiments).

However, the therapist is not interested just in how the experiment grew from the relational field of the therapy situation. They also explore, what was their own awareness *during the process of the experiment*. The therapist can for example experience themselves as too directive and controlling during the experiment, or on the other hand, too indecisive and cautious. Becoming aware of it, the therapist explores it as a phenomenon of the field, as information about a relational pattern by which the actual relational field is organising itself. The therapist's awareness affords information about such a pattern, because their experience, impulses, and needs are a function of the relational field during the whole process of therapy, as well as in the experiment.

And finally, what was the therapist's awareness *at the end of the experiment*? What did they experience with the client then? Was there for example a moment of shared relief and proximity? The therapist pays attention to how such an experience brought by the experiment has influenced the therapeutic relationship and how it can be meaningfully integrated into the whole of the psychotherapy process through a dialogue with the client. Or, was the therapist for example aware of their frustration that more could be reached through the experiment? Again, this awareness is valuable information (probably about high expectations and a goal oriented pattern) and the therapist explores how it can be integrated back into the relational dynamics between the client and the therapist.

Clinical Example[1]

The following example illustrates the individual steps of an experiment procedure and it focuses especially on the integration of the relational experience of an experiment into the whole of the therapy process. I, as the therapist here, use the model of steps in experiment described above to reflect the real therapy process with its natural flow, exciting surprises and pitfalls.

Experiment as a Specific Intervention

A 50-year-old client, Hana, entered therapy because of the sudden and unexpected death of her husband two years previously. Six months of therapy gave Hana a place for mourning and for sharing her pain and sadness. The dialogical aspect of Gestalt therapy has been in the foreground of our work with the experimental one naturally in the background. The actual session described here occurred after Hana returned from a one month-long summer holiday break.

In the beginning of our session we spent some time talking about Hana's holidays. Our dialogue naturally flowed and we discussed what had happened during the time we hadn't seen each other, and how it had been for her. Hana said that, within the period without the therapy, she had coped quite well in general. She also described a couple of difficult moments, but all in all she felt competent. "I realized I can manage even without it," she says. Saying this, Hana glanced up, looked at me briefly and then continued staring on the floor.

At that moment, my aesthetic sensing of the situation was that it was a good time to explore. It was based on the holistically felt impression of several tiny observations of Hana and also of my own awareness. I noticed a slight change in Hana's body posture: she was sitting more uprightly and at the same time in a more relaxed way. I understood it as an embodied self-support. Also, in the way she spoke to me and looked at me I noticed a tiny, but significant change from what I perceived as "Please, help me!", which was present in our previous work, to "I want to share something with you." I experienced the contact with Hana as less demanding and urgent, rather more energizing and curiosity-provoking.

Based on this "intrinsic diagnosis" (Roubal, Gecele, Francesetti, 2014), I estimated that her already developed self-support and also our well-

[1] This is an amended version of a case description used already in my other texts (Roubal, 2009, in press).

established relationship could withstand a more challenging intervention. I perceived the situation as slightly different from our previous sessions, where safety, support, and containment were needed and so the dialogical aspect of Gestalt approach was naturally figural. Now, I sensed there might be a good time for allowing the experimental aspect to come forward.

I decided to offer Hana an experiment that would help us to become more aware of the process going on in our relationship here and now. Making this decision, I actively and with awareness switched my role towards Hana from a companion to a guide. For that, I established a new ***mind-set***, which was different from the previous dialogical one. I became focused and sensitive to the aspects of the here-and-now situation (***Grounding in here and now***), which were inviting me for a further exploration and discoveries (***Openness to discoveries***). I consciously became ready to take a lead and actively suggest an experiment (***Active suggesting***). I allowed myself to be fascinated by the creative process and I allowed my intuition to follow an inspiration for an experiment (***Courage to creativity***). At the same time, I was ready to hold my intention for an experiment just lightly and I was ready to adjust the experiment or skip it, if it would not fit Hana (***Strategic leadership***).

I used the sentence Hana brought herself spontaneously ("I can manage without it [the therapy]"), and I suggested to her that she could change the sentence a bit and say to me, "I can manage even without you."

My intention was to highlight the outline of the figure arising from the contact between the client and the therapist. The figure was not clear yet, but it seemed to be characterized by moving towards a more equal relationship and less dependency of the client on the therapist.

Hana agreed to try it. She leant forward and firmly grasped the arm rests. She was silent for a while concentrating on her thoughts, then uttered the words I suggested. She kept looking at the floor. When I pointed this out, she tried again, looking into my eyes this time, "I can manage even without you." Her face coloured. We remained with the present experience for a while, and then talked about the feelings that arose. She said there was a mixture of very strong feelings: joy, sadness, helplessness, and also a pleasant feeling of own competency.

I built the experiment on the phenomena naturally appearing in the here-and-now situation (***Grounding in here and now***), using Hana's own sentence, noticing and describing her body expression and exploring her experience. By discussing her experience with her, the dialogical aspect of therapy became more figural and the experiment could be finished here. However, using the aesthetic criteria for a momentary diagnostic picture, it seemed to me the intensity of her experiencing much exceeded what would

fit the here and now situation. This discrepancy made me curious and I allowed myself to be led by my curiosity (***Wait for curiosity***). At the same time, I took a little time for myself to make up some understanding of the situation. My working hypothesis was that not all Hana's very strong feelings belonged solely to the relationship between the two of us, rather they suggested some unfinished matters concerning Hana's other relationships too. Based on both my curiosity-driven intuition and my cognitive conceptualisation I decided to offer another step in the experiment.

I suggested to Hana, "Who else would you like to say it to? "She replied, "To my mother who feels sorry for me all the time and treats me like a little girl."

Hana seemed captivated by this discovery, but, on the other hand, she did not express any strong emotions. It seemed to me that her new awareness was more on a cognitive level. My understanding was that Hana was coming close to a new awareness, but she kept to the safer position of repeating the already discussed topic of her relationship with her mother. I myself was aware that the excitement of our shared experience was decreasing, which for me was a sign of "operating in the safe territory".

And then, Hana added: "And, in fact, [I would like to say it] to my husband, as well. "

The excitement was immediately high. It was a sign for me that we were touching some new experience. Hana brought the sentence from her own impulse, which for me indicated her natural need to broaden her awareness on this issue. Now, the challenge for me was to support this naturally appearing drive in Hana and at the same time not to lead her too far into the unknown territory, where the excitement would get frozen into anxiety (***Hit the edge***).

I asked Hana if she wanted to explore this issue with her husband more. She agreed.

An idea of an empty chair experiment came to me. The idea was not in my mind as a prepared intention before, it appeared spontaneously only now from the on-going process and so I trusted this inspiration. However, I hesitated before suggesting such a demanding experiment to Hana. It would be the first time in our work when I would use an experiment so explicitly. I was uncertain if this was a good idea. I explored my awareness and I discovered that I was pulled back by feeling ashamed to offer the empty chair to Hana. My position with her was more of someone who is calm, stable, receptive. Now I would have to step out of this (quite comfortable) position and to risk suggesting such a crazy idea as speaking to a chair! Then, I said to myself: well, when you invite her to do something out of her

comfort zone, you need to step out of your own comfortable zone too. So, I decided to risk it (***Jump into uncertainty***).

I suggested that she could imagine her husband sitting in the empty chair in front of her. Hana looked surprised, and nodded. I put a chair in front of her.

This was the moment when the experiment took on its own dynamics. I was aware that now I could just guide Hana forward (***Guide forward***) towards an unknown discovery. I let my interventions be driven by the dynamics of the experiment itself, controlling neither the process nor the results. For that I needed to rely on my creativity and to trust in my previous experiences with experiments.

Hana looked at me with a kind of amused expectation.

I considered several opportunities to attune the intensity of the experiment (***Attune the intensity***). I could leave the experiment more open and suggest to Hana to visualize her husband in the empty chair, describe him to me. We would then explore how it would be for her to meet her husband and the empty chair dialogue would develop from there. Or I could keep the more focused link from which the experiment had actually developed, because it all started with the sentence "I can manage without it". Even here I could decide to grade the experiment lower: "Could you imagine you would say such a sentence to your husband?", or higher, which I finally did:

"Could you say the same sentence [as before] directly to him?"

Hana hesitated, considered the proposal. Then she looked at the chair in front of her, blushed, started to breathe heavily, but kept silent.

An image came to me: I saw Hana as getting ready to jump. I paid attention to breathing freely myself and to keeping a self-supported body position in my chair. I muttered something like: "You are doing fine", but the words were not important. By my body position and by the tone of my voice I provided Hana a support to go through the impasse (***Support in impasse***).

"I can manage without you ... ", Hana said to her husband in the empty chair. "Yes, it's true. I can manage without you! ", she repeated. Hana smiled through her tears, nodding. There was quite a long moment of silence.

At this point, I could go on and grade up the experiment a bit more. I could ask her, what she imagined her husband would have answered to her. From there, I could support a developing dialogue between them. However, my aesthetic sensing of the situation gave me clear information that it would be too much, I would have overloaded the situation.

Instead, I kept silent, too, being aware of the high intensity of the present experience, grounding myself in my body and breathing, staying present and available. Hana was immersed in her new experience and I just waited for signs of a natural experiential integration of her new awareness (***Wait for relief***).

Finally, Hana's body posture relaxed. Then, after some time, she turned to me.

I could clearly sense that this was the time to close the experiment. The excitement was replaced by a relief and tiredness, which I could feel myself and observe in Hana, too. The experimental aspect of the Gestalt approach was slowly withdrawing into the background and the dialogical aspect was becoming figural again. My position was changing from a guide to a companion and my task was to help Hana to assimilate the experiment (***Help to integrate***).

Reflecting the experiment, Hana found that through the dialogue with her husband, she had gained new awareness of her own competence. The cognitive knowledge of her competence grew to an emotional and bodily-experienced sense of the competence to live her life on her own.

When talking about her experience from the experiment, Hana said she had actually known she was coping without him, but saying it directly to the image of her husband was a new experience for her. "I knew it, in fact. But now I could feel it."

Experiment as a Part of the Whole

How the experiment creatively grows out of the actual figure-ground formation was illustrated here. The process of the experiment formation was unfolding gradually, beginning with the sentence, "I can manage without it", through directing this sentence to the therapist, to the dialogue with her deceased husband in the empty chair. The experiment started from the situation here and now, grew from the actual field dynamics and outlined the emerging figure.

However, this is only one part of the story. Gestalt therapy presents the unique combination of a task-focused experimental approach with the psychotherapy relationship focused dialogical approach. The benefits of such a combination lie in the possibility of processing the relational experience from an experiment both as information about fixed relational patterns and also as an opportunity for a new, corrective relational experience.

Because the end of the session was approaching, it was necessary to finish the experiment, to make the symbolically occupied chair empty again.

However, Hana seemed unable to take this step. When I checked it, I realized she still saw her husband sitting in the chair in front of her. She did not want to say this symbolic goodbye to him.

I found myself in quite a difficult situation. It was clear to me that Hana needed more time and support, but I was expecting another client to come within a couple of minutes. I decided to share this dilemma with Hana. We discussed it together and finally, being under the pressure of time, we arrived at a provisional solution. Hana imagined taking her husband from the chair with her. She did that symbolically with her hands putting him into her chest. She felt satisfied, as this was the way she was used to living, always in his company.

However, I was left with a feeling of dissatisfaction, incompleteness after the session. There were many doubts and questions in my mind after the session. What happened? Why had the experiment, which had so fluently emerged from a situation in the here and now, not reached a complete Gestalt? Or at least I had not perceived it as such.

When reflecting on the session, I was aware of two levels in the therapy process. The first concerns the *methodology of the experiment*. The problem was in the timing and grading of the intensity of the experiment. To some degree I neglected the collaborative aspect of developing the experiment. I was not monitoring the risk carefully enough and so the experiment was graded too high for the client and for the time we had at our disposal. The mere experience of saying to her therapist, "I can manage even without you," might have been fruitful enough for Hana. The rest of the session could have been used for allowing more awareness and for its assimilation. Perhaps during some other sessions Hana would be more ready to make another step.

I am afraid I had overestimated Hana's capacity for self-management in the described session. I became over-involved in the experiment and I was fascinated by its dramatic progress. I was wishing for Hana that she reach a good resolution of her mourning, I realized only afterwards that I had a hidden agenda that she „should" say goodbye to her husband. It would make sense to me and it would make me feel like a successful therapist. Maybe I even anticipated using this experiment as an illustration, when teaching about the use of experiment in Gestalt therapy. Anyway, it seems, I might be gratifying my own needs without being aware of it, and thus I ceased to be adequately perceptive to the needs of my client. I was too demanding towards Hana, and now, in my thoughts, I apologise to her for doing so.

However, when reflecting on all this, I need to be aware that experiment is always an adventure with an unclear ending, so it inherently cannot come off badly. So, I try not to evaluate the result of this experiment as good or

bad, as successful or unsuccessful. When I explore the end of the session phenomenologically instead, I can discover valuable diagnostic information there. Hana was not able to symbolically part with her husband. It is evident that she is still actively processing her husband's death, and her mourning has not yet arrived at a stage where she would be able to both bury him on an emotional level and live independently. It is clear that the experiment brought to light the actual phase of her mourning process. She still needs her husband in her life and therefore she cannot send him away, even symbolically in the therapy. She may even decide not to send him away at all. I am not there to decide for her, but to support her here, where she is.

There is yet one further aspect of the process, that I want to focus on more carefully. This second level of evaluating the therapeutic process requires a consideration of the *experiment as a phenomenon of the field.* Every outcome of an experiment, including the "mistakes" of the therapist, is a function of the shared field of the client and the therapist. The "mistakes" are phenomena of the field and offer valuable information about the fixed relational patterns. For being able to look closely at the process of my relationship with Hana during the experiment from this perspective, I need to explore my own awareness and also my active contributions to the field organisation.

After the session, I was disappointed with myself and I was also angry at Hana. I considered myself too demanding towards her in burdening her with a task that was beyond her actual capacities. My impression was that she could manage on her own, but I was too pushy, too fast. It was the first session after her holidays, and Hana evidently needed more time to settle down. Instead of that I was offering too powerful an experiment, too soon. At the same time, I am aware of my anger towards Hana. I wanted the best for her and I was working hard for her. I realize I felt angry and unappreciated at the end of the session.

It is challenging not to follow the immediate impulse to criticize myself. Instead, I can try to observe my own awareness with curiosity as a phenomenon of the field. I need to remind myself that the therapist within the therapy is a function of the field, and the words and interventions they use are also functions of the field. The way the therapist intervenes represents a valuable source of information about patterns that organize the field, and also about how both the client and the therapist contribute to it.

Moreover, it seems that those situations, when therapy somehow does not proceed the way the therapist expects and would prefer, provide especially valuable information. In these moments, the fixed Gestalts dominate the organization of the field. The therapist can use themselves in

this sense, because everything they experience and do is a function of the field and can be used as diagnostic information.

For example, when grading the experiment, I asked Hana quite directly: "Who else would you like to say it to?". Why did I not ask a more open-ended question like, "Is there maybe someone else you would like to say it to"? I think I assumed to know what was best for her and I worked instead of her. When I look at my awareness as a phenomenon of the field, this was my contribution to the fixed Gestalt. I was pushing a hidden agenda, and I assumed I knew how Hana would complete her unfinished business with her husband. Again, I try not to criticise myself for that, but observe my awareness with curiosity. What was the complete Gestalt in my opinion? I wished for her that she could say goodbye to her husband and start to live an independent life, maybe even become ready to meet someone else. But she did not meet my expectations, she managed the end of the session her way and at her speed.

During the next meeting with Hana, we reflected on the process of the previous session. How had it been for her to do the experiment?

"It was really powerful and very useful for me. The experience resonated in me after the session quite a lot..."

And how had she felt with me, when I had suggested the experiment and had led the therapy this way?

I returned back to the experience from the previous session to reflect on how using the experiment has influenced our relationship and what we could learn from it (***Reflect the relationship***). I switched from the one-person approach (What have you discovered about yourself?) to the two-person approach (What have we discovered about our relationship?).

"Well...", Hana said, "in the last session, I felt with you ... like not being an adult really ... as though unable to be fully responsible for my life..."

Hearing this, I shared with her my awareness described above. I said I was really trying to help her and only after the session I had realized that I had a hidden agenda, a wish for her to finish the mourning well and to be able to go on. I said I was sorry to realize that I was pushing her towards my intention.

Hana was moved. She realised that what I described is very similar to the way her mother treats her now after the death of Hana's husband. Her mother treats her like a child, she implicitly pushes her to another partnership, she is too demanding...

Hana continued to blame her mother for some while. She said she felt helpless, trapped in the fixed pattern with her mother.

Being aware that both the fields of her relationship with her mother and the one of the therapeutic relationship can be organized by a similar fixed

pattern, I offered to Hana to explore more the relational aspect of the last session.

How did she feel with me? What could be her part of the co-creation of the fixed relational pattern? First it was difficult for Hana to reflect back on the details of the process, so I started from my side. I shared that I was at first very enthusiastic to help her and then I became confused and finally disappointed that she did not use fully the opportunity I offered to her. Then I became aware that I was pushing her towards my good intentions and I felt sorry and ashamed.

"I can see it now!" she exclaimed. She started to explain to me what she realized about the way she contributes to the fixed Gestalt with me – and with her mother, too. She realised she resists passively, and then at the end, as also happened at the end of our last session, she somehow manages to sabotage the effort of the other and succeeds in not fulfilling the expectations of the other – me or her mother.

As a result, she explained more how she herself does not feel adult, rather she experiences a sense of incompetence and helplessness. Hana said this pattern describes well what happens regularly between herself and her mother and it helps her to understand why her mother feels unappreciated, and at times becomes irritated, reproaching her, because she wants the best for Hana, has tried so much and worked so hard for her.

Again, I suggested that Hana return to the last session and explore what her needs had been in that situation. What had she needed from me to feel more adult, more competent?

She said she needed me to speak with her as I was doing now in the present session. Could she be more specific? Yes, she needed me to respect her own wisdom, her own vision of the future, her own timing.

Hana said it was fine for her that I suggested the experiment. She found it helpful and useful in several ways. And she also needed me to speak more openly about my intentions in the process of evolving the experiment and that I consult more with her on the grading of the experiment. Saying this, she realized that, in fact, she needs her mother to do exactly the same.

At the end of the session, Hana felt less helpless. She found this new awareness supportive for her to become more independent and self-confident in the contact with her mother. She felt excited to try to speak from this adult position with her.

After exploring together the exciting adventure of the experiment our relationship was also transformed. It has become more collaborative and more personally open. The experiment has opened new ways in our common work and strengthened our working alliance. The therapy was not so focused on "healing the past wounds" anymore, rather it offered a

meeting space for "discovering new meaningful ways of living". My position in the therapy with Hana also changed. From being a helping professional I became more present as a living person who can make mistakes.

Learning from this case, I can see an experiment as a flower which grows out of the ground of the therapeutic relationship. The seed is planted by the therapist, and then the flower is raised by both the client and the therapist through the creative collaborative process. Later, the flower of an experiment drops seeds back into the ground of the therapeutic relationship.

Conclusion: The Art of Double Availability

Recently I saw a mother with a five-year-old son in the street. They were holding each other's hands, being on their way home. I overheard the young man speaking about his big love from kindergarten. He was explaining something with great passion and the mother was listening to him attentively. I was touched, and with a professional interest I was also observing what the mother was doing. She was listening to her son with her whole body, bending down to him, fully attuned, and present. She was answering him, encouraging him with questions, mirroring non-verbally his emotion. However, I also realized that she was doing something else at the same time, fulfilling another task in parallel. She was monitoring the cars in the street and, when it was safe, she prompted her son to cross the street. She greeted someone briefly from a distance. She was observing the signs on the passing trams and waited for the right one.

This picture provides a metaphor (with all the limits the use of metaphor brings) that illustrates the work of the therapist during the experiment. Their mind is fulfilling two different kinds of tasks at the same time; they are available to the client in two parallel ways. Through embodied inclusion they find themselves experiencing how it is to live life the way the client does. At the same time, the therapist is grounded in themselves and in the broader context of the therapy situation. This allows them to explore what intention the experiment can have at the moment, how to arrange a fitting timing and grading of the experiment, or when it is the right time to bring the experiment to a close.

Such a double availability is probably always present in the work of a psychotherapist. However, it is useful that the therapist is especially attentive to it when using an experiment to avoid the risk of applying a technique with the purpose of changing the client. Lead by following, a Tao principle of a servant leadership, can well be applied to the dialogical work of a psychotherapist, who follows the issues the client brings and attunes to

the client in a genuine and unique dialogue in such a way that leads the client to new relational experiences.

When using experiment, the therapist temporarily decides to change this approach and takes a lead in an explicit way. At the same time, however, they follow the intentionality of the present situation for creating a task. They suggest the task to the client and follows the process adjusting the level of challenge to the client's capacities and balancing it with support. They let their leading suggestion be led by the situation with the client here and now. The therapist follows by leading.

An experiment is a natural part of the work of the Gestalt therapist and so it's a natural part of the co-created flow of a dialogical meeting of the client and the therapist. An experiment loses its essential existential quality when it is extracted and isolated from the whole of the psychotherapy process. However, if we want to use experiment competently and to make use of its whole potential, we need to explore it as a specific intervention with its procedures, benefits and limits. To cultivate our use of experiment, we need to become aware of the delicate details in using it, of the steps in creating it, of the useful and hindering conditions for using it. We cannot rely only on an intuitive creative work, we need to make explicit the skills needed for the use of an experiment. And then, when meeting the client, we need to rely on our therapeutic competence to forget all this theory and use our intuitive insights and creative freedom to enjoy the adventure of the experiment together with the client.

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References

Addis, M. E., Cardemil, E. V., Duncan, B. L., & Miller, S. D. (2006). Does Manualization Improve Therapy Outcomes? In: J. C. Norcross, L. E. Beutler, & R. F. Levant (eds.). *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions,* 131-160.

Amendt-Lyon, N. (2001a). Art and Creativity in Gestalt Therapy. *Gestalt Review*, 5, 4, 225-248.

Amendt-Lyon, N. (2001b). "No Risk, No Fun!" A Reply to Commentaries. *Gestalt Review*, 5,4, 272-275.

Amendt-Lyon, N. (2003a). Toward a Gestalt Therapeutic Concept for Promoting Creative Process. In: Spagnuolo Lobb, M., & Amendt-Lyon, N. (eds.). *Creative License. The Art of Gestalt Therapy.* Wien, New York: Springer-Verlag, 5-20.

Amendt-Lyon, N. (2003b). Memorable Moments in the Therapeutic Relationship. In: Spagnuolo Lobb, M., & Amendt-Lyon, N. (eds.). *Creative License. The Art of Gestalt Therapy.* Wien, New York: Springer-Verlag, 211-226.

Amendt-Lyon, N.A. (2003a), Toward a Gestalt Therapeutic Concept for Promoting Creative Process. In: *Creative License: The Art of Gestalt Therapy,* Spagnuolo Lobb, M., & Amendt-Lyon, N. (eds.). Wien and New York: Springer, 5-20.

Bohart, A.C. (2000). The Client Is the Most Important Common Factor: Clients' Self-Healing Capacities and Psychotherapy. *Journal of Psychotherapy Integration,* 10, 127, https://doi.org/10.1023/A:1009444132104

Bowman, E., Nevis, E.C. (2005), The History and Development of Gestalt Therapy. In: *Gestalt Therapy. History, Theory, and Practice,* Woldt, A. L., & Toman, S.M. (eds.). Sage Publications, Thousand Oaks, 3-20.

Buber, M. (1958). *I and Thou.* New York: Charles Scribner's Sons.

Burley, T., Resnick, R., & Resnick, R. (2005), Dear "experiment" contributors and readers. Retrieved from www.GATLA.org

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 66, 7–18. doi:10.1037/0022-006X.66.1.7

Chambless, D. L., & Hollon, S. D. (2012), Treatment validity for intervention studies. In H. Cooper, P. Camic, D. Long, A. T. Panter, D. Rindskopf, David, & K. J. Sher (eds.). *APA handbook of research methods in psychology, Vol 2: Research designs: Quantitative, qualitative, neuropsychological, and biological.* Washington, DC: American Psychological Association, 529-552.

Elliott R., Stiles W.B., Shapiro D.A. (1993). Are Some Psychotherapies More Equivalent Than Others? In: Giles T.R. (ed). *Handbook of Effective Psychotherapy.* Boston: Springer.

Elliott, R., Greenberg, L.S., & Lietaer, G. (2004), Research on Experiential Psychotherapies. In: *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change,* Lambert, M.J., ed. New York: John Wiley and sons., 493-540.

Elliott, R., Watson, J., Greenberg, L. S., Timulak, L., & Freire, E. (2013), Research on humanistic-experiential psychotherapies. In: M. J. Lambert

(Ed.), *Bergin & Garfield's Handbook of psychotherapy and behavior change*, 6th ed. New York: Wiley, 495-538.

Evans, K.R. (1994). Healing Shame: A Gestalt Perspective. *Transactional Analysis Journal*. 24, 2, 103-108.

Fiebert, M.S. (2012). Stages in a Gestalt therapy session and an examination of counselor interventions. *International Review of Social Sciences and Humanities*, 2, 2, 49-61.

Fogarty, M., Bhar, S., Theiler, S., & O'Shea, L. (2016). What do Gestalt therapists do in the clinic? The expert consensus. *British Gestalt Journal*, 25, 1, 32-41.

Francesetti, G. (2015). From individual symptoms to psychopathological fields. Towards a field perspective on clinical human suffering. *British GestaltJournal,* 24, 1, 5-19.

Francesetti, G., Gecele, M., & Roubal, J. (2013b). Gestalt Therapy Approach to Psychopathology. In: Francesetti G., Gecele M., & Roubal J. (eds.). *Gestalt Therapy in Clinical Practice. From Psychopathology to the Aesthetics of Contact*, Milano: FrancoAngeli, 59-76.

Frank, J. D., & Frank, J. B. (1993). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: John Hopkins University Press.

Frank, R. (2003). Embodying Creativity, Developing Experience: The Therapy Process and Its Developmental Foundation. In: Spagnuolo Lobb, M., & Amendt-Lyon, N. (eds.). *Creative License. The Art of Gestalt Therapy.* Wien, New York: Springer-Verlag, 181-200.

Garfield, S. L. (1995). *Psychotherapy: An eclectic-integrative approach second edition* (2nd ed.). New York, NY: John Wiley & Sons.

Goldfried, M. R. (1980). Toward the delineation of therapeutic change principles. *Applied and Preventive Psychology, 13,* 1-4, 3. https://doi.org/10.1016/j.appsy.2009.10.015

Goodman, P. (2003). Novelty, excitement and growth. In: Wheeler, G. (ed.). *Reading Paul Goodman: Gestalt for our times.* Hillsdale, New Jersey: The Analytic Press/GestaltPress.

Grawe, K. (2004). *Psychological therapy*. Cambridge, MA: Hogrefe & Huber Publishers.

Greenberg, L. & Foerster, F. (1996), Resolving unfinished business: The process of change. *Journal of Consulting and Clinical Psychology,* 64, 3, 439-446.

Greenberg, L. S., Rice, L., & Elliott, R. (1993), *Facilitating Emotional Change: The Moment-by-Moment Process.* New York: Guilford Press.

Greenberg, L., Brownel, P. (1997). Validating Gestalt. *Gestalt!,* 1/1, http://www.g-gej.org/1-1/greenberg.html

Greenberg, L., & Clarke, K. (1979), The differential effects of the two-chair experiment and empathic reflections at a split. *Journal of Counseling Psychology*, 26, 79-85.

Greenberg, L., & Dompierre, L. (1981), The specific effects of Gestalt two-chair dialogue on intrapsychic conflict in counselling. *Journal of Counselling Psychology*, 28, 288-294.

Greenberg, L., & Higgins, H. (1980), The differential effects of two-chair dialogue and focusing on conflict resolution. *Journal of Counselling Psychology*, 27, 221-225.

Greenberg, L., & Rice, L. (1981), The specific effects of a Gestalt intervention. *Psychotherapy, Theory, Research & Practice*, A.P.A. Journal Division 29, 18, 31-37.

Greenberg, L.S. & Webster, M. (1982). Resolving decisional conflict by means of two-chair dialogue and empathic reflection at a split in counseling. *Journal of counseling Psychology*, 29, 468-477.

Hatcher, C. (1978). Intrapersonal and interpersonal models: Blending Gestalt and family therapies. *Journal of Marriage and Family Counseling*, 4, 1, 63-68.

Jacobs, L. (1995). Dialogue in Gestalt theory and therapy. In: *The healing realtionship in Gestalt therapy*, Hycner, R. & Jacobs, L. (eds.). Highland, NY: Gestalt Journal Press, 51-84.

Joyce, P., Sills, C. (2006). *Skills in Gestalt Counselling & Psychotherapy*. London: Sage.

Kellogg S. (2004). Dialogical Encounters: Contemporary Perspectives on "Chair work" in Psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 41, 3, 310–320.

King, S. (1988). *The differential effects of empty chair dialogue and empathy for unfinished business.* Unpublished master's thesis, University of British Columbia, Vancouver.

Lampropoulos, G. K. (2001a). Bridging Technical Eclecticism and Theoretical Integration: Assimilative Integration. *Journal of Psychotherapy Integration*,11, 1, 5–19.

Lampropoulos, G. K. (2001b). Common processes of change in psychotherapy and seven other social interactions. *British Journal of Guidance and Counselling, 29,* 1, 21–33. https://doi.org/10.1080/03069880123285

Luborsky, L., & DeRubeis, R. J. (1984). The use of psychotherapy treatment manuals: A small revolution in psychotherapy research style. *Clinical Psychology Review*, 4, 1, 5-14.

Mackewn, J. (1999). *Developing Gestalt Counselling*. London: Sage.

Mann, D. (2010). *Gestalt Therapy: 100 Key Points and Techniques.* Routledge.

Maslove, V. J. (1989). *The differential effects of empathic reflection and the gestalt empty-chair dialogue on depth of experiencing.* Unpublished master's thesis, Department of Counselling Psychology, University of British Columbia, Vancouver, Canada.

McKee, S. (1995). *Voice quality and depth of perceptual processing of depressed clients engaged in two types of experiential therapy.* MA thesis, York University.

Melnick, J. (1980). The Use of Therapist Imposed Structure in Gestalt Therapy. *The Gestalt Journal,* 2, 4-20.

Melnick, J. (2001). Editorial. Gestalt Review as Experiment. *Gestalt Review*, 5,4, 221-224.

Melnick, J., Nevis, S.M., & Shub, N. (2005). Gestalt Therapy Methodology. In: *Gestalt Therapy. History, Theory, and Practice,* Woldt, A. L., & Toman, S.M. (eds.). Sage Publications, Thousand Oaks, 101-115.

Meneses, C. W., & Scuka, R. F. (2016). Empirically supported humanistic approaches to working with couples and families. In: D. J. Cain, K. Keenan, & S. Rubin (eds.). *Humanistic psychotherapies: Handbook of research and practice, 2nd ed.* Washington, DC: American Psychological Association, 353-386.

Newman, M. G., Castonguay, L. G., & Borkovec, T. D. (1999). New dimensions in the treatment of generalized anxiety disorder: Interpersonal focus and emotional deepening. *Paper presented at the Society for the Exploration of Psychotherapy Integration*, Miami, FL.

Olivieri, M., & Fiebert, M.S. (2013). Integrating Couple Polarities through Gestalt Counseling. *International Review of Social Sciences and Humanities,* 5,1, 164-174.

Parlett, M. (2003). Creative Abilities and the Art of Living Well. In: *Creative License: The Art of Gestalt Therapy,* Spagnuolo Lobb, M. & Amendt-Lyon, N. (eds.). Wien and New York: Springer, 51-62.

Parlett, M. (2005). Contemporary gestalt therapy: Field theory. In Woldt, A. L., & Toman, S. M. (eds.). *Gestalt Therapy. History, Theory, and Practice.* Thousand Oaks: Sage Publications.

Perls, F., Hefferline, R.F., & Goodman, P. (1951). *Gestalt Therapy, Excitement and Growth in the Human Personality.* Gestalt Journal Press, Highland, NY.

Perls, L., Rosenfeld, E. (1978). An Oral History of Gestalt Therapy. Part one: A Conversation with Laura Perls. *The Gestalt Journal*, 1. http://www.gestalt.org/perlsint.htm

Philippson, P. (2001). *Self in Relation.* Highland, NY: The Gestalt Journal Press.

Polster, M. (2005). Gestalt terapie: Vyvoj a vyuziti [Gestalt Therapy: Development and Application]. In: *Umeni psychoterapie [Evolution of Psychotherapy]*, Zeig, J., ed. Praha: Portal, 516-532.

Prochaska, J. O., & Norcross, J. C. (1999). *Systems of psychotherapy: A transtheoretical analysis* (4th ed.). Pacific Grove, CA: Brooks/Cole.

Robine, J-M. (2013). Anxiety Within the Situation: Disturbances of Gestalt Construction. In: Francesetti, G., Gecele, M., & Roubal, J. (eds.). *Gestalt Therapy in Clinical Practice: From Psychopathology to the Aesthetics of Contact*. Siracusa, Italy: Istituto di Gestalt HCC Italy, 470–487.

Rosenzweig, S. (1936/2002). Some implicit common factors in diverse methods of psychotherapy. *Journal of Psychotherapy Integration, 12,* 1, 5–9. https://doi.org/10.1037//1053-0479.12.1.5

Roubal J.., Gecele M., & Francesetti G. (2013). Gestalt Therapy Approach to Diagnosis. In Francesetti G., Gecele M., Roubal J. (eds.). *Gestalt Therapy in Clinical Practice. From Psychopathology to the Aesthetics of Contact*. Milano: FrancoAngeli, 79-106.

Roubal, J. (2009). Experiment: A Creative Phenomenon of the Field. *Gestalt Review*, 13,3, 263-276.

Roubal, J. (in press). "What has grown from this field?" Elaborating the theory of experiment based on a case study. In: O'Neill, B. & Meyer, K. (eds.). *The New York Institute at 65: Creatively Alive & Radically Evolving*. Peregian Beach Australia: Ravenwood Press.

Roubal, J., Gecele, M., & Francesetti, G. (2013). Gestalt Therapy Approach to Diagnosis. In: G. Francesetti, M. Gecele & J. Roubal (eds.). *Gestalt Therapy in Clinical Practice. From Psychopathology to the Aesthetics of Contact*. Milano: FrancoAngeli, 79-106.

Spagnuolo Lobb, M. (2017). From losses of ego functions to the dance steps between psychotherapist and client. Phenomenology and aesthetics of contact in the psychotherapeutic field. *British Gestalt Journal*, 26,1, 28-37.

Spagnuolo Lobb, M., Amendt-Lyon, N. (2003). Introduction. In: *Creative License: The Art of Gestalt Therapy,* Spagnuolo Lobb, M., & Amendt-Lyon, N. (eds.). Wien and New York: Springer, 1-4.

Staemmler, F. M. (2002). Here and now, critical analysis. *British Gestalt Journal,* 11, 1, 21–32.

Stevens, C. (2004). Playing in the sand. *The British Gestalt Journal*, 13, 19-23.

Stiegler, J.R., Molde, H., & Schanche, E. (2017). Does an emotion-focused two-chair dialogue add to the therapeutic effect of the empathic attunement to affect? *Clin Psychol Psychother*. 1–10. https://doi.org/10.1002/cpp.2144

Vidakovic, I., Zeleskov-Djoric, J., Roubal, J., Baalen, D.v., Francesetti, G., & Wimmer, B. (2015). *Professional Competencies and Quality Standards: Specific Competencies of Gestalt Therapists.* Retrieved from http://www.eagt.org/pcqs/PC&QS%20-%20competencies.pdf

Wampold, B. E. (2001). *The Great Psychotherapy Debate. Models, Methods, and Findings.* Mahwah: Lawrence Erlbaum Associates.

Wampold, B. E. (2012). Humanism as a common factor in psychotherapy. *Psychotherapy, 49,* 4, 445–9. https://doi.org/10.1037/a0027113

Whelton, W., & Greenberg, L. (2005). Emotion in Self-criticism. *Personality and Individual Differences*, 38, 1583-1595.

Williams, D.C., & Levitt, H.M. (2007). Principles for facilitating agency in psychotherapy. *Psychotherapy Research*, 17, 1, 66-82.

Williams, J., M., G. (2010). Mindfulness and psychological process. *Emotion*, 10, 1, 1–7.

Yontef, G, & Schulz, F. (2016). Dialogue and experiment. British Gestalt Journal, 25, 1, 9-21.

Yontef, G.M. (1993). *Awareness, dialogue and process.* New York: The Gestalt Journal Press.

Zinker, J. (1977). *Creative Process in Gestalt Therapy.* New York: Vintage Books.

Zinker, J.C. (2003). Beauty and Creativity in Human Relationships, In: *Creative License: The Art of Gestalt Therapy*, Spagnuolo Lobb, M. & Amendt-Lyon, N. (eds.). Wien and New York: Springer, 141-152.

CHAPTER ELEVEN

THE FIELD PERSPECTIVE IN CLINICAL PRACTICE: TOWARDS A THEORY OF THERAPEUTIC PHRONĒSIS

GIANNI FRANCESETTI

The concept of field has been used in psychotherapy in a variety of ways by different authors, but also in a variety of ways by the same authors at different times. Without clarifying the meaning of the term, the risk is of creating a Babylonian confusion in which it is often unclear what we are talking about (Staemmler, 2005). The aim of this chapter is not to propose a universal definition of the concept, but to offer - taking into consideration the complexity of the matter - a theoretical framework that is sufficiently clear and to illustrate its consequences for clinical practice.

In the previous edition of this book (Brownell, 2008) the chapter on the field perspective in Gestalt therapy was prepared by Gaffney and O'Neill. There the authors described the field concept in all its complexity and highlighted the differences among the main conceptions in use (in particular, Lewin's and Perls, Hefferline & Goodman's)[1], presenting the consequences of the perspective in clinical practice and offering a number of precious examples of therapy. In this chapter, I build on that excellent discussion and on the work of other authors who have developed these concepts (Latner, 1983; Yontef, 1984; Parlett, 1991, 2005; Wheeler, 2000; Cavaleri, 2001, 2003; Yontef, 2002; Kennedy, 2003; Robine, 2004; Jacobs, 2005; Staemmler, 2005; O'Neill, 2008; Wollants, 2008; Jacobs and Hycner, 2009; Bloom, 2011, 2016, 2017; Spagnuolo Lobb, 2013; Day, 2016; Philippson, 2017b). In the background lie other conceptions of field from other models, in particular from psychoanalysis, where the field concept

[1] See Lewin (1952) and Perls, Hefferline and Goodman (1951).

today is attracting growing interest (Stolorow, Brandchaft and Atwood; 1994; Orange, Atwood and Stolorow, 1997; Baranger, 2005; Baranger and Baranger, 2008; Stern, 2010; Neri, 2016; Ferro, 2016), and from other approaches (Tolman, 1959; Pribram, 1971; Combs, 1999).

Here I draw on this literature to propose a phenomenal, phenomenological, and psychopathological field perspective and strategy to underpin a specific conception of human suffering and of therapy in practice. This field perspective does not offer a technique that can be reproduced as a behaviour or a procedure but proposes an approach to therapy to help steer the therapeutic act as it emerges in the specific situation. Therapeutic effectiveness is based on the here-and-now unfolding of the therapeutic alliance and on intersubjective phenomena rather than on manualized techniques (Duncan, Miller, Wampold and Hubble, 2010; Day, 2016). A field 'strategy' is not *tekhnē* (i.e., the repetition of specific behaviours to achieve a purpose), but rather *phronēsis*[2]: the capacity to steer a path given the potentiality and limitations of the present situation (Orange, Atwood and Stolorow, 1999; Sichera, 2001). The *phronēsis* of this field perspective supports an orientation and an intervention which, although emerging anew in any given situation, unfold along a line of approach that can be identified as specific and as such can be considered for the purposes of research, too. So, the field perspective is not a theory of a technique, but a theory of phronēsis. The view I present builds on the field concept in psychotherapy in general, and not only in Gestalt Therapy, and seeks to develop the concept of the organism/environment field introduced by Perls (1942) and Perls, Hefferline and Goodman (1951). This perspective helps us understand therapy work in a radically relational light.

Common Elements of Field Theories

Different field perspectives are found in psychotherapy, as well as in Gestalt therapy, revealing deep-rooted theoretical differences that underpin clinical practices that can be quite divergent. A common ground from a Gestalt therapy perspective can be described by the five principles of field theory identified by Malcom Parlett (1991, pp. 3-6):

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[2] While *tekhnē* is the reproduction of actions to produce an object as identical as possible to a prototype (like a craftsman producing terracotta cups), *phronēsis* is the capacity to act in accordance with the current situation, which is never exactly the same, thus requiring creativity and the capacity to grasp all the significant aspects present. In phronesis lies the artistic nature of therapy.

Organisation

Everything is inter-connected and the meaning derives from the total situation. Properties of things are defined by their context of use, by a wider organisation of overall meaning.

Contemporaneity

The constellation of influences in the present field explains present behaviours. No particular special causal status is accorded to events in the past nor a special status as "goals" is accorded to future events, though they are both part of the experiential field in the present. "The psychological past and the psychological future are simultaneous parts of the psychological field at a given time": the interest of the therapist is in how past or future events are part of the present actuality of the present field.

Singularity

Each situation is unique, each set of circumstances and each person is unique. Generalisations are quite unavoidable, but they can lead to *a priori* structuring of reality perceived which can easily lead in turn to finding in the present what one is looking for. Concentrating on similarities can lead one to lose sight of the specificities of the actual situation: we should be able to keep a unique perspective.

Changing Process

The field is in flux, each experience is provisional, we cannot twice have an exactly identical experience (cf. Heraclitus: "No man ever steps in the same river twice"). Nothing is fixed and static in an absolute way; reality unfolds in ways which can never be fully predicted.

Possible Relevance

Everything in the field is part of the total organisation and is potentially meaningful, though it may seem irrelevant. Gestalt therapy is interested in the obvious, in rendering afresh what has become automatic or is being taken for granted or regarded as of no relevance. The range of possible relevance is not restricted to some parts of the total field, we have to be open to the present configuration of the field, without a fixed criterion of what is relevant.

These principles form a horizon on which the various field theories found in psychotherapy and in Gestalt therapy can be situated. They form the basis for a variety of perspectives, one of which is the perspective of the phenomenal field, the phenomenological field, and the psychopathological field, which I present here.

The Phenomenal Field as a *Half Entity*: A Radical Phenomenological Perspective

> *"A particular question eventually becomes unavoidable. Is 'the field' ultimately just a metaphor, a useful derived concept and framework that can be used to explain what is difficult to explain? Or is 'something there' in the form of an explicit energy field in the 'space between'?"* (Parlett, 2005, p. 60).

The foundational text of Gestalt therapy (Perls, Hefferline and Goodman, 1951) speaks only and specifically of the organism/environment field. Through this concept, the founders rejected the reductionist perspective of viewing the organism without considering its environment to adopt a perspective that takes into account interaction between the two. Interaction is continuous, indispensable, and indissoluble, and underpins the shift from a view centred on the individual to a view centred on the interactions between the organism and environment. All the various Gestalt therapy authors would appear to agree on this, but it is at this point that their perspectives diverge. Some authors (Robine, 2008) hold that at any specific time, everyone has a specific organism/environment field, just as everyone has their own visual field, consisting of the horizon of all that they can see, or their own affective field, consisting of the horizon of all that is relevant to them affectively at that moment. Thus, each person's field is different and dependent on the present situation (and hence different in every situation). Other Gestalt therapy authors have proposed another conception of field, which has been called the 'phenomenological field', which is co-created in the encounter (Cavaleri, 2003; Spagnuolo Lobb, 2013; Francesetti, 2015a). This concept allows us to focus on the *emergent experiential quid* of the encounter, that something which is experienced in the situation.

For a clearer theoretical understanding, and basing myself also on the work of other authors (Crocker, 2009; Bloom, 2009), I believe it is necessary to distinguish between the phenomenal field and the phenomenological field.

The Phenomenal Field[3]

By "phenomenal field" I mean the horizon within which emergent experiential phenomena are generated in the encounter. It can be considered as *the horizon of all possible forms*, constituting the *possibilities* (in this field many different forms of experience can emerge) and *limitations* (in this field not all forms of experience can emerge). It is *a region of space-time in which a force produces an effect* (Maxwell)[4]. The phenomenal field is generated by all that is relevant and extends into space and time *as far as it can produce a difference in experience* – these are its boundaries. It is affected not just by what can be perceived by the five senses, but also by past memories and future expectations. For instance, the presence of a loved one or of a person we fear in the room next door affects our present experience, such as our state of mind while reading a book, even though the senses do not directly perceive anything. The field is not perceived through the differentiated perception of the five senses, but through sensations that are synaesthetic and essentially undifferentiated, with a strong kinaesthetic element that is protopathic rather than epicritic. The perception of clear and defined objects is, in fact, only one way of perceiving and generally the result of the perceptive processes. The flow of time, for example, is certainly felt, although it is not perceived by any specific sensory organ, nor can it be identified with a specific object of perception. Or the sinister atmosphere of the onset of psychosis, which is felt in the air, without being associated with any defined object that can be described. It is grasped through an aesthetic awareness, which is sensorial but not yet related to any sort of object constituted in a definite way. The phenomenal field is something that emerges *between* us and *around* us in our encounter. We could also say that the field is *how* Kantian transcendentals manifest themselves, representing at the same time the conditions of possibility and limitation – it is how time, space, boundaries, and the sense and way of being become manifest in the here and now, making certain forms of experience possible and others not (see also Bloom's chapter in this book). For instance, in a depressive field time slows down, and every experiential phenomenon is coloured and shaped by that slow down. This perspective sheds light on psychopathological phenomena not only in the therapy room, but on a much broader social level, as well. Without going into depth on the matter,

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[3] Parts of the following are taken from Francesetti (2015a).

[4] Cf. the concept of magnetic field introduced in the 1840s by Maxwell and Faraday: "the region where a particular condition prevails, especially one in which a force or influence is effective regardless of the presence of a material medium" (*The New Oxford Dictionary of English*, 1998, p. 680).

an example is to think of what happened in Zimbardo's Stanford Prison Experiment (Zimbardo, 2008), where the participants were taken by something that they themselves had co-created, but which was *much powerful than them*, a force present in that space-time which gave shape to their experience and led them to exert a level of violence that none of the participants – outside of that field – would have used, such that Zimbardo was compelled to suspend the experiment.

Although perceived as 'real', a phenomenal field does not exist in the same way *external* objects do. It is not an object. It does not have the physical perceptual characteristics of a chair, for instance. But nor can it be reduced to a mere subjective, *internal* experience. Rather, in some way it is perceived unfolding *between and around* subjects; it engages them, influences them and in turn is influenced by them. Thus, we find ourselves dealing with a region of existence that defies a Cartesian and positivistic description of the world based on its reduction to subjects and objects–such a world view does not conceive the existence of phenomenal fields and hence cannot contemplate them. Another philosophical ground is needed to understand experiential phenomena when we regard them as expressions of the field. The phenomenological tradition (Husserl, 1913; Heidegger, 1953; Merleau-Ponty, 1945; Zahavi, 2015) provides this ground. Some inputs from the New Phenomenology, as theorised by Hermann Schmitz, can also be interesting: in particular he describes a class of entities that exist in this third dimension. For this author, ever since Democritus (5th century BC), Western culture has progressively scotomised and denied this dimension, splitting the external world (of Euclidean geometry) from the internal realm (the intrapsychic) and locating experience within the subject, and objects in the world. The Cartesian method of doubt (Descartes, 1998), which admits only 'clear and distinct ideas' and casts out anything overshadowed by doubt, is a method that systematically eliminates almost-entities from its world view[5]. Such scepticism has sterilised and done away with the 'half-way world', disenchanting the world (Weber, 2004). According to the work of Gernot Bohme on aesthetics (2010; 2017), every perception starts out as an atmosphere[6]. Such atmospheres constitute the perceptive *prius* of every

[5] Cartesian dualism obviously served an evolutionary purpose at a time when casting out all that was shadowy meant casting off the yoke of the Medieval world, paving the way towards the light of reason, the individual, science and technology.

[6] It is important to underline that Bohme's understanding of atmosphere is very different from Schmitz's. For the first author an atmosphere is a perceptive phenomenon in the process of perception itself, for the second the atmospheres exist in the world independently from the subject. Here I am clearly referring to Bohme's

figure of experience. A depressive field actualised in a group, for instance, is palpable and perceptible by the participants as an atmosphere. Someone who walks into the room will feel its presence; she may be contaminated by it, or may react to it, or may notice a discrepancy between the atmosphere encountered and her own frame of mind, if in a good mood. The field exists as an almost-entity, ephemerally present among the participants[7]. In contrast with objects, almost-entities do not perdure continuously in time; they can appear and disappear, continuously changing, and can be seen as the way how we perceive the processes. Secondly, they are surfaceless and are poured out spatially. A chair perdures in time–if my chair is not in the room, it makes sense to ask where it is; and it has clear-cut, geometrical surfaces which I can touch. Phenomenal fields can instead be described as almost-entities. They exist between and around the subject and object and cannot be reduced to either of them; perceptively they come before them. Each of us retains and actualises in different situations psychopathological fields – our own modes of presence of absence. These fields give rise to the specific atmosphere that each of us evokes at a given moment, in an immediate preverbal and prereflective way.

Such a perspective restores dignity to emergent phenomena, re-opening the gates to the enchantment[8] of the 'half-way world' – a world that Western society has all but consigned to oblivion (although traces remain in language), squeezing almost-entities into the ranks of external things (*ob-jectus*) or internal experience (*sub-jectus*). But experiential phenomena (implying indivisibly the lived body and the phenomenal field) are almost-entities that constantly vibrate in the *in-between.*

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conception of atmospheres as perceptive phenomena without any independence from the subjects' presence.

[7] This concept is also significant for our understanding of corporeity. In the Cartesian worldview, the body is reduced to a machine, separate from the world and from the psyche – it is the *Koerper*, as German thinkers have called it, the anatomical-functioning body of medicine (or the athletic or cosmetic body of the consumer society). The lived body (or felt body) – the *Leib* in German (sharing the same etymological root as *love* and *life*) – is the body that we experience in being alive and in contact with the world (Husserl, 1913; Merleau-Ponty, 1945). The *Koerper* is an object; the *Leib* is an almost-entity. The difference can be understood effectively through a simple experiment. Place your hand near another person without actually touching them; at a certain point you will feel a change in the mutual experience: you are not touching the person's *Koerper* (which ends at the surface of the skin), but their *Leib* (which exists beyond the skin, in the space-time between and around bodies).

[8] Max Weber spoke of positivist science's disenchantment of the world (see Weber, 2004).

From this point of view, to answer Parlett's question at the beginning of this section, the field is not just a metaphor, but *something* which produces effects and that perceptively exists.

The phenomenal field is the *ecstasy* of the present situation, that includes the lived bodies that come into play in the situation. We can also add that the field that is actualised is not static but changing and tends towards a certain type of contact in the encounter. That tendency is the fruit of the intentionality for contact. What happens tends towards the actualisation of the potentiality for contact, or, in Gestalt therapy terms, the potentiality for encounter with nourishing novelty. Intentionality for contact is a tendency that is rooted in the id and personality functions of the situation and which becomes intention when it is taken up by the ego function of the self. It is the emergence of intercorporeal feeling (id function), which is such given the situation and roles[9] (personality function of the self). The relationship between the field and the subjects is hermeneutically and endlessly circular – we constitute the field in the present situation and the field emerges and constitutes us; it is actualised and gives shape to our experience. Within the range of possibilities for contact, the field that emerges is the unique synthesis of the histories of the client and the therapist, and the situation that brings them together; it is the result of a creative act that actualises the encounter of their histories and evolves with it. Thus, the field is a dimension that is neither subjective nor objective, a dimension that is the foundation from where subject and object emerge and become distinguishable. At the root of experience, where the figure/ground dynamic in which experience is generated dawns, the subjective and objective have yet to be distinguished.

To recap, under the perspective that I present, what are the characteristics of a phenomenal field?

Is it subjective or objective? A phenomenal field is the ongoing outcome of the process of co-creation that is rooted in a dimension that is prior to the definition of the subject, and as such it is a phenomenon that is not only subjective. At any given moment, there are not as many phenomenal fields as there are subjects, but one shared field emerges. That field is perceived subjectively in different ways by each person, and these different perceptions modify the field, therefore neither is it solely objective. In this way, the phenomenal field cannot be reduced to being either subjective or objective alone.

Does it have extension and duration? The field is a process that

[9] There cannot be, for example, an intentionality for sexual relationship in the therapeutic encounter, as the therapeutic encounter, by constitution, is not equal.

extends across space to the point that it produces a difference in perception, and hence experience, without having clearly surfaces. It endures in time[10] and changes, something which happens continuously in a more or less perceptible way, while still supporting a certain experience. Here we are speaking of lived time and space, as described in the phenomenological tradition, and hence not the chronological time or Euclidean space of an external observer.

Is it material? The phenomenal field is not material, it is not a 'thing'. Nevertheless, its existence is real and perceptible in time and space. It cannot be reduced to or described within the Cartesian dichotomy of the *res cogitans* and the *res extensa*, which carved an abyss between the subjectivity situated *inside* us and objects situated *outside* us. It may be considered an *almost-entity*, i.e., an entity diffuse in space and without temporal persistence, just like music is, for instance, or the climate sensed in a situation. It is not matter, however, but an atmosphere that is felt as emotionally charged and hence able to be situated in the dimension of perception.

How do we perceive it? It can be perceived *aesthetically* through the senses, at the sensorial root of experience where the subject and object emerge (but are not yet entirely separated) and the senses work in a synaesthetic way, where perception is undifferentiated and affectively charged (Metzger's *Vorgestalten*, 1941).

What is its relationship with the situation? The situation is the set of conditions (i.e., limitations and potentialities) present here and now which are actualised in the field as experience, taking on form and pulsating life. The phenomenal field is the *ecstasy* of the situation, just as music is the ecstasy of the vibrating strings of a harp; it is the coming out of the potentialities and limitations (i.e., length and tension of the strings) in play in the situation, which actualise the specific perceptive field.

Is it generated or does it generate corporeality? The phenomenal field is generated by the bodies in play in the situation, but at the same time it circularly generates their specific corporeality in the specific situation. It is an example of a hermeneutic circle which cannot be escaped, like Escher's hands, which reciprocally draw each other.

Does it have a direction? Yes, the field is moved and transformed by the intentionalities for contact within the limits and potentiality of the situation itself. It tends to transform towards the *now for next*. The field emerges from the restlessness of intentionalities, it is not at rest but in tendency.

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[10] The duration of the present moment, and hence the minimum permanence of the field, is more or less five seconds (Stern, 2004; Tschacher, 2013; 2017).

The Phenomenological Field

The phenomenological field is the result of a kind of "phenomenological conversion" (Husserl, 1913), of the capacity to look upon phenomena that emerge with curiosity and seek their sense and intentionality. It requires a shift from the immediate perception/action that emerges as the phenomenal field and is generated by curiosity and a feeling of wonder about what is happening (Bloom, 2009). As Eugen Fink (1933), Husserl's collaborator, says, *wonder about the world* is the best definition of the phenomenological attitude. The *phenomenal* field is suffered, in the sense that it seizes us and we are *subject-to* what emerges. It is *pathos (i.e., suffered)* and hence it is the actualisation of what comes into play. The *phenomenological* field is the result of a shift, implying the movement from being *subject-to* to being *subject-of*. It is an enhancement of freedom. It is not a *meta*-position as it is not above or outside the phenomenal field, but at the same time it is a position from which we can take notice, with curiosity and wonder, of what is happening to us, between us and around us. It is an enhancement of freedom while dwelling the phenomenal field, i.e. in the ecstasy of the situation. The therapist puts his corporeality into play to let the potentialities of the encounter emerge and takes an actively curious approach, which enables him to notice what emerges and consider it to be interesting, thereby occupying the in-between (from the Latin, *inter-esse, being-in-between*). A clear example that can help distinguish these two perceptual experiences is that of bipolar experience, where the depressive and manic phenomenal fields are very different, even opposite, yet the phenomenological field can be the same, in the sense that the two phenomenal fields are the expression of the same impossibility of reaching the other (Francesetti, 2011; 2015b). Phenomenal fields emerge at every instant of our experience, but the shift involved in expanding one's presence to look with curiosity upon how our experience emerges and to occupy it so as to sustain its potentialities is specific to the therapy situation. It is as though by sitting down opposite a client we co-create a world, and this happens at every moment of our experience. However, the specific task of therapy is to take notice and take care of how we constitute that world and dwell in it. The setting is the specific device that supports the therapist to do so: without a clear setting the therapist suffers the phenomenal field and risks to just identify with it and repeat the old story with the illusion to change it. Through this shift of conversion, the therapist's perception moves from the phenomenal field to a phenomenological field.

The Field Perspective Revolution in Clinical Practice: Psychopathological Fields

If we take these to be the characteristics of a phenomenal field and understand psychopathology as absence at the contact-boundary[11] (Francesetti and Gecele, 2009; Francesetti, 2011; 2012; 2014), it follows that a psychopathological field is a phenomenal field in which there is an absence at the contact-boundary: it is a field in which suffering is present as an absence. Absence is a presence that does not irradiate, that is mute, that moves away, that does not arrive at the contact-boundary. It is the experience of not fully existing for the other or that the other does not fully exist for me. The *degree of fullness* is not absolute from the situation and cannot be measured by comparing it to an external scale, but it is the result of the potentialities and of the intentionalities for contact of the present situation.

Therefore, I take the object of psychopathology to be the field, not the individual. This shifts the epistemological ground of psychopathology itself, in the definition, understanding and treatment of suffering. Thus, I assert that it is not in the client that we locate suffering, but rather we regard it as an emergent phenomenon at the contact-boundary. Accordingly, if psychopathology is an absence at the boundary and the boundary is a co-created phenomenon, there can be no psychopathology of the isolated individual or mind. Being *of the field* (Robine, 2016), the therapist does not 'work on the client', but in the field and on the field that is actualised between the therapist and client. Given that this field is co-created, the therapist works primarily on himself and on modulating his presence and absence at the contact-boundary.

Let us consider the example of depressive suffering (Francesetti, 2015b). If we say that the client *is depressed*, we lose sight of the fundamental fact that he is also not depressed[12], and our perception of him becomes crystallised, objectifying him and reducing input to therapy. We might, therefore, choose to say that the client *is suffering from depression*, but this reifies depression, turning it into an abstracted thing, extraneous to the

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[11] In psychopathology, suffering is not pain but absence. Desensitisation or anaesthesia at the contact-boundary prevents presence in full (Francesetti, 2012, 2014). For example, the pain of grief is not psychopathological because it is a presence; the absence of pain in sociopathy or the absence of joy in neurosis are instead psychopathological phenomena.

[12] To cite Minkowski, it is important to grasp the extent to which a patient is schizophrenic, but it is just as important to grasp the extent to which she is not (Minkowski, 1927).

person and his history, and thus offering no help in giving sense to his suffering. In reality, such approaches are not even sufficient for the correct use of drug treatment as they do not support the search for meaning, something which the client always needs. Alternatively, we can say that the client is having *a depressive experience*. This does not reduce the client to the suffering itself and opens up possibilities to explore and give meaning to the experience, but it ultimately still remains within an individualistic frame of reference. In a radically relational frame of reference, we can instead say that in the encounter with this client a *depressive field* is actualised. This places the depressive phenomenon in a relational frame of reference, bringing to the fore the co-creation of the experience, activating the search for meaning within the therapy context and immediately helping the therapist to feel part of and within a psychopathological field. In this sense, Gestalt psychotherapy is *deconstructive*. The crystallised symptom is progressively deconstructed so as to bring out the relational field and its suffering, which in becoming actualised makes movement and transformation possible.

In this way, a depressive psychopathological field, to continue with our example, can be considered the actualisation of a phenomenal field in which the client and the therapist experience a hopeless sense of defeat in their attempt to reach the other. This defeat, and the helplessness it provokes, imbues the field in various ways, giving rise to experiences that are typical and recognisable by both the client and the therapist (Francesetti, 2011, 2015b; Roubal, 2007, 2014). The situation is no longer one where 'the therapist encounters a depressed client', but rather, '*this* depressive field is actualised between the therapist and the client' – a field that is different with different clients, different with different therapists and different with the same client in different moments (Robine, 2004; Francesetti, 2011, 2015b; Spagnuolo Lobb, 2013). Similarly, panic disorder, and a certain kind of hypochondria, arise in a phenomenal field in which denied solitude (Francesetti, 2007) is present. Or a schizophrenic delusion arises in a field in which the differentiation between subject and object has not emerged sufficiently, the relational boundaries are blurred and the experience rests beyond the Pillars of Hercules (Francesetti and Spagnuolo Lobb, 2013). Focusing on the psychopathological field reveals how suffering is actualised in reality, in the here and now, co-created at the contact-boundary, in the *in-between* and around the therapeutic relationship, and how it is experienced by the client and the therapist. Compared to a psychopathology of the isolated individual, to see psychopathology as a phenomenon of relational suffering that becomes real and alive in the therapeutic encounter can be revolutionary. It might be objected that the client is depressed even outside

the therapy room and hence her depression does not emerge in the therapy setting. But the argument seems not valid to me: the fact that the client is depressed before and after the therapy session serves to show that she brings and actualises a depressive field in the different contexts she encounters, perhaps even in all of them. Of course, we could use an extrinsic diagnosis and label her a patient suffering from depression. But this does not change the perspective that *during the session the depressive field is co-created every time* and that the way it is actualised is specific and different in different situations and, as may be the case, with different therapists. The field perspective enables the therapist to move from the question 'What can I do for such a depressed client?' to 'How are we depressing together right now?' (Roubal, 2007; Francesetti and Roubal, 2013). It is precisely the element of co-creation that gives the therapist margin for therapy, as minimal as it can sometimes be. Since the therapist himself is part of the id and the personality of the situation (Robine, 2004), he will always be able to affect a choice (ego function) that is rooted in the here and now of the situation and is an expression of the intentionalities at play in the field. Such a perspective also presents psychopathology with two new tasks: to describe the specific way the *Gestaltung*[13] unfolds for different types of suffering; and to describe the specific phenomenal and aesthetic aspects (Bloom, 2003) of the different psychopathological fields actualised. Work on the first task is exemplified by studies on panic disorder (Francesetti, 2007), depression (Francesetti, 2011; 2015b), schizophrenic psychoses (Francesetti and Spagnuolo Lobb, 2013), obsessive-compulsive disorder (Francesetti, forthcoming) and other disorders (Francesetti, Gecele and Roubal, 2013). The second task has largely yet to be explored in a systematic way.

A Field Perspective in Clinical Practice: HARP as the Unity of the Therapeutic Act

Sadness is contagious,
my love, and from this we see
that we have joined hearts
and are one, but appear as two.

And so I
inseminate joy

[13] *Gestaltung* is the process by which a Gestalt is formed; it is the emergence of a figure from a background, and hence the becoming and defining of a figure of experience.

in this thing that does not consist
but yet exists and keeps us both tied.
It is I
who puts in
the joy.

(M. Gualtieri, *Bestia di Gioia*, 127)

Thus we have posited our theoretical premises. As soon as the therapist and client sit down and face one another, a phenomenal field is actualised in the situation of the therapy setting, which tends to actualise the potentialities for contact in play. In this co-created field, the therapist may have very different experiences, which in general can be distinguished as attunement and resonance. From these two experiential phenomena, the therapeutic act in a field perspective lies in the modulation of the therapist's own presence, abandoning any attempt to change the client, and all the paradoxes and performance anxiety that it entails (Beisser, 1970). This perspective is in line with what Myriam and Erving Polster (1976) proposed when they underlined the need that the therapist modulates his way to be in contact according with the client's possibilities and limitations.

I shall call the experiential unity of the therapeutic act "HARP" – Human Attunement, Resonance and Presence.

Attunement

Attunement phenomena[14] have been widely described in philosophy (Stein, 1989), phenomenology (Merleau-Ponty, 1945), infant research (Stern, 1985; 2010), neurosciences (Gallese, 2006a, 2006b; Gallese, Eagle and Migone, 2007; Rizzolatti and Sinigaglia, 2008), and in psychotherapy (Rogers, 1951; Bandler and Grinder, 1975; Erickson, Rossi and Rossi, 1976; Yontef, 1993; 2002; Schore, 1994; Thompson, 2001; Siegel, 2012; Tschascher et al, 2013; 2017). Generally speaking, it is the therapist's experience of feeling *on the same wavelength* as the client, of having similar or even the same feelings. The discovery of *mirror neurons* (Rizzolatti and Craighero, 2004; Rizzolatti and Sinigaglia, 2006) has shed light on the neural bases underpinning the ability to experience a situation in the same way, regardless of whether it happens to me or to somebody else.

[14] I think that the concept of attunement that I present here corresponds, or is very close, to Yontef's concept of "inclusion" from Buber (Yontef, 1993; 2002), however I prefer the term attunement as it is used in a range of other studies, in particular in infant research and neuroscience.

Attunement is an event of great therapeutic value in and of itself, as it is a central phenomenon in the process of acknowledging the client and contributes to the validation of his experience. Attunement is distinct from confluence, where a figure does not emerge from a ground or where the boundaries between the organism and the environment cannot be perceived. With attunement, a clear figure emerges and the boundaries between me and the other are also clearly defined, in the sense that it is clear that I feel what you are feeling and that you feel that I feel what you are feeling. Attunement, in different situations, helps the client validate the feeling that his experiences are real, and thus to feel he is not crazy, and to feel the dignity of his experience, to feel understood, to feel he is not alone, to feel that it is possible to encounter the other through his suffering. These are, therefore, therapeutic phenomena which are fundamental and essential for the processes of meeting, containment, change and growth. As shown by infant research and clinical studies, attunement is not a static phenomenon, but is extremely mobile and mutual. It is a process in continuous movement. The mobility of experience requires a process of continuous adjustment, which never stands still. An example of this is our eyes. When we look somebody in the eyes, our eyes are never still – looking is not a static phenomenon, but a continuous movement of reciprocal adjustment of direction, focus, eyelid movement, of looking away for a fraction of second to then catch the other's gaze again, before losing it once more. Besides being continuously mobile, attunement also alternates with moments in which attunement is lost, or interrupted, and is then restored, moments when attunement is lost and then found again, through a new attunement. Rupture and restoration of attunement would appear to be crucial therapeutic phenomena (Ornstein, 1974; Colli and Lingiardi, 2007). It is this process of continuous adjustment and attunement, and not a static, uninterrupted attunement, which characterises healthy human relationships, including the therapeutic relationship. The shifts present in attunement enable, in Gestalt therapy terms, the ongoing perception of boundaries which would otherwise be lost through the natural adaptation of the senses, if contact were static.

Resonance

Resonance is a concept coming from the physics, and in particular physics of music[15]. In this context, resonance phenomena refer to the

[15] Two systems which are *entraining* each other into a shared rhythm of oscillations in such a way that together they form an overarching synchronized system whose oscillations are regulated by its own order parameter (Fuchs and Koch, 2014).

therapist's feelings which emerge in the therapy setting[16] (or before or after the session) but are not similar or identical to those of the client – indeed, they can be very different. For example, a client may feel a deep sense of sadness or desperation, while the therapist may be bored, or frightened, or even annoyed. Even the client, on her part, will experience resonance phenomena in the presence of the therapist. Resonance phenomena are bodily, sensory experiences which are essentially undifferentiated in their origin; synaesthetic – before than kinaesthetic - resonances that are not configured in definite objects. Often they are unexplainable bodily sensations and feelings that do not immediately make sense, but may then take the shape of images or memories, fleeting fantasies, words of poetry or melodies, tactile sensations or localised bodily pain, emotions, feelings, etc. To grasp them, the therapist needs to be sensitive to them by focusing on what can be called the aesthetic dimension, a sensorial world without clearly defined objects of perception, and to slow time down just enough to grasp the fleeting, or at times more persistent, emergence and touch of these emergent sensory phenomena. Often the therapist perceives resonances as disturbing and unexplainable sensations, feelings or thoughts; she can feel guilty about them and try to avoid them or put them aside. But they are incredibly precious elements of the co-created phenomenal field – from otherwise rejected stones, in a field strategy they become the cornerstones.[17] A resonance is often perceived as something out of place that can elicit wonder, it is an '*atopon*': "Gadamer reminds us that the Greeks had a word for that which brings understanding to a standstill. This word was *atopon*, which in reality means 'that which cannot be fitted into the categories of expectation in our understanding and which therefore causes us to be suspicious of it'" (Costa, 2014, 356).

These are fundamental phenomena, first recognised by psychoanalysis as transference and counter-transference, on which a vast literature exists – too vast to be covered here. From a field perspective, however, resonance phenomena are not experiences which the client projects and situates in the therapist, or which the therapist projects and situates in the client (how experiences pass from one person to the other is a tricky theoretical problem for psychoanalysts, see Stolorow *et al.*, 1999; Eagle, 2011; for a critique of the concept of projection see Jacobs, 2012). Gestalt therapy's theory of self (in line with phenomenology and contemporary neurosciences) considers subjects as co-emerging from the present situation; they are co-creating

[16] Resonance phenomena are present in all human relationships, however here we will focus solely on their relevance in therapy.

[17] "The stone the builders rejected has become the cornerstone" (*Psalm* 118, 22).

together (Francesetti, 2016). Our way of being, i.e., the ecstasy of our corporeality, co-creates the phenomenal field and the experiential phenomena that the client and the therapist experience. What we have is not two separate individuals who influence each other through their encounter, but the emergence in the here and now of two subjectivities that co-shape each other[18] and take this specific form. Resonance is the *epiphany*, or the unfolding, of this co-creation. Moreover, resonance phenomena are not the mere re-proposal of past scenarios, but how the potentialities of the field take sensible form here and now. Suffering takes shape depending on the potentiality for transformation that the situation offers. The client is not just narrowly building his experience as he has learned to do in the past, implying that the therapist should help widen his sights. Rather, he brings a legacy that is trying to ex-sist here and now in order to reach the other and be transformed. This is a teleological perspective: cherishing pain and suffering has a meaning and it is not just a learned and rigid way of reacting and behaving. *Suffering* means "to bear" (from the Latin *fero*, to bear) and the client bears the pain that in this specific encounter can potentially be felt, recognised and transformed (Francesetti, 2012).

Resonance phenomena have been treated in very different ways over the history of psychotherapy and have attracted plenty of interest in the current literature (Howard, Orlinsky and Hill, 1969; Brody and Farber, 1998; Roubal and Rihacek, 2014; Wolf, Goldfried and Muran, 2013a; 2013b; Gazzillo *et al.*, 2015). Early psychoanalysis treated them as interferences to be cleaned up, although later they were seen as the gateway to interpretative analysis, while more recent developments would have the therapist's resonances placed at the disposal – implicitly or explicitly – of the client (Stolorow *et al.*, 1999; Eagle, 2011; Boston Change Process Study Group, 2010). In humanistic experiential therapies, including Gestalt therapy, resonance has been used as a central tool through *self-disclosure*, where the therapist shares her own experience. Resonance phenomena are therefore precious in that they are singular events, unique to the moment and to the particular client – a true epiphany of mutual co-creation. But they are also mysterious, because at the immediate moment they emerge, the therapist *is moved* but does not understand either where they come from or what they mean. It should be remembered that self-disclosure is not in and of itself therapeutic – indeed, it can be dangerously re-traumatising. If performed without there being sufficient ground to support it, it can cause harm by re-traumatising and invalidating the client's experience. The direct and crude

[18] Staemmler (2016) has called this relational perspective "strong relationality"; see also Francesetti (2012; 2015a).

expression, for instance, of the fear felt by the therapist in a psychotic field or of desperation in a highly depressive field, or of irritation in a hysterical field can greatly worsen the client's suffering[19].

The crucial question is, therefore, what to make of resonance in a field perspective.

Presence: From the Phenomenal to the Phenomenological Field

We said that resonance, in a field perspective, is the epiphany of the co-creation process. It is, therefore, something that the therapist feels, but which does not belong to the therapist alone. It emerges from the process of co-creation and belongs to the field, and only makes sense when considering the field. It is the most precious sign of the field that we constitute and the themes that circulate within it, between the client and the therapist. Themes are the typical contents of the co-created field and they steer us in identifying the field we are experiencing. The relevant relational themes have been recently described by Lynne Jacobs (2017), who calls them *Enduring Relational Themes (ERTs)* and proposes them as a way to understand transference phenomena in the Gestalt Therapy theoretical frame. I fully agree with Jacobs that ERTs emerge as co-created phenomena in contact processes; indeed they do not belong only to the client. I also agree they should not be considered projections (both for the clinical risks and theoretical inconsistency) and that they are potentialities that lead to relational novelty and transformation (see also Philippson, 2002).

In the view I am proposing here I want in particular to describe two specific processes. First, that themes *circulate* in the co-created phenomenal field; this implies that they can be felt and enacted both by the client and/or by the therapist. Secondly, through the themes, suffering emerges in the here and now and moves towards the *transformation* of absence in pain and of pain in beauty (Francesetti, 2012). Resonances are the way we can sense and feel the themes. To recognise them is a crucial part of the therapeutic process, since one of the main risks is to attribute the theme only to the client. When the therapist recognizes it, s/he modulates her/his presence and – by doing so – s/he changes the field. Let us look at some clinical examples to illustrate how the modulation of the therapist's presence can be a central element of therapy based on the field perspective.

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[19] Consider that research shows that the condition of around 8% of patients in therapy deteriorates (Hansen, Lambert and Forman, 2003).

First clinical example: Co-creating a narcissistic field. One issue that can be highly present in a therapeutic encounter is that of disregard and shame. The therapist may feel disregarded and ignored and this can be very unpleasant. He may feel he has to do something to be taken notice of, something, perhaps, to prove he is professionally competent, as it would seem that the client shows very little regard or esteem for him. If he simply perceives and reacts to the resonance, he may start doing something to show that he is indeed competent – he might think of all the articles he has authored, for instance, and perhaps even cite a few. At a certain point he might feel that he does not want the client to know certain things about his life as he would feel ashamed of them and, without realising it, he avoids them entirely. The client, for instance, may frequent only people of a certain social standing while the therapist comes from a much more humble background, something he would rather the client did not know. Slowly but surely, without even realising it, the therapist manages to assert himself in this way in the encounter and feels more at ease – luckily the session is going better and better in his view. But then, to his surprise, the client ends the session saying he feels annoyed and that, in the end, therapy will not help. The risk for the therapist is that he may feel wounded by the comment and attribute it to the client's narcissism, because 'like a typical narcissist he is unable to accept what the therapist offers'. In this way he does not see how he himself has contributed to the emerging of these phenomena and is unable to appreciate the legitimacy and truth of the client's experience. What the therapist does is attribute the suffering to the client alone and identify with a theme in the field, that of regard/disregard. He fails to place what he feels in the context of a ground in which to make sense of it and instead identifies with what he feels and acts it out without realising that it is the outcome of a co-creation process.

An alternative is that the therapist becomes aware of what he experiences without identifying with it. To do this, he needs to be curious about what he is feeling – "I feel ignored, disregarded, ashamed… how hard it is right now to bring up my background and feel its worth… perhaps these are themes that are circulating between us." The shift here is to value what we feel and to place ourselves on much broader terrain from which to perceive what we feel with a sense of curiosity. Perhaps the therapist can find in that terrain a strength that comes from his humbleness, the strength to feel his worth without denying his limitations, or concealing them. If this happens, the therapist will have modulated his presence, enabling the tolerability and value of limitation to emerge in the field, thereby changing the field itself. If this happens, if the therapist modulates his presence, having limits will no longer be prohibited or denied. We could say that the

field I have described has narcissistic elements. If the therapist identifies with the themes of disregard, he will contribute to co-creating it; instead, if he manages to make sense of his experience and let the legitimacy and tolerability of limitation emerge, the field will be a little less narcissistic and will open up space for the possibility for what is not always valued positively to have dignity and the right to exist.

Second clinical example: Co-creating a depressive field. A therapist sees a client suffering from severe depression and she is sometimes very worried, at times irritated and annoyed, because nothing changes. She feels the client is not making enough effort in therapy and with recent appointments found herself hoping right up to the last minute that the client would not turn up and decide to go to another therapist. The shift of modulating the therapist's presence, from a field perspective, enables her to ask herself, "How am I, the therapist, co-creating this experience? How am I letting my body freeze up and not breathe? How am I losing my hold on life? How are we depressing together (Roubal, 2007) and how I am myself getting depressed?" (Francesetti and Roubal, 2013; Francesetti, 2015b; Roubal and Rihacek, 2014). These questions shift the focus from what the client does to what the therapist herself does. By becoming aware of how she is influencing the field, the therapist can regain the freedom to breathe or feel once again the throbbing weight of her body, or notice that a butterfly has landed on the window and remember that spring is coming, or recall a poem by Mary Oliver (2004): "And now I will tell you the truth. Everything in the world comes". This would modify the therapist's presence and the atmosphere of the session would lighten up, enabling a greater receptiveness on the part of the therapist to emerge. The specific sequence of experiences in a depressive field has been explored and described by Roubal and Rihacek (2014) as a 'depressive co-experiencing trajectory'. Their research findings fit perfectly with the HARP model presented here: therapists experience attunement (and contagion by depression), resonances (i.e., distance from the client), and finally they modulate their presence by focusing on what is happening in the therapeutic relationship. This last move, made possible when they become aware of what is emerging as a co-created phenomenon, allows the therapists to feel that something meaningful, helpful, and relieving is emerging and changing the experience of both the therapist and the client.

Third clinical example: Co-creating an hysterical field. A theme that may circulate in a field is that of authenticity/inauthenticity. It is easy for the therapist to feel irritation over a suffering that the client evidently and openly shows, but that the therapist is unable to feel, with a consequent tendency to judge the client as not being authentic and be annoyed by this.

If the therapist does not recognize the theme and is unable to look at it and disassociate from it, the risk of re-traumatizing the client is high. The shift in therapy is to broaden the ground of experience and for the therapist to ask herself how she herself is co-creating this theme, how authentic she really is being. Is she really expressing what she feels? Maybe not. Maybe she is torn between expressing the irritation she feels and the fear that this may re-traumatise the client by representing yet another rejection, for which she finds herself in a position in which what she expresses is not what she feels, which means she herself is not being authentic. If she realises this, she can understand her contribution to the co-creation of the field and - by paying more attention to what she feels in feeling this - she can realise more still, such as *the pain of not feeling the pain* of the person suffering in front of her. In this way she can feel real pain and find the words to say authentically that *she feels the pain of not feeling the pain of the other person.* If she manages to do this, she will be fully and authentically present and this will change the emerging field.

These examples help describe a shift that changes the perspective in therapy, by realising that *in the here and now* the therapist suffers and creates the co-created phenomenal field just as much as the client suffers and creates it. The focus of the therapy act is therefore on the quality of one's presence, rather than on changing the client.

Therapist's Competences for Working with the HARP Model

I now present the competences implied when working with the HARP model. In this description they become a sequence of different and explicit steps, but they constitute a fluid and implicit flow. For each of them I will provide a short description, draft the experience of the therapist, and offer some short clinical examples from the three fields presented above. The phenomena that I describe are quite typical of the fields used here as examples, but, of course, in a session different feelings will emerge according to the specificities of the therapist, of the client and of the situation. Nevertheless, it is usually possible to recognize some features of a field where a specific suffering emerges.

Modulating the therapist's presence therefore requires:

- **Openness and willingness to experience attunement and resonance phenomena**: the therapist is able to slow down and focus on the aesthetic dimension, i.e., on what she feels, what the client

feels, what she feels is emerging in the between[20] *without dismissing any element* of her experience. This is at the level of the phenomenal field. In order to be able to dwell in this native dimension of the experience, the therapist needs to developed a specific aesthetic sensibility (Francesetti, 2012; 2015a). Clinical vignettes:

- **With Tony**: "I feel I'm not a good enough therapist for Tony, he is so brilliant and has achieved so many important goals in his life! I need to do something more or I should hide part of who I am in order to appear ok. I feel disregarded and I feel the unpleasant pressure of 'having to be something more."
- **With Jim**: "I oscillate between feeling depressed and reacting to it: when I am sitting with Jim, I feel a heaviness, a terrible tiredness... or sometimes I simply feel dumb, sleepy, empty, falling down... then I take my distance from Jim, I can't stand this anymore, I don't want to fall into such a black hole! When I'm with him time slows down, the space in the between becomes wider, darker and more burdensome; I feel anguish, impotence and then the wish to fly away."
- **With Rose**: "With Rose I feel annoyed, bored, disturbed, irritated, even though she clearly shows her suffering. Sometimes I feel attracted by Rose's manifestations of suffering, so colourful, even though something not completely real or authentic is suspended in the air... She doesn't seem authentic!."

- **Curiosity about the therapist's own resonances and a willingness to let them be, without attributing them in advance to the client alone or to oneself alone**: the therapist ask herself "What's happening to me? That's strange, I really can't understand why, but I feel this way." Throughout her awareness, the therapist does not identify with the phenomena of attunement and resonance: this is the shift from the phenomenal field to the phenomenological field. Clinical vignettes:
  - **With Tony**: "I am aware of this feeling of being dismissed or not being good enough and I just wonder about this, without reacting in order to be better than who I am."
  - **With Jim**: "I am aware of my own oscillations, my feelings of being depressed and then reacting against it, I am tempted to dismiss them or to feel guilty because of them... it's interesting."

[20] On these three focuses of feeling during training processes, see Philippson (2017a).

- **With Rose**: "I am aware of my resonances of rejection or attraction, I notice the sense of something not completely authentic and I wonder what is happening to me and to us."

- **Tolerance of the uncertainty** that such an approach entails (Staemmler, 1997; 2006), **accepting that we do not know the direction the therapy process is taking**: the therapist feels sensations and feelings or images come to her and she does not know why, she cannot give any immediate meaning to them, so she offers and gives time to the process by tolerating the uncertainty. Clinical vignettes:
  - **With Tony**: "I would like to be a better therapist, more on the ball, I don't know what it means, could it be a theme circulating in the field that we are co-creating?'
  - **With Jim**: "I try to cope with this deep lack of energy and interest, without knowing where it emerges from – am I too tired after seeing so many clients? Am I distancing myself from the themes that Jim is bringing about his relationship problem? Yesterday evening I had a harsh discussion with my partner... Is this a way to perceive and co-create a depressive field?
  - **With Rose**: "I don't know what to do... Should I share my feelings or not? If not, am I being authentic or not? I don't know... yet.'
- **Expanding attention so as to feel what emerges from the background, from the fringes of the resonances:** the therapist is still feeling and waiting, in the hope that something else will still arise… The question is: "What does the therapist feel in feeling what she feels?" Clinical vignettes:
  - **With Tony**: "I now feel an almost imperceptible sadness, coming out from somewhere...just a slight movement in the background of my feelings..."
  - **With Jim**: "I feel that space and time change when sitting with Jim, I feel an anguish when I focus on the space between us, I feel impotent and my body becomes paralyzed... but by being interested in these feelings I start to feel something different'
  - **With Rose**: "I start to feel some pain, a feeling of loneliness perhaps... yes, I feel alone and it's strange because Rose seems so present to me...'
- **Grasping what emerges and looking for its meaning in accordance with the emerging intentionality for contact**. The therapist asks herself: "What does this mean for me? For my client? For us? For the situation we find ourselves in? What theme is

emerging? What landscape we are in? Where is it taking us?" Clinical vignettes:

- **With Tony**: "Yes, I feel sad...I feel a sadness for my feelings of not being good enough, for the effort required in my life to try to be who I am not..."
- **With Jim**: "I would like to be able to feel that I'm alive while sitting with Jim, just this... and feel the possibility of moving, I feel this wish..it reminds me of my moments of deep depression..."
- **With Rose**: "Yes, I feel loneliness, as if I have no chance to really be reached by Rose or to reach her. I can't really feel her pain... is this a theme circulating between us?'

- **Using this awareness to modulate the therapist's presence, how she stays in the situation, revealing or not explicitly revealing, depending on the situation, what she feels**. Before expressing what she feels, the therapist should assess whether she has grasped the resonances' meaning or, if she has not, whether the client, therapeutic relationship and situation can cope with and make use of that input. If she decides to share something of her sensations, feelings and thoughts, she has to convey them to the client when she feels that this will support the contact between them. The *'how'* she expresses is a sign of the increasing presence and existence of both the therapist and the client. A criterium that I propose in order to decide whether to express the resonance or not is the following: *the therapist should not express her resonance until she perceives only it*. In order to express the resonances she has to grasp some background around them, to feel that she feels curiosity towards them and that she is not completely identified with them. Usually, the more the client is severely suffering, the more the resonances are strong, the more it is difficult not to be identified with them and the more the risk of re-traumatisation is high. Clinical vignettes:
  - **With Tony**: "I now feel the profound need to be who I am, to give dignity to my person, to my history, even to my stupidity and to my limitations. This gives me a sense of dignity, integrity and freedom, of humbleness and strength at the same time. Tony now looks different to my eyes: I can feel his effort, endless effort, of being 'something more'... I feel sad for this and a feeling of tenderness emerges in my body. I can now stay here and I could say, with a soft voice, tenderly and looking straight into his eyes: 'Tony, I'm impressed by how many important things you have done in your life... And I also see how much

work and effort you have done for all of this. Aren't you tired sometimes?'"

- **With Jim**: "Yes, we are co-creating a depressive field... let me allow myself to expand my chest and inhale, just inhale... I feel better, I can see Jim more clearly, with some colour... I'd like to bridge the space in between, but I don't know how to do this. But I feel better, this willingness is already a relief. Now I can breathe and stay here and I could say, with warm words emerging from my experience of deep darkness: 'Jim, I feel the heaviness of what you're bringing, and I feel the impotence, too. I feel a wish to overcome it, but I don't know how, I can't yet. But I can stay and breathe with you, and maybe you can breathe with me.'"
- **With Rose**: "I now feel the real pain of not really feeling Rose's pain. What loneliness! And what a relief in feeling this real feeling! Now I can stay here, with her, I feel that somewhere I am meeting her, and I could firmly say: 'Rose, I see your pain, the pain in your story, and I can feel how alone you have been with it, how difficult is to be reached there... I feel pain now, while saying this to you'. And real tears can come out in my eyes."

Conclusion: Lending the Therapist's Flesh to the Client

At the level of the phenomenal field, both the client and the therapist are responsible for what they feel. But the therapist is responsible for shifting from the phenomenal field to the phenomenological field and modulating her presence to support the intentionality for contact underway, and not just reproduce the phenomenal field that is actualised. In this, the therapeutic relationship is not an equal relationship.

To use the words of Jean-Luc Marion (2003), the therapist lends her flesh to actualise and feel the suffering of the client. The body of the other was absent in the client's experience since the other was not there to welcome and transform her/his pain. The pain precipitated in the client's body, the *Leib* became *Körper*, the palpitating atmospheric emotion became a clot. The therapist's flesh is now called to receive this cherished pain in order to allow the transformative process of the meeting to happen. Psychopathological suffering is psycho*patho*logical precisely because it precipitates into the client's flesh without the possibility of it being felt as an affective and emotional experience *in the in-between*, with the support of the other's presence. There is not freedom here: what is suffered is *pathòs*, passively felt. The symptom is the memory of the other's absence and a

grain of the potentiality of encounter. It is absence in that it is the memory and evidence of the absent other. It is absence in that it is a silent presence that does not resonate. It is the presence of an absence that wants to ex-sist, i.e., to come out, and to play the melody that it cherishes – the therapist is the embodied instrument that resonates with the melody. Human beings are loyal to their pain and bear it (i.e., they suffer) in the form of a symptom, which is a creative way of bearing pain without succumbing to it (Borgna, 2005). When the other – the therapist – becomes present in therapy, he lends his flesh to the client's pain and that pain can reach the contact-boundary. When this happens, the therapist grasps the face of the other and there is a sense that something important is happening and the fundamental sentiment that emerges is tenderness (Lévinas, 1987). Here, time becomes event (Maldiney, 1991); the novelty is co-created and met, the potentialities for contact are fully expressed, according to the possibilities and limitations of the present situation. The HARP model is a way to allow the psychopathological field to be co-created (the absence becomes present), to let the suffering emerge (the pain arrives at the contact boundary) and the transformation happen (the intentionality for contact unfolds); the therapist does not identify with the circulating themes: she lends her flesh in order to let what is suffered exist in the here and now (she is reached by the suffering) and by relying on her aesthetic sensitivity she modulates her presence and supports the intentionality for contact. She pumps into the situation new aesthetic elements and so a new freedom springs up.

How suffering emerges in therapy follows aesthetic rules and opens the way to easing and joy – the cup that holds suffering is the same that holds joy (Gibran, 1923). It is a human way of bearing pain until it is transformed at the contact-boundary and new freedom is gained. It is the transformation of absence in pain and of pain in beauty (Francesetti, 2012; 2015b). Human beings work like musical instruments that harmonise – they pluck the strings of their hearts to play in unison[21]. Like two harps, when one sounds, the other resonates. This is why from a field perspective the unity of the therapeutic act can be called HARP[22] – Human[23] Attunement, Resonance and Presence. Its unity comes from the emergence of feelings of attunement and resonance which lead the therapist to modulate his presence to sustain the expression of the potentiality for contact present in the situation. This

[21] Translator's note: "Cuore" "heart" in Italian derives etymologically from the Latin *cor*, which gives us both "cuore" (heart) and "corde" (cords/strings) in Italian. Unfortunately, this could not be rendered in the English.

[22] I dedicate this appellation to my daughter Chiara, harper and psychologist.

[23] I thank Joyce Sciberras for having suggested to add the 'H' from 'Human'. As suggested by Alison Clare the 'H' could also refer to 'Heart'.

perspective helps us understand how *suffering* is the *bearing* (from the Latin *fero*) of an absence which in therapy becomes presence, and which thanks to the presence of the therapist transforms into potentiality for contact. And so, in emerging beauty.

As a consequence, not only does the client change. The transformation of the cherished pain is a transformation of the legacy of a history that creatively changes the present situation. And the therapist changes, too. And with them, the fabric of the world and of life changes.

References

Bandler R. & Grinder J. (1975). *The structure of magic. A book about language and therapy.* Palo Alto, CA: Science and Behavior Books.

Baranger M. (2005). Field theory. In S. Lewkowicz & S. Flechner (Eds.) *Truth, reality and the psychoanalyst: Latin american contributions to psychoanalysis, pp. 49-71.* London, UK: International Psychoanalytical Association.

Baranger M. & Baranger W. (2008). The analytic situation as a dynamic field. *International Journal of Psychoanlaysis*, 89: 795-826 (first publ. 1961-62).

Beisser A.R. (1970). The paradoxical theory of change. In J. Fagan & I. Shepherd (Eds.), *Gestalt therapy now: Theory, techniques, and applications, pp. 77-80.* Palo Alto, CA: Science and Behavior Books.

Bloom D. (2003). Tiger! Tiger! Burning bright. Aesthetic values as clinical values in gestalt therapy. In M. Spagnuolo Lobb & N. Amendt-Lyon (Eds.) *Creative license. The art of gestalt therapy*. Wien-New York: Springer.

Bloom D. (2009). The phenomenological method of gestalt therapy: Revisiting Husserl to discover the essence of gestalt therapy. *Gestalt Review*, 13(3), 277-295.

Bloom D. (2011). Sensing animals/knowing persons. A challenge to some basic ideas in gestalt therapy. In T. Bar-Yoseph Levin (Ed.) *Gestalt therapy: Advances in theory and practice, pp. 71-82.* New York, NY: Routledge.

Bloom D. (2016). The relational function of self: Self function on the most human plane. In J.-M. Robine (Ed.) *Self: A polyphony of contemporary gestalt therapists*, pp.65-84. St. Romaine-La-Virvée: L'Exprimerie.

Bloom D. (forthcoming). Sensing and knowing, *Gestalt Review*, np.

Böhme G. (2010). *Atmosfere, estasi, messe in scena. L'estetica come teoria generale della percezione*, Milano: Marinotti (or. ed.: *Aisthetik. Vorlesungen über Ästhetik als allgemeine Wahrneh-mungslehre*, München: Wilhelm Fink Verlag, 2001).

Böhme G. (2017). *The Aesthetics of Atmospheres*. New York, NY, Routledge.

Borgna (2005). *L'attesa e la speranza*. Milano: Feltrinelli, Milano.

Boston Change Process Study Group (2010). *Change in psychotherapy. A unifying paradigm*. Ww Norton&Amp.

Brody E.M. & Farber B.A. (1996). The effects of therapist experience and patient diagnosis on countertransference. *Psychotherapy: Theory, Research, Practice, Training*, 33: 372-380. doi: 10.1037/0033-3204.33.3.372

Brownell P. (Ed.) (2008). *Handbook for theory, research and practice in gestalt therapy*. Newcastle upon Tyne: Cambridge Scholars Publishing.

Cavaleri P.A. (2001). *Dal campo al confine di contatto. Contributo per una riconsiderazione del confine di contatto in psicoterapia della Gestalt*. In M. Spagnuolo Lobb (Ed.), *Psicoterapia della Gestalt. Ermeneutica e clinica*. Milano: FrancoAngeli.

Cavaleri P.A. (2003). *La profonditá della superficie. Percorsi introduttivi alla psicoterapia della Gestalt*. Milano: FrancoAngeli.

Colli A. & Lingiardi V. (2007), Valutare l'alleanza terapeutica attraverso trascritti di sedute: l'attendibilità dell'IVAT-R nello studio di quattro psicoterapie. *Ricerca in psicoterapia*, 10(1), 75-97.

Combs A.W. (1999). Being and becoming: A field approach to psychology. *The Humanistic Psychologist*, 25(3), 237-243.

Costa C., Carmenates S., Madeira L., & Stanghellini G. (2014). Phenomenology of atmospheres. The felt meanings of clinical encounters. *Journal of Psychopathology*, 20(4), 351-357.

Crocker S. (2009). Phenomenology in Husserl and in gestalt therapy. *British GestaltJournal*, 18(1), 18-28.

Day E. (2016). Field attunement for a strong therapeutic alliance: A perspective from relational gestalt therapy. *Journal of Humanistic Psychology*, 56(1), 77-94.

Descartes R. (1637/1998). *Discourse on method*. Indianapolis, IN: Hackett Publishing Company.

Duncan B.L., Miller S.D., Wampold B.E., & Hubble M.A. (Eds.) (2010). *The heart and soul of change: Delivering what works in therapy* (2nd ed.). Washington, DC: APA Press.

Eagle M.N. (2011). *From classical to contemporary psychoanalysis. A critique and integration*. New York, NY: Routledge/Taylor and Francis.

Erickson M., Rossi E.L., & Rossi S.I. (1976). *Hypnotic realities. The induction of clinical hypnosis and forms of indirect suggestion.* New York, NY: Irvington Publishers.

Ferro A. (2016). *The field evolves.* In S.M. Katz, R. Cassorla, & G. Civitarese, *Advances in contemporary psychoanalytic field theory.* New York, NY: Routledge/Taylor & Francis Group.

Fink E. (1933). Die phänomenologische Philosophie Husserls in der gegenwärtigen Kritik, *Kant-studien,* 38(1-2): 319-383.

Francesetti G. (Ed.) (2007). *Panick attacks and postmodernity. Gestalt therapy between clinical and social perspectives.* Milano: FrancoAngeli.

Francesetti G. (2011). *Fenomenologia e clinica dell'esperienza depressiva.* In G. Francesetti & M. Gecele (Eds.), *L'altro irraggiungibile. La psicoterapia della Gestalt con le esperienze depressive.* Milano: FrancoAngeli.

Francesetti G. (2012). Pain and beauty. From psychopathology to the aesthetics of contact. *British Gestalt Journal,* 21(2), 4-18.

Francesetti G. (2014). *Il Dolore e la Bellezza. Dalla psicopatologia all'estetica del contatto.* In G. Francesetti, M. Ammirata, S. Riccamboni, N. Sgadari, & M. Spagnuolo Lobb (Eds.). *Il dolore e la bellezza. Atti del III Convegno SIPG, pp. 23-53.* Milano: FrancoAngeli.

Francesetti G. (2015a). From individual symptoms to psychopathological fields. Towards a field perspective on clinical human suffering. *British Gestalt Journal,* 24(1), 5-19.

Francesetti G. (Ed.) (2015b). *Absence is a bridge between us. Gestalt therapy perspective on depressive experiences.* Siracusa: Istituto di Gestalt HCC Italy Publ. Inc.

Francesetti G. (2016). "You cry, I feel pain." The emerging, co-created self as the foundation of anthropology, psychopathology and treatment in gestalt therapy. In J.-M. Robine (Ed.) *Self. A polyphony of contemporary gestalt therapists, pp. 147-168.* St. Romain-La-Virvée: L'Exprimerie.

Francesetti G. (forthcoming). *"Suspended from shaky Scaffolding / we secure ourselves with our fixations."* A phenomenological and gestalt exploration of obsessive-compulsive disorder. *British Gestalt Journal,* np

Francesetti G. & Gecele M. (2009). A Gestalt therapy perspective on psychopathology and diagnosis. *British Gestalt Journal,* 18(2), 5-20.

Francesetti G. & Griffero T. (Eds.) (forthcoming). *Neither inside nor outside. Psychopathology and atmospheres.* Newcastle upon Tyne: Cambridge Scholars Publishing.

Francesetti G. & Roubal J. (2013). *Gestalt therapy approach to depressive experiences.* In F. Francesetti, M. Gecele, & J. Roubal (Eds.), *Gestalt therapy in clinical practice. From psychopathology to the aesthetics of contact, pp. 433-462.* Milano: FrancoAngeli.

Francesetti G. & Spagnuolo Lobb M. (2013). *Beyond the pillars of Hercules. A gestalt therapy perspective of pychotic experiences.* In F. Francesetti, M. Gecele, & J. Roubal (Eds.), *Gestalt therapy in clinical practice. From psychopathology to the aesthetics of contact, pp. 393-432.* Milano: FrancoAngeli.

Francesetti G., Gecele M., Roubal J. (2013). *Gestalt therapy approach to psychopathology.* In F. Francesetti, M. Gecele, & J. Roubal (Eds.), *Gestalt therapy in clinical practice. From psychopathology to the aesthetics of contact, pp. 59-78.* Milano: FrancoAngeli.

Fuchs T. & Koch S.C. (2014). Embodied affectivity: On moving and being moved. *Frontiers in Psychology*, 5, 508, 1-12. doi: 10.3389/fpsyg.2014.00508

Gallese V. (2006a). Intentional attunement: A neurophysiological perspective on social cognition and its disruption in autism. *Experimental Brain Research*, 1079: 15-24.

Gallese V. (2006b). Mirror neurons and intentional attunement: A commentary on David Olds. *Journal of the American Psychoanalytic Association*, 54: 46-57.

Gallese V., Eagle M.N., Migone P. (2007). Intentional attunement: Mirror neurons and the neural Underpinnings of interpersonal relations. *Journal of the American Psychoanalytic Association*, 55,1: 131-176.

Gazzillo F., Lingiardi V., Del Como F., Genova F., Bomstein R.F., Gordon R.M., McWilliams N. (2015). Clinicians' emotional responses and psychodynamic diagnostic manual adult personality disorders: A clinically relevant empirical investigation. *Psychotherapy*, 52(2), 238-246.

Gibran K. (1923). *The prophet.* New York, NY: Vintage Books.

Griffero T. (2014). *Atmospheres: Aesthetics of emotional spaces.* Farnham: Ashgate.

Griffero T. (2017). *Quasi-things. The paradigm of atmospheres.* Albany, NY: State University of New York Press.

Gualtieri M. (2010). *Bestia di gioia.* Torino:Einaudi.

Hansen N.B., Lambert M.J., & Forman, E.M. (2003). An evaluation of the dose-response relationshop in naturalistic treatment settings using survival analysis. *Mental Health Services Research*, 5(1), 1-12.

Heidegger M. (1953). *Being and time.* New York, NY: Harper&Row.

Howard K.I., Orlinsky D.E., Hill J.A. (1969). The therapist's feelings in the therapeutic process. *Journal of Clinical Psychology*, 25(1), 83-93. doi:10.1002/1097-4679(196901)25:1<83::AID-JCLP2270250127>3.0.CO;2-G

Husserl E. (1913). *Ideas. General introduction to pure phenomenology*. New York, NY: MacMillan.

Jacobs L. (2005). The inevitable intersubjectivity of selfhood. *International Gestalt Journal*, 28(1), 43-70.

Jacobs L. (2012). Critiquing projection: Supporting dialogue in a post Cartesian world. In Bar-Yoseph Levine T. (Ed.), *Gestalt therapy. Advances in theory and practice pp. 59-69*. New York, NY: Routledge.

Jacobs L. (2017), Hopes, fears and enduring relational themes. *British Gestalt Journal*, 26(1), 7-16.

Jacobs L., Hycner R. (Eds.) (2009). *Relational approaches in gestalt therapy*. New York, NY: Routledge/Taylor & Francis Group (1st ed.: New York, NY, A Gestalt Press).

Kennedy D. (2003). The phenomenal field. *British Gestalt Journal*, 12(2), 76-87.

Latner J. (1983). This is the speed of light: Field and systems theories in gestalt therapy. *Gestalt Journal*, 6(2), 71-90.

Lévinas E. (1987). *Time and the other*. Pittsburgh, PA: Duquesne University Press.

Lewin K. (1952). *Field theory in social science: Selected theoretical papers*. New York, NY: Harper & Brothers.

Maldiney H. (1991). *Penser l'homme et la folie*. Grénoble: Jérôme Millon.

Marion J.-L. (2003). *The erotic phenomenon*. Chicago, IL: University of Chicago Press.

Merleau-Ponty M. (2003). *Phenomenology of perception: An introduction*. New York, London: Routledge.

Metzger W. (1941). *I fondamenti della psicologia della Gestalt*, Firenze, Giunti Barbera, 1971 (or. ed.: *Die Entwicklung ihrer Grundannahmen seit der Einführung des Experiments*, Darmstadt, Dietrich Steinkopff Verlag, 1941).

Minkowski E. (1927). *La schizophrenie. Psychopathologie des schizoides et des schizophrènes*, Paris: Payot.

Neri C. (2016). *The analytic field as a resonator and instrument for revealing the presence of other fields*. In S.M. Katz, R. Cassorla, & G. Civitarese (Eds.), *Advances in contemporary psychoanalytic field theory*. New York, NY: Routledge/Taylor & Francis Group.

O'Neill, B. (2008). Relativistic quantum field theory: Implications for gestalt therapy. *Gestalt Review*, 12(1), 7-23.

Oliver M. (2004). *Why I wake early*. Boston, MA: Beacon Press.
Orange D.M., Atwood G.E., Stolorow R.D. (1997). *Working intersubjectively: Contextualism in psychoanalytic practice*. Hillsdale, NJ: The Analytic Press.
Orange D.M., Atwood G.E., Stolorow R.D. (1999). *Inter-soggettività e lavoro clinico. Il contestualismo nella pratica psicoanalitica*. Milano: Raffaello Cortina Editore.
Ornstein A (1974). The dread to repeat and the new beginning: A contribution to the psychoanalysis of the narcissistic personality disorders. *Annual of Psychoanalysis*, 2, 231-248.
Parlett M. (1991). Reflections on field theory, *British Gestalt Journal*, 1, 68-91.
Parlett M. (2005). *Contemporary gestalt therapy: Field theory*, in: A.L. Woldt & S.M. Toman (Eds.) *Gestalt therapy. History, theory, and practice*. London: Sage.
Perls F. (1942/1969). *Ego, hunger and aggression. A revision of Freud's theory and method*. New York, NY: Random House.
Perls F., Hefferline R.F., & Goodman P. (1951/1994). *Gestalt therapy. Excitement and growth in the human personality*. Gouldsboro, ME: Gestalt Journal Press.
Philippson P. (2002). A gestalt therapy approach to transference. *British GestaltJournal*, 11(1), 16-20.
Philippson P. (2017a). Three levels of training. *British Gestalt Journal*, 26(1), 3-6.
Philippson P. (2017b). Revisiting the field (Kindle version). Retrieved from https://www.amazon.it/s/ref=nb_sb_noss/262-9211115-1726344?__mk_it_IT=%C3%85M%C3%85%C5%BD%C3%95%C391&url=search-alias%3Ddigital-text&field-keywords=Peter+philippson
Polster E. & Polster M. (1976). *Therapy without resistance: Gestalt therapy*. In A. Burton (Ed.) *What makes behavior change possible?* New York: Brunner/Mazel.
Pribram K.H. (1971). *Languages of the brain: Experimental paradoxes and principles in neuropsycholgy*. Englewood Cliffs, NJ: Prentice-Hall.
Rizzolatti G. & Craighero L. (2004). The mirror-neuron system. *Annual Review of Neuroscience*, 27, 169-92.
Rizzolatti G. & Sinigaglia C. (2006). *So quel che fai. Il cervello che agisce e i neuroni specchio*. Milano: Raffaello Cortina Editore.
Robine J.-M. (2004). *Plis et Deplis du Self*. Bordeaux: Institut Français de Gestalt-thérapie.

Robine J.-M. (2008). Le fond du champ. En arrière-plan du concept. *Cahiers de Gestalt-thérapie*, 22(1), 197-210.

Robine J.-M. (2016). *Self: Artist of contact*. In J.-M. Robine (Ed.) *Self. A polyphony of contemporary gestalt therapists, pp. 213-232*. St. Romain-La-Virvée: L'Exprimerie.

Rogers C.R. (1951). *The client-centered therapy. ItscCurrent practice, implications and theory*. Boston, MA: Houghton Mifflin.

Roubal J. (2007). Depression. A gestalt theoretical perspective. *British GestaltJournal*, 16(1), 35-43.

Roubal J. & Rihacek T. (2014). Therapists' in-session experiences with depressive clients: A grounded theory. *Psychotherapy Research*, 26(2), 206-219.

Schmitz (2011). *Nuova fenomenologia. Un'introduzione*. Milano: Marinotti.

Schore A. (1994). *Affect regulation and the origin of the self. The neurobiology of emotional development*. Hillsdale, NJ: Eribaum Associates.

Sichera A. (2001). *A confronto con Gadamer: per una epistemologia ermeneutica della gestalt*. In M. Spagnuolo Lobb (Ed.), *Psicoterapia della gestalt. Ermeneutica e clinica, pp. 17-41*. Milano: FrancoAngeli.

Siegel, D.J. (2012). *The developing mind: How the relationships and the brain interact to shape who we are* (2nd ed.). New York, NY: The Guilford Press.

Spagnuolo Lobb M. (2013). *The now-for-next in psychotherapy. Gestalt therapy recounted in post-modern society*. Milano: FrancoAngeli.

Staemmler F.-M. (1997). On cultivating uncertainty: An attitude for gestalt therapists. *British GestaltJournal*, 6(2), 40-48.

Staemmler F.-M. (2005). A babylonian confusion? On the uses and meanings of the term "field." *British Gestalt Journal*, 15(2), 64-83.

Staemmler F.-M. (2006). The willingness to be uncertain. Preliminary thoughts about interpretation and understanding in gestalt therapy. *International Gestalt Journal*, 29(2), 11-42.

Staemmler F.-M. (2016). Taking another turn. *British Gestalt Journal*, 25(2), 3-19.

Stein E. (1989). *On the Problem of Empathy. The Collected Works of Edith Stein*. Dordrecht: Springer.

Stem D.N. (1985). *The interpersonal world of theInfant. A view from psychoanalysis and developmental psychology*. New York, NY: Basic Books.

Stem D.N. (2004). *The present moment in psychotherapy and everyday life*. New York, NY: Norton & Co.

Stern D.N. (2010). *Forms of vitality. Exploring dynamic experience in psychology and the arts.* New York, NY: Oxford University Press.

Stolorow R.D., Atwood G.E., & Brandchaft B. (Eds.) (1994). *The intersubjective perspective.* Northvale, NJ: Jason Aronson.

Stolorow R.D., Brandchaft B., & Atwood G.E. (1987). *Psychoanalytic treatment. An intersubjective approach.* Hillsdale, NJ: The Analytic Press.

Thompson, E. (2001). Empathy and consciousness. *Journal of Consciousness Studies*, 8(5-7), 1-32.

Tolman E.C. (1959). *Principles of purposive behavior.* In S. Koch (Ed.) *Psychology: A study of a science*, vol. 2, pp. 92-157. New York, NY: McGraw-Hill.

Tschacher W., Ramseyer F., & Bergomi C. (2013). The subjective present and its modulation in clinical contexts. *Timing and Time Perception*, 1(2), 239-259. doi: 10.1163/22134468-00002013

Tschacher W., Ramseyer F., & Koole S.L. (2017). Sharing the now in the social present: duration of nonverbale synchrony is linked with personality. *Journal of Personality*, Dec. 15. doi:10.1111/jopy.12298

Yontef G. (1984). Modes of thinking in gestalt therapy. *Gestalt Journal*, 7(1), 33-74.

Yontef G. (1993). *Awareness, dialogue and process: Essays on gestalt therapy.* Highland, NY: Gestalt Journal Press.

Yontef G. (2002). The relational attitude in gestalt therapy theory and practice. *International Gestalt Journal*, 25(1), 15-36.

Weber M. (2004). *The vocation lectures. Science as a vocation. Politics as a vocation.* Indianapolis, IN: Hackett Publishing Company.

Wheeler G. (2000). *Beyond individualism: Toward a new understanding of self, relationship and experience.* Hillsdale, NJ: The Analytic Press/Gestalt Press.

Wolf A.W., Goldfried M.R., & Muran J.C. (2013a), *Introduction.* In A.W. Wolf, M.R. Goldfried, & J.C. Muran (Eds.). *Transforming negative reactions to clients: From frustration to compassion, pp. 3-18.* Washington, DC: American Psychological Association.

Wolf A.W., Goldfried M.R., & Muran J.C. (2013b). Conclusion and clinical guidelines. In A.W. Wolf, M.R. Goldfried, & J.C. Muran (Eds.). *Transforming negative reactions to clients: From frustration to compassion, pp. 269-282.* Washington, DC: American Psychological Association.

Wollants G. (2008). *Gestalt therapy: Therapy of the situation.* London: Sage.

Zahavi D. (2015). *The Oxford handbook of contemporary phenomenology*. Oxford: Oxford University Press.
Zimbardo P.G. (2008). *The lucifer effect. Understanding how good people turn evil*. London: Random House.

CHAPTER TWELVE

USE OF SELF IN PRACTICE

Part I—Self: Artist of Contact
Jean-Marie Robine

I.

More than sixty-five years ago, Perls and Goodman introduced a turning point in psychotherapy with *Gestalt Therapy* (hereafter designated PHG [Perls, Hefferline and Goodman], 1951). With many of their proposals – which have most likely still not yet been sufficiently developed – they anticipated many later developments in the social sciences. This is particularly true for the concept of self, which was displaced, decentered and then relocated and temporalized. At the time, so-called modern psychology – a solipsistic discipline if ever there was one – recognized only an individualized self as the sole "reality", and the psyche was one of its main variations. Based on "the simplest and first reality" – namely that no human function exists without contact with the environment – the authors structured a fundamentally innovative way of thinking and praxis, in direct contact with this natural conception of human nature. This fundamental human activity – which consists in establishing and modulating contact with one's environment; bringing out and constructing adapted, creative figures from the novelty of each situation; deconstructing any completed or obsolete figures – is the limited but essential function they assign to the self.

If the founders attribute to the self the task of activating and synthesizing the functions it is necessary to engage in a creative contact with the environment, it is clear that the self exists only *when* and *where* there is contact: an ephemeral function, a function of varying intensity depending on the difficulty presented by the field. Under this conception, there is no claim that the self existed beforehand and reveals, manifests or expresses itself in contact; instead, it *is* contact; it is created in and through contact. In a field defined as "an organism and its environment", the self-function designates the internal movements of this field: movements of integration and differentiation, unification and individuation, action and transformation...

To grow and develop, the organism must encounter what is new, different, not itself; it makes it into a figure – that is to say, it forms a Gestalt – and in the operation of contact that it thereby carries out, driven by the excitement accompanying this formation of forms, it returns to this continued individuation, this unceasing self/world differentiation. This process is called self." [Self] is only a small factor in the total organism/environment interaction, but it plays the crucial role of finding and making the meaings that we grow by" (PHG, 1951, Chapter 1, §11).

This relocation of the self and its repositioning as a field phenomenon may seem astonishing due to its prophetic nature, pre-empting the work of many philosophers, sociologists and essayists of the second half of the 20th century. However, the attentive reader of *Gestalt Therapy* will notice certain oscillations between a traditional conception of a self-entity – sometimes called a "self-object" by some later authors – and the innovative design they sketched out, and with it a new paradigm that would be developed in diverse forms – often less radical than the original – by several authors of postmodernity, social constructionism, intersubjective psychoanalysis or other identity theorists.

II.

In my native language (French), the concept of self cannot be translated by any exact equivalent. Some authors choose to translate "self" as "*soi*", thereby reducing it to a more conventional concept. In *Gestalt Therapy,* while "self" refers to the function of the field mentioned above, in the same text it is also used to designate the sedimentation that may take place in the aftermath of creative organism/environment contacts and in this case, "*soi*" may be an appropriate translation. English seems to be one of the rare languages in which "self" can refer to both the process and its result.

Several authors – in particular the British philosopher Stephen E. Toulmin (1977) – have shown that in the English language "self" originally existed only as a suffix (e.g. "myself") or a prefix (e.g. "self-control"), emphasizing its fundamentally reflexive nature, until the relatively recent point when the word found itself isolated, nominalized and therefore theorized as a noun. William James (1890) and later George H. Mead (1934) probably played the biggest role in turning this prefix/suffix into a separate concept. In most other languages, this reflexive process and its result cannot be designated by a single concept. As a result, it can be difficult for Gestalt therapists from other cultures to appropriate the use of this concept.

In my language, this reflexive character is expressed by two pronouns: "*je*" ("I"), which designates the verbal agent, and "*me*" or "*moi*" ("me" or

"myself"), which designates the beneficiary or receiver of the action carried out by "*je*". We call this form the "reflexive voice", as in "*je me promène*" ("I walk" but literally "I walk myself") or "*je me lave les dents*" ("I brush my teeth" but literally "I wash myself the teeth"). (This is the same reflexive form that will be used to express retroflection.) One of the three essential properties that Perls, Hefferline and Goodman attribute to the self is the *middle voice* (which they mistakenly call "the middle mode" since in grammar, "mode" refers to the indicative, the subjunctive, the participle, etc.) in reference to ancient Greek grammar, which has this form of conjugating verbs (and thus actions) without the need for differentiated pronouns (PHG, 1951, Chapter 10, §4). The two other properties they focus on are *spontaneity* and *engagement in the situation*, which we will return to later on.

III.

How can we use a concept that has barely any roots in a given culture? If self, with its two meanings – process and structure – does not correspond to an equivalent definition in another language, how can this term find its place in the clinician's vernacular "toolbox", to borrow an expression from Foucault (1972)?

In fact, in daily practice, drafting session notes, during supervision and in the thoughts of the practitioner in action, the concept of self is hardly present. But Perls and Goodman provided a description of its functions and its dynamics which makes up a set of valuable, operative beacons. In the same way that physicists can describe light sometimes as particles and sometimes as waves, the clinician can address the self sometimes by turning its partial structures (also called functions) into figures and sometimes by tracking its temporal deployment (also called contact sequence or construction/deconstruction of a Gestalt).

Self is thus a unifying concept that brings together the ingredients required to enable the creative adjustment of an organism and its environment. "For the most part the self creates special structures for special purposes [...] The subject-matter of a formal psychology would be the exhaustive classification, description and analysis of the possible structures of the self. (This is the subject-matter of Phenomenology)" (PHG, 1951, Chapter 10, §5).

As such, I believe – and am aware that this is a choice on my part – that the theory proposed by our founding book need not be approached as a metapsychology but rather as a *theory of practice*, or even *a theory* for *a specific practice*, based on an anthropology, a conception of man in the

world. As in philosophy, it is possible to differentiate between *metaphysical* approaches and *phenomenological* approaches, and the psychological movement that Perls and Goodman belonged to proposes to develop based on what is observed at the organism/environment contact boundary, not metapsychological inferences or speculative preconceptions.

I have often had occasion to denounce the pan-explanatory hegemonic temptation to apply certain theoretical systems to a field that is not theirs (Robine, 2004, 2011). On the contrary, I am in favor of placing different frames of reference in dialectical tension with one another, without looking for a truth that, in any event, will always escape us.

IV.

Our cultural tendency urges us to reify the self, place it at the heart of the individual, define its outline and provide it with attributes – some of which are supposedly "true" and others "false". Yet, as we mentioned, "It is a reflexive operation by which the actor is specified, limited and defined. This operation presupposes integration into a field to achieve ongoing differentiation. It is individuation, not the individual. It is Montaigne's 'I do not paint the being; I paint the passage' (1580/1969)" (Robine, 2004/2012). The self is unfolding, in flux, constantly evolving, becoming by connecting, through its contacts with its human and non-human environment.

Our authors study three partial structures of the self (which, they regretted, were often taken for the overall functioning of the self) which "are the major stages of creative adjustment" (PHG, 1951, Chapter 10, §5).

It should be noted that for Perls and Goodman, there can be no question of reducing the self to these three functions alone: they choose to limit their focus to these three because they are essential to organizing the figure/background process; in other words, they are the three functions that act in implementing an adapted, creative contact.

These three partial structures of the self (or functions) are called personality-function, id-function and ego-function, names that condense the ideas they refer to: the self functioning in ego mode, the self functioning in personality mode, etc.

The id-function means "the given background dissolving into its possibilities, including organic excitations and past unfinished situations becoming aware, and the environment vaguely perceived, and the inchoate feelings connecting organism and environment" (ibid.).

The personality-function "is the created figure that the self becomes and assimilates to the organism, uniting it with the results of previous growth" (ibid.).

The ego-function is "the progressive identification with and alienation of the possibilities, the limiting and heightening of the ongoing contact, including motor behavior, aggressing, orientation and manipulation" (ibid.).

V.

Although Gestalt therapy theorists always take the precaution of attaching the term "function" to each of these partial structures so that their definitions are not confused with those used in psychoanalysis, many regret that they still contain psychoanalytical terms – "id" and "ego" in particular.

"Id" refers to the function of the self that manifests needs, desires, appetites, impulses... It is the direction of meaning. Given that this moment of the experience is lived in a subverbal mode, the body is its expression – or, to alter Freud's well-known formulation, one could say that the body is the "royal road" to access the id. But the road should not be confused with what it leads to... It is more *awareness* than *consciousness* that grants us access to the ephemeral contents of the id-function, if indeed it can be addressed independently of other functions.

Although the terms are not fully superimposable – far from it, in fact – I am tempted to address this moment of the experience using the term *intentionality*. Returning to Husserl: "Intentionality is an essential peculiarity of the sphere of mental processes taken universally in so far as all mental processes in some manner or other share in it; nevertheless, we cannot say of *each* mental process that it has intentionality [...] Intentionality is what characterizes *consciousness* in the pregnant sense and which, at the same time, justifies designating the whole stream of mental processes as the stream of consciousness and as the unity of *one* consciousness" (Husserl, 1913/1950, p. 283).

Transferring such an important, widely commented concept from the philosophical sphere to the psychological sphere is, admittedly, risky business (Robine, 2004). I attribute the characteristic of the *implicit* to intentionality, and will reserve the *explicit* for [deliberate] intention. I thereby establish the same difference and the same relationship between intentionality and intention as the one that may exist between creativity and creation. Creativity – potential and direction of meaning – can only be exercised or perceived through a creation, which is a reduction of the possible forms in which creativity could manifest itself.

History has taught us that the dissemination of the concept of "ego" in the psychological sciences seems attributable to the English translator of Freud, who saw fit to translate Freud's *"Ich"* as *"Ego"*, and this Ego was adopted by the francophone tradition, which translated it as "*Moi*". And that

is how, if we think back to the distinction mentioned earlier between the "I" and the "me", the "me" would become the agent, instead of being the beneficiary or result of the action! It would therefore be wise, given the very definition of the "ego-function" provided by our founders and when it occurs in the experience, to restore its name to "*I*" or "*I-function*". It is indeed the function of the self, which is also ephemeral, which is responsible for selection and rejection, and the construction of the figure, i.e. the ongoing contact.

And the attribution of the *Ego* could fall on the personality-function, since this "I" is made up of sedimentations of successive experiences. But I do not deny the tradition that uses "personality" to refer to the set of characteristics of a particular individual, although PHG emphasize the difference between "who I am" and "who I think I am." And it is more this second aspect that defines the personality-function.

In his unpublished teachings, Isadore From stated that the ego-function was the bridge between the personality-functions or between the id and the environment; in other words, this ego-function could not get involved without support from one of the other two functions.

VI.

A simplistic reading of these functions could lead some Gestalt therapists to try to make their patients' words fit within the narrow framework of these partial structures as one might do with independent entities. Thus, if the patient described herself or stated one of her characteristics ("I am someone who…"), the therapist would diagnose a manifestation of the personality-function; a patient who stated his desire or need – or even ahead of that possibility, who expressed a bodily feeling – would be interpreted as driven by the id-function; a patient who made a choice would be seen as manifesting the exercise of her ego-function. This conception of a subject as made up of "little boxes" that are more or less sealed is far from meeting with my approval, since all experience mobilizes the entire self, and the therapist's focus on one partial function or another is related to the work that takes place from one moment to the next.

An expression that might "traditionally" be read as an expression of the personality-function could thus be used in work to build up access to the id-function, if such an orientation seems relevant. An amusing example can be imagined based on something Perls often said at his Esalen seminars: "I believe that I am the best therapist for any type of neurosis in the States, maybe in the world" (1969a; 1969b). If this statement were taken at face value, it might reveal the traits of a personality that is, at the very least, not

characterized by modesty. But the choice of organization of how the message is heard by the recipient can lead that listener down other paths: "What is this Perls trying to accomplish by having me hear this representation he has of himself? What does he want from me?" And in this way a focus placed on the id-function of the self can come to the foreground.

The concepts put forth to approach the deployment of the self can thus be used more dynamically and less structurally to serve as a gateway to the experience lived from moment to moment.

In addition, although the various functions of the self described by our authors can be addressed as partial structures, they can also be regarded as specific moments of the experience, as momentary dominant features in the course of building a Gestalt.

VII.

The second way of looking at the self involves its temporal dimension. This modality is described by the founders as a *sequence*: a succession or sequence of operations that may lead to a phenomenological observation. In its so-called subsequent developments, this sequence was renamed "cycle" by certain schools of thought, which to me seems to be a completely inappropriate term. A cycle describes a recurring – and thus predictable – phenomenon such as the cycle of the seasons, the menstrual cycle, the cycle of the tides and the lunar cycle. This is – let us hope – far from being the case of the human experience and the creation of figure/background relations which lead to novelty and therefore the unknown.

This sequence is also described in terms of "process". In this regard, it seems important to consider the difference between "process" and "sequence". A process is defined by two basic characteristics: first of all, it is an ordered sequence that leads to a result. We can thus describe the series of operations that allows us, for example, to cook an egg or to complete an apprenticeship; the objective is specific and clearly defined. The second characteristic of a process is that the phenomena that follow one another in time present a coherent unity with the objective. Boiling water is part of the egg-cooking process, as is immersing the eggs in the water. But if during this operation I answer the phone or set the table, these actions are not part of the egg-cooking process, yet they are actually part of the sequence – that is to say, the series of my actions. Thus, during a therapy session – one of whose lines of work may concern "interruptions of contact" – is it more operative to focus on the process or on the sequence? In fact, we can only really know a process once it has been completed, since it then becomes possible to show the series of operations that contributed to its completion,

without retaining parasitic or irrelevant parallel actions. However, these so-called parasitic actions that occur during contact and the construction of a Gestalt will not be absent from subsequent dysfunctions or even their attachment in a psychopathological form.

During a group therapy session, Pierre discusses his difficulty in accessing bodily sensations and the fact that, on the rare occasions when they do reach his consciousness, he cannot make sense of them and does not know what to do with them.

Work begins, focused on the consciousness of his bodily experience and, supported by the safety of the group setting and his trust in our contact, he manages to emerge and name sensations, not without some anxiety. Explicitly, the next moment appears to be a search for meaning and direction in contacting rooted in these sensations.

He pauses, then reports that something is happening in his mouth and that before continuing he would like to eat a piece of candy. He looks for the basket where the group organizer had set out a selection of sweets.

I draw his attention to this "need" to swallow something, just when the possibility of an action of expression was opening up – that is to say, the opposite movement, directed toward the world, not turned back toward the organism.

He asks for my support to experience this other possibility, suddenly aware of his propensity to interrupt at this specific point in the process by "swallowing" his feelings.

I suggest that he use his breathing – especially exhaling – to experience how it feels when he turns "something" rooted in his bodily sensations toward the world. Then, while remaining at a distance, I invite him to direct his breath in my direction, as if he wanted to hit me in the face with his exhalation. After a few breaths, emotion accompanies his breathing; the feeling of being welcomed opens access to the other, to the world, and the sequence can continue in the novelty of this mode of contact.

This illustration shows how a mini-event – which appears to be a parasite to the process – takes its place in the sequence. It also reveals how the "status" that the therapist assigns to the event can be decisive. The current concept of "interrupting the contact" – which should obviously be understood to mean "interrupting the figure of contact being constructed" and not "interrupting the contact between you and me" – therefore strikes me as highly ambiguous. I am more inclined to entertain the hypothesis that contact (the construction of the figure) continues despite appearances by taking on a form whose "logic" may escape me but which should be considered connected to the experience. The interruption may thus be caused by the therapist following the *process* rather than the *sequence*.

VIII.

This sequence has been described multiple times throughout the history of Gestalt therapy. In my view, the description provided by Perls and Goodman is still fully relevant insofar as it addresses the sequence in terms of figure/background relationships rather than in behavioral terms as was generally the case later on. They highlight how each phase is characterized by a specific figure, supported by a background that is no less specific, and thus creates a kind of dance between figures that advance into the foreground and then return to the background, enriching it and enabling the establishment of a brighter, clearer, sharper figure. What is offered is thus a true aesthetics of the self: a description of the formation of forms *(Gestaltung).*

It does not seem necessary, within the framework and limits of this chapter, to detail how the sequence of the deployment of the self unfolds, since this is extensively discussed in Chapters XII and XIII of PHG (PHG, 1951). Let us only briefly review its theoretical choreography:

Initially there is creative undifferentiation, that moment where nothing constitutes a figure and where the permanence of the background is ensured by the body. (Here I am of course speaking of the "phenomenal body" as theorized by Merleau-Ponty in his first book (1945) and which he later came to call "flesh" (1964).) Then the situation opens up to the emergence of sensations outside of this undifferentiated background. The figure, driven by the background, is then constituted by the direction of meaning (desire, need, appetite, urge, etc.). This is the forecontact phase. The figure joins the background, melting into it. The background is no longer just "body" but becomes what might be called a "desiring body", and the "possible objects" to contact are built into figures (others, objects, contacts, meanings, experiences, environment, etc.). The "I" is at work making choices and rejections. The choices – and then THE choice – refine the figure. Rejected hypotheses move into the background, thereby feeding it. This is the contacting phase. Next, what made up the direction of meaning can blend momentarily into the chosen "object". This is the final contact phase, a term which recalls that this contact, this construction of a figure was aimed at reaching this *final purpose.* But it is not the *end* of the sequence, since the time has now come for withdrawal and the assimilation of the experience. What has been experienced with "the chosen object" joins the background and the experience enriches the self's personality-function. The figure gradually fades away until it disappears as such. This is the post-contact phase.

This sequence, which I have oversimplified here, can be criticized due to its relatively solipsistic description. It gives rise to various subsequent

contributions to fit into the field paradigm, which places it in a perspective of co-creation. We will return to it when we discuss this paradigm.

IX.

Approached in its temporal dimension, the self appears to be an ever-changing function: operating at very low intensity when the organism is at rest and only slightly mobilized when the situation is contacted through routines and systems of habit, the more difficult the field and the more it requires both adaptation and creativity, the more the self is fully engaged.

It is often described using the metaphor of the sea or the river ("We never bathe twice in the same river," wrote Heraclitus in the sixth century B.C.E.). Although it is mobilized in various ways and constantly created by the novelty of situations, the self is not multiple (in the sense of having multiple selves). The sea can be calm, choppy, stormy, warm or cold, with or without waves, turquoise or grey, but it will always be "the sea" because the word "sea" designates what unites all of these changing characteristics, whatever they may be. I see "the self" as the unifying principle of the forms of experience.

X.

I would like to briefly mention what our founders called "interruptions of contact", which they only discussed in the last chapters of the founding book (PHG, 1951, Chapters 14 & 15). It should however be noted that these interruptions were the focus of most of the practical section written by Hefferline and Perls (PHG, 1951).

These modalities – confluence, introjection, projection, retroflection, egotism, repression, sublimation and reaction formation – have been the subject of much controversy in the community, concerning their names as much as their status in the theoretical apparatus. The *Gestalt Journal* amply documented this debate over the course of the 1990s. Incidentally, it should be noted that repression, sublimation and reaction formation seem to have fallen out of fashion – or been rejected? – by the majority of Gestalt clinicians, without having been the subject of a critical study.

Some currents of Gestalt therapy place these modalities at the center of therapeutic work, which may lead the therapist to engage in a real hunt for what they see as major disruptions. Moreover, for a long time, in a process initiated by Perls and amplified and expanded by the Polsters (Polster, E. & M. 1973/1983), these modalities were considered "resistances" before the theoretical error was recognized.

The term "interrupting the contact" manifests a certain ambiguity related to the implicit definition that each of us may have of contact. A human being is always in contact with something or someone, be it with the air he breathes or the ground on which he stands. Contact can move – even very rapidly – from one figure to another (in a sort of noematic change, to twist Husserl's term) just as it can change modalities, switching from visual contact to emotional contact, for example (which would be a noetic variation). This means that it is not "the contact" that is interrupted, but rather the object of the contact or the modality that is replaced by another. As I mentioned following the illustration quoted above, I can also hypothesize that the self engaged in a situation remains involved in a theme for longer than it may seem...

Since these modalities are described in two chapters entitled "Loss of ego-functions", Isadore From (1981sq.) gave them this name in the plural. His reading of this chapter led him to understand that when a subject presented disturbances of the id-function or the personality-function, the ego-function was no longer able to make healthy identifications and alienations, and was therefore momentarily lost. Then, in this absence of functioning in ego-mode, along came one of these modalities as a substitute (projection, introjection, etc.), an expression of dysfunction and therefore of pathology.

Another reading can also be made of the rhetoric of this chapter. What happens when there is a loss of the ego-function? When this is the case, what happens to the modalities of contact called introjection, projection, etc.? How do they operate *differently*? It is therefore no longer they themselves that are dysfunctional, but instead the experience in the absence of the self's ego-mode. Each of us could cite many examples of situations in which it felt "healthy" to retroflect or introject!

Another difficulty associated with these concepts is related to the confusion that can occur between these modalities – specific moments of the ongoing contact – and making them chronic. Introjection or retroflection designate operating modes during the course of a contact sequence, so *introject* or *retroflect*, for example, designate their fixation. This confusion, which is unfortunately quite common, leads some to speak of an *introjection* which, for example, is supposedly rooted in childhood experiences, whereas they are perhaps in the presence of "old" *introject* – the fixation of content and making it chronic – and certainly not an *introjecting* person. Psychopathology should be thought of in terms of calling on fixed forms rather than implementing a creative adjustment.

To give a categorical name to these modalities, in 1997 I proposed the term "*flexions*" found in the French translation of Binswanger's *Dream and*

Existence (1930). This term, borrowed from linguistics, describes the way words (verbs or nouns) are conjugated or declined. It therefore has no pejorative or dysfunctional connotation: it only refers to derivations, variations related to the context. It seems to me that this concept lets us address these contact boundary phenomena as *variations* rather than symptoms. It helps us avoid focusing on these phenomena, unfolding instead them as gateways to the experience.

XI.

In the preceding pages – aside from certain reservations, critiques or personal formulations – I tried to stay as close as possible to the original proposals of our founders. The occasionally solipsistic or intrapsychic dimension of certain statements will probably not have escaped the eye of an attentive reader.

In recent decades, a turning point occurred among a number of theorists and practitioners faced with the observation that although the field perspective was still always mentioned among the founding principles of Gestalt therapy, for a long time Gestalt therapy was far from being integrated into psychotherapeutic practice, which often remained individualistic. The field principle appeared to be more of a slogan than a reality, and our concepts needed to be revisited to allow a greater coherence to emerge.

When we launch this type of paradigm shift, it may therefore be appropriate to look at whether the conception of the self requires a few inflections, or even a redefinition.

The field that Perls and Goodman discuss is not a "thing": they call it the "organism/environment field". That means that every field is a field "of". There is always an organizing principle of the field: the eye's field of vision; a conscious being's field of consciousness; the field of psychology, with psychology taken to be the organizer of a field of knowledge; etc. (Robine, 2008).

Frank Staemmler (2006) made a major contribution to clarifying this concept as discussed throughout the various sources and by all the different contributors, and also highlighted the inconsistencies and contradictions of successive authors' implicit or explicit definitions. Some would approach a conception of the field as an entity or a semi-entity, others as an experience – in the phenomenological sense – which is both continuous and transient. As with any attempt at theorization, there are choices to be made. For my part, I consider the field as an experience of interrelatedness between an organism and its environment, and prefer to try to use other concepts to designate other specific regards: context, situation, realm, milieu,

background, environment, system, etc. What is certain is that none of us is immune to shifts in the use of the concept!

"When referring to contact and other field phenomena, Perls and Goodman periodically introduced the distinction between 'in the field' and 'of the field'. Placing the subject, the body, the contact, etc. as events of the field and not in the field clarifies the matter by opposing the two major uses of the concept of field: one that results in reification and the other that maintains the field in flux" (Robine, 2004).

According to this conception, "field" is a paradigm that fundamentally defines a posture, a focus on how each of us can be created by our environment at the same time as we are creators of our environment. In one of his writings – I do not know which – Peter Philippson evoked the famous Escher drawing *Drawing Hands* which shows a hand drawing a hand, which itself is drawing the hand that is drawing it... A great metaphor!

In the context of psychotherapy, this means taking into account the process-related fact that the therapist is co-created by the encounter with her patient, just as the patient is co-created by the encounter with his therapist. What is felt by each person involved, the experience that unfolds, spoken words, sensory and motor patterns, memories summoned, fantasies, historical parallels, the constructions of meaning... are first of all products *of the situation.*

The starting point of my question on "the situation" is found in a small expression by Perls and Goodman when they are discussing "the id of the situation" (Robine, 2002). This is again not a contextualized id, the id *in* a situation that they are talking about, but "the id *of* the situation". Far from the theory of "internal" drives and forces that animate us, the source of the id is localized in the situation – a joint creation – to then give rise to a specific, differentiated, individuating feeling in each of the actors involved.

I use the term *situation* to designate the overall perception/proprioception of elements of the field of all the actors involved: a perception that allows them to structure the context of their encounter, give it meaning and implicitly define the modalities of their interaction. It is a space that is constructed and delimited by each of the actors, who are themselves simultaneously constructed by that space and by the definition they give it.

It is also important not to lose sight of the fact that acting and reacting to the situation means simultaneously acting with one's own memory and one's own emotions, since they are part of each participant's [organism/environment] field.

To articulate the concept of field with that of situation, I would say – perhaps only provisionally! – that the situation is created by the intersection of and interaction between the fields of each of the actors involved. Each

participant's immediate and selective perception of the implicit organization of the field of all the actors involved organizes the situation. From the field of the actors involved emerge affordances (Gibson, 1979) and valences (Lewin, 1936, 1951) which combine to form the situation (Robine, 2015).

The idea of a "common field" seems to have spread in recent years, both among Gestalt therapists (e.g. Francesetti, 2015) and certain psychoanalysts, following Baranger's founding article (1961), built upon in particular by Ferro A. et al. (2009). To designate what is referred to by the term "common field" – or one of its variants ("bi-personal field", "dynamic field", etc.) – I prefer to use that of the situation to avoid using the same concept to refer to two different approaches, since this "common" field cannot match the descriptions of the organism/environment field as proposed by Perls and Goodman. The idea of "common" could too easily be understood as "shared", or even "similar".

What is important, to quote Merleau-Ponty, is implementing the following conception:

> "In the experience of dialogue, a common ground is constituted between me and another; my thought and his form a single fabric, my words and those of my interlocutor are called forth by the state of discussion and are inserted into a shared operation of which neither of us is the creator. Here there is a being-shared-by-two, and the other person is no longer for me a simple behavior in my transcendental field, nor for that matter am I a simple behavior in his. We are, for each other, collaborators in a perfect reciprocity: our perspectives slip into each other, we coexist through a single world" (1945, trans. Routledge 2012, p. 370).

From this perspective, the constantly renewed novelty of the situation is what organizes the experience, and therapeutic work focuses less on what *was* than on what *will happen*. The therapeutic situation is no longer a simple repetition of history, but instead a potential space-time opening up to transformation. Traditional causalist assumptions are reversed: it is neither the patient's past nor even the therapist's that gives form to the now, but instead the situation co-created in the now that may possibly mobilize engrammatic patterns or projections on the future.

The self can therefore once again be addressed as one of the agents and the provisional outcome of every situation. Engaged in co-creation – which does not exclude conflict – creator and created, "our perspectives slide into one another." The undifferentiated part of the intersubjective opens up to the progressive constitution of subjectivity – and thus the self – which is constantly renewed. This taking form (Gagnon, 1999) is an emerging process of contact with the immediate environment; naturally, one of the essential dimensions consists in situating in the contact with the other, but

it is important not to ignore the other components of contact, the one that is established with the non-human environment (Robine, 2010).

> "...Every form has its roots in the movement that traces it: a form is nothing but recorded movement" (Bergson, 1934, p. 279).

XII.

Since the self designates this ability to give form to contacts with the world, in recent years there have been more and more parallels drawn with aesthetics, allowing the discipline to extricate itself from a purely medical model. Already in the founding text, the authors stated that for their definition of the self in a situation of creative adjustment, they made reference to the creative artist and the child at play (PHG 1951, Chapter 2, §8). They draw from Otto Rank's study, *Art and Artist (1932),* which Goodman said "is beyond praise" (PHG, Chapter 11, §6 note) and on child-play. Although they do not reveal the source of that latter reference, I suppose they primarily relied on the study of G.H. Mead who himself had drawn extensively from the study of children's play to support his conception of the self (Mead, 1934).

Laura Perls (1992) liked to recall that the term "Gestalt" belonged to the vocabulary of aesthetics and, in fact, all the characteristics of a Gestalt which are listed in *Gestalt Therapy* fall within this same family.

Following this tradition, multiple studies have appeared promoting the aesthetic reference in the phenomenology of the session and the posture of the psychotherapist as much as in diagnosis, clinical settings and psychopathology (Robine, 1984, 2006a, 2006b; Miller, 2002; Alvim M. 2004; Bloom, 2003, 2005; Spagnuolo Lobb, 2003, 2013; Francesetti, 2013, 2015, etc.)

We discussed the fact that when Perls and Goodman presented the self through its partial structures or functions, they mentioned that *among* the possible functions of the self, they chose three that seemed essential to enabling creative adjustment: the id-, ego- and personality-functions.

Based on contemporary developments in the theory of Gestalt therapy and my own clinical experience, I attach equal importance to a fourth function: ***the aesthetic function***.

This function could bring together various forces at work in the creation of forms of contact:

- The *aesthesic* function. Aesthetics, in its original definition derived from the Greek word "aesthesis", refers to the science of sensory knowledge; it is sensitivity and sensitive individuals that make it

possible to recreate meaning and existence, and generate new forms of subjectivity. What is felt – which is at the heart of the work of Erwin Straus (1970) – could take its place among the sources of experience and be differentiated from the id-function.

- The *aesthetic* function itself, which concerns the formation of forms, the reference to art that allows aesthetics to put into action and become a privileged, paradigmatic manifestation. When she describes the artist, Laura Perls formulates her description in such a way that it could equally apply to the Gestalt therapist: "The main concern of the artist is certainly not the 'exercise of aesthetic transformation' of truth into beauty, but the organization of a multitude of various, disparate, incompatible experiences – which threaten the individual or society with disintegration and therefore are experienced as ugly – into a meaningful, integrated whole, a unity within which they make sense and which therefore is or may be experienced as beautiful" (L. Perls, 1992, p. 62).
- The *spiritual* function – which in my view cannot be based on a rational, logical way of thinking – is a form that is also rooted in the *aesthesis*: the sensitive. In certain subjects, this function seems to have a role similar to the aesthetic function in others. But perhaps this hypothesis belongs to another discussion.

This aesthetic function of the self, this formation of forms, is exercised daily in all human activity. What is emotion, then, if not a form that lets us manifest what we feel in the contact related to experienced situation and our personal history? What is a symptom if not the form that a subject constructs as a way of responding and adapting to a difficult context?

In his course at the Bauhaus, Paul Klee wrote: "The doctrine of Gestaltung deals with paths leading to the Gestalt, to the form [...] The word 'Gestaltung' is in direct contact with the concept [...] of a certain mobility" (Klee, 1998).

"We seek the meaning of each form formed in the act of formation itself," as Maldiney put it (1986), summing up Prinzhorn's main contribution concerning Gestaltung (1922).

When Prinzhorn describes what he calls the movements of expression, he lists, with the vocabulary of his time, a number of components at work in the Gestaltung: the urge to play and be active, enrichment of one's surroundings, the tendency to put into order, to reproduce, the need for symbols, the need to express, to give form... It is easy to make connections with concepts that define the attributes and functions of the self.

The self is the formation of forms, the architect of Gestaltung, followed by the formed form, to then return to being the formation of forms... according to the circular modality already demonstrated by Otto Rank: "the artist not only creates his art, but also uses art in order to create" (1932/1975, p. 7).

"Experience is the only authentic theme of psychology. Psychology deals or should deal with experiencing beings, not with a mind or an intellect nor with a nervous system or an apparatus, not with a consciousness and data of consciousness, not with stimuli and motor responses. Psychology can be defined as a branch of knowledge dedicated to the study of experiencing beings" (Straus, 1966, p. 249).

> The self is the organizer of contact,
> the catalyst of experience
> and the artist of life.

Translated from French by Claire Blatz

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References

Alvim, M. Bothelo (2004). *Experiência estética e Corporeidade: fragmentos de um diálogo entre Gestalt-terapia, Arte e Fenomenologia.* Brasilia, 2004, French translation in Robine (2006b)

Baranger, M. & W. (1961). "La situation analytique comme champ dynamique ;" French translation in *Revue Française de Psychanalyse,* Vol. XLIX, Nov.-Dec. 1985, 6

Bergson, H. (1934). *La pensée et le mouvant,* PUF, Paris

Binswanger, L. (1930/1954). *Le rêve et l'existence.* Desclée de Brouwer.

Bloom, D.J. (2003). "Tiger! Tiger! Burning bright." Aesthetic values as clinical values in gestalt therapy. In M. Spagnuolo-Lobb & N. Amendt-Lyon, *Creative license. The art of gestalt therapy.* Wien-New York: Springer.

Bloom, D.J. (2005). A centennial Celebration of Laura Perls: The aesthetic of commitment. *British Gestalt Journal,* 14(2). French translation in Robine (2006)

Dewey, J. (1934/1980). *Art as experience.* New York: Wideview/Perigee Books; French translation: *L'art comme expérience,* Farrago, Pau, 2005

Ferro, A. & Basile, R. (2009). *The analytical field. A clinical concept.* Karnac Books; French translation: *Le champ analytique, un concept clinique,* Ithaque, Montreuil sous Bois, 2015

Foucault, M. (1972). "Les intellectuels et le pouvoir" (interview with G. Deleuze), *L'arc,* No.49. Reprinted in Foucault M., *Dits et Ecrits I, 1954-1976,* Quarto-Gallimard, Paris 2001

Freud, S. (1900/1926). *L'interprétation des rêves,* PUF, Paris

Francesetti, G. & al. (2013). *Gestalt Therapy in Clinical Practice – From Psychopathology to the Aesthetics of Contact.* Franco-Angeli, Milano. French translation: *Psychopathologie en Gestalt-thérapie,* L'exprimerie, Bordeaux, 2013

Francesetti, G. (2015). "From individual symptoms to psychopathological fields. Towards a field perspective in clinical human suffering". *British Gestalt Journal,* Vol. 24, No. 1

From, I. (1981-1994). *Enseignement et conversations personnelles.*

Gagnon, J. (1999). "Prendre forme en relation – Fondements pour une compréhension gestaltiste des pathologies limites". *Cahiers de Gestalt-thérapie,* No. 6, 1999, L'exprimerie Bordeaux

Gibson, J.J. (1979). *The Ecological approach to Visual Perception,* Houghton Mifflin, Boston, MA; French translation: *Approche écologique de la perception visuelle,* Ed. Dehors, 2014

Gibson, E.J. (2002). *Perceiving the Affordances,* Lawrence Erlbaum Associates, Pub. Mahawah, NJ

Heraclitus (1991). *Les fragments,* Les immémoriaux-Fata Morgana

Husserl, E. (1913). *Ideen I,* § 84; French translation: *Idées directrices pour une phénoménologie,* Tel-Gallimard, Paris 1950

James, W. (1890). *The Principles of Psychology,* Volume I. Dover, New York, 1950

Klee, P. (1998). *Théorie de l'art moderne,* Denoël/Gonthier, Paris 1975

Lewin, K. (1936). *Principles of Topological Psychology,* McGraw-Hill Book Company, New York & London

Lewin, K. (1952). *Field Theory in Social Science. Selected theoretical papers.* London, Tavistock Publications

Maldiney, H. (1986). "De la gestaltung", *Psychologie Médicale,* 1986, 18, 9: 1419-1422

Mead, G. H. (1934). *Mind, Self and Society, from a standpoint of a social Behaviorist.* University of Chicago Press, Chicago. French translation: *L'esprit, le soi et la société,* PUF, Paris, 1963

Merleau-Ponty, M. (1945). *Phénoménologie de la perception,* Gallimard, Paris, 1945

Merleau-Ponty, M. (1964). *Le visible et l'invisible,* Gallimard, Paris, 1964

Miller, M.V. (2002). *La poétique de la Gestalt-thérapie,* L'exprimerie, Bordeaux, 2002

Miller, M.V. (2011). *Teaching a paranoid to flirt – the poetics of gestalt therapy.* Gouldsboro: Gestalt Journal Press

Montaine, M. (1580). *Essais*, Book III, Chapter II: "Du repentir". Reprinted by CFL, Paris, 1969

Perls F.S. (1951). *Gestalt therapy, excitement and growth in the human personality.* New Yor, NY: Julian Press. French translation of the theoretical section: *Gestalt-thérapie,* L'exprimerie, Bordeaux, 2001 & French translation of the practical section: *Gestalt-thérapie, technique d'épanouissement personnel*, Stanké, Montréal 1977.

Perls, F.S. (1969a). *Gestalt therapy verbatim.* Real People Press; French translation *Rêves et existence en gestalt-thérapie,* Epi, Paris 1972

Perls, F.S. (1969b). *In and out the garbage pail.* Real People Press; French translation *Ma gestalt-thérapie. Une poubelle-vue-du-dehors-et-du-dedans,* Tchou ed. Paris, 1976

Perls, L. (1992). *Living at the boundary.* Gouldboro : The Gestalt Journal Press; French translation: *Vivre à la frontière*, L'exprimerie, Bordeaux 2001

Polster, E. & M. (1973). *Gestalt therapy integrated*; French translation *La Gestalt,* Ed. Le Jour, Montréal, 1983.

Prinzhom, H. (1922). *Expressions de la folie*, Gallimard-Connaissance de l'inconscient, Paris 1984, French translation of *Bildnerei der Geisteskranken – Ein Beitrag zur Psychologie und Psychopathologie der Gestaltung.* Springer-Verlag, Berlin, 1922

Rank, O. (1932/1975). *Art and artist.* New York, NY: Agathon Press; French translation: *L'art et l'artiste,* Payot, Paris, 1984

Robine, J.-M. (1984). "Une esthétique de la psychothérapie", reprinted in Robine (1998)

Robine, J.-M. (1997). Anxiété et construction des gestalts, *Cahiers de Gestalt-thérapie,* 1997-1, reprinted in Robine J-M. (1998) and in Francesetti, et al. (2013)

Robine, J.-M. (1998). *Gestalt-thérapie, la construction du soi,* L'Harmattan, Paris

Robine, J.-M. (2002). "L'intentionnalité en chair et en os. Vers une psychopathologie du precontact". *Cahiers de Gestalt-thérapie,* 2002, No. 12, reprinted in Robine J.-M. (2004)

Robine, J.-M. (2004a). *S'apparaître à l'occasion d'un autre,* L'exprimerie, Bordeaux

Robine, J.-M. (2004b). "Le self de la situation", *Actua Psy,* 2004. Reprinted in Robine J.-M. (2012)

Robine, J.-M. (2006a). "M'importe d'être un homme plutôt qu'un gribouillis" in Robine (2006b)

Robine, J.-M. ed. (2006b). "La psychothérapie comme esthétique", L'exprimerie, Bordeaux, 2006

Robine, J.-M. (2008). "Le fond du champ – En arrière-plan du concept". *Cahiers de Gestalt-thérapie,* No. 22. L'exprimerie (reprinted in Robine J-M., 2012)

Robine, J.-M. (2010): "Le contact à la source de l'expérience". *Cahiers de Gestalt-thérapie,* No. 25. Reprinted in Robine (2012)

Robine, J.-M. (2012). *Le changement social commence à deux,* L'exprimerie, Bordeaux

Robine, J.-M. (2015). L'homme de la situation *(forthcoming)*

Spagnuolo-Lobb, M. & Amendt-Lyon, N., Eds. (2003). *Creative license: The art of gestalt therapy.* Wien, New York: Springer; French translation: *Permis de créer,* L'exprimerie, Bordeaux, 2006

Spagnuolo-Lobb, M. (2013): *The now-for-next in psychotherapy: Gestalt therapy recounted in post-modern society.* Milano: FrancoAngeli; (French translation forthcoming from L'exprimerie)

Staemmler, F. (2006). A Babylonian confusion? On the uses and meanings of the Term Ffield." *The British Gestalt Journal,* 15(2); French translation: "La tour de Babel: confusions dans l'utilisation et les significations du terme 'champ'", *Cahiers de Gestalt-thérapie,* L'exprimerie, No. 22, 2008

Straus, E.W. (1935). *Vom Sinn der Sinne., Ein Beitrag zur Grundlegung der Psychologie.* Springer Verlag, Berlin; French translation: *Du sens des sens,* Millon Ed., Grenoble 1989

Straus, E.W. (1966). *"The Sigh" in Phenomenological Psychology.* New York, NY: Basic Books; French translation: "Le soupir, introduction à une philosophie de l'expression" *Le cercle Herméneutique, April 2003, No. 1*

Straus, E.W. & Griffith, R.M. (Eds.) (1970). *Aesthesis and aesthetics: The fourth Lexington conference on pure and applied phenomenology.* Pittsburgh, PA: Duquesne University Press

Toulmin, S. E. (1977) Self-knowledge and knowledge of the 'self.' In T. Mischel (Ed.) *The Self: Psychological and Philosophical Issues.* Oxford: Basil Blackwell.

Part II—Self: Implications for Therapeutic Practice
Elvira Dueñas Jurado

In the first part of this chapter, we have received some key ideas of Jean-Marie Robine's thinking in relation to the concept of **self** in gestalt therapy. From his proposals, we can become aware of his interest in unfolding and clarifying some concepts, which he considers core to our theory and method. This is the case with his permanent distillation of the concept of *contact* as a technical concept, which is distinguished from the concept of *relationship*; or his understanding of the *id of the situation* that is supported by his reflections around the concept of *intentionality*; or the importance he gives to a *field perspective*, that becomes more concrete with his definition of *situation*; or his point of view on psychotherapy from an *aesthetic* perspective, which guides our interest towards the forms that experience takes. All these concepts are grounded on the idea of a "**delocalized self**" (Robine, 2004b; 2016). This is a consequence of Perls' and Goodman's proposal of considering contact as *"the simplest and first reality"*(PHG, 1951, p. 3,) and proposing that the focus of psychotherapy is the analysis of the contacting operations that happen in the contact-boundary within the organism/environment field. Then, some questions that arise are: who is organizing experience moment-to-moment in the contact-boundary? what makes meaning creation possible? Wanting to answer these questions makes us define self functioning in the way that Robine presents it at the beginning of his chapter: "*This fundamental human activity –which consists in establishing and modulating contact with one's environment; bringing out and constructing adapted, creative figures from the novelty of each situation; deconstructing any completed or obsolete figures– is the limited but essential function they assign to the self.*" (Robine, 2016, p. 213)

Holding a conception of a delocalized self implies to consider that experience is crossed by a temporal artery, i.e., that experience is emergent and we build it from moment to moment. In a therapy session, we therapists are co-creators of the emerging experience of our patient. Contact is defined as the operation by which the world/the other affects me and constructs me –and at the same time, and through the same operation, I affect the world/the other and I transform it (Robine, 2004a; 2004b). It is a process in constant motion. Therefore, answering the questions "what configures experience? what structures it? what synthesizes it?" makes us consider a conception of a delocalized self. Undoubtedly, this is the great adventure that Perls and Goodman compel us to embrace when they say that the focus of psychotherapy is contact-boundary operations. Jean-Marie Robine has developed this direction in a radical way. And then, what are the implications of thinking

in terms of *delocalized self* for therapeutic practice? How do we use the concept of self in our work?

In order to respond to these questions, we will offer some hints through the analysis of a therapy session conducted by Jean-Marie Robine, in the light of a number of issues that we think that become deduced from a temporal conception of self.

Consequences for the Practice: The Therapist's Positioning

As we will see in the analysis that we are proposing below, the therapist's position is that of becoming curious in the patient's experience, by keeping and practicing an attitude of *"cultivated uncertainty"*, in the words of Frank Staemmler (Staemmler, 1997). The therapist remains interested in unfolding what is being presently manifested. He relies on the ephemeral nature of experience and, therefore, keeps a curiosity that is focused on the impact that his moment-to-moment interventions have on his patient, and vice versa. An attitude of cultivated uncertainty allows us to be oriented towards the future, towards what follows, towards the next, as Goodman called it. Robine has later pointed out that "the *next* contains both the spatial and the temporal conception of experience" (Robine, 2008, p. 58).

Events can have different meanings when you look at them in the light of the future.

Focusing on Contacting Operations. Keeping Track of Verbs

Making a difference between **self** as a "system of contacts," and **contact or contacting** understood as the boundary operations that occur from moment to moment, seems essential. One of the ways in which Robine defines **contacting** is as the operation by which we constitute something as a figure, an operation that occupies consciousness and is, therefore, psychological. Hence, on a practical level, we will keep an interest in two fundamental questions while we work: what is my patient contacting with from moment to moment? And... how? In which modality? (Robine, 2002).

Obviously, we do not literally ask these questions to our patient, but they permanently guide our interest in understanding from moment to moment how he or she is structuring experience, what he or she is doing, what verbs operate. Consequently, focusing our work on the analysis of the sequence of contacting operations –of verbs, of actions, makes us become very interested in how some things succeed others. We analyze the sequence, which constitutes the temporal dimension of self.

Use of the Here and Now as a Tool

An inevitable consequence of working with a delocalized, decentralized concept of self is that we are compelled to keep in mind the temporary nature of the co-construction of the experience. On the one hand, we co-construct experience. Therefore, we must pay a very precise attention to the moment-to-moment micro-impacts that we experience throughout a session. On the other hand, if we want to use temporality then we must take into account the particular conception of time that is envisaged in PHG and that other authors have developed later. We are referring to a non-linear conception of time and to the implications it has on the use of the here and now as a therapeutic tool (Robine, 2008).

In the analysis of the session below, we will see how Robine relies on the following hypothesis: "*one could say that there is no time in the present moment, because present, past and futures are intimately blended: there is a thickness, there are strata, layers that are superimposed and coexisting. Even more than coexisting: entangled.*" (Robine, 2008, p.53) This is a non-linear conception of time. The implications for the practice are straightforward. Each moment of the experience, each contacting operation, evokes a thickness that is made of past times and future projects. Jean-Marie Robine also names this as *consistency* (Robine, 2008, p. 54). In the present moment, there is consistency. This way of envisioning temporality as an accumulation or as a consistency has some practical consequences, as we will see in the therapy session that is described below. We do not work by progressing in the sequence of contact in a linear way. We rather see comings and goings of "moments" and "modes" of the experience –for instance, a vibration in fore-contact mode, then in contacting mode, then again in fore-contact mode, in a way that is not understood as turning back, but as a progression of the experience in its full thickness. Something that can be seen in this session, for example, is how an attempt to make contact allows both patient and therapist to sharpen the desire and the emerging need of the patient, and how the consistency or thickness of the present moment allows to deploy something that can contain past time and future project. That is, we can see a progression that is not linear at all, but it does not constitute a turning back in the sequence either, but rather a progress in the construction of an emergent figure.

In other words, this conception of the thickness of experience allows us to handle the here and now as a therapeutic tool by taking into account the thickness of the present experience. Robine says that we work with a *"structure of the experience"* (Robine, 2008, p. 55). We do not collaborate with emergent experiences that are isolated and groundless. Instead, each present moment has a *consistency*, it brings up a *structure* that includes a

past time and a future project and that gives direction to what is happening now. We can see an interesting example of this in the exploration of dreams. And this is an additional aspect that has led us to choose the therapy session that we are including in this paper, since the exploration that is done there is partly supported by a dream. In this session, we can observe two interesting aspects of how the therapist explores a dream with his patient. In the first place, he is working with the dream using Isadore From's proposal of treating dreams as an occasion for undoing a retroflection –in the sense of being able to "say something to the therapist" that has not been expressed yet. In the second place, we can appreciate how the therapist relies on the hypothesis that experience does not know about time but, rather, that there is a thickness within which to explore and collaborate with the patient's emergent gestalt in the present moment.

Intentionality, Emergence, Id of the Situation

As it can be seen in the analysis, I think this session is quite representative of the so-called construction of the emergent need. In the first interventions, we can see how therapist and patient begin from something *vague, confusing*, from what it does not have a form yet (Robine, 2012). The patient says that, a priori, she has nothing in particular to work with. So we can see how the therapist follows his patient's experience from moment to moment, trailing the background. We are with the "*given of the situation*" (PHG 1951, edition GJ Press 1994, p. 182.) The session begins with an exploration of the sensations in the patient, through which the therapist can feel the pulse of the direction of meaning.

Robine invites us to think of intentionality in terms of a *tendency to,* or an *aiming at*, or a potentiality that is still vague. The emergence is a moment in the process of deployment of the experience in which the preverbal dominates –sensation, affection. There are not specific forms that can be concreted yet, because prior to an intention that is built and deliberate, there is intentionality, which is vaguer, in the same way that creativity precedes creation. (Robine, 2016)

A practical consequence of collaborating with the construction of the emerging need is that we have to stay tuned to the micro-impacts that we experience in our own flesh as therapists from moment to moment and, especially, we have to keep track of the micro-impacts that our interventions produce on our patients. Robine relies on the hypothesis that "*whenever an individual is in the presence of another, an intentionality is created: affecting the other, obtaining something from the other. It is a form of recognition of their existence, even in the case that the 'project' might be not*

to affect the other" (Robine, 2004a, p. 146). Intentionality, so understood, makes reference then to all possible modes in which it is possible to affect the other in a given situation. This dance of impacts, supported by this hypothesis of intentionality, helps us therapists be open to exploration, without restricting ourselves to the representations that are proposed by the personality function.

Analysis of a Session

Inspired by the researchers of the therapeutic process, we consider the analysis of our sessions to be an inexhaustible source or inquiry that can help us reflect about our interventions (Greenberg, L. and Elliot, R. 1993; Greenberg, L. 1997), in particular about whether our interventions are coherent with our theory and method or not. Logically, the questions that we can pose when we are analyzing one session in particular may vary depending on the more global question that we are posing to our study. Now, that our goal is to ask ourselves how we use the concept of self in therapeutic practice, we are geared to use questions that arise from thinking about a delocalized self. Some of these questions could be the following:

- What is the patient's emerging need during the session?
- How did patient and therapist collaborate in following the trail of important elements in the background and what were these elements?
- How did a sequence of contacting operations –verbs– deploy from moment to moment? How did the therapist favor the co-construction of the emerging need?
- How can we describe the stages of the temporal sequence that we have built in terms of fore-contact, contacting, final-contact and post-contact?
- What modes of self have we been tuning in to? Ego, id or personality mode?
- How can we understand the id of the situation? In what aspects of the encounter did it manifest?
- What is the assimilable novelty with which the patient seems to have contacted?
- What is the process that seems to have been unfolded?
- How did patient and therapist mutually affect each other, from moment to moment? In other words, how do we rely on mutual micro-impacts in order to understand something of the intentionality of the experience of one and the other? And always keeping in mind

that we work for the construction of our patient's gestalt and not the other way around!

On the basis of some of these questions, we propose the analysis of a therapy session by Jean-Marie Robine in the context of a training program for gestalt therapists. This will allow us to unfold how Robine applies his understanding of a delocalized self in his practice. The session took place during a training seminar. Due to my own interest in the investigation of the concept of contact and its distinction of the concept of self, I was allowed to record the sessions that were held during the seminar, for research and teaching purposes. This is one of the sessions that were recorded. I have chosen it for this text because it seems very interesting to me from the point of view of the emergency of the experience and the use that the therapist makes of the here and now of the session. From the initial moment, the patient mentions that she does not have anything specific to work with. This allows us to keep track of how the therapist collaborates with the co-construction of the emerging need. We see how the progressively emerging need is grounded in the present moment and belongs to the situation. It is possible to keep track of how the "given" or id of the situation progressively dissolves in possibilities. If we observe the interventions of both patient and therapist, we can clearly see how the emerging gestalt is given shape by some weaving that is done with the micro-impacts that they have on one another.

If the reader has the time for it, we suggest carrying out a comprehensive reading of the session in the first place, without reading the analysis notes, in order to have a complete, uninterrupted perspective of the session, and then get the support of the comments on the process in a second reading. We hope that this annoyance will be compensated by the interest of the session itself, as well as by our wish that these comments are useful.

Therapy Session

P: I want to work, but I don't know what about...

T: Aren't you aware of having any project?

P: No

The therapist begins by trailing the background. He checks if there is any "pushing" theme for the patient. This allows him to check if there is any explicit demand.

T: And what is present for you?

P: My heart is beating, my hands are sweating. A little excitement, a little fear for what it may happen. And also for what is happening right now,

I'm here with you and everybody is looking... there is a part that I like and another part that seems threatening.

The patient manifests an awareness of her bodily sensations in the present moment. PHG proposes that excitement is a "reality check." We are attuning in terms of the id function of self. Or, better, we are feeling the pulse of the id of the situation, the 'given' of the situation. The interventions that follow help to keep testing the quality of these sensations in the patient. We keep trailing of the background. We are in the fore-contact modality of self.

T: What could be the threat?

P: Well... that something could happen that makes me feel bad, or embarrassed, or that it makes me feel guilty or makes me think that this wasn't a good idea.

Here we are attuning to some representations of the personality function...

T: Hmm, hmm. You're confronted with something unpleasant.

P: Yes.

T: And, on the other hand... you had a threatening part and an exciting one.

P: Yes.

T: And what is that excitement?

He keeps testing the quality and presence of this excitement in the present. The therapist relies on what is present, he unfolds it.

P: Hmm... the expectation that something could happen that... I don't know... that can be useful in some way. Something from having a good time here with you, to... I don't know... anything.

T: Hmmm

P: But I thought it could be an opportunity. (Silence) I was thinking that when I go to therapy without any issue... as it happens now... and well, here in this moment I was thinking... that it gives me some kind of security... I have the idea that you will do something with that, because for me it is a bit uncomfortable, this time of... (she laughs.)

It seems that the patient is experiencing some excitement the direction of which is not obvious yet. The therapist remains with the "vague", the "confusing", attentive to intentionality.

T: Of something emerging?

P: Yes.

T: I see you smile very much since we started.

He remains attentive to small movements, verbs, actions. Contacting is in verbs. And he remains attentive to all small movements in order to join them together in some direction of sense –the id of the situation.

P: It has to do with embarrassment. I like to be here and I feel embarrassed as well.

T: I don't understand, embarrassment?...

P: It has to do with being exposed.

T: And does being exposed imply to feel embarrassed?

Even though the patient is naming sensations and emotions, the therapist questions the evidence that the personality function of self is providing. This is one of the ways in which the therapist makes excitement grow so that the direction it takes can gently be clarified and, at the same time, we can see how the id function (with the present excitement) and the attribution of meaning that comes from the personality function live together.

P: I do think I'm embarrassed because I'm flushing, and I'm quavering just a little bit. But it is mainly the hot flush that talks about embarrassment.

T: (He nods) For me, when you talk about this flush, this heat, it makes me rather think of some form of energy that pushes up.

P: (She nods) Yes, I feel... I feel very much like that.

T: But you are expecting that I will do something with that.

The therapist confronts desire, and he makes excitement grown when he addresses the ego function of self... "what do you want to do? what are you looking for...?" This intervention excites the contact-boundary in order to increase the intensity of a direction of desire, still formless. It helps to leave confluence, understood as a situation of no-contact, no-figure.

P: Partly... Yes, because when I was thinking that you could do something with it... something that also came to mind had to do with not putting... not to leave everything in your hands, right?

T: I am also looking forward to this moment being really for you.

P: When you say that, the idea of "how could it not be?" comes to mind.

T: It could not be if it was me who induced anything.

This an interesting moment that returns all the legitimacy to the patient for deciding and giving shape to her excitement. The therapist is not usurping the patient's ego function, and he is "inviting/allowing/compelling" her to do something with the present excitement. He is not shaping it prematurely. We are still in the fore-contact stage. This implies, thus, to persist, to insist, not to desist, while remaining with the vague, the confusing –paying attention to verbs, to the direction of the sensations that are being evoked.

P: (Silence for a while)... Well... there *is* something that was present during this weekend in relation to what I could work with you. And... but I wasn't living it as a need, but as "giving myself the pleasure." And... it wasn't clear to me, or... let's say that when I came out a few moments ago my idea wasn't so much to share this that I've been thinking about these days, but

just to see what could happen being here with you. But well, this is what has come up being here with you. And... well... eh... it's something that... sharing it...

The previous intervention has made possible that the patient can take her time and begin naming her desire... We start leaving confluence. This will bring again an intensification of excitement. Again, the therapist stays next to the forms that experience takes in the body. We are still trailing the background. We still are, therefore, in the fore-contact stage.

T: Hmm.

P: It's something that... it's as if sharing it... thinking of talking about this scares me a little bit.

T: I see that your breathing becomes a little more difficult.

P: Yes, and it's nice!

T: Hmm.

P: I think it doesn't have as much to do with what I can tell you, but with seeing what happens with what I tell you, seeing what I may be saying while telling your this... And, well, it's a dream I had around one year ago, and it's a dream I had with you, that brought me a sensation. It was a very emotional dream, in which I felt a sense of security and protection in a very vivid way. So that, even next day, I could still feel this when recalling it. And this is something I was needing very much at that time. I imagine that I needed it because it was a pleasure to feel it. And it came to me through you. You represented the person that made me feel that way. I remember it as something beautiful and I was feeling like sharing it, and since I wasn't going to do it during a break, I thought this could be a way of doing it.

For the first time, the patient names a form for her experience with a direction of desire... She relies on a dream that she lived one year ago which, curiously enough, she has chosen to bring up in this moment. Consider the "thickness" of experience we mentioned above.

T: (Silence) I like that you take me to your dreams for giving you protection. How was it difficult for you to share this? You talked about your fear...

This intervention validates the experience of the patient, it provides support to it and it allows its unfolding. The therapist attunes and already points at some verbs. He listens to them as possible contacting operations: you take me with you... giving protection.

P: Because I didn't now how this would turn out, how I would feel while doing it.

T: Hmm, hmm... and...

P: Now I've done it and I'm ok, I feel at ease with what I've shared.

T: Really?

P: I'm thinking about what you were saying yesterday, that any memory talks about our now as well, and I'm thinking about how this could be talking about my present.

T: This was the question I wanted to ask you. Because you are describing your dream as a confirmed fact. I am here and I protect you. I don't know very well how I'm protecting you, but you feel protected. And my question is: if we regarded that dream not as a confirmation, but as a request for something, or as the expression of a need, what would the protection, the safety that you need be, that I'm perhaps not giving you, or not giving you enough of?

The therapist relies on Isadore From's hypothesis of taking the dream as an occasion to undo a retroflection. The dream constitutes an opportunity, a mode or a vehicle for being able to tell the therapist something that has not been expressed yet. The dream becomes a modality, it is a form for the emerging need. In the following interventions, we can see how the therapist will explore the emerging need relying on the verbs, actions, contacting operations that the patient has named while telling her dream. We will see how he relies on what we have previously called "the structure of experience." The use of now relies on a non-linear conception of time. The structure of experience is timeless and it has a thickness.

P: I don't recognize myself in that.

T: I don't know.

P: I think that I know what makes me feel safe here with you in the group, when I've worked with you before. That's what comes to mind on the one hand. But it also comes to mind that nowadays I feel protected. There is something in my life that it's a source of that for me.

T: And what specific type of protection do you need?

P: The thing is that I don't feel that I'm asking for that right now.

T: I'm not saying that. In your life, at this moment, how is this issue about your need of protection active? What it is for you to be protected today? Protected against what, how?

P: Well... I don't know, it would be like... like being protected against adversity or something like that.

T: (He makes a gesture with his hands as meaning "of everything")

P: In my day, protected from little and big things that can... or fears that I could carry in my everyday life...

T: And how are those protections exerted?

P: Well, through my belief that I am protected.

We can see how the personality function of self is giving shape to experience in this moment, through the representations that the patient has of herself.

T: Yes, but how are you protected, in what way?

P: It would be... it is my belief that I am protected what makes me be protected. It's like saying... this is the part (she laughs) that I can share with you.

T: Try to be more specific, more precise. For instance, try to specify how you feel protected by me, since you're referring to it here.

The therapist seeks to ground the experience that the patient is manifesting in personality mode, using it as an entrance door for mobilizing the id function of self. And he does it relying on the fact the part of this structure of experience is being mobilized in the present.

P: I can tell you how I've felt protected when I've worked with you. And there has been something subtle but very important for me that had to do with... it's like... I feel that I could easily not take myself into account, that I could overstep my boundaries, somehow I could have a lack of respect for myself, while working, when I chose to work or felt a need of working... I felt that you were taking care of that. That you took charge of something that I didn't... and this was very important for me in my work with you. As if you were making sure that I was respecting myself.

T: OK. Then, could I imagine that the fact that this dream is coming to mind today could be related with this issue being current somehow, so that in this moment you might tend to –I don't know– not respecting yourself enough?

The therapist offers his hypothesis, his comprehension of what the patient is manifesting, by attuning with a structure of experience that is similar to the one that the patient describes in her dream. He relies on the thickness of the experience that has no "time." For this, he has relied on the verbs that the patient has manifested. He offers it as a possibility, as an ephemeral, mobile form, that requires the ego function of self in order to check whether it has a sense for the person or not. We are attuning with the constant come and go of contacting and fore-contact. It gives the patient the chance of feeling if this fits with her experience or not.

P: I don't feel it like that. I feel it's quite the opposite. I feel that I take myself into account, that I try to take care of myself throught that.

Here is the ego function, rejecting and choosing possibilities, grounded in the id function and in coherence with the personality function. The possibilities of the environment are here bestowed by the therapist's interventions. We are in the vibration between the fore-contact and contacting stages. We will see these movents in many later interventions in which therapist and patient –in a very subtle and persisting way– give themselves the time to adjust to each other, checking the pertinence of the forms for experience that the patient receives from the therapist.

T: In a way that suffices you?

P: Well... I can't answer with a yes or a no. I rather think that, this comes from... I'm never feeling with a particular person in a particular situation... it is from there that I feel that it is not enough, that I can amplify my awareness much more.

T: OK.

P: Because I think that... among other things, my "not having myself into account" has to do with that.

T: And how has it been activated by what has happened with our group in the last few hours?

The therapist is trying to connect the experience to the ground and to the present situation. This is the use of here and now, again inspired by the idea of "id of the situation" and by the thickness of experience. Here, we can also observe the use of the "principle of possible relevance" of field theory: "What it happens belongs to the situation, and we can understand it through the parameters that are present in the situation." Precisely because with have a non-linear conception of time, the now has a thickness, it contains the "past of present" and the "future of present." The present situation can have an experiential structure that mobilizes an emerging need, with an intentionality. We keep exploring the emergence of experience.

P: But I don't think this has been activated by the group in the last hours. I think that since I had that dream, it was something that I thought that maybe some day I would share with you... But well, it is true that I've finally decided to do it and this should have to do with what I'm living throughout the weekend.

T: For you, the most important thing was to find the moment to tell me that there has been an important moment for you in your evolution.

The therapist refines a bit more what he understands it is the patient's need. We see the constant come and go of contacting and fore-contact as modalities of experience. This is the hardly linear process with which patient and therapist help each other in a permanent refining and outlining of the pushing need. This will lead the patient to unfold her experience a bit further.

P: (She repeates the therapist's sentence aloud as if to test it in her own skin.) There has been an important moment for me in my evolution...

T: That moment of the dream has had a strong impact.

P: (Silence) Maybe telling you about the dream was my way of telling you about what I said before, about how you helped me when we've worked.

T: Hmm.

P: And well, the time when I had that dream, I remember it was a time in which... I... like needed to hold on someone. I even remember... Because

it was a training weekend and I remember that it was after the workshop, on Sunday. And during that weekend I remember that my groupmates and I were walking down the street (long silence... she is intensely moved, tears come to her eyes) and... I felt like holding on... but at the same time I knew I would not be satisfied with that, as if they could not give me the support that I was needing. And well, it was in that context.

Moment of intense emotion for the patient. The excitement takes the form of emotion. Notice the verbs that the patient is using for describing her experience: a need to hold onto, a need of support...

T: I see that when you talk about that moment there is a strong emotion, and emotion is not past.

Excitement as a reality check. Something begins to become figural to awareness. The therapist focuses on the experience that is emerging in the present moment. Remember that emotion is a function of the field, it happens in the present when the environment is "hit." It is emotion as an indicator of the passage from the physiological to the psychological, since it entails meaning. It constitutes a form that experience can take and that has an "adaptative direction," so it contains information about the situation that can help satisfy or better identify the emerging need. At the same time, this evident excitement allows to trace the id function of self. In the following interventions we keep seeing how the therapist does not separate from the body indicators so as to ground experience in the present moment and collaborate in the co-construction of the emerging need.

P: Hmm, hmm. (She breathes and looks down.)

T: What are you feeling?

P: I'm not sure what the feeling is. It touches me to think how I need, how I needed and still need an arm to hold onto, someone to rely on. That touches me but I don't know what the feeling is. I don't know if not having that makes me sad. I don't know. But, it's like there is also ... now I say it with some serenity... it makes me feel sad but I can be with it.

T: When I saw your emotion, I didn't think of sadness. I don't know what it is, but it was like a big emotional charge, probably full of various things. And it is true that, for me, the message I receive from your dream is that you are telling me "I need protection," and the second thing is "this protection I need, I can't get it by myself, I need someone."

We remain attentive to the verbs that the patient manifests, finding support in what the patient says and what is manifested in her body, as well as in the micro-impacts that the therapist is experiencing. This is what we could call "the intentionality" of his patient on him. He is "full of", "reached by", "inhabited by" his patient's experience. We are vibrating between the stage of contacting and the final contact towards which we are going, in the

sense that there is contact with a need that is emerging in the present. A direction of sense for the experience is being built.

P: (She nods and breaths.) Partly... yes... there one part where I feel... I'd say in which I protect myself, but there is a part... in which I need of... yes. (She breathes in).

T: If I take the examples you gave me before into account, the part in which the other is necessary for you is a help for respecting yourself better.

P: It's just that... in relation with what I told you, I understand that you are telling me this, but actually what I am with, about the part that I need from the other, when I think of protection, has rather to do with warmth, with support. I don't think so much about respect, I think more about a container (she laughs).

We see how the patient keeps making her choices and rejections –her refinements.

T: One doesn't prevent the other.

P: Yes, yes, but I wasn't with the idea of respect as much...

T: My question is, where do you search for the information about what you need?

Interesting question that comes again to question the evidence. It is like taking a step foward, but now again in a fore-contact modality. The therapist seeks to strengthen the gestalt, to allow the emergence of a consistent figure.

P: The information about what I need... (smiles) I think I have it.

T: Of course! But you can go to find it in your thoughts, in your representations, in your memories, in your images, in your sensations, in your projects, in your body...

Again, he is tracing body indicators very closely.

P: Now I feel that it's more in my body.

T: Yes. Can you tell me how you are feeling it? First, where does it happen, where does it take place?

P: Well... From my arms up... I have a sensation from my waist up (she makes a gesture with her arms.)

T: And the protection you need, is it in your back?

P: (Long silence) I don't know. I was thinking how I'd like it... I imagine protection in terms of a hug, of holding me, and I wonder... in what way? I don't know, but I do know that the tingling, the sensations are in my arms... Like this. But I don't know if I need to have my back protected.

T: These sensations you are talking about, are they present or are they a memory?

P: Now they are fading, but when you asked they were present. Now I feel them from my elbow downwards.

T: Are they the sign of anything for you?

P: I can't identify what it could be.

T: If you let your hands go... is there any movement, any gesture?... Can you animate those hands, those arms with these sensations, without anticipating it, without preventing it?

P: I don't know how to do it... My sensation is as if something were preventing that I move my hands now.

T: How could you make me feel it?

T: What it prevents me from moving my hands?

T: Yes. How do you feel that something is impeding you? What form does it take?

P: Of fear. Yes, some fear. My heart is racing a little.

T: If I say this in a sentence, it could be: "if I move my hands and arms, something dangerous could happen."

P: But, especially, I'm connecting it as well with that lack of awareness I was telling you about before regarding what I need. And since I don't know... then...

T: May I propose something?

P: Yes.

T: I propose that I get a little closer and what we imagine some kind of theater scene betwee the two of us, and that we begin to move our hands as if they were dancing, and that we become the observers of what they do, rather than being the ventriloquist that moves the puppets. Are you interested in trying it?

The therapist proposes an experiment –a way of exciting the contact-boundary. This will allow to show a bunch of aspects of how experience is structured and to keep refining the emerging need.

P: Yes, I would like to try.

T: (He begins moving his hands... and the patient begins moving hers as well.)

(After a few minutes of experiencing silently.) You can try to use some words, to tell me what you are feeling...

P: It's like, let's see... tension... fear... (she is moved, she cries) I don't know... it comes to me... sadness, insecurity (she cries and pants). A little bit of all that, and at the same time also some satisfaction, some tranquility of being able to be with this or to do something with it. After all, it would be like respecting it.

We are in another moment of intense emotion, as a modality of contacting, to which the therapist will give a direction of sense relying on his impacts.

T: Hmm. You have expressed a strong sense of loneliness to me, and a feeling of containing yourself.

P: Yes, I feel recognized in that.

T: Are you afraid that we interact?

P: I feel that we are interacting, maybe I'm scared of a more intimate interaction. It connects me very much with shame.

T: The shame of wanting a more intimate interaction?

P: I don't know, I get a bit lost with that. I think it could be that but it is not only that.

T: Probably.

P: (Silence)

T: What comes up?

P: Ideas about feeling inadequate.

T: Here now?

P: About how that can also have to do with the fact that I'm not sure whether I need a more intimate interaction in this moment or not.

T: You're using the word "intimate" and the word that comes to my mind is rather "more open" or "less retained." Which does not necessarily mean more intimate.

This intervention makes a lot of sense to the patient, and it configures part of her emerging need. We are in a modality of full contact. The emotion that was lived before allows to identify what the patient needs in a more precise way, and whether she feels understood and with a direction.

P: Yes, and I've felt closed when we were doing that with our hands.

T: I have the feeling that you are telling me something through your dream and in other ways. It is as if you were wondering what the place is that you can give the other in your experience. How to contact the other in the form that best suits you, with which you can respect yourself? Or something like that.

P: Yes.

We see how the therapist completes his full contact intervention for the patient.

T: In order to finish our meeting today, I would like to suggest that you rest your hand on my hand and that you take your time to feel what it is like.

This is interesting inasmuch they could have ended right here but, instead, the therapist proposes a form for the experience.

(They do it.)

P: I am aware of the need of partly letting myself fall, but also of doing something... like this... (she grasps him.)

This intervention has intensified the experience and has made it vivider, clearer, in full contact mode. So it is an opportunity to feel a completely

integrated body dimension, exploring a form that allows a small movement of novelty. Seeing how the patient grasps is very interesting and intense. It is part of the verbs that the patient has named during the process. Thanks to this proposal, it also becomes visible as a possible contacting operation at the present moment.

It is nice.

T: And I don't feel this as a need one should be ashamed of. Tell me... what are you feeling now?

He confirms the emerging need and he validates it by giving it a few seconds of life. This gives shape and allows for the existence of this need and its satisfaction.

P: Recognition or something like that... Feeling taken into account with what it happens comes to mind and I like it.

T: OK. Shall we stop with this?

P: Yes. Thanks.

Closing Remarks

We hope that this text has contributed somehow to the comprehension of the application of the concept of delocalized self to therapeutic practice, as Robine has been proposing for a long time. We are aware of the inapprehensible nature of many of the concepts of our theory. Self is inevitably one of those theoretical concepts that Robine calls a "thinking machine". Personally, our theory and, in particular, this concept of delocalized self, make me recall the metaphor of the light of a lighthouse.In the same way that a boat uses the flashes of the light from a lighthouse for orientation, and in carrying out its crossing, it needs to rely on an endless number of concret maneuvers, using specific machinery, and performing a series of sequences of linked movements (operations, contacting, verbs) which allow it to go in one direction or another; in the same way, we use our theory of self, as inaprehensible as the light from the lighthouse, but without which we risk further not being able to orient ourselves for our interventions aimed to collaborate with creative adjustment.

Translated from Spanish by David Pico Vila

References

Dueñas, E. (2007). "To reveal (to be discovered), to encounter, to unfold: An aesthetics of presence." *International Gestalt Journal*, 30(1).

Greenberg, L.S., Rice, L.S., & Elliot, R. (1993). *Facilitating emotional change.* New York: Guilford.

Miller, M.V., Robine, J.M., Yontef, G.M., Lichtenberg, P., Spagnuolo-Lobb, M., Philippson, P., Frazão, L. (2002). *Contact.* DVD-L'exprimerie.

Perls F.S., Hefferline, R., Goodman, P. (1951). *Gestalt therapy, excitement and growth in the human personality.* New York, NY: Julian Press. (Edition Gestalt Journal Press, 1994).

Robine, J.-M. (1998). *Gestalt-thérapie, la construction du soi.* Paris : L'Harmattan.

Robine, J.-M. (2004a). *S'apparaître á l'occasion d'un autre. Études pour la psychothérapie.* Bordeaux, l'exprimerie. (Engl. Transl.: *On the Occasion of An Other,* The Gestalt Journal Press, Gouldsboro, 2011).

Robine, J.-M. (2004b). "Le self de la situation", Actua Psy, 2004. New edition in Robine, J.-M. (2012).

Robine, J.-M. (Ed.) (2006). *La psychothérapie comme esthétique.* Ed. L'exprimerie, Bordeaux (France). (Engl. Transl. In *International Gestalt Journal,* Vol 30, n°1, 2007)

Robine, J.-M. (2008). "Le maintenant a-t.il un avenir?" in Goriaux, P.-Y. (Ed.), *Le Maintenant,* Minibibliothèque de Gestalt-thérapie n° 110, L'exprimerie, Bordeaux & New edition in Robine, J.-M. (2012).

Robine, J.-M. (2012). *Le changement social commence à deux,* L'exprimerie, Bordeaux. (Engl. Transl. *Social Change Begins with Two,* Editions of Istituto di Gestalt HCC, Siracusa, 2015

Robine, J.-M. (Ed) (2016). *Self. A Polyphony of Contemporary Gestalt Therapists.* Editions L'Exprimerie, Bordeaux (France).

Staemmler, F. (1997) Cultivated uncertainly: An attitude for gestalt-therapists. *British Gestalt Journal*, 6(1), 40-48.

CHAPTER THIRTEEN

THE GESTALT THERAPY FIDELITY SCALE

MADELEINE FOGARTY, SUNIL BHAR
AND STEPHEN THEILER

For more than a decade now there has been a strong voice emerging in the Gestalt International community. That voice is calling for greater consensus about a common language for understanding the clinical practice of Gestalt Therapy (GT) (Parlett, 2007; Francessetti, Gecele & Roubal, 2013). More recently, researchers in the GT world have recognized the need to develop an evidence base to establish that GT is an effective form of psychotherapy (Barber, 2009; Brownell, 2014; Burley, 2014; Butollo, 2013). But before we can tell whether or not GT works, we first need a measure for determining whether or not the therapy that a particular therapist is delivering can properly be described as GT (Perepletchikova, 2011; Waltz, Addis, Koerner & Jacobson, 1993). Such a measure – known as a "fidelity scale" - would be used by an independent rater to determine how faithful therapy being delivered by a therapist is to the methods that characterize GT. The need for such a measure that operationalizes GT therapist behaviours that are essential to GT and differentiates GT from other therapeutic modalities was explored at length in Fogarty, Bhar, Theiler and O'Shea (2015).

Another reason why GT might benefit from the development of a fidelity scale relates to the diversity of the Gestalt community. Parlett (2007) has suggested that if you were to investigate or dissect any Gestalt term, principle, idea or method a great deal of theoretical difference and confusion would be revealed. Parlett was concerned that this disparity between Gestalt thinkers threatened the possibility of securing the GT "brand" in the wider therapeutic community:

> I am thinking of students and trainees who have few stable guidelines after the elementary stage and other experienced professionals who want to grasp quickly what gestalt offers. If we want to take care of our collective contact

> boundary with 'interested but not Gestalt educated others', then surely we have to find more consensual rubrics for describing the approach, so we do not put off or confuse this group but rather attract and intrigue them. One need here is to return to practice more, to what we do, and to spelling out our understanding. (Parlett, 2007, p 54)

Parlett's concern, in other words, was that the wide-ranging divergence of opinion about method and theory within the Gestalt community was a threat to the future of GT. Unless, the Gestalt community could agree about what GT was, then it would be difficult to continue to attract students to the "brand," or to explain what GT is to others.

In this chapter we describe the development and validation of a fidelity scale for GT: the Gestalt Therapy Fidelity Scale (GTFS).

Development of the GTFS

Fidelity scales are usually based on pre-existing treatment manuals (Perepletchikova, 2011; Waltz et al., 1993). However, GT has never had a manual, and many experts argued that it would be impossible to create one (Mann, 2010; McConville, 2014; Wollants, 2008; Yontef & Jacobs, 2013). In the absence of a manual, an alternative way to develop a fidelity scale was to use the "Delphi" method (Linstone & Turoff, 1975).

The Delphi Method

The Delphi method involves a group of experts making private, independent ratings of agreement on a series of statements. In contrast to other data gathering and analysis techniques, the Delphi invites participants to engage in a process of multiple iterations, in which feedback and analysis from one round is integrated into subsequent rounds until a consensus of 80% agreement is reached on each item. Consequently, in the Delphi process participants may have the opportunity to augment or modify their initial position in relation to the analysis and feedback provided by other panel members and communicated by the researcher who facilitates the Delphi process.

The Delphi method has been widely used in Information Technology and in the field of education to determine prototypical practices for new technologies and practices (Carley, Shacklady, Driscoll, Kilroy & Davis, 2006; Clayton, 1997). More recently it has been adopted by the health sector in establishing bench mark practices for identifying and treating various disorders (de Villiers, de Villiers & Kent, 2005; Falzon, Sabiston, Bergamaschi,

Corrion, Chalabaev & D'Arripe-Longueville, 2014; Hart, Jorm, Paxton, Kelly & Kitchener, 2009).

The Expert Panel

Potential panelists were identified on the basis that they had edited one of the three major Gestalt journals, had published one or more books or articles about GT, and/or had been a trainer or director at a GT training center and were able to complete study tasks in English. A further consideration in selecting panel members was that the panel would reflect the diversity and geographic spread of GT (Fogarty, Bhar, Theiler & O'Shea, 2016). More than one hundred and sixty people were invited to participate in the study. Sixty-three experts, from 17 countries, accepted the invitation (58 participated in both rounds of the study, two participated in only the first round, and three participated in only the second round). There were 24 participants from Europe, 22 from North America (USA and Canada), 11 from Oceania (Australia and New Zealand), four from Latin America, and one each from Israel and Japan. The names of participants were published in (Fogarty et al., 2016).

Generation of Items

Items for submission to the expert panel were generated on the basis of an extensive literature review (Fogarty et al., 2016). A search conducted through a university library located approximately two hundred books (and reviews of books) published in English with GT in the title between 1968 and 2015, and more than 350 journal articles in the same period. We focused on the books and articles that had been most frequently cited, and on articles appearing in the three major GT journals, the *British Gestalt Journal*, the *Gestalt Review* and *Gestalt Journal of Australia and New Zealand*.

We identified eight concepts that emerged repeatedly and that appeared to be collectively capable of succinctly accounting for GT's theoretical foundations and methods. Those concepts were developing awareness, dialogic relating, working in the here and now, phenomenological practice, working with embodied awareness, field sensitive practice, working with contacting processes, and experimental attitude. Descriptions of each of these concepts were drafted with a view to identification of aspects of each concept that were distinctive to GT. For example, the therapeutic relationship is a common factor in therapy; therefore, in describing the Gestalt concept of "dialogic relating" the specific and distinctive way in

which Gestalt therapists understand and work with the therapeutic relationship is underscored.

We also drafted descriptions of 35 therapist behaviors that were intended to operationalize these concepts in a clinical setting. The guiding principles in drafting these descriptions were clarity and succinctness. Descriptions ranged in length from eight to 23 words. The behaviors were grouped according to the concept with which they appeared to be most closely associated. Because the concept of developing awareness appeared to underlie all of the other concepts, and to be a common aim of the behaviors, developing awareness was not used as an organizing category.

The Delphi Study

The eight concepts and 35 associated behaviors were submitted for the consideration of the expert panel through an online survey platform, Qualtrics. The first round of the Delphi was launched on 3 September 2015. With each concept, the panelists were presented with a label or descriptor for the concept; a description of the concept's theoretical foundations and clinical manifestations; and a number of associated therapist behaviors. Panelists were asked whether they agreed (using a 5-point Likert scale) that the concept was fundamental to GT, whether the description was accurate, and whether each of the therapist behaviors reflected that concept. Panelists were also given the opportunity to provide qualitative feedback, including the opportunity to suggest additional therapist behaviors. The responses to the first round of the study were used to refine and revise both the concepts and behaviors. Revised descriptions of the concepts (together with some discussion of participants' feedback) were published in Fogarty et al. (2016).

The second round of the Delphi was launched on 19 December 2015. In this round, participants were presented with a list of 25 therapist behaviors, grouped by concept, and asked whether each of these behaviors reflected that concept. A list of behaviors submitted in the second round of the Delphi was also published in Fogarty et al. (2016). Full details, including a statistical analysis, of the results of the second round of the Delphi have been published by the authors in Fogarty, Bhar & Theiler (2019). For present purposes it is sufficient to say that the expert panelists involved in the Delphi study agreed that 24 of the therapist behaviors reflected one or more of the eight key concepts.

Preliminary Testing of the GTFS

The draft 24-item GTFS was then subjected to preliminary testing through a pilot study in which a group of experienced Gestalt clinicians used the GTFS to rate video recordings of clinical work by three well-known Gestalt therapists (Michael Clemmens, Bob Resnick and Gordon Wheeler), and an equally well-known therapist from a different modality (Jeff Young, Schema Therapy). The issues to be explored in the pilot study concerned the usability of the GTFS, and its capacity to distinguish Gestalt therapy from other modalities. Video, rather than audio, recordings were used because in a modality such as GT language and speaking are only one aspect of the phenomenological, experiential, embodied world of the client. Furthemore, as many GT training centres are now using video to assess and supervise trainees' work, the practice of working with videos of clinical sessions is both familiar and appropriate to the potential applications of the GTFS.

The six participants met as a group with author Madeleine Fogarty in a room at Gestalt Therapy Australia (GTA) in Melbourne, Australia. The group first discussed a number of questions about the draft GTFS, such as whether they were familiar with the words and concepts used in it, and whether they thought they would be able to identify each of the therapist behaviors when watching a video recording of clinical work. Participants then rated the four videos using the draft GTFS. In rating the videos, participants were given three options for each behavior: "yes" if they observed the behavior at any point during the session, "no" if they did not observe it; and "not applicable" if they thought there were legitimate reasons why the therapist did not engage in the behavior in that session. Finally, the participants discussed their experience in using the GTFS.

All of the participants gave higher scores on the GTFS to the videos of Gestalt therapists than to the non-Gestalt therapist. Participant feedback also led to the elimination of four items (on the basis that they were overlapping or repetitive); to the revision of others (on the basis that they were unclear); and to the replacement of the "not applicable" option (which participants said they found confusing) with a final item that allowed raters to indicate (and describe) the presence of "significant unusual factors" that "justified the therapist not engaging in the behaviors described in this scale." The resulting 21-item GTFS is published as an Appendix A to this chapter.

Validation of the GTFS

The final step in the development of the GTFS was to validate it through an international study. Given the breadth of GT, the fact that it has been established for nearly seventy years, and that it is practiced around the world, it seemed important to conduct validation studies in as many countries as possible.

Videos Used for the Study

The principal investigator recorded a series of short videos (approximately 25 minutes in length) of simulated clinical sessions, with GT and non-GT trained therapists who had similar levels of experience. The videos were recorded in the same room, with the same lighting and production values. The non-GT-therapists were Masters students doing placements in the Swinburne University Psychology Clinic and the GT-therapists were students doing placements in the Connect Ground clinic at Gestalt Therapy Australia in Melbourne.

"Real play" was chosen over scripted sessions or role play, as this provided a fresher, more authentic context, and greater verisimilitude. "Real play" involves the client bringing something that is real for them in the here and now, but that is also manageable in the circumstances of a simulated therapeutic encounter. The aim is both to be realistic, and to support the therapist to feel grounded in their competence and ability within their therapeutic modality. For the same reasons, people who volunteered to play the role of client needed to be familiar with therapy.

Filming took place in November 2016. The client and therapist first discussed the client's "issue," to ensure that both felt comfortable working with the material. In this "first session" themes and styles of working were introduced. We then recorded the "second" session. Feedback from the trainee therapists has been that the process of recording (and then watching) the videos has been very useful in helping them to understand their therapeutic practice and development.

There were more volunteers for the project than anticipated, which provided a pool to select from. Recordings were selected for gender balance, variety of themes and different modalities. Two GT videos and two non-GT videos were selected for inclusion in the validation study. These four sessions were all assessed as competent by a small panel of psychology and GT trained professionals. The videos were then uploaded onto a private YouTube channel that participants in the validation study could only access once each video had been shared with them.

The principal investigator also recorded a video explaining how to use the GTFS and answering a series of "frequently asked questions" about the GTFS that had come from the participants in the pilot study. This "FAQ" video was also uploaded onto the private YouTube channel (Fogarty, 2018).

Participants in the Study

Invitations to participate in the study were circulated at GT conferences and through GT discussion lists. People who responded to these invitations were asked to invite other GT therapists in their location to undertake the study with them and to organize a room with facilities for watching videos. In the end, more than 175 people representing 18 countries participated in the validation study. Participants were asked whether they wished to be acknowledged in publications arising from the study: a list of those participants who indicated that they did is published as Appendix B to this chapter.

Prior to the day, raters were asked to read and familiarize themselves with the article by Fogarty et al. (2016), the GTFS, the FAQs about the GTFS, and the participant information statements and consent forms that formed part of the ethics process. On the day of the validation study, participants were asked:

1. To complete the consent forms and a demographics information sheet;
2. To watch and discuss the FAQ video;
3. To watch and rate the Michael Clemmens and Jeff Young videos that the focus group had rated (this was both for practice in using the GTFS, and as a test of rater competence in doing so); and
4. To watch and rate the four videos of simulated clinical sessions.

Participants' Responses

Feedback from those participating in the validation studies was overwhelmingly positive, with participants reporting both that the GTFS was simple and fun to use, and that the day provided an opportunity for lively collegial discussion and a deepening awareness of their own practice as Gestalt therapists. The Czech group described the validation day as "exciting and challenging" and the Austrian group found it "interesting and inspiring," noting "how the GTFS transforms personal competencies into a visible inventory of Gestalt practice." Members of the Sheffield group

found the day "fascinating and enriching" and "the scale really useful for reflecting on our own work and supervision and training," with one member adding that she would "be bearing the scale in mind for personal self-supervision."

The Dutch group described a "beautiful experience" of spending "this day of reflecting and noticing what was going on in the contact of therapist-client in the videos. It sharpened our awareness and we had nice discussions about the several concepts to be observed in the rating process." The group in Slovakia also "had a lot of discussions (sometimes quarrels!) but it was very useful." And in Zagreb, eight Gestalt practitioners met when the outside temperature was -6°c and said that they enjoyed working together "for the validation of Gestalt therapy" in "a country where the politics is so disappointing that most of the people don't believe any more that people can do something together."

Conclusion

The results of the validation study confirmed that the GTFS can be reliably used as a measure for evaluating whether a therapist is administering GT. Full details, including a statistical analysis, of the results have been published by the authors in Fogarty et al. (2019).

In addition to the use of the GTFS in clinical trials research, and qualitative or mixed methods research, we consider that the GTFS could be a useful instrument in psychotherapy training and supervision, including self-supervision. Many of the participants in the validation study reported that they thought that the scale would be useful for this purpose, and training centers in Belorussia, Italy and Mexico have already started to use the GTFS in this way.

References

Barber, J. P. (2009). Toward a working through of some core conflicts in psychotherapy research. *Psychotherapy Research,* 19, 1–12.

Brownell, P. (2008). *Handbook for Theory, Research, and Practice in Gestalt Therapy.* Newcastle, UK: Cambridge Scholars Publishing.

Brownell, P. (2014). C'mon Now: Let's Get Serious about Research. *Gestalt Review,* 18(1), 6-23.

Burley, T. (2014). Can We Get Back to Being Serious about the Processes of Experience, Awareness, and the Action of Gestalt Formation Resolution?" *Gestalt Review,* 18(1), 17-21.

Butollo, W. (2013). Comment. In G. Francesetti, M. Gecele, & J. Roubal, (Eds.) *Gestalt Therapy in Clinical Practice: From Psychopathology to the Aesthetics of Contact*, pp. 330-333. Milan: FrancoAngeli.

Carley, S., Shacklady, J., Driscoll, P., Kilroy, D., & Davis, M. (2006). Exposure or expert? Setting standards for postgraduate education through a Delphi technique. *Emergency Medicine Journal*, 23, 672-4.

Clayton M. J. (1997). Delphi: A technique to harness expert opinion for critical decision-making tasks in education. *Educational Psychology*, 17, 373-86.

de Villiers M.R., de Villiers P.J., & Kent A.P. (2005). The Delphi technique in health sciences education research. *Medical Teaching*, 27, 639-643.

Falzon, C., Sabiston, C., Bergamaschi, A., Corrion, K., Chalabaev, A., & D'Arripe-Longueville, F. (2014). Development and Validation of the Cancer Exercise Stereotypes Scale. *Journal of Psychosocial Oncology*, 32(6), 708-726.

Fogarty, M. (2018). The GTFS: How to use the Gestalt Therapy Fidelity Scale. [YouTube video]. Available at https://youtu.be/chDT-6KqJ9M.

Fogarty, M., Bhar, S., Theiler, S., & O'Shea, L. (2015). Creating a Fidelity Scale for Gestalt Therapy. *Gestalt Journal of Australia and New Zealand*, 11(2), 39-54.

Fogarty, M., Bhar, S., Theiler, S., & O'Shea, L. (2016). What do Gestalt therapists do in the clinic? The expert consensus. *British Gestalt Journal*, 25(1),32-41.

Fogarty, M., Bhar, S., & Theiler, S. (2019). The Development and Validation of the Gestalt Therapy Fidelity Scale. *Psychotherapy Research*, DOI: 10.1080/10503307.2019.1571688.

Francesetti, G., Gecele, M., & Roubal, J. (Eds.) (2013). *Gestalt Therapy in Clinical Practice: From Psychopathology to the Aesthetics of Contact*. Milan: FrancoAngeli.

Hart, L. M., Jorm, A. F., Paxton, S. J., Kelly, C. M. & Kitchener, B. A. (2009). First Aid for Eating Disorders. *Eating Disorders*, 17(5), 357-384.

Linstone H.A., & Turoff, M. (1975). The Delphi Method techniques and applications. Boston, MA: Addison-Wesley.

Mann, D. (2010). *Gestalt therapy: 100 key points and techniques*. London & New York: Routledge.

McConville, M. (2014). Commentary 1: Gestalt Therapy, research and Phenomenology. *Gestalt Review*, 18(1), 23-31.

Parlett, M. (2007). Response to the *Festschrift*. *British Gestalt Journal*, 16(1), 53-56.

Perepletchikova, F. (2011). On the topic of treatment integrity. *Clinical Psychology: Science and Practice,* 18, 148-153.

Waltz, J., Addis, M. E., Koerner, K., & Jacobson, N. S. (1993). Testing the integrity of a psychotherapy protocol: Assessment of adherence and competence. *Journal of Consulting and Clinical Psychology,* 61, 620-630.

Yontef, G., & Jacobs, L. (2013). Gestalt therapy. In D. Wedding & R. Corsini (Eds.), *Current Psychotherapies*, pp. 299-336. Belmont, CA: Brooks/Cole.

Appendix A: the GTFS

Rater:

Video:

		YES	NO
	Dialogic relating		
1	The therapist follows the client attentively, tracking the awareness process and the client's experience, not following a predetermined agenda	☐	☐
2	The therapist responds non-judgmentally to the client, creating the conditions that allow for the most effective client expression	☐	☐
3	The therapist demonstrates a willingness to be uncertain and to work with creative indifference	☐	☐
4	The therapist draws on their relationship with the client as the ground for challenge and growth	☐	☐
	Working in the here and now		
5	The therapist enquires about the client's immediate experience	☐	☐
6	The therapist supports the client to accept and deepen their awareness of their presenting issue rather than trying to change it	☐	☐
	Phenomenological practice		
7	The therapist supports the client to describe, deepen and become more present to their immediate sensation, affect, cognitions and/or somatic presentations	☐	☐
8	The therapist describes and validates the different experiences of the therapist and client	☐	☐
9	The therapist encourages the client to widen their choices rather than establishing a program for change	☐	☐
	Working with embodied awareness		
10	The therapist makes observations and enquires about the client's embodiment (including breathing)	☐	☐

11	The therapist invites the client to identify sensations, feelings, emotions, thoughts or images that emerge as a consequence of attending to somatic experiences	☐	☐
12	The therapist invites the client to engage with their body through experiment	☐	☐
	Field sensitive practice		
13	The therapist investigates the ground (or context) from which the client's presenting figure emerges	☐	☐
14	The therapist supports the client to identify how their perception of their environment and prior relationships and needs organize current experience	☐	☐
	Working with contacting processes		
15	The therapist works with the client's interactional patterns as they emerge between client and therapist	☐	☐
16	The therapist and the client identify the figure together	☐	☐
17	The therapist co-creates a space in which the client and therapist explore how they are impacting each other	☐	☐
	Experimental attitude		
18	The therapist uses material that emerges in the therapeutic encounter as the basis for introducing experiments to develop the client's awareness	☐	☐
19	The therapist grades the experiment by eliciting feedback from the client regarding the degree of challenge and support that the client perceives	☐	☐
20	The therapist supports the client to integrate learning and awareness that emerges from an experiment	☐	☐
	Presence of unusual factors?		
21	In your view, were there any significant unusual factors about this clinical session that justified the therapist not engaging in the behaviors described in this scale? If "Yes" what were those factors, and what departures did they justify?	☐	☐

Appendix B: Participants in the Validation Study

The names of group facilitators are italicized, and are followed by the names of the participants in the groups they facilitated. Apologies to any participant whose name has been inadvertently omitted or facilitator whose name has not been italicized.

Australia: *Greer White,* Alan Meara, Angela Shaw, Leila Davis, Paddy O'Regan; *Susanna Goodrich,* Carolyn Choy, Michael Reed,

Austria: *Ursula Grillmeier-Rehder,* Angelika Böhm, Günther Kuhn-Ditzelmüller, Ingeborg Netzer.

Belgium: *Everd Van Soom,* Erik Cuyvers, Leen Bruyninckx, Marianne De Wulf, Maya Van Zelst, Paul Derkinderen, Sara Hendrick, Veerle Meurs, Veronique Vermeir.

Belorussia: *Elena Iasaja,* Alena Artsemenkava, Andrei Butsko, Antonina Melnick, Julia Martyniuk, Olga Ilchyk, Olga Prylishch, Olga Sharaj, Vladimir Adotic.

China: *Annette Hillers-Chen,* Deng Yangrui, Han Xiaoyan, Hu Dan, Wu Yanmin, Yang Juan, Zhang Wenhui.

Croatia: *Irena Bezic,* Adrijana Bjelajac, Ana Milcic Horvat, Biseka Tomljenovic, Daria Rovan, Iva Zegura, Ivan Vracic, Ljiljana Igric.

Czech Republic: *Marek Nečas,* Dagmar Dokoupilová, Jana Míchalová, Tomáš Přikryl, Jan Roubal; *Martin Černý,* Darina Fialová, Petr Pašek.

France: *Florence Belasco,* Emmanuelle Gilloot, Lynne Rigaud, Marc Bittar, Sylvain Risse, Sylvie Schoch De Neusorn.

Germany: *Albrecht Boeckh,* Otto Glanzer; *Rosemarie Wulf,* Christiane Molkenbuhr, Josta Bernstaedt.

Greece: *Vassia Karamanoli,* Despina Balliou, Elena Papadopoulou, Ioanna Koutopoulou, Kostas Konstantinos, Maria Skordia.

Hungary: *Arpad Mondok,* Agnes Gomola, Andrea Ballint, Beata Mate, Dia Bozsogi, Dora Hegedus, Edit Moldovan, Eszter Konta, Flora Milan, Iren Gulyik, Judit Bence, Judit Stefany-Toth, Lili Valko, Olivia Antal, Orsolya Virag, Rita Jokay, Tamas Avar, Virag Babacsy.

Italy: *Margherita Spagnuolo Lobb*, *Alexander Lommatzsch*, Adelaide Gargiuto, Alessandro Cini, Anna Maria Acocella, Anna Ravenna, Aura Matiradonna, Barbara Bellini, Carmina Maria Viccaro, Carolina Alfano, Edoardo Brutti, Efisio Temporin, Emanuela Lops, Enrico Armenise, Fabio Cardone, Federica Paragona, Franco Gnudi, Giovanni Di Cara, Giovanni Spizzico, Ilenia Blasi, Irene Tria, Katia Gallo, Katia Righetti, Lidia Durante, Mariano Pizzimenti, Mirko Anoncecchi, Monica Prato, Oliviero Rossi, Paola Vianello, Paolo Baiocchi, Patrizia Marone, Pierluca Santoro, Roberta La Rosa, Roberta Melis, Rosa Spennato, Rosanna Biasi, Rosanna Militello, Santina Pierro, Serena Catapano, Silvia Adiutori, Silvia Ragni, Sonia Zangarini, Teresa Falcone, Tiziana Battaglia, Valentina Barlacchi.

Japan: *Noriyoshi Okada*, Akira Enatsu, Takemi Danno, Yoko Kawamura.

Netherlands: *Els Boumans*, Alma Koric, Ans van de Steeg, Barbara Pompe-Gelissen, Martijn Kets, Maris van Venrooij, Paul van Beuzekom.

Slovakia: *Roland Cagáň*, Jan Ballx, Zuzana Palenčárová.

Spain: *David Picó*, Cristina Salis, Detlef Hoffman, Enara García, Erika Kjellander, Irina Trinchant, María Inés Gómez, Pilar Ocampo, Santiago Sánchez Tapioles.

United Kingdom: *Belinda Harris*, Christine Stevens, Margaret Rosemary, Sharon Beirne; *Diane Hodgson*, Christine Dukes, Jason Woolfe, Lucy Chamberlin, Lucy Christopher, Lynda Osborne, Ruth Nightingale, Sally Denham-Vaughan, Tessa Gunn; *Kay Young*, Elaine Thomas, Karen Chinnadonai, Wendy Robertson.

United States of America: Bud Feder, Marlene Blumenthal, Mark Reck.

PART THREE

ISSUES RELEVANT TO GESTALT-RELATED RESEARCH

CHAPTER FOURTEEN

THE IMPLICATIONS OF SCIENTIFIC FINDINGS

PETER PHILIPPSON

Why do people practice Gestalt Therapy (or Psychotherapy) rather than another approach? This simple and obvious question leads to some uncomfortable answers, because unfortunately for many practitioners and trainees (and indeed some trainers), it is not through a knowledge and understanding of other approaches, and of what the issues are in choosing one over another. Rather it has been true in my experience as trainee, graduate and trainer (including teaching in Gestalt Training Institutes internationally) that many people practice Gestalt Therapy because that is all they know, and because they have introjected a belief in the superiority of the approach from their trainers and supervisors. Or alternatively, they have adopted ideas from other therapies (whether Self Psychology, Cognitive Behaviour Therapy, Hellinger's (Hellinger et al, (1998) Family Systems Therapy) to remedy perceived deficiencies in the Gestalt approach, with neither a full training in the approach, nor a full understanding of the way Gestalt Therapy has theoretically approached these questions, or how it plays out in clinical practice.

Many Gestalt Therapists (and some trainers) have not read or understood the basic foundational texts, nor do they have the wider perspective needed to evaluate the theory and the claims, and mostly they have even less perspective to evaluate the competing or complementary claims of other approaches. For some, e.g. Naranjo (1993), the 'atheoretical' nature of how they see Gestalt Therapy is a central theme of their approach, seemingly unaware that, if they are offering this as a service to paying users, the statement that this is a useful approach is itself a theoretical statement, which needs evaluation as does any theory.

The end result of this is that training programmes (including places where I have trained) take on the character of religious cults led by a guru, each of which establishes its own network of adherents, its own cultural norms, mythology and beliefs, and its sanctions for non-belief. And one

characteristic of such a group is that it is wary of opening itself to outsiders/unbelievers to evaluate, because they 'won't get it' (we have seen similar processes among orthodox psychoanalysts). While there is some truth in this, there is a wide range of possible evaluative activities, many exemplified by chapters in this book, which give a sense of whether people *are* being helped by the approach, and whether there are situations where a different kind of help might be preferable. And it is important to be aware that such an 'in-group' argument applies equally to our clients, making us again the holders of esoteric knowledge doing our magic to the client, rather than a horizontal relationship where we are working together (and the complex and sometimes troublesome transferential interactions between us are able to be seen as *part* of this working together, delineating the relational process that we are working with).

And the scientific research method is actually a good description of what therapist and client do in Gestalt Therapy. As Perls et al (1994/1951: 64) describe it:

> 'The patient, as an active partner in the experiment, concentrates on what he is actually feeling, thinking, doing, saying ... The goal is that in the safe emergency, the underlying (repressed) intention action, attitude, present-day object, memory will become dominant and re-form the figure.'

We are together exploring a process, which at first the client finds inexplicable and uncontrollable, or has come to realise that the old explanations no longer fit the situation. This is very similar to the circumstances where (Kuhn, 1970), exploring scientific method, says that 'normal science', whose 'paradigm' has been unchallenged for a long time, breaks down and allows for a 'scientific revolution' where a new understanding takes its place. I would want to emphasise that the exploration in Gestalt Therapy is of a relational process rather than an observation of just the process of the client, but this has actually been a central plank of the scientific paradigm for the last century.

Gestaltists have historically not given much attention to research, or have seen it as antithetical to the Gestalt approach. They have seen it as part of a 'medical model', where the practitioner does something *to* the patient to change them, and uses research to make their work as change agents more effective. Gestalt Therapy, on the other hand, operates from the Paradoxical Theory of Change (PTC) (Beisser, 2004), and rejects the notion of the therapist as a 'changer'.

Furthermore, the 'gold standard' of randomised control trials (RCTs), where people being researched are randomly put into different groups, each receiving a specific and different treatment or placebo, does not fit well with

a therapy that adopts a relational approach and therefore avoids set procedures. While some researchers have bitten that bullet and compared specific procedures from different therapies (e.g. Greenberg & Watson, 1998), there is a question of whether this gives an accurate view of the effectiveness of a Gestalt approach (e.g. Yontef & Philippson, 2008).

Yet, if we look at the Beisser paper, he makes a claim:

> '...*change occurs when one becomes what he is, not when he tries to become what he is not*. Change does not take place through a coercive attempt ... to change him ... rejecting the role of change agent, we make meaningful and orderly change possible. (Beisser, 2004: 103-4, italics in original)

This is a persuasive and far-reaching claim, but is it valid? And how would we know whether it is? Are we meant to take it as an act of faith? Are we supposed to check our experiences with clients, and how would we do that? In the absence of RCTs, what do we compare it with? (In fact, my clinical experience gives evidence that it is a simplification of the theory, nicely stated but not of universal significance. See below.)

Immediately the issue of research comes up right in the middle of our beloved PTC! Some people have gone the first route, taken it as an act of faith. But I would argue that it is not right to offer oneself as a psychotherapist on that basis alone. At its extreme, as I wrote above, we would be passing off a cult as a professional service, and training students to become true believers rather than questioning adults. If that is not satisfactory, we immediately face the pitfalls that make RCTs so inviting in the first place. I will list some of these.

Pitfalls of Determining Validity of a Theory

1. Assuming that what we believe are the significant factors are actually the important ones. For example, you could argue that the very act of seeking therapy changes the situation, being willing to put oneself out and spend time and money. Maybe that is the most significant factor. Or the therapist's interest and attention: many clients have had very little sustained and honourable attention in their lives, so maybe that is the major factor. Or, as Jay Haley (1984) has argued, we do not have coming-of-age ordeals in our societies, and the task of therapy is to provide something spuriously linked to the problem, but stressful enough as an ordeal that people feel they have earned the right to change.
2. Assuming that what we see in the therapy room is a guide to what happens outside, e.g. that a client who has a good experience in therapy is likely to act differently in their lives, not just immediately but longer-

term. And of course that they would tell us accurately if this is the case. Conversely, we may assume that people who do not come back after one or two sessions are dissatisfied rather than needing nothing more. This kind of projection on what is not seen is similar to the story that dolphins rescue shipwrecked sailors by giving them a ride to land. Actually, dolphins are playful and can be happy to give people a ride. Those that are taken closer to land tell the story, those who are taken further out to sea don't!

3. Assuming that the therapy has any significance at all. 'There is a consistent finding that between fifty and seventy percent of patients on waiting list control groups not only do not wish treatment after the waiting list period but have really recovered from their emotional problems – despite the previous theories which did not consider this possible.' (Haley, 1989) Many alternative therapies are given spurious support from the fact that people tend to get better much of the time on their own, and therefore the 'treatments' they take while doing that can be seen as 'causing' the cure.
4. Doing what many 'researchers' (in particular drug companies, see Goldacre (2008)) do: publishing trials that support their claims and not publishing those that don't. Human beings consistently overemphasise positive evidence and underemphasise negative evidence. Taking an anecdote as showing a general truth, when different anecdotes (about dissatisfied clients) would present a different picture.

So I would say that it is necessary for us as therapists to find some ways to compare our approach with other approaches, or with no approach all (leaving the client without therapy). We need to be critical of what we do (using 'critical' in its best form, asking an open question about whether this does lead to clients having more satisfying lives, and being open to a 'yes' as well as a 'no' answer). We need to try out different things, and not assume that what we have first learned is the best way for us to do therapy.

An Example: The Paradoxical Theory of Change

I started with the question of whether Beisser was right in his assertion about the best way to promote change. I have now explored that question in my own practice, and with the many people I have supervised. My findings so far are that it works in many situations, but not in others: where the client is in poor sensory contact with the world, where the early attachment led to poor neural development that does not support self regulation. In those situations, the therapist needs to spend time directing new ways of sensing

and engaging with people, which the clients will not find for themselves. (Philippson, 2012)

And yet Gestaltists have taken time in print to try and interpret what therapists do in such situations as somehow consistent with the PTC (see for example Jacobs, 2014: 43-45). While there would be ways to present such a consistency, for me the energy in such a response speaks to a wish to conserve an important signpost rather than questioning 'why this signpost rather than that?'.

Two Kinds of Evidence: Internal and External

Much of the emphasis in psychotherapy research has been on what I would call 'internal' evidence: qualitative or (less frequently) quantitative analyses of the process and outcome of the therapeutic encounter using a particular methodology. Yet there is another, maybe even more useful, approach to research, exploring whether the newest discoveries – of how the brain work, how human beings develop, and how that development gets derailed into distress – are consistent with the approach. This is an 'external' support for the approach. I have argued (Levine Bar Yoseph, 2011: 83 – 92) that we can learn things about what is effective in psychotherapy from scientific research on topics such as neuroscience and infant development (and of course the links between these topics). How does perception and memory work? How does our early experience affect our neural development? How do we process relational events? Do we regress, store memories, repress? How does our brain process time, and is it consistent with a psychoanalytic view of 'the past' or a Gestalt Therapy view of the past as a present organisation of memory and narrative? The writings of researchers such as Daniel Stern (2004), Rizzolatti, & Craighero, 2004, and Louis Cozolino (2002) give strong support to what Gestalt theory has been saying for 60 years:

> 'We no longer see our minds as so independent, separate, and isolated. We are no longer the sole owners, masters, and guardians of our subjectivity… The idea of a one-person psychology or of purely intrapsychic phenomena are no longer tenable in this light.' (Stern, 2004: 77 78)

> 'When observers see a motor event that shares features with a similar motor event present in their motor repertoire, they are primed to repeat it. The greater the similarity between the observed event and the motor event, the stronger the priming is.' (Rizzolatti, & Craighero, 2004: 180/183)

> 'Although Gestalt Therapy is not widely practiced, it is a unique expression of psychodynamic therapy that is particularly relevant to the notion of neural

integration.' (Cozolino, 2002: 60).

Memory research such as McDonough & Gallo (2010) supports a Gestalt view of time:

> 'Consistent with the idea that past and future autobiographical elaboration have overlapping cognitive processes, recent studies have shown that the neural signatures of remembering the past (past elaboration) are similar to those of imagining the future (future elaboration) ..., suggesting overlapping processes between past and future events'. (p. 3)

They go on to show that 'accuracy [was] greater when searching memory for future events than when searching for past events.' (p. 9), so that future intention supported more accurate recall of past events.

Similarly, Damasio (1999: 20) writes that 'understanding the biology of consciousness becomes a matter of discovering how the brain can map *both* the two players *and* the relationship they hold.' (Italics in original) Later he complains of:

> 'the noticeable absence of a notion of *organism* in cognitive science and neuroscience.' (op. cit.: 40, italics in original)

There is an explosion in the field of *social neuroscience* (Harmon-Jones & Winkielman, 2007). For example:

> '... rather than the picture of a meaning-giving brain that looks at the outside world ... what emerges from some work in social cognitive neuroscience is the view of a human brain that needs a body to exist in a world of shared social norms in which meaning originates from being-in-the-world.' (op. cit: 440)

The idea, most strongly associated with Stern (1985), that child development does not occur in completed stages, rather in domains that may start sequentially, but continue as counterpoints to each other throughout life was startlingly prefigured by Perls in a 1957 lecture (Perls, 2012: 143 – 166), and his five domains (Perls calls them 'layers', but they are not the same as his better known theory of the five layers of neurosis) bear strong similarity to Stern's:

> 'The essence of a healthy person is that there is a unity, an integration of all the layers; he does not live merely in one level.' (op. cit. 156)

I do not think it is an exaggeration to say that, in such researches, in fields which mirror the research Goldstein and Perls carried out in Frankfurt, Gestalt Therapy is being supported as much as, or more than, any other approach to psychotherapy. The mechanisms which we rely on for our work

are actually very well supported by researchers who have no formal connection with Gestalt Therapy at all.

An Application of this Research: Can I Know Another Person?

Many Gestaltists I met in the 1980s particularly took the view that we can never know another person, we can only project onto them. Therefore, we can only enquire, check our projections with them. This never fitted my understanding of Gestalt theory in several ways. It does not fit with the idea of self as a co-creation, and it makes the central Gestalt term 'contact' (as well as other important ideas like love) meaningless. It also assumes that we know ourselves more clearly than others know us, which is not always true. This last statement is also supported by research:

> '... researchers have obtained evidence that perceivers' judgments about the causes of their own behaviors can be altered by manipulations that implicate a causal factor which, in reality, probably played little role in the subjects' actions.' (Olson, 1990, p. 17)

However, if self and a human other are co-creating in the contact, sharing information non-verbally by the nature of our human neurological organisation, we are not strangers to each other, and if we sometimes misconstrue what is happening with the other (or are deceived by the other for their own purposes), we can also do all this for ourselves in our self-understanding.

Another application: does Gestalt Therapy need a developmental theory?

This has been treated as a criticism of Gestalt theory by both psychoanalysts and Gestaltists. And of course, in conventional terms such as the theory of Mahler et al. (1975), it does not. It specifically does not, as we saw above, have a theory of consecutive and completed developmental stages. Yet these theories have themselves been found wanting, and the work of developmental theorists, particularly Stern (1985, 2004) show a much closer link with Gestalt ideas, and in fact Stern collaborated with Gestaltists. For a more detailed comparison of the ideas of Stern's group and Gestalt theory, see Philippson (2013).

Conclusion

To sum up, the establishment of a research tradition in Gestalt Therapy is important in order to demonstrate to the world outside ourselves of the effectiveness of the approach, it is also important internally to keep us questioning our own understanding, to be a theory among other theories rather than a 'higher truth'. We need to be able to demonstrate to the potential users of our services not only that it is a worthwhile project to undertake, but also that we have worked to check whether we are using theory in a meaningful and useful way, and not just taken our teachers' word for it.

I have also shown that there is considerable evidence for the accuracy of our understanding from research right outside our therapeutic circle, and that we can take our stand as much on that as on our own research projects. What we do has been shown to make sense by people who have no allegiance to the Gestalt approach, which should support us to go into the research area with confidence, rather than with dread. Yet scientific research has bigger possibilities than that, and can actually inform us about the directions to look in our therapeutic work, as it did for Kurt Goldstein, and his assistant Dr. Frederick Perls.

References

Beisser, A. (2004). The paradoxical theory of change. *International Gestalt Journal*, 27(2), 103-107.

Cozolino, L. (2002). *The neuroscience of psychotherapy.* New York, NY: W.W. Norton.

Damasio, A. (1999). *The feeling of what happens.* London: William Heinemann.

Goldacre, B. (2008). *Bad science.* London: Fourth Estate.

Greenberg, L. & Watson, J. (1998). Experiential therapy of depression: differential effects of client-centred relationship conditions and process experiential interventions. *Psychotherapy Research*, 8(2), 201-224.

Haley, J. (1984). *Ordeal therapy: Unusual ways to change behavior.* San Francisco: Jossey-Bass.

Haley, J. (1989). *The power tactics of Jesus Christ and other essays.* New York: Triangle Press.

Harmon-Jones, E. & Winkielman, P. (2007). *Social neuroscience: Integrating biological and psychological explanations of social behavior.* New York, NY: Guilford Books.

Hellinger, B., Weber, G. & Beaumont, H. (1998). *Love's hidden symmetry: What makes love work in relationships?* Phoenix, AR: Zeig, Tucker.

Jacobs, L. (2014). Relationality and paradoxical theory of change. *British Gestalt Journal*, 23(1), 43 – 45.

Kuhn, T. (1970). *The structure of scientific revolutions.* Chicago, IL: University of Chicago Press.

McDonough, I.M. & Gallo, D.A. (2010). Separating past and future autobiographical events in memory: Evidence for a reality monitoring asymmetry. *Memory & Cognition*, 38(1), 3-12.

Mahler, J.S., Pine, F., & Bergman, A. (1975). *The psychological birth of the human infant.* New York, NY: Basic Books.

Naranjo, C. (1993). *Gestalt therapy: The attitude and practice of an atheoretical experientialism.* Carmarthen, Wales: Crown House Publishing.

Olson, J.M. & Zanna, M.P. (Eds.) (1990). *Self-inference processes.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Perls, F., Hefferline, R., & Goodman, P. (1994/1951). *Gestalt therapy: Excitement and growth in the human personality.* New York, NY: Gestalt Journal Press.

Philippson, P. (2012). Paradox: Strategic, naive and gestalt. In *Gestalt Therapy: Roots and Branches – Collected Papers*, 159 – 166. London: Karnac.

Philippson, P. (2013). A moment of meeting with a relative: A review of change in psychotherapy: A unifying paradigm, by the Boston change process study group. *British Gestalt Journal*, 22(1).

Rizzolatti, G. & Craighero, L. (2004). The mirror-neuron system. *Annual Review of Neuroscience*, 27, 169-192.

Stern, D.N. (2004). *The present moment in psychotherapy and everydaylLife.* New York, NY: W.W. Norton.

Yontef, G. & Philippson, P. (2008). A unified practice. In P. Brownell (Ed.) *Handbook for theory, research, and practice in gestalt therapy, pp. 257-276.* Newcastle upon Tyne: Cambridge Scholars Publishing.

CHAPTER FIFTEEN

UTILIZING CONSILIENT RESEARCH IN THE WIDER FIELD

PHILIP BROWNELL

In 2016 I wrote a chapter in David Cain's handbook on humanistic psychotherapies (Cain, Keenan, & Rubin, 2016). I wrote about gestalt therapy, and the editors wanted me to include references to research recent at that time. So, I considered the first edition of that chapter, one in which a mention of the word "gestalt" resulted in a study being included. However, the more I thought about it, the more I realized that some approaches mentioned gestalt therapeutic techniques but were not what my colleagues in gestalt therapy would admit was essentially gestalt therapy. These things, like schema therapy and emotion focused therapy, were hybrids. They were part gestalt and part something else. The more I thought about all that the more interested I also became in another class of research related to gestalt therapy–gestalt consilient research.

This subject relates to something Peter Philippson said in chapter fourteen in this book:

> I have also shown that there is considerable evidence for the accuracy of our understanding from research right outside our therapeutic circle, and that we can take our stand as much on that as on our own research projects. What we do has been shown to make sense by people who have no allegiance to the Gestalt approach, which should support us to go into the research area with confidence, rather than with dread.

One way of understanding what he is referring to there is the realization that what gestalt therapists do in some ways resembles what non-gestalt therapists do, but they are from different clinical approaches. Conversely, often what other therapists do makes sense to us, and gestalt therapists have been known to complain, "That's gestalt. They have stolen gestalt and then called it something else." Well, "they" have not done that. Rather, what has taken place is the formation of consilience.

What Does "Consilience" Mean?

Consilience refers to the "jumping together" of knowledge. It's an overlap of knowledge across various domains. There are many instances of the concept being used today; for instance, Bell and Kandler (2017) explored the possibilities of consilience between genetics and sociology. Some see applications of evolution to the humanities, cognitive science, and even religion (Carroll, McAdams, & Wilson, 2016; Franek, 2016). Connolly and van Deventer (2017) explored overlaps between self-organizing principles in biology and psychoanalysis.

The jumping together referred to above is like a doppelgänger effect– the *double-goer*; it's a noticeable similarity. The features of one person jump to the features of another. One can see that they look alike.

In psychotherapy the dialogical approach of person-centered psychotherapy resembles the relational approach of contemporary gestalt therapy. The phenomenological approach of gestalt therapy resembles that of existential and phenomenological psychotherapy. The entire approach of relational systems psychoanalysis resembles the application of the phenomenological and hermeneutic field theory of gestalt therapy. The existential experimentalism of gestalt therapy resembles the behavioral experiment of cognitive-behavioral therapy. And so on. The principle of consilience is based on the unity of knowledge. It refers to obtaining the same result from diverse means.

The Metaphor of Convergent Evolution

Much of the conversation about consilience comes from the field of evolution; so, let me take what could be considered a metaphor from that field to make clear what I mean by research into consilient gestalt features.

Consider the topic of convergent evolution. Science Daily (2018) quoted the Wikipedia in offering a definition of the term: "In evolutionary biology, convergent evolution is the process whereby organisms not closely related (not monophyletic), independently evolve similar traits as a result of having to adapt to similar environments or ecological niches."

It is not that other people have stolen gestalt therapy and called it something else. It is, rather, that psychotherapy evolves, it adapts to changing climates, social, and cultural forces. And there is a kind of convergence to its contemporary evolution. CBT admitted emotions, not simply as consequences of thoughts but also as instigators of thinking. Psychoanalysis, in the due course of time, moved out from behind the couch and met the analysand as another person. Along the way adaptations and

assimilations have been going on of various interventions as well. Many see similarities between mindfulness and the gestalt therapy tenet of awareness, between acceptance and commitment therapy and the paradoxical theory of change, and between narrative therapy's observational language and gestalt's subtle tracking of the givenness of the client in contacting.

Benefits of Utilizing Consilient Research

While the gestalt therapy research tradition gains momentum and more and more research is conducted, it would benefit gestalt therapists to become familiar with consilient research in order to justify the use of their various techniques and interventions. For instance, Bennet-Levy (2003) compared behavioral experiments to CBTs use of automatic thought records and found that significant improvement over automatic thought records can be achieved by the use of behavioral experiments. Participants attributed the benefit to the impact of evidential experience and compared to automatic thought records felt more finished, with the results being believed becaue they had been experienced (Bennett-Levy, et al., 2004). In what is likely one of the closest parallels or examples of consilience, behavioral experiments closely resemble the existential experiments used in gestalt therapy and the research on them can legitimately be applied to the processes of gestalt therapy.

It is efficient and advantageous for gestalt therapists to read the research literature in order to discover other such examples of research already conducted that can rightfully be applied to gestalt process. Other examples of consilient research can be found in my chapter in Cain's book (Brownell, 2016).

Requirements to Utilize Consilient Research

What does it take to qualify as consilient research? I will make this brief:

- There must be a one-to-one match between the tenet of some approach that is under investigation and some aspect of gestalt therapy theory and/or practice.
- This match must be recognizeable and not forced.
- The research conducted must be sound research with acceptable effect sizes or multiple studies drawing distinct and logical inferences from the data.
- The tenet in question must be assimilable to gestalt practice and again, not forced or lamenated over the top of it.

- As it is assimilated, the similarity between the tenet and the assimilated version of the tenet must reamain sufficient so as to legitimately claim the research as significant for gestalt practice.

References

Bell, E., & Kandler, C. (2017). The genetic and the sociological: Exploring the possibility of consilience. *Sociology, 51*(4), 880-896. http://dx.doi.org/10.1177/0038038516629908

Brownell, P. (2016). Contemporary gestalt therapy. In D. J. Cain, K. Keenan, & S. Rubin (Eds.), *Humanistic psychotherapies: Handbook of research and practice* (pp. 219-250). Washington, DC, US: American Psychological Association. http://dx.doi.org/10.1037/14775-008.

Cain, D.J., Keenan, K., & Rubin, S. (Eds.). *Humanistic psychotherapies: Handbook of research and practice*. Washington, DC, US: American Psychological Association.

Carroll, J., McAdams, D. P., & Wilson, E. O. (Eds.) (2016). Darwin's bridge: Uniting the humanities and sciences. New York, NY, US: Oxford University Press.

Connolly, P., & van Deventer, V. (2017). Hierarchical recursive organization and the free energy principle: From biological self-organization to the psychoanalytic mind. *Frontiers in Psychology, 8,* Article ID 1695. http://dx.doi.org/10.3389/fpsyg.2017.01695

Franek, J. (2016). Methodological consilience of evolutionary ethics and cognitive science of religion. *Journal of Cognition and Culture, 16*(1-2), 144-170. http://dx.doi.org/10.1163/15685373-12342173

Science Daily (2018) downloaded May 23, 2018 from https://www.sciencedaily.com/terms/convergent_evolution.htm

PART FOUR

EXAMPLES OF TEACHING AND CONDUCTING RESEARCH IN THE GESTALT WORLD

This section is an addition to the second edition (with new chapter contributors) and extends the ideas in the final section of the first edition.

CHAPTER SIXTEEN

TEACHING AND CONDUCTING GESTALT RESEARCH THROUGH THE ISTITUTO DI GESTALT, HCC ITALY: CAPTURING THE VITALITY OF RELATIONSHIPS IN RESEARCH

MARGHERITA SPAGNUOLO LOB

The pursuit of truth and beauty
is a sphere of activity in which
we are permitted to remain children
all our lives.
A. Einstein

In this paper, I would like to share my experience as a Gestalt therapy trainer for almost forty years now and relate how important research has been in my work. When I opened my institute with other colleagues in 1979, I came from a solid academic background and I loved Gestalt therapy. I had just turned 23 and, after graduating and working for two years as a university lecturer in Rome, I had moved back to Sicily, where there was certainly no tradition of the approach. The spirit of curiosity and creativity that underpins Gestalt therapy has always appealed to me, as much as the spirit of research. Moreover, as all of my family were mathematicians, statistics has always been in my blood.

Today I can say that research falls perfectly within the scope of the challenge that the founders set themselves–the challenge of creating a method that could describe and sustain the spontaneity of life, without depriving relationships of their vitality through diagnostic categories or interpretive practices (Perls et al., 1994). The most interesting research that Gestalt practitioners can pursue is that which confirms the validity of the core principal of our work, which is that therapy lies in supporting a

spontaneity that the therapist grasps in the movement co-created with the client. I have sought to uphold this spirit in the training and research activities of my Institute.[1]

I will begin with the Gestalt therapist's encounter with training and research; that is, with a discussion of the particular experience of Gestalt training, which is phenomenological, aesthetic, and field-oriented. Then I will give a brief description of the underlying concepts of the approach and provide examples of related research. Psychopathology, the development of relational suffering, the therapeutic alliance, and other aspects will be examined from the point of view of research. What will emerge is how the aims of research cannot be severed from the actual purpose of psychotherapy, even though our approach was established for very different ends. I will then introduce the concept of *aesthetic relational knowledge* of the field and the concept of *dance steps* as a proposed description of the attunement between the therapist and client, in line with new cultural forms of expression. Finally, I will present the cutting-edge research my Institute has done on dance steps and its clinical application.

Gestalt Practitioners' Experience of Research

What students learn in psychotherapy training is, in a nutshell, the beauty with which they have faced pain in their lives. I believe this is a crucial lesson, as it enables them to understand the depth of the experience of their clients (to see the beauty in their pain). The tools that enable them to grasp that beauty lies in phenomenology and aesthetics. Through the lens of phenomenology, they learn to get in touch with their feelings, which enables them to foster the same process in the client. In that way, the therapeutic setting evolves to a more profound level, where deeper emotions are breathed and what has been locked up in the depths of the heart can be said. Thanks to an aesthetic approach, the Gestalt therapist learns to use her senses to situate what she feels in the field and to understand the aesthetics of the movement and presence of the client as though he were a work of art, and wonder at the harmony that underlies his way of being in the specific form of his suffering. Thus the therapist can grasp the creative way in which the client has sought to resolve difficult situations. This complex and effective art of Gestalt can only be transferred if, alongside the formal and

[1] The Istituto di Gestalt HCC Italy (www.gestaltitaly.com) was established in 1979 and currently has three branches, in Siracusa, Palermo, and Milan. It is an EAGT accredited training institute, and its courses leading to a professional psychotherapy qualification are accredited by the Italian Ministry for Universities and Research.

in-depth study of theoretical concepts, students can experience for themselves the freedom of being able to express themselves with the other in ways that were previously off limits. This is the most original lesson for the Gestalt practitioner and the most profound. If theoretical learning is not rooted in such a process of self-awareness, people cannot become Gestalt therapists. Philippson (2017) recently identified three levels of training. The first relates to the client, the second to one's feelings with the client, and the third to the relationship between them. According to our British colleague, very few institutes focus on the third level. In my view, these three skills originate from the active transformation students experience through the group process which takes place over the four years of basic training. By enabling the intentionalities of the members to evolve over the course, the group provides a space for profound experience to emerge, under the expert guidance of the trainer (Spagnuolo Lobb, 2013 a, pp. 229 ff.).

When I bring a group to a close after four years of training, I never fail to be moved by the figures they manage to create (videos, gifts, etc.) from the depths of their being as a group, having explored and loved the more painful sides of themselves and their colleagues. I know that it is what will make them good therapists and that they have acquired the mechanism to continue learning from therapy in practice and from all the other training courses they will do over their lives.

But when I think of a university researcher, whose job it is to verify the effects and methods of psychotherapy, I can see how those videos, so moving for me and for the group, would be rather disappointing to see as the effect of psychotherapy training. Researchers and Gestalt therapists generally speak two, rather diverse languages. Yet that is not the way it should be! It is important that the beauty of our approach does not remain within the limits of our circle. We need to validate it through research, so as to be able to transfer it to other approaches. At the same time, it is important for researchers to be open to life and to be curious about how a creative approach that sustains spontaneity works. In our own small way, we have always sought to describe and validate what we teach our students at our institute. In recent years, however, there has been a widespread movement towards research across the international Gestalt community, a movement in which I have actively taken part. I believe it is a blessing for the development and survival of Gestalt therapy.

One might ask, why do research on what we do? My initial answer to that question is that beauty should be shared. We are part of a broader psychotherapy community and it is our duty to make the effort to communicate with our colleagues. The narcissistic era in which we thought that if others wanted to understand what we do then they should come and

learn from us is over. As I wrote for the European Research Conference organised by the EAGT in Rome in 2014, "the research mentality is possible among Gestalt therapists if we overcome the original (narcissistic) attitude to fight against rules and reown the original tradition of phenomenological research used by Gestalt theory around 1920" (Spagnuolo Lobb, 2016b, p. 46).

Our approach conveys an insight that is unique with respect to others. The specificity of what we do needs to be protected and shared.

What Research Should Gestalt Practitioners Do?

The teaching of Gestalt therapy should cover the ability to transfer the art itself. It is precisely for that reason that we need to teach our students to do research. We cannot consign them to the professional world without having taught them to transfer what they have learned.

Leaving to other colleagues the description of the types of research (see Migone, 1996; Brownell, 2008; Elliott, Greenberg et al., 2013; McLeod, 2013), I will talk about the *core principles* and some related research examples.

The development of phenomenological research has helped Gestalt therapists to consider research as an interesting tool both to check the efficacy of their work and to understand better what they do.

These two needs (to check the validity of their work and to understand what changes and how) are solved by two different traditional methods of research in psychotherapy: 1) *outcome research* that measures the results after psychotherapy, for instance the differences between before and after psychotherapy with standardized instruments; 2) *process research* that studies various aspects of the psychotherapy process, which can be measured even while treatment is ongoing, independently from the results.

For instance, a few outcome tools that we have been using and teaching for a few years to our students are the CORE-OM (Mellor-Clark and Barkham, 2006; Palmieri et al., 2009; Stevens et al., 2011), the CHAP (*change after psychotherapy interview*) interview by Rolf Sandell (1997), adjusted to Gestalt therapy, and the study on single case. Of course, the last two are both outcome and process researches. Besides, we have validated new models with outcome results, like my model to give birth (Spagnuolo Lobb, 1992a).

While outcome research is important to validate the effectiveness of our approach, process research helps us to understand what happens when we do Gestalt therapy, how and for whom it works, which dimensions (usually related to therapeutic alliance) we can consider and how we can dialogue

with other modalities. Process research is of course supported by outcome research. Both kinds of research are better validated by the use of specific Fidelity Scales of the psychotherapeutic approach. They concern in particular the use of rating scales that measure the degree to which a sample of treatment is within the principles of the technique. Thanks to the work of M. Fogarty et al. (2016) we can provide our research with the important value of reliability of the Gestalt psychotherapists who are involved.

Staying with Core Principles of Gestalt Therapy and Doing Research

Given the kind of research that we choose to do, the other basic aspect is "what to research on?" Considering the value of researching, both inside the Gestalt community and in dialogue with other approaches, we need to anchor our researches to the core principles of the Gestalt method. I will now describe a few of these principles, and for each of them I will give examples of researches that have been conducted in my Institute. These examples have to be considered as mere possibilities, they are not exaustive nor exclusive. I describe them here in the hope to encourage other researches related to Gestalt theoretical aspects, and to develop enthusiasm in doing reseacrh.

The Self

The self, the hinge on which all psychotherapeutic approaches are based, is conceived in *Gestalt Therapy* as the ability of the organism to make contact with its environment spontaneously, deliberately and creatively. The function of the self is to contact the environment (in our terminology, the "how" of human nature).

To think of the "self as function" still represents a unique perspective among personality and psychotherapeutic theories. The theory of Gestalt therapy studies the self as a function of the organism-environment field in contact, not as a structure or an instance. This is based on the conviction that the task of anyone who studies human nature is to observe the criteria that produce spontaneity, not the criteria that allow human behavior to be schematized.

Id, ego and personality are just three of the many possible experiential structures: they are understood as examples of the person's capacity to relate to the world: the id as the sensory-motor background of the experience; the personality as assimilation of previous contacts; and the ego as the determined movement that, on the basis of the other two functions,

identifies with and alienates from parts of the environment. [2]

Research example. We can refer to this basic concept in many ways when we do research. Just as an example, I want to mention a process research that we have made about the experience that adolescents have of the concept of legality. We have built a questionnaire based on the three functions of the self, according to Gestalt therapy theory of self (Perls et al., 1994, pp. 149 ff.). We have then applied this questionnaire to 300 high school students of the town of Siracuse (Italy). This first phase of the research (which is still on) had the purpose of validating the inner coherence of the items and of gathering first data about the experience of legality that students have. All items showed a high inner coherence, while the difference between the three functions was not significant. A change in the descriptons related to the three functions is needed if we want to have significant data about the three different experiences of the self.

What seems evident from these partial data is: the concept of legality is mostly based on a self-help sense of justice, on a trust in one's own capacity to solve problems instead of on a trust in the other and in institutional forces. What has been researched is the related sense of excitement and bodily feelings, defined starting from the Gestalt therapy theory of self. On the other side, there is a full trust (maybe excessive, almost 80%) into parents' availability to listen, in case of illegal actions done by adolescents, connected with a sense of confluence in parents/child contact. All this is also based on cultural dimensions of course: adolescents of Northern Europe might score differently.

Another example is the research/clinical record, a tool which has been built basing on the theory of self. We needed to use a clinical record for clients, which was in line with our theoretical and methodological frame of reference, so in the years we have improved a record which starts from the three functions of the self, and traces the support to intentionality of contact and to the *Dance Steps* between therapist and client, staying with the experience of the field (see Spagnuolo Lobb, Conte, Mione, 2017). This clinical record is used in our clinical centers for supervision and research.

The Process of Contact

Attention to the process in Gestalt therapy leads us to see the experience of contact as it develops, thus considering the time dimension. In fact, in an ordinary healthy experience, from an initial undifferentiated unitary state, in the field energies and hence differentiations emerge, which lead to the emergence of differentiated perceptions constituting the contact boundary,

[2] For more detailed and interesting descriptions of the functioning of the self in Gestalt therapy, I invite you to read the book edited by Jean Marie Robine, 2016.

the place where the intentionalities of contact are fulfilled in the concreteness of the here and now of the contact. The process of the making of the self-in-contact is precisely this going through an initial lack of differentiation, which gives way to a growth of excitement, accompanied by the perception of a novelty in the phenomenological field. It is precisely the excitement of the senses that allows differentiation (I realize that my movement is different from others', so I identify myself, I define myself precisely because I am different from them). The contact boundary is defined by meeting one another in diversity, which is then developed in deciding the movement towards the other, undertaken as from the solidity of one's own diversity (from the ground of self-awareness) (see Perls et al., 1994, p. 157).

Our research must take this procedural perspective of Gestalt therapy into account, as a fundamental principle of both the outcome and the process research.

Does the process of contact lead to the growth and effective achievement of the training and clinical objectives? For this reason, each outcome or process evaluation must include the definition of contact boundary and the process of contact in terms of excitement, novelty and growth (see Perls et al., 1994, p. 179 ff.).

Research example. I have already mentioned the adaptation of the *change after psychotherapy interview* by Sandel (1987) to the Gestalt categories, both in the case of post-psychotherapy evaluation, and in the case of post-training assessment (in this case we have called it CHAT, *change after training interview,* see Settanni et al., 2017). These evaluations are still ongoing and allow us to study the perception of growth in patients and students.

In addition to this type of subjective evaluation of the process of growth, we have conducted research on the effectiveness of some Gestalt applications to specific populations. By way of example, I quote the research carried out in the late 80es on the effectiveness of women's preparation at childbirth performed with the Gestalt therapy model called "Childbirth as relational rebirth" (Spagnuolo Lobb, 1992 a).

On a sample of 250 pregnant women (100 prepared with the method in question, 100 with other methods and 50 without any preparation) the duration and the physiological spontaneity of the delivery and the subjective perception of the childbirth were noted. The average duration of labor was shorter than 4 hours compared to unprepared women and shorter than 2 hours compared to women prepared in other methods. A decrease in caesarean sections was also found. The perception of contractions was less painful and the perception of self was more positive. In short, what changed

was not the definition of the painful sensation, but the definition of self in the face of pain.

Dental Aggression, Self-Regulation and Vitality of Human Relations

Fritz Perls' intuition on childhood development, which gives value to the deconstructing implicit in the development of the teeth (*dental aggression*, Perls, 1942), is based on a conception of human nature as capable of self-regulation, certainly positive as compared with the mechanistic conception in force at the tum of the 19th-20th century. The child's ability to bite supports and accompanies her/his ability to deconstruct reality. This spontaneous, positive, aggressive strength has a function of survival, but also of social interconnection, and allows the individual to actively reach what is available in the environment, deconstructing it according to her/his curiosity (Spagnuolo Lobb, 1992b; 2007; 2013 b; 2014).

Gestalt psychotherapy borrows the concept of "intentionality" (Husserl, 1965) from phenomenology. Consciousness exists only in its "relating to", in its "in-tending towards" an object, in its transcending itself (see Bloom, 2008; Brownell, 2015). It is in the act of "transcendence" that subjectivity is formed (Spagnuolo Lobb and Cavaleri, 2010). If the person is formed essentially in being formed, in being in-tentioned, in entering into contact with what surrounds her/him, this implies the need for psychopathology and psychotherapy to address the analysis of this continual transcending, being intentioned, entering into contact. «It is in this relationship with the world, in this in-tending towards it, that the origin of mental suffering and at the same time the space of the treatment must be identified» (*ibidem*).

Gestalt therapy thus wonderfully puts together the "animal" soul and the "social" soul, for centuries considered mutually antagonistic in western philosophical culture: if the contact is a super-ordinate motivational system, there is no separation between instinctive motivation to survival and social gregarious motivation.[3]

The stress Gestalt therapy puts on relationality thus has an anthropological valence in considering self-regulation (between deconstruction and reconstruction) of the organism/environment interchange and a socio-political valence in considering creativity a "normal" outcome of the

[3] Daniel Stern's theory of intersubjective knowledge as superordinate motivational system in humankind confirms the intuition of the Gestalt theory of contact, brought to light a good 50 years earlier (see Spagnuolo Lobb *et al.*, 2009).

individual/society relationship. *Creative adjustment* is in fact the result of this spontaneous strength of survival that allows the individual to be differentiated from the social context, but also to be fully and importantly part of it. Every human behavior, even psychopathological behavior, is considered a creative adjustment.

Research example. There are many possibilities to do research on this peculiar Gestalt concept that integrates the bodily experience with the social one, launching both towards a co-created transcendent reality. An example is *research on groups*. The group is seen in Gestalt therapy as an opportunity to experiment with more spontaneous contacts of growth, and also as a self-regulating space-time, based on the shared intentions of its members (cfr. Spagnuolo Lobb, 2013 a, pp. 229 ff.; Gaffney, 2006; Hodges, 2006; Feder and Frew, 2008).

In the Institute we have developed a model of Gestalt work with groups that takes into account two macro-criteria as regards group observation: the *synchronic*, which looks to the here-and-now of the presence of the group members, and the *diachronic*, which instead looks at the evolution of the experience of being-in-group, i.e. the intentionality of contact between its members (Spagnuolo Lobb, 2016 a; 2012 a; 2012b; Macaluso, 2012).

Regarding the synchronic criterion, we identify three indices of well-being related to the group as a single entity: 1. The vitality and the presence of the group members; 2. The flexibility of the leadership; 3. The ability to accept the novelty and diversity of the group members.

As to the diachronic criterion, it's about the group process, which is seen as a story of intentionalities of contact and of the support they receive at the various moments of development. (cf. Spagnuolo Lobb, 2013 a, p. 257 ff.). The ground of the group is constituted by its process, the underground current of relational experiences that are developed through time, giving form to the intentionalities of contact typical of each phase. The reason for being together is declined in shared individual experiences. Time marks the life of the group directing its energies of contact. From the initial desire to be accepted, the members of the group seek the security of defining themselves, the strength of being-there as persons-in-contact. Hence the interest of the group is focused on the risk of criticism, of the deconstruction of the acquired certainties, which is a necessary condition for being authentic: basically, when we risk saying to the other "I don't trust you", we do it in the hope of understanding her/him to the point of being able to trust her/him. In the next phase, then, the group goes through the experience of abandoning oneself to the other, of revealing themselves to one another with the feeling of intimacy. After this moment, the group is ready to disband; the members are ready to go into the world taking with them what they have

learned (ibid.).

Based on this frame of reference, we have studied various group settings, using qualitative research.

An example is the *organizational consulting* setting. To facilitate the integration of the idea that the manager has of his working group, with the actual experience of the workers, an interview with the manager is recorded (the interview is based on synchronic and diachronic criteria; see Romano, 2016). It is then analyzed with tools of qualitative research (atlas.t). The results are compared with the phenomenological observation, on the part of the consultant, of the group of workers; the observation is based on the same factors on which the interview to the manager is structured. This comparison allows to give the manager a feedback on the synchrony between his choices and the experience of the employees, in order to support the full presence of all the people involved. It is a research/intervention that is used by gestalt practioners trained in this field and allows to integrate the various subjective experiences that are intertwined in the company field [4].

The Contextual Method, the Field and the Aesthetic Relational Knowledge

Our phenomenological soul reminds us of the impossibility of getting out of a field (or situation) in which we find ourselves, and gives us tools to operate with, while remaining within the limit imposed by the "situationed" experience. The founders of Gestalt therapy from the very first proposed the "contextual" method (Perls et al., 1994, pp. 20-21), which, in line with the notion of situatedness and the hermeutic circle described by Heidegger (1927), proposed a hermeneutic circularity between the reader and the book: «Thus the reader is apparently confronted with an impossible task: to understand the book he must have the "Gestaltist" mentality, and to acquire it he must understand the book» (Perls et al., 1994, p. XXIV).

In the field of clinical psychological practice, Gestalt therapy, thanks above all to the contribution of Isadore From, passed from a focus on the resolution of the individual needs (see Wheeler, 2000; 2006), to the focus on the *organism/environment field*, a unitary phenomenal event, from which differentiations and contact boundary emerge.

Moving from the intrapsychic paradigm to that of the "between" implies that the therapist sees her/himself and the patient not as separate entities but as a dialogic totality (Yontef, 2005). Every communication on the part of the patient is inscribed and receives meaning from the *Gestalt* of the mutual

[4] The research is presented in Spagnuolo Lobb, 2016 a.

perceptions, in which the relational intentionality is expressed. It is a "lively" taking care of the patient's perception, of which the therapist is profoundly part, with her/his emotions and sensations, which certainly participate in the co-created phenomenological field.

The research must therefore address mutual perceptions, considering not only the patient's and the therapist's perception as isolated events, but also the perception of one as a response to the other. The patient's "projection" is a perception, which has a hook in the therapist, whose personal characteristics are considered necessary aspects for the co-creation of the contact boundary.

Perception is not an isolated process; it emerges and is co–created together with the other and with the environment in general. Today, interest in the participation of the other in perceptive processes is growing not only because of recent discoveries of neuroscience (e.g., mirror neurons; Gallese, Migone, and Eagle, 2006) and epigenetics (e.g., the transgenerational transmission of traumas; Spector, 2013), but also because of the need to develop clinical tools with which to focus on the pre–defined, i.e., the pre-reflectable, pre-experienceable foundation of self as the basis for the possibility of awareness, perceptive moments prior to the formation of differentiated figures and perceptions of self (see Bloom, 2010). The needs of our clients today as a matter of fact seem not related any more (like 50 years ago) to receiving support to their autonomy (to their ego in front of societal rules); they are rather connected with the capacity of feeling oneself in front of the other, of building a sense of self from the perception of oneself-and-the-other at the boundary (I feel myself when I see you seeing me)[5].

"Sensory data – which emerge from a 'being–with' as figures connecting with other complex data in a shared background – allow us to be part of a 'natural self–evidence'" and to belong to the world (see Blankenburg, 1998; Rubino, 2008).

A consequence for the research is that we need to observe and measure how the *field* changes (not only the client): the perception of the client and that of the therapist change, and both changes must be taken into account.

This field-oriented perspective brings us to develop the concept of awareness, towards the more phenomenological and aesthetic concept of *aesthetic relational knowledge of the field* (Spagnuolo Lobb, 2018). The term explains the two spontaneous competences at the contact boundary that can be observed in both the therapist and in the client. We are immersed in

[5] For a description of the relationship between psychotherapy and the evolution of society, see Spagnuolo Lobb, 2016d.

a phenomenological field and a dance already known to the client.

As a therapeutic competence, *aesthetic relational knowledge* is the instrument through which the therapist resonates with the client during the session, as well as the lens through which she/he looks at the client's vitality. Therefore, the therapist's act of sensing/perceiving is not only *empathy*, an identification with the client's experience, but also *resonance*, a personal and sensitive reaction to the field in the presence of the client. It is the "other side of the moon" of the client's experience. With it, the therapist can see the beauty, the harmony and grace, with which the client has faced life's difficult situations, all the while maintaining the intentionality of contact with significant others and the reactions of others–the resonance of the field.

This basic concept of the field and the development of the concept of awareness into the more contextual and situated idea of *aesthetic relational knowledge* can orient our research towards observing reciprocity in perception and emotional processes.

Research example. An example of this research path is a cooperation with prof. Vittorio Gallese's group in Parma University (where mirror neurons were discovered). Referring to a wider study in the realm of neuroaesthetics, conducted by Vittorio Gallese and Alessandra Umiltà, we have studied bodily and emotional experiences of people who observe faces which express physical pain and faces which are neutral, tailored from art masterpieces or photos of actors. We have asked to people participating in the research to score from 0 to 10 the intensity of their bodily experience, of their wish to help, and of their wish to tum their attention elsewhere. We have put them three questions:

1. I felt the *emotion expressed by the face* inside my body
2. I felt a desire to help
3. I wanted to look somewhere else

The aims of the research (which is still in action) are: 1) to see whether there are differences in the perception of simulated and represented pain, and 2) whether the need to help the other is correlated with the perceived intensity of the bodily experience.

The first data show meaningful differences between the wish to help in case of faces expressing pain and neutral faces, and a positive and meaningful correlation between the wish to help and the intensity of the bodily experience. We are in the process of getting more data.[6]

[6] The research has been conducted by dr. A. Balena and dr. M. Carollo.

The clinical purpose of this research is to connect and support bodily resonance of the other's expression in contact making.

The Experience of the Ground and the Concept of Psychopathology in Gestalt Therapy

> "A strong error is already a creative act and must be solving an important problem for the one who holds it."
> (Perls, Hefferline & Goodman, 1994, pp. 20-21).

We believe that any symptom or behavior that is usually defined as pathological is a creative adjustment of the person in a difficult situation. The so-called losses of *ego-function* are creative choices which allow the organism, althought a partial loss of awareness, to keep contact and therefore growth.

The *anxiety* accompanying these losses of ego-function is the consequence of excitement not being adequately supported by oxygen (adequate breathing) at the physiological level and by environmental response at the social level. This implies a certain desensitization of the contact boundary: in order to avoid perceiving anxiety, it is necessary to anesthetize part of the sensitivity in the here and now of contacting the environment; the self cannot be fully concentrated, awareness decreases, the act of contact loses the quality of awareness and of spontaneity. [7]

The sufferings of the process of contact that we call psychopathology can occur along a continuum that ranges from a minimum to a maximum degree of anxiety, in which the unitary sense of self is no longer preserved. The purpose of Gestalt psychotherapy is on the one hand to facilitate awareness (alias spontaneity) in the contacts that bear suffering, and on the other hand to restore the possibility of contact where growth is not experienced. The experiences, the acquired contacts, form the experiential background that supports the co-created gestalt of contact figures.

When we focuse on the experience of the ground, we need to define developmental processes. The teaching of Daniel Stern has been important in my understanding of development in Gestalt therapy terms.[8] Generally

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[7] These concepts are the basis of the theory of Gestalt clinical practice (see Perls, Hefferline and Goodman, 1994, p. 227 ff.).

[8] In contrast to the stage model of development, Stern (1985) elaborates a theory of development that includes the subjective sense of self as an organising principle. He believes that once the different senses of self (emergent, core, subjective, verbal, and narrative self) have formed, they operate continuously and simultaneously, defining the different fields of interpersonal experience. All the senses of self remain part of

speaking, development can be seen as a form of music that supports contact-making towards the other. *Polyphonic development of domains* is the term that I use (Spagnuolo Lobb, 2012c) to mean the complexity of the ground experience of contact-making and the support from several competences, harmonised with each other. Domain can be defined in Gestalt therapy as an area of processes and competences for contact-making, interacting with the other capabilities, or domains, which form the ground.

Our research is concerned not with the *stage* of development at which the client is blocked, but with *how* their present capabilities of contacting (developed through time) are combined in their being-in-therapy as a whole gestalt. Domains which have been acquired with anxiety, because experiences could not be closed, create a ground full of anxiety, where the ego function cannot deliberate easily.

There are different "musics", different combinations of domains as ground experiences and determinations of the self-function, which create particular kinds of figure/ground formation. All the habitual modes of contact "shape" the music the client plays with the therapist and the music they play together. The experience of contact unfolds in the various phases (fore contacting, contacting, full contacting, post contacting) in a figure/ground balance which can be more or less spontaneous and flexible.

The more the ground of domains is calm (that means full of sufficient closed gestalten, versus too many unfinished businesses), the more the self can concentrate and be spontaneous at the contact boundary. Domains which have been acquired with anxiety, because experiences couldn't be closed, create a ground full of anxiety, where the ego-function cannot deliberate easily. Unfinished gestalten create an anxious experience of the ground, which at a psychological level is experienced as unsupported excitement, at a physiological level is the inability to release muscles in exhaling, at the contact boundary level is an interruption of contact flow (see Philippson, 2001; Spagnuolo Lobb, 2016e).

Research example

Based on Kernberg (see Clarkin *et al.*, 2000, p. 5 ff.), and on my clinical experience in recent years, I have considered four kinds of perception at the contact boundary: neurotic, borderline, psychotic, and the post traumatic

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us for our entire lifetime, as separate but interdependent fields of experience and, as such, are constantly expanded and refined. Stern (2010) also proposes five aspects which create the sense of vitality: movement, force, time, space, and intention (or direction). These five elements make a spontaneous gestalt, which is the experience of vitality (see Spagnuolo Lobb, 2013c; Stern et al., 2003).

perception, which seems to be widespread following recent social change.

Table 1. summarizes *The experience of the ground, the unfolding of self-in-contact, the figure and the field in the case of suffering of the between.*

Perceptive style	**The experience of the ground**	**Excitement and growth at the contact boundary**	**The (co-created) emergent experience of the figure**	**Diagnostic feelings in the field**
Neurotic	The ground is sufficiently clear about *who feels what* and provides a *basic existential safety*. This normal condition can be experienced on a continuum which ranges from a less to a more anxious perception	The contact boundary is partly desensitized (as an effect of anxiety), some spontaneity is lost, the other (environment) cannot be reached with a good balance between active and passive presence (middle mode)	In case of desensitization of the contact boundary, the ego-function cannot deliberate in the fullness of senses: the other is not seen clearly and some figures can be predominant and not "in contact".	The field is experienced as reliable and clear, although with painful contents
Psychotic	The ground is so full of anxiety that it's difficult to see who feels what and to rely on some feeling of safety	There is no perception of the contact boundary; there is not a distinct self and a distinct environment, one cannot feel oneself-in-contact	No clear figures are possible. They are based on the need to control (paranoiac) or to suspend (depression) or to enforce (schizophrenia)	No perceived possibilities in the field to stop or calm the anxiety

			the excitement for contact	
Borderline	The ground experience is unstable and polarized: opposite (bad and good) perceptions of oneself and the other.	The contact boundary is characterized by the activity of preserving a "draft" of the sense of self, in order not to be swallowed into "fusion" with the environment and madness	The wish to overcome the unstable and contradictory sense of self and reach the other with a differentiated sense of self is the recurrent figure.	What seems stable can become unstable. The client can never be sure that the therapist is good (or bad), the therapist can never be sure that the client's (good or bad) experience will last
Traumatized/ abused	Collapsed sense of ground: mixed feelings and confusion about roles and moral aspects (nothing is sure any more); it's impossible to integrate the episode(s) and let another figure emerge	Dissociation: the self continues to exist on "another level", where the traumatic situation doesn't exist.	The traumatic figure becomes a fixed one, in a compelled way. The figure is not the solution for an intentionality for contact, it doesn't close the gestalt	Everything has to remain under control and not openly said

Traumatized/ loss	Collapsed sense of ground: sudden and uncontrolled loss of ground security	The self cannot integrate the new situation, and continues to function trying to ignore the novelty	Figures are no longer supported by habitual ground, they can be repeated (obssession) or forgotten (anaesthesia)	A void (like an air bubble)

Table 1 - – *The experience of the ground, the unfolding of self-in-contact, the figure and the field in the case of suffering of the between* (source: Spagnuolo Lobb, 2016c, p. 53).

This description can be the starting point for researches that aim to validate observational tools of clinical situations based on phenomenological descriptions both of the experience of therapist and client and of what is visible at the contact boundary.

For instance, the body evidence and the language are important tools of phenomenological reading for the therapist. A patient might define her/his experience by saying: "Your voice has entered my brain", or "That glass of water has destroyed my stomach", or "It wasn't the hero of the film who was bleeding, it was me, but you could see it on the screen", or again "When you smile I breathe easier". These examples remind us of the strict connection between perception of external and of internal in the case of psychotic experiential structures, and the body relaxation or rigidity (or even desensitization) shows the quality of this experience (with more or less anxiety). Of course, these are important aspects to orient the therapeutic intervention.

Various research projects (which for space reasons I cannot describe here) are under way in our Institute on the body experience and the verbal language of psychotic patients admitted to psychiatric emergency services[9].

The Dance Steps between Therapist and Client: The Growing Edge of Our Research

As mentioned above, due to the unfolding of societal trends, the aim of psychotherapy has changed in these last decades, and consequently we need to shift our research focus. The aim of psychotherapy (and of Gestalt therapy) today is to solve a clinical problem which has moved beyond

[9] This research is coordinated by dr. Martina Passalacqua.

supporting the possibilities of the ego in the face of imposed social rules. The clinical problem today is – on the contrary – the need to build the sense-of-being-in-contact of the client with the therapist. The therapeutic relationship must therefore provide a sense of security in the relationship and in the other, facilitating a clear perception/differentiation of a spontaneous and intentioned self. How can we trace and validate this process with research?

We need to work on relational tools that allow Gestalt therapists to focus on the between, rather than on the client (or on the therapist).

Research example. I basically popose to remove the individualistic language that is still in Gestalt therapy's categories called "losses of ego functions", by using the idea of dance, which includes the feelings and the movements of both therapist and client (Spagnuolo Lobb, 2016e; 2017a; 2017b). This perspective is in line with contemporary studies of neurosciences, intersubjective and relational psychoanalysis (Stern, 2010; Beebe and Lachmann, 2002); it also allows the therapist to stay with the spontaneity of the co-creation of the therapeutic contact (the *dance steps*), and at the same time to include developmental and psychopathological aspects of the experience (the *polyphonic development of domains*), as part of the experience of the ground.

The criteria that have led me to describe contact-making (between caregivers and child first and between therapist and client later) in dance steps are of an aesthetic and phenomenological nature: in brief, *grace* (good form), *rhythm* (emotional regulation), and *fluidity* (movements) can be our aesthetic criteria for seeing how much spontaneity or anxiety the client and the therapist experience in their contact-making. They can be research criteria for us (see PHG, 1994, p. 39; Bloom, 2003). I have described these 'dance steps' as procedural spontaneous actions of contact between the child and their caregivers (Spagnuolo Lobb, 2016c). Later, I have proposed to use them also for therapist and client contact-making (Spagnuolo Lobb, 2017 a; 2017b).

They ideally show a *sequence of contact*, but that does not mean that all the steps are always present in contact-making, nor that they always appear in the same order. Each dance is unique; it might be a dance with no recognition of each other, or with no sense of reaching each other, but it is nonetheless a dance, that can be observed or lived.

Here are the dance steps[10]:

[10] For a detailed description of dance steps see Spagnuolo Lobb, 2017 a.

- to *intuit each other/resonate with each other*
- to *perceive each other*
- to *recognise each other*
- to *adjust to one another*
- to *take bold steps together*
- to *have fun*
- to *reach each other*
- to *let oneself go to the other/take care of the other*

Table 2. shows a possible *observational tool of excitement at the contact boundary, vital competences and risks of contact-making in the caregivers/child field*.

Forms of contact co-creation	***Experienced excitement at the contact boundary***	***Vital competences***	***Risks when the contact boundary is desensitized***	***The therapist's (or researcher's) resonance***
To intuit each other/resonate with each other	To feel one's own and the other's feelings and movements in the field	Embodied empathy Being attuned	Confluence Confusion Madness	
To perceive each other	The self activates in contacting the other	To perceive with senses open Staying with the diversity of the other	It's impossible to perceive the other. The need to control the diversity of the other takes over the field.	
To recognize each other/intentional resonance	To resonate with the diversity of the other bringing one's own uniqueness in the field	To creatively differentiate from the other	It's impossible to resonate with otherness Depression	

To adjust to one another	Energy for contact is perceived in a middle mode: active and passive at the same time	To contain one's own energy and moderate it, synchronizing it with the other's energy	Rigidity Inability to negotiate one's own presence with the other's the other is either introjected or abused	
To take bold steps together	Sense of risking with the other It's possible to create a third reality together with the other	Courage Agency Capacity	To project Paranoiac experience Boredom	
To have fun	It's possible to exhale To let the control go	Trust in the world and in oneself	Control Paranoia Obsession	
To reach each other	Feeling that the tension towards the other has reached its goal	Efficacy Trust in one's own ability to reach the other To use one's own strenght at the benefit of the other	Being unsatisfied	
To let oneself go to the other/take care of the other	Feeling of being-with the other	Intimacy	To retroflect Solitude Grandiosity Egotism	

Table 2 – ***Excitement at the contact boundary, vital competences and risks of contact-making in the caregivers/child field*** **(source: Spagnuolo Lobb, 2016, p. 53).**

The tool includes a column for the therapist's or researcher's resonance, which is an important part of the field.

This phenomenological description of each step brought to a first action of the research: to define the steps in the light of caregiver/child interactions. Which specific behaviours of the caregiver and of the child correspond to each step?

In cooperation with a group of the University of Palermo, we have identified 4 behaviours of the caregiver per each step and 4 specular behaviours of the child. We have obtained 32 behaviours which are observable in the caregiver and 32 behaviours which are observable in the child. The second action is to validate the inner coherence of the steps, with the collaboration of a large group of expert Gestalt therapists. They will attribute each behavior (listed in a random list) to one step.

The third action will be in two directions: 1. a clinical use of the steps for supervision; the supervisor can use the dance steps to supervise the therapeutic situation. A clinical tool will be developed for this purpose. 2. Use of the steps for research: the researcher can use this tool to describe what happens between caregivers/child or therapist/client in different populations. For instance how the dance improves after family psychotherapy (in terms of grace, rhythm and fluidity), or how it differs in families of authistic children and in other families, or how it differs with depressive or narcissistic clients.

Table 3. shows how to gather *perceptions of the caregivers and of the researcher, and how to describe aesthetic evidence of the child in dance steps.*

Dance steps	The therapist's perception	First caregiver's perception	Second caregiver's perception	The child's aesthetic evidence	The therapist's or researcher's resonance (Aesthetic Relational Knowledge)
1 – Basic care: the caregivers are focussed on the child's need and provide containment for his/her movements					
2 – General feeling of rhythm, fluidity, grace					

3 – *To perceive each other*					
4 – *To recognize each other*					
5 - *To adjust to one another*					
6 - *To take bold steps together*					
7 - *To have fun*					
8 - *To reach each other*					
9 - *To let oneself go to the other/take care of the other*					
10 – The ground experience: anxiety, bodily and relational rigidity? Describe when and how.					
11 – Dance steps between caregivers					
12 – Dance steps between the siblings					

Table 3 – ***Perceptions and aesthetic evidence of the caregivers, child and researcher in dance steps*** **(source: Spagnuolo Lobb, 2016c, p. 61-62).**

Conclusions

In this work, I've tried to demonstrate that a knowledge which is incarnated, intentioned-to-contact and aesthetic, rooted in the unitary nature of organism/environment field, is what does most justice to our approach,

and this is the basis for our research. As Merleau-Ponty (1945) reminds us, phenomenological knowledge every time implies a "re-learning to see." In the world of phenomenology knowledge does not exclude intuition in that it emerges from perception. And, since perception is based on the senses, perception is strictly linked to aesthetic judgment.

The clinical problem that is posed to the Gestalt therapist is in line with phenomenological research, which, starting from the natural evidence, arrives at a transcendental knowledge, setting aside any judgment and letting ourselves be guided by intuition. It is also in line with pragmatism, which roots the experience in the sensation (James, 1980) and considers it to be an aesthetic process of the organism and the environment in co-creative equilibrium, gifted with grace, harmony and rhythm (Dewey, 1934)[11]. The Gestalt therapist does not intend to bring the patient to a "healthy" or "mature" standard of experience or behaviour, but to lead her/him to (re)appropriate spontaneity in making contact, to (re)acquire the fullness of her/his being-there in the contact.

The fact that we root ourselves in the *phenomenological method* (see Bloom, 2010) implies also that we work from a perspective of participation, in which the experience of the beholder cannot be excluded. To be phenomenological, any description of contact-making must consider the experience of the partners in contact. Therefore, the therapist (or researcher) must also consider their own resonance in front of the client. And what does the therapist feel? How do their respective physiological parameters regulate themselves? How does their closeness create a sense of security or tension between them?

What really interests us is the *how* of the experience. And, in this co-creation of the experience of contact, movement is fundamental[12]: it embodies the phenomenological perspective of intercorporeal experiencing (cf. Merleau-Ponty, 1945), and of the excitement-towards (cf. Heidegger, 1953), the *now-for-next* (Spagnuolo Lobb, 2013 a).

Our aesthetic attitude, as Gestalt therapists, enables us to know the other, ourselves and the field through our senses, which are the organs of perception, our contact boundary. Our sense of self is born and develops in the space between. Through the aesthetic glance we use our senses, and the related energy for contact, to focus on what makes us "vibrate" in the contact with the client. In parallel with the betweenness of Buber (1958), the focus on the other of Levinas (cfr. Levinas, Poller, 2003), and the

[11] See Bloom (2003, p. 65).

[12] See the work on basic relational movements by Ruella Frank (2001).

intersubjective play of Stern (1985), we can develop a peculiar research language related to experience and to the senses.

I would like to conclude by recalling how the founders' dream was to develop a theory and method able to grasp the vitality of human relationships. As such, it is our duty to train Gestalt therapists who are able to dance with their clients, but at the same time able to do research and engage with colleagues from other approaches.

References

Beebe B., Lachmann F.M. (2002). *Infant Research and Adult Treatment: Co-constructing Interactions*. New York: The Analytic Press.

Blankenburg W. (1998). *La perdita dell'evidenza naturale*. Milano: Raffaello Cortina Editore.

Bloom, D. (2003). "Tiger! tiger! burning bright" –aesthetic values as clinical values in gestalt therapy. In M. Spagnuolo Lobb & N. Amendt-Lyon (Eds.), *Creative license, the art of gestalt therapy, pp. 63-78*. Vienna: Springer-Verlag.

Bloom, D. (2008, July 24)). *Embodied intentionality: the engine of contact*. Paper presented at the meeting of the AAGT International 9th International Conference. Manchester, UK.

Bloom D. (2010), The Phenomenological Method of Gestalt Therapy: Revisiting Husserl to Find the Essence of Gestalt Therapy, *Gestalt Review*,13(2). 277-295.

Brownell, P. (2008). *Handbook for theory, research, and practice in Gestalt therapy*. Newcastle: Cambridge Scholars Publishing.

Brownell P. (2015). *Spiritual Competency in Psychotherapy*. New York: Springer

Buber M. (1958). *I and Thou*. New York: Scribner.

Clarkin J.F., Yeomans F.E., Kernberg O.F. (2000). *Psicoterapia delle personalitá borderline*. Milano: Raffaello Cortina Editore.

Dewey J. (1934). *Art as experience*, New York: Perigree Book

Elliott, R., Greenberg, L. S., Watson, J., Timulak, L., & Freire, E. (2013). Research on humanistic-experiential psychotherapies. In J. McLeod (Ed.), *Bergin & Garfield's handbook of psychotherapy and behavior change, 6th ed., pp. 495–538*. New York, NY: Wiley.

Feder, B. & Frew, J. (2008) (Eds.). *Beyond the hot seat revisited: Gestalt approaches to group*. New Orleans, LA: Gestalt Institute Press.

Fogarty M., Bhar S., Theiler S. & O'Shea L. (2016). What do gestalt therapists do in the clinic? The expert consensus. *British Gestalt Journal*, 25(1), 32–41.

Frank R. (2001). *Body of Awareness. A somatic and developmental approach to psychotherapy.* Cambridge, MA: Gestalt Press.

Gaffney S. (2006). Gestalt with Groups. A Cross-Cultural Perspective. *Gestalt Review*, vol. 10, n. 3, pp. 205-219.

Gallese V., Migone P., Eagle M.N. (2006). La simulazione incamata: i neuroni specchio, le basi neurofisiologiche dell'intersoggettività e alcune implicazioni per la psicoanalisi. *Psicoterapia e Scienze Umane*, XL, 3: 543-580.

Hodges, C. (2006). Commentary V: Gestalt with groups. *Gestalt Review*, 10 (3).

Husserl E. (1965). *Philosofie als strenge Wissenschaft*, Frankfurt am Main: V. Klostermann.

James W. (1980). *The principles of psychology*, Boston: Harvard University Press

Levinas E., and Poller N. (2003). *Humanism of the Other*. Urbana and Chicago, IL: University of Illinois Press.

Macaluso M.A. (2012). Oltre il modello Perls-Goodman. Dal campo organismo/ambiente al campo relazionale. Quaderni di Gestalt, XXV, 2: 67-84. DOI: 10.3280/GEST2012-002005

McLeod, J. (2013). Qualitative research: Methods and contributions. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change,* 6th ed., pp. 49–84. Hoboken, NJ: John Wiley & Sons.

Merleau-Ponty, M. (1945/2009). *The Phenomenology of perception.* Abingdon: Routledge.

Mellor-Clark, J., & Barkham, M. (2006). The CORE system: Developing and delivering practice-based evidence through quality evaluation. In C. Feltham & I. Horton (Eds.), *Handbook of counselling and psychotherapy,* 2nd ed., pp. 207-224. London: Sage Publications.

Migone P. (1996), La ricerca in psicoterapia: storia, principali gruppi di lavoro, stato attuale degli studi sul risultato e sul processo, *Rivista sperimentale di freniatria*, CXX, 2: 182-238.

Palmieri, G., Evans, C., Hansen, V., Brancaleoni, G., Ferrari, S., Porcelli, P., & Rigatelli, M. (2009). Validation of the Italian version of the clinical outcomes in routine evaluation outcome measure (CORE- OM). *Clinical Psychology & Psychotherapy, 16*(5), 444-449.

Perls F. (1942/1947/1969a). *Ego, hunger and aggression: A revision of Freud's theory and Method.* London: G. Allen & Unwin, 1947/New York: Random House, 1969.

Perls F., Hefferline R., & Goodman P. (1994, ed. or. 1951). *Gestalt therapy: Excitement and growth in the human Personality.* New York: The Gestalt Journal Press.

Philippson P. (2001). *Self in relation.* Highland, NY: Gestalt Journal Press.
Philippson P. (2017). Three levels of training. *British Gestalt Journal*, 26(1), pp. 3-6.
Robine J.M. (Ed.) (2016). *Self. A poliphony of contemporary gestalt therapists.* St. Romain la Virvée (France): L'Exprimerie
Romano F. (2016). Organizational well-being and vitality of the working group: A qualitative study on a business consultation model. In J. Roubal (Ed.). *Towards a research tradition in gestalt therapy, pp. 366-379.* Cambridge Scholars Publishing.
Rubino V., 2008. Sulle tracce dell'empatia: Una visione gestaltica e neuroscientifica rivolta al cuore della relazione. *Idee in Psicoterapia.* 1.3:41-49.
Sandell, R. (1997). *Rating the outcomes of psychotherapy or psychoanalysis using the change after psychotherapy scales (CHAP): Manual and commentary.* Stockholm: Stockholm County Council Institute of Psychotherapy and Karolinska Institute.
Settanni M., Francesetti G., Guerri E. and Spagnuolo Lobb M. (2017). A new instrument to assess the effects of Gestalt Therapy training: The CHange After Therapy Interview. Lecture presented at the EAGT-AAGT Research conference "Exploring practice-based Research in Gestalt-therapy," Paris, May 26-28, 2017.
Spagnuolo Lobb M. (1992 a). Childbirth as re-birth of the mother. A psychological model of training for childbirth by the gestalt therapy approach. *The Gestalt Journal*, 15(1), pp. 7-38.
Spagnuolo Lobb M. (1992b). Training in gestalt therapy. How the perspective of dental aggression changes the traditional concept of training. *Studies in Gestalt Therapy*, 1, 43-51.
Spagnuolo Lobb M. (2007). Ego, hunger and aggression: Do we bite in the same way as in the 50s? A contribution to the development of the concept of aggression in gestalt therapy theory and practice. *Gestalt Review*, 11(3), 239-243.
Spagnuolo Lobb M. (2012a). Il now-for-next nella psicoterapia di gruppo: la magia dello stare insieme. Un modello di intervento gestaltico nei gruppi. *Quaderni di Gestalt*, XXV/1: 51-62.
Spagnuolo Lobb M. (2012b). La psicoterapia della Gestalt con i gruppi. Dall'esperimento di Perls in California alla scelta politica del New York Institute, fino alle moderne applicazioni. *Quaderni di Gestalt*, XXV/1: 37-50.
Spagnuolo Lobb M. (2013 a). *The now-for-next in psychotherapy. Gestalt therapy recounted in post-modern society.* Siracuse: Istituto di Gestalt HCC Italy Publ. Co.

Spagnuolo Lobb M. (2013 b). From the need for aggression to the need for rootedness: A gestalt postmodern clinical and social perspective on conflict. *British Gestalt Journal*, 22(2), 32-39.

Spagnuolo Lobb M. (2013c). Goodbye to Daniel Stern (1934-2012): A genious who confirmed gestalt therapy from the outside. *British Gestalt Journal*, 22(1), 5-11.

Spagnuolo Lobb M. (2014). Aggression and conflict in post modem society and in psychotherapy. In D. Bloom & B. O'Neill (Eds.). *The New York institute for gestalt therapy in the 21st century. An anthology of published writings since 2000, pp. 109-124.* Wollongong, Australia: Ravenwood Press.

Spagnuolo Lobb M. (2016 a). Stress and organizational well-being. A gestalt organizational consulting method supported by grounded theory. In J. Roubal (Ed.) *Towards a research tradition in gestalt therapy, pp. 161-176.* Newcastle upon Tyne: Cambridge Scholars Publishing.

Spagnuolo Lobb M. (2016 b). Researching in gestalt therapy: A way for developing our model. In J. Roubal (Ed.) *Towards a research tradition in gestalt therapy, pp. 46-55.* Newcastle upon Tyne: Cambridge Scholars Publishing.

Spagnuolo Lobb M. (2016c). Gestalt therapy with children. Supporting the polyphonic development of domains in a field of contacts. In M. Spagnuolo Lobb, N. Levi, A. Williams (Eds.). *Gestalt therapy with children. From epistemology to clinical practice*, pp. 25-62. Siracuse: Istituto di Gestalt HCC Italy Publ. Co.

Spagnuolo Lobb M. (2016 d). Psychotherapy in post modem society. *Gestalt Today Malta.* 1(1), 97-113.

Spagnuolo Lobb M. (2016e). Self as contact, contact as self. A contribution to ground experience in Gestalt Therapy theory of self. In J.M. Robine (Ed.). *Self. A poliphony of contemporary gestalt therapists, pp. 261-289.* St. Romain la Virvée (France): L'Exprimerie.

Spagnuolo Lobb M. (2017 a). From losses of ego functions to the dance steps between psychotherapist and client. Phenomenology and aesthetics of contact in the psychotherapeutic field. *British Gestalt Journal*, 26(1), 28–37.

Spagnuolo Lobb M. (2017b). Phenomenology and aesthetic recognition of the dance between psychotherapist and client: a clinical example. *British Gestalt Journal*, 26(2), pp. 50.56.

Spagnuolo Lobb M. (forthcoming). Aesthetic relational knowledge of the field: A revised concept of awareness in gestalt therapy and contemporary psychiatry. *Gestalt Review*, np.

Spagnuolo Lobb M., Stern D.N., Cavaleri P., Sichera A. (2009). "Key-

moments" in psicoterapia: confronto tra le prospettive gestaltica e intersoggettiva. *Quaderni di Gestalt*, XII, 2: 11-29.

Spagnuolo Lobb M., & Cavaleri P. A. (2010). Intenzionalità. *Gestaltpedia.* http://www.gestalt.it/gestaltpedia/doku.php?id=intenzionalita

Spagnuolo Lobb M., Conte E., & Mione M. (2017), La scheda clinica gestaltica: presentazione di uno strumento di lavoro. *Quaderni di Gestalt*, vol. XXX, n. 2.

Spector T. (2013). *Uguali ma diversi. Quello che i nostri geni non controllano.* Torino: Bollati Boringhieri.

Stem D. N. (1985). *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology.* New York: Basic Books.

Stem D. N. (2010). *Forms of Vitality. Exploring Dynamic Experience in Psychology and the Arts.* USA: Oxford University Press.

Stem D., Bruschweiler-Stem N., Harrison A., Lyons-Ruth K., Morgan A., Nahum J., Sander L., Tronick E. (2003). On the other side of the moon. The import of implicit knowledge for gestalt therapy. In M. Spagnuolo Lobb & N. Amendt-Lyon (Eds.), *Creative license: The art of gestalt therapy,* Vienna and New York: Springer, 21-35.

Stevens, C., Stringfellow, J., Wakelin, K., & Waring (2011). The UK gestalt psychotherapy CORE research project: The findings. *The British Gestalt Journal, 20*(2), 22-27.

Wheeler, G. (2000). *Beyond individualism: Toward a new understanding of self, relationship, and experience.* Hillsdale, NJ: The Analytic Press.

Wheeler G. (2006). New directions in Gestalt theory and practice: Psychology and psychotherapy in the age of complexity. *International Gestalt Journal.* 29(1), 9-41.

Yontef G. M. (2005). Gestalt therapy theory of change. In A. Woldt & S. Toman (Eds.). *Gestalt therapy: History, theory, and practice,* Thousand Oaks, CA: Sage, 81-100.

CHAPTER SEVENTEEN

TEACHING AND CONDUCTING GESTALT RESEARCH IN HONG KONG

TIMOTHY YUK KI LEUNG
AND GRACE SUK MAN LEUNG

Gestalt therapy was understood by Perls, Hefferline & Goodman as the "science and technique of figure/background forming in the organism/ environment field" (1951/1994, p. 250). Use of Gestalt therapy in counselling practice requires the learning of skills, the philosophical background of the modality, and the development of the self of the counsellor living in the here and now, with an awareness of the interruptions in the field that inhibit the person from living in full contact with the environment. Indeed, Gestalt therapy is an approach difficult to be taught by transmission of knowledge through classroom teaching, as it requires not just an understanding of theoretical concepts but the practitioner's readiness to live out its values as a way of being. Further, Gestalt practices require improvisation between the therapist and the client in development of experiments to enhance the awareness of one's interruptions in contact with the environment. In this chapter, we will describe and discuss the various methods that we have utilized in training counsellors and social workers in Hong Kong to use the Gestalt therapy.

In Hong Kong, there is no statutory license system for counsellors and therapists, and the government subvented social workers and clinical psychologist stationed in government and NGO family service centres to provide counselling and family support services. Thus, subvented social workers provide the majority of its counselling services. There is also a sector of counsellors providing fee-charging counselling services. Thus, we would like to share our experiences in the promotion of Gestalt therapy among helping professionals in Hong Kong through our teaching and research.

Gestalt therapy was introduced systematically in Hong Kong in the late eighties and early nineties of the last century, by the regular visits of Dr. Paula Bottome, who was under the tutelage and direct supervision of Fritz Perls and Laura Perls. She came regularly each year for more than a decade and was one of the founders of the Gestalt Institute for Self-Development and Training (GIST) in Hong Kong in the 1990s. Throughout these years, a number of Gestalt therapists were trained, and they have since practiced Gestalt therapy in Hong Kong. In the past decades, we have explored different approaches in training and teaching Gestalt therapy to social workers and counsellors in the city.

Teaching the Gestalt Approach in University Courses

As some GIST members are faulty members of the Chinese University of Hong Kong, the Hong Kong Polytechnic University, and the University of Hong Kong, lectures on Gestalt therapy have been incorporated in the syllabus of clinical social work practice and counselling courses in Hong Kong universities, introducing social workers in training about basic concepts of Gestalt therapy. Yet, we found that although the sharing of cases and concepts about Gestalt therapy could be conducive to their work, they would not necessarily understand what Gestalt really is. Thus, experiential learning workshops were held for students to experience at first hand the process of Gestalt work. Such drills as the empty chair and awareness forming are difficult to be understood unless one has the chance of direct observation and participation in the Gestalt work. As a module in the university curriculum, it provides an additional advantage, i.e. that we can request participants to write reflective journal or papers about their observations of the Gestalt work in workshops, thereby helping them to integrate theory with practice. Past students found the process of writing their understanding of their Gestalt work useful in combining theory and practice. In addition, some students have written essays about the use of gestalt therapy in groups as well as with various target groups. This writing process is vital for their learning of concepts about Gestalt therapy.

Use of Intensive Residential and Marathon Workshops

Through the establishment of GIST, regular workshops on Gestalt therapy were held regularly so that counsellors and social workers had chances to learn Gestalt therapy. We found that the provision of intensive workshops/camps would be helpful. First, they provide chances for observing the Gestalt work in group setting and the work of the therapists

in using Gestalt therapy in actual practices. For Gestalt approach is best learnt through actual work rather than by role-play. Further, students found that they were able to observe how the worker followed the pace of the client as regards the exploration and improvisation of experiments for various participants, as we tend to conduct Gestalt work for four to five participants in a day. Third, they provide opportunities for workers to work on their own issues and to experience the Gestalt process at first hand. Fourth, we tend to have debriefing sessions at the end of the workshop, so that participants can ask questions related to practice and concepts about Gestalt therapy, enhancing their learning; and they can ask questions about the process in the morning. Fifth, we would conduct mindfulness sessions at evening time by another experienced Gestalt therapy practitioner or trainer, enhancing the awareness of bodily sensations through mindful stretching, walking and even dancing. We found that facilitating the sensitivity of counsellors about their bodily sensations would enhance their awareness and their ability to understand themselves and their clients.

In the process of training workers, we found that intensive workshops would not be adequate to equip them to practice Gestalt therapy. In addition, we have organized training groups for experienced practitioners with longer durations of training and for those who already had more intense instruction in the nineties.

Use of Videotape in Teaching the Gestalt Approach

We have utilized videotaping to record the Gestalt work in training workshops. We would review the tape together with the protagonists and the facilitators-in-training about their work. This process of self-observation through watching their videotapes was particularly helpful in assisting members to recognize their interruptions in stopping themselves from contacting with the environment, such as gritted teeth, bitten nails, clenched fists, and even speaking in a tight voice with shallow and constricted breathing. Simultaneously, the participants would have deeper resonance to the feedback from their peers, for they were able to see themselves what had happened in the process. Yet, it requires the development of trust and security in the learning group so that members feel safe to share and learn to give and receive feedback from one another. Thus, we utilized a small group format in training and the group size would not be greater than sixteen members.

Reading Relevant Gestalt Literature

Even though we say that Gestalt must be learnt through direct experiences, we found that asking participants to read relevant literature is helpful. Apart from a reading list, we would tailor the reading to the specific needs of the participants. For instance, we would ask the trainees interested in integrating Gestalt therapy with children to read Oaklander's work (Oaklander et al 2003); or reading Tilda Norberg's *Consenting to Grace* if he or she is interested in using Gestalt under pastoral setting (Norberg, 2006). For one who is interested to integrate Gestalt with the object relation approach, we would recommend the trainee to read Gilles's book, *Object Relation in Gestalt Therapy* (Gilles, 2013).

Recently, we have started experimenting the idea of digital learning, developing an electronic reference database so that learners can read articles and even write their notes on essays and references beside the essay. Yet, this is at the beginning phase and we would explore ways to enhance participation of members.

Maintaining Exchange and Dialogue with Overseas Gestalt Practitioner

Through the connection of Paula, we have established connections with Gestalt therapists in Japan and the United States; we also conducted joint Gestalt workshops with facilitators from these places in San Francisco in 2000, Hong Kong in 2006 and 2017, Japan in 2010, and in Long Island in 2011. One thing that we learnt much from these experiential workshops is that they have provided chances to observe Gestalt work by working with people from different cultures and ethnicities. Second, they provided opportunities for participants to have their own work by different therapists speaking different languages. Yet, such workshops require simultaneous translation, and the costs would be high, thus limiting the frequency of these workshops. Further, the number of participants has to be limited so that the workshop can still be manageable in operation and in the development of trust and cohesion. Usually, we would have large group session for all participants and have them divided into parallel groups after the common session. Running Gestalt workshops with participants from Japan and Hong Kong together with the support of simultaneous translation was a wonderful experience, as it expanded the horizon for members from different cultures, expanding awareness about how culture and the field affects our contact process.

In recent years, we have also invited such Gestalt therapists as Dr. Rieko Tawara (Japan), Dr. Philip Brownell (USA), and Dr. Margherita Spagnuolo Lobb (Italy) to Hong Kong to conduct workshops and seminars on Gestalt therapy, which introduced recent developments of Gestalt therapy, such as Gestalt work with people having addiction as well as phenomenology and Gestalt therapy. We have also experimented the idea of running workshops utilizing both Gestalt therapy and psychodrama together.

Using Long-Term Gestalt Growth Groups

Apart from utilizing Gestalt therapy in cases and workshops, we have experimented with the idea of running long-term growth groups for counsellors and social workers. The group was recruited on a yearly basis in which members would commit for a year with regular sessions so that they had chances to observe and experience the long-term impact of Gestalt approach. In addition, they were able to work on their own issues at their own pace. Outcome study was also implemented to study the effectiveness of the group. Further, the group process would be audiotaped or videotaped for reflection and review by members. The group, for its part, utilized a closed group format with 12 to 13 members conducted by one to two facilitators. After the completion of the year group, members could choose to join for another year, or to terminate if they felt that their issues had been resolved. The members enjoyed the group process. Till now, this training format using the long-term growth group model has been a success so far as the responses from the participants (in terms of quantitative and qualitative feedback) are concerned. Yet, one disadvantage is that new members have to wait for two or three years to join the group because the turnover rate is low. Apart from enhancing personal growth, the group also provides a platform for members to learn more about Gestalt approach. Another advantage of long-term groups is that it allows members to experience the paradoxical process of change as described by Beisser (1970): that change starts to occur when we are what we are, without trying to change who we are. The long-term group allows members the space to live with the struggles and polarities, and even to experience the pain and anguish instead of forcing oneself to be positive and to let go. Further, as warned by Polster and Polster, Gestalt experiments "must not become palliative or a substitute for valid engagement" (Polster & Polster, 1973, p. 235). The long-term group facilitates members to experience Gestalt work, and experiments must be conducted under strong and genuinely caring relationship between therapists and clients.

Using Publications to Promote Gestalt Therapy

We have also produced various publications on Gestalt therapy: the first author of this chapter has published a book, *Gestalt as a Way of Being*, which introduces the Gestalt approach through essays using the Gestalt perspective on such topics as death, anxieties, bodily awareness, sadness, anger, sickness, and interruptions (Leung, 2012). The format utilizes the essay form, with each topic lasting about a thousand words sharing stories and experiences in Gestalt workshops and counselling about the topic. The aim is to promote Gestalt therapy in the society and to provide an alternative means for helping professionals to understand the Gestalt approach. Further, we have produced a training manual for internal use in GIST so as to train Gestalt practitioners in Hong Kong. Bottome and Gardner, for their part, have published *Gestalt awareness: A photo essay* (Bottome & Gardner , 1996) to promote and introduce the Gestalt approach. In her book– *Completing the Circle: Taking Gestalt to Asia* (Bottome, 1997)– Bottome used a journal log format to record her experiences and reflection in doing Gestalt work with Asians in the nineties. Through these endeavors, we hope to expand the horizon and perspectives of therapists, counsellors and social workers interested in using the Gestalt approach in their work.

Research

There exists a need to collect empirical evidence on the efficacy and effectiveness of our clinical interventions. The evidence collected, on one hand, can inform and refine our practice. On the other hand, it makes our profession accountable because our practice is grounded in evidence. The belief in evidence-based practice supports the building of a research component in the gestalt intervention projects in Hong Kong. Here we would like to report a few research studies conducted by members of GIST in Hong Kong over the past decade.

Gestalt Workshops for Helping Professionals

The GIST conducted in total, over the period, four gestalt workshops for social workers, psychologists, and clinicians. The workshops were in the format of residential camps, and each workshop lasted for 18 hours. The objectives of the workshops were to enhance the self-awareness of the helping professional and to assist them to work through their own psychological and emotional blockages. It is believed that the helping

professionals would then be able to have genuine contact with service-users if their blockages had been overcome.

The study used a pre- and post-test design in which the participants were invited to fill in the questionnaire before and after the Gestalt workshop (G. S. M. Leung, Leung, & Ng, 2013). Two measures were used: The Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983), and the State Hope Scale (Snyder et al., 1996). The analysis of data from 55 participants indicated that there was a decrease in the levels of anxiety and depression, and there was an increase in both dimensions of State Hope Scale–sense of agency and hope pathways. The *Cohen's d* revealed that the intervention was of a medium effect size.

Gestalt Growth Groups

The GIST conducted marathon Gestalt growth groups for social workers and allied professionals. The two objectives are to assist the participants to have personal transformation through working on their past hurts and traumas; and to enhance participants' understanding of Gestalt therapy. The group started in 2013 with regular monthly meetings or whole-day sessions in the year. A qualitative approach using in-depth interviews was used to solicit participants' feedback. In the preliminary analysis, the participants commented that, with the support of the facilitator, they were able to get in touch with their emotional pain. They gained knowledge of their own needs and had improvement in their mental well-being.

Gestalt Group Intervention for Anxious Parents and Children

The project was funded by the Quality Education Fund of the Hong Kong Special Administrative Region. The Gestalt groups, launched in eleven primary schools, were targeted at anxious parents and children. The objective of the parent group was to enhance parents' contact and acceptance of anxiety by encouraging self-awareness and self-kindness. Each group had four sessions and each session lasted for two hours. The study used a non-randomized control group with a pre- and post-test design, with 76 parents in the experimental group and 80 in the control group (G.S.M. Leung, Khor, Yip, & Wong, November, 2013; G.S.M. Leung & Khor, 2017). The measures used were as follows: Zung Anxiety Self-Assessment Scale (Zung, 1971), Acceptance and Action Questionnaire (Hayes et al., 2004), Self-compassion scale – the self-kindness and self-judgment dimension (Neff, 2003), and Five Facet Mindfulness Questionnaire

(Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006). Comparing the post-group findings of the experimental and control group, it was revealed that the participants in the experimental group had less anxiety and more self-kindness and showed a decrease in avoidance of uncomfortable internal experience as well as an increase in levels of mindfulness. The *Cohen's d* results indicated that the effect sizes were within small range.

Gestalt group for anxious grade 3-5 children were conducted in eleven primary schools. The goal of the children group was to enhance children's awareness and expression of anxious emotions. The group consisted of six one-and-a-half-hour sessions. The selection of participants for the experimental and control groups was not randomized because the school personnel would like children with high levels of anxiety to join the experimental group (G. S. M. Leung, June, 2016). There were 75 children in the experimental group and 85 children in the control group. The measures used were as follows: Screen for Child Anxiety Related Emotional Disorders (Su, Wang, Fan, Su, & Gao, 2008); Emotion Expression Scale for Children (Penza-Clyve & Zeman, 2002); Subjective Happiness Scale (Lyubomirsky & Lepper, 1999), and Rosenberg Self-esteem scale (Rosenberg, 1965). At the pre-group stage, children in the experimental group had– both of statistically significance–higher levels of anxiety and lower levels of self-esteem than those of the control group. At the post-group stage, there were no difference in both groups in these two aspects.

Indeed, research studies were combined with teaching and training of participants using Gestalt therapy. Apart from conducting process and outcome studies, experiential workshops were conducted to acquaint social workers with the Gestalt concepts. The participants in the workshops had a chance to be engaged in Gestalt chair work. To facilitate the learning of gestalt approach, the school social workers were invited to observe the group process while the facilitators were conducting the groups in schools; and debriefing were conducted to clarify the Gestalt concepts and skills used after each group session.

Conclusion and Future Directions

The challenge of Gestalt practitioners/researchers in Hong Kong, however, is to promote and implement more practice research studies that can demonstrate the process and effectiveness for the holistic, process-orientated phenomenological Gestalt approach but are, all the same, sufficiently robust to demonstrate efficacy in the contemporary evidenced-based practice context. Further, we need to establish stronger connections and dialogue with other Gestalt practitioners/researchers in the world. This

would enable us to maintain contacts and continue to learn from the global Gestalt community.

References

Baer, R. A., Smith, G. T., Hopkins, J., Krietemeyer, J., & Toney, L. (2006). Using self-report assessment methods to explore facets of mindfulness. *Assessment, 13*, 27-45.

Beisser, A. R. (1970). The paradoxical theory of change. In J. Fagan & I. Shepherd (Eds) *Gestalt therapy now: Theory, techniques, applications*, pp. 77–80. Palo Alto, CA: Science and Behaviour.

Bottome, P., & Gardner, S. (1996). *Gestalt awareness; A photo essay.* Tokyo: Gestalt Network Pacific Rim.

Bottome, P. (1997). *Completing the circle: Taking gestalt to Asia.* San Francisco, CA: Clear Glass Press .

Delisle, G. (2013). *Object relations in gestalt therapy*. London: Karnac.

Hayes, S. C., Strosahl, K., Wilson, K. G., Bissett, R. T., Pistorello, J., Toarmino, D., . . . Mccurry, S. M. (2004). Measuring experiential avoidance: A preliminary test of a working model. *The Psychological Record, 54*, 553-578.

Leung, G. S. M. (June, 2016). *Facilitate emotional expression: Gestalt play therapy group for anxious children in schools.* Paper presented at the Joint World Conference on Social Work, Education, and Social Development, Seoul, Korea.

Leung, G. S. M., & Khor, S. H. (2017). Gestalt intervention groups for anxious parents in Hong Kong: A quasi-experimental design. *Journal of Evidence- Informed Social Work, 14*(3), 183-200. https://doi.org/10.1080/23761407.2017.1311814

Leung, G. S. M., Khor, J. S. H., Yip, I. S. K., & Wong, K.K. W. (November, 2013). *With mindfulness and compassion, I stay with my anxiety.* Paper presented at the the Asia Mental Health Conference 2013, Hong Kong, China.

Leung, G. S. M., Leung, T. Y. K., & Ng, M. L. T. (2013). An outcome study of gestalt-oriented growth workshops. *International Journal of Group Psychotherapy, 63*, 117-125.
doi: http://dx.doi.org/10.1521/ijgp.2013.63.1.117

Leung T. Y. K. (2012) *Gestalt as a way of being*. Beijing:Chemical Industry Press (CIP). (Translated into Chinese by Longdi and Yau Kwok Wai)

Lyubomirsky, S., & Lepper, H. S. (1999). A measure of subjective happiness: Preliminary reliability and construct validation. *Social Indicators Research, 46*, 137-155.

Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self and Identity, 2*, 223-250.

Norberg Tilda. (2006). *Consenting to grace: An introduction to Gestalt pastoral care.* Staten Island, NY: Penn House Press.

Oaklander, V., Carlson, J., Keat, D. B., Governors State University. Communication Services., (2003). *Gestalt therapy with children.* Allyn and Bacon.

Penza-Clyve, S., & Zeman, J. (2002). Initial validation of the emotion expression scale for children (EESC). *Journal of Clinical Child and Adolescent Psychology, 31*, 540-547.

Perls, F. (1969). *Gestalt therapy verbatim.* Moab, AZ: Real People Press. Perls, F. (1973). The gestalt approach & eye witness to therapy. Palo Alto, CA: Science and Behavior Books.

Perls, F. S., Hefferline, R. F., & Goodman, P. (1951/ 1994). *Gestalt therapy–Excitement and growth in the human personality.* New York: Vintage Books.

Polster E., & Polster M. (1973). *Gestalt therapy integrated: Contours of theory and practice.* New York: Vintage Books.

Rosenberg, M. (1965). *Society and the adolescent self-image.* Princeton, N.J.: Princeton University Press.

Snyder, C. R., Sympson, S. C., Ybasco, F. C., Borders, T. F., Babyak, M. A., & Higgins, R. L. (1996). Development and validation of the state hope scale. *Journal of Personality and Social Psychology, 70*, 321-335.

Su, L., Wang, K., Fan, F., Su, Y., & Gao, X. (2008). Reliability and validity of the screen for child anxiety related emotional disorders (SCARED) in Chinese children. *Journal of Anxiety Disorders, 22*, 612-621.

Zigmond, A. S., & Snaith, R. P. (1983). The hospital anxiety and depression scale. *Acta Psychiatrica Scandinavica, 67*, 361-370.

Zung, W. W. K. (1971). A rating instrument for anxiety disorders. *Psychosomatics, 12*, 371-379.

CHAPTER EIGHTEEN

TEACHING AND CONDUCTING GESTALT RESEARCH IN RUSSIA

ILLIA MSTIBOVSKYI AND MARINA ARALOVA

A Bit of History

At the time Gestalt therapy in Russia appeared, there was a unique situation about mental health counseling and psychotherapy. The atmosphere was fresh and enthusiastic on the background of more than half a century of isolation and lack of contacts with the international psychotherapist community in the Soviet times. This revival was facilitated by the cultural and social situation in the late 80s of the last century with its outburst of energy and susceptibility to new aspirations for the future.

Many people in Russia developed a colossal interest in psychology, self-knowledge, learning how to help other people cope with their problems. Therefore, the humanistic values of the Gestalt approach, its simplicity and clarity, variety of methods and creativity have found a wide response. The Russian mentality was close to integrating aspects of western and eastern philosophy thanks to Russia's multinationality and Eurasian geographical position. The principle of "here and now" opened up the opportunity to live not so much in the past and the future, which is more characteristic of Soviet ideology, but primarily in the present. Seeking oneself, increasing awareness and responsibility for one's life corresponded to challenges and opportunities which appeared in this transitional time.

The unprecedented general upsurge of culture in Russia at the end of the last century created an enabling field for including modem psychotherapy into it. In our opinion, in Gestalt therapy in Russia there is a number of substantial advantages, compared to approaches and practices competing with it, but those advantages are still not used to the full extent. These include possibility of applications in clinical practice, development of existential and dialogical aspects of the approach, its integrative potential, as well as the interest of therapists in conducting efficacy research.

The Gestalt therapy best corresponds to such features of Russian mentality as craving for sincere communication, search for depth and meaning, creativity, use of both philosophy and art, desire for freedom and self-realization, and a large amount of people doing "physics" (i.e., exact sciences) who are passionate about "lyrics" (i.e., humanities).

Currently, the development of the Gestalt approach in Russia and its struggle for the potential clients' attention continue. Therefore, it would be very important to have clear evidence of the efficacy of Gestalt therapy and to be able to promote it among psychology and psychotherapy practitioners, as well as all those who are interested in modern psychology. And there are quite a few of them in contemporary Russia.

Undoubtedly, during this time Gestalt therapy in Russia won one of the leading positions among a variety of psychological approaches. Often it is naturally integrated with body therapy, psychodrama, art therapy, psychosynthesis, family therapy and other leading psychotherapeutic trends. At the same time, competing with them, Gestalt therapy urgently needs a clear indication of its features, advantages, boundaries and development prospects.

Gestalt Institutes

Current state and trends in development, training, theory and practices of Russian Gestalt therapy are associated with several large Gestalt institutes which are considered as recognized authorities in this sphere, as well as a variety of small psychological centers and a large and constantly reinforced army of private practicing Gestalt therapists. There is a gradual expansion of use of Gestalt therapy in areas of personal development, clinical practice, social work. Programs and methods of teaching, as well as requirements for the level of qualification of certified Gestalt therapists are being constantly improved.

Four leading Russian Gestalt institutes are united into the Association "Federation of Russian speaking Gestalt Institutes" (ARGI). They include the largest Moscow Gestalt Institute (MGI); the big-sized Moscow Institute for Gestalt and Psychodrama (MIGP), the latter being the place where the authors of this chapter have been collaborating as trainers, supervisors and regional leaders for many years; Gestalt Institute of St. Petersburg (SPbIG), which is a unique institute in Russia to receive accreditation from the EAGT and EAP; Moscow Institute for Gestalt Therapy and Consulting (MIGTIC).[1]

[1] Websites of these main Russian Gestalt institutes: www.gestalt.ru, www.migip.ru, www.gestalt.spb.ru, www.gestalt-therapy.ru

Historically, MGI was the first to emerge. The relations between these four institutes, in our opinion, are characterized as mutual understanding, as well as competition in many regions of the country, where several institutes are represented simultaneously.

At present, the main Russian Gestalt institutes are among the largest in the world. It is impossible not only to describe, but even to imagine the number and variety of annual activities conducted by them: educational programs, clinical seminars, personal development workshops, therapeutic groups, conferences, residential workshops, collections of articles etc. So, nowadays MGI has more than 300 trainers (including leading and associated trainers), MIGP has regional representations in about 40 largest cities of Russia and the countries of the former USSR, leaders of SPbIG are the authors or editors of a number of basic books on Gestalt therapy in Russian, which have preserved their unchanged popularity for many years (Lebedeva & Ivanova, 2005 and other).

Each of these institutes represents a strong Gestalt therapy school with its traditions, special methods and approaches, theoretical views and areas of practical interests, and these schools, in addition, continue to thrive. Thanks to the versatile interaction between the leaders of these institutes, in particular within the framework of ARGI, there is an exchange of experience and latest achievements, uniform policy of educational activity and a tendency to develop the Gestalt approach.

All these institutes are well integrated into the international Gestalt community. Over the past years they have been actively cooperating with Gestalt Associates Training Los Angeles (GATLA), the French Gestalt Institute (IFGT), the École Parisienne De Gestalt (EPG) and many others.

The works of the leaders of Russian Gestalt therapy are well-known in the international Gestalt community. Eg., the rector and founder of MIGTIC Oleg Nemirinskiy is a recognized specialist in the field of clinical Gestalt therapy both in Russia and in the West, being the author of a chapter in the famous Gestalt therapy handbook on psychopathology (Nemirinskiy, 2013). The founder and rector of MIGP Nifont Dolgopolov was an international trainer (member of the GATLA Faculty), author of numerous books and articles, author of the unique and efficient method "Futuropraktika", combining Gestalt approach with psychodrama (Dolgopolov, 2015). The founder and leader of MGI Daniil Hlomov is international trainer and author of "The dynamic concept of personality in Gestalt therapy" (Hlomov & Kaliteevskaya, 2008), Natalya Kedrova from MGI, also standing at the source of Gestalt in Russia, is well known for her remarkable works in the field of Gestalt therapy with children (Kedrova, 2015).

In the Russian-speaking Gestalt community there are many distinctive authors. Their non-exhaustive list, besides the above-mentioned authors, includes the following names of MIGIP trainers: Andrey Gronsky, Rimma Efimkina, Victoria Dubinskaya, Maria Lekareva, Illia Mstibovskyi, Marina Aralova, Marina Myasnikova, Vyacheslav Ilyin; of MGI: Elena Kaliteevskaya, Konstantin Korolyov, Elena Mazur-Maretskaya, Alexander Mokhovikov, Natalya Olifirovich, Igor Pogodin, Alexander Tenkov, Denis Hlomov, Irina Fedorus, Vladimir Filipenko; of SPbIG: Natalya Lebedeva, Elena Ivanova, Anna Lebedeva (Ritter), Dmitry Ovechkin, Alexey Yakovlev; of MIGTIC: Irina Bulyubash, Irina Zakharyan, Olga Silnova, Boris Zelikson, Elena Lasaya, Vadim Grechka, Sergey Serov.

Many participants from Russia have been at the latest conferences on Gestalt therapy in Taormina in 2016 and on research in Gestalt therapy in Paris in 2017. And although not many of them were speakers and leaders of workshops, the works of Maria Lekareva, Natalya Kedrova and Polina Egorova, Oleg Nemirinskiy, Illia Mstibovskyi have never failed to generate interest.

The picture of how Gestalt therapy is taught and conducted in Russia would be incomplete without mentioning the relatively small Gestalt institutes and their leaders. Among them there is Integrative Gestalt Training Institute (IGTI) under the direction of Elena Petrova and the East European Gestalt Institute (VEGI) and its leader Konstantin Pavlov in St. Petersburg, Moscow Psychological Centre "Youcanlive" (Yulia Filatova and Svetlana Remizova), Southern Regional Gestalt Institute (SRGI) in Rostov-on-Don and its founder, director Marina Aralova, Russian School of Gestalt in Taganrog and its founder and director Marina Perepelitsyna.[2]

Of course, any Gestalt institute or a regional representation of a large institute serves not only as a methodical, theoretical, publishing, organizational center, but also as a center for practical work of Gestalt therapists, supporting them with their brand, supervision, advertising and continual professional development.

The Russian Gestalt is a whole world, with its countries, peaks, seas and rivers, cities and villages, living its own life, which is waiting for its discovery, exploration, and research.

[2] Websites of these Gestalt institutes: www.gestalttrening.ru, www.vegi.ru, www.youcanlive.ru, www.gestalt-don.ru, www.gestalt-taganrog.ru

Overview of Efficacy Research in the Field of Gestalt Therapy Held in Russia

At the moment in Russia there are very few completed researches. All of them use the group mode consisting of the main (experimental) and comparative (control) groups, and sometimes of the main group only, for which group sessions on Gestalt therapy are conducted.

As a rule, these researches are performed on the basis of large state clinics, but there are cases when the Gestalt institutes serve as the basis. The researchers are Gestalt therapists belonging to or cooperating with the leading Gestalt institutes, named above. Among them there are both professional psychologists and professional physicians, who determine not only psychological but also medical orientation of some research. Most of the studies conducted are used for submitting a thesis for a scientific degree (PhD).

These researches use methods and instruments well-known throughout the world, as well as those created and tested in Russia, but not translated into other languages. For the processing of results, a wide variety of methods of statistical analysis is used.

The efficacy of Gestalt therapy was not measured through conventional measures related to various forms of Effect size, but with the help of measures that meet the goals of each research. Only one of the studies we found in available sources was conducted on the basis of a large state institution and used the RCT methodology.

A lot of research has been devoted to the influence of Gestalt therapy on the key factors of human psychology: aggressiveness, sexuality, I-concept. Others have focused on the efficacy of Gestalt therapy in the treatment of patients with various disorders: depressions, gastrointestinal disorders, neurotic and stress-related ones.

Depending on the purpose of the research, the form of Gestalt therapy was either individual work, which had specific features corresponding to its goal, or a specially developed training program for group work.

More information about these studies is given below. This section presents the largest studies in the field of Russian Gestalt therapy, found in available sources.

The Research of Change of I-concept Under the Influence of Gestalt Therapy

In the PhD thesis of Maria Lekareva, co-founder of MIGP, chief of the Faculty of Gestalt therapy MIGP, the subject matter for the research was

the change of I-concept of psychology students in the process of their learning the foundations of Gestalt therapy within the specially designed educational program (Lekareva, 1999).

The first unit of this program was dedicated to awareness of the I-concept for the group members, in particular, self-attitude and all its components: self-esteem, self-acceptance, self-interest, disposition to self-blame, self-confidence, etc. This unit contained procedures and exercises designed to focus the participants' attention on the awareness of their feelings, sensations, states, stereotypes, experiences, thoughts and ideas about themselves.

The second unit of the program was dedicated to acknowledgment by all participants that they exist as organisms in the process of contact with the environment. The group members' attention was directed to awareness of their needs, ways of satisfying them or dissatisfaction, the usual ways of establishing or avoiding relationships.

Within the third unit of the program the participants developed their professional skills: establishing contact with the client, making the contract, the ability to analyze a problem, working with various techniques of Gestalt therapy.

The research used the following methods: test questionnaire for self-relationship by V.V. Stolin and S.P. Panteleyev, which is the invention of Russian authors based on the principle of a standardized self-report; method of studying self-esteem in the modification by Dembo-Rubinstein, the original modification of projective drawing tests "Free contact on paper", "Drawing the Other", the original modifications of the method of self-description and the method for analyzing the self-reports of participants.

Conclusions: the original Gestalt-based educational program is an effective method that creates conditions for positive changes in the components of the I-concept of psychology students, namely:

- it increased the level of positive self-relationship of the program participants; they developed awareness of thoughts and feelings, which proves changes that occur in their I-concept. They also improved skills of communicating and entry in contact, the willingness to accept themselves and others increases;
- the Gestalt therapy principle of not using judgements and comparisons led to changes in self-relationship aspects like self-acceptance, autosympathy, self-interest (closeness to oneself), self-confidence, expectation of a positive attitude from others, in the absence of changes in such aspects of assessment as self-esteem, self-understanding, self-guidance and self-consistency;

- participants, whose self-assessment was less than the average for the group, demonstrated the greatest increase in the degree of positive attitude to themselves, whereas participants, whose self-esteem indicators are more than average in a group, showed an adequate.

The Research of Gestalt Therapy Working with Patients with Psychogenic Depressive Problems.

The PhD thesis of Leonid Tretyak, trainer and leader of MGI programs, teacher and member of the supervisory council of VEGI, gives a theoretical justification for the option of using Gestalt therapy in the system of personality-oriented reconstructive psychotherapy for the treatment of psychogenic depressions of the neurotic level (Tretyak, 2007).

The research was conducted on the basis of the Clinic of Neuroses at St. Petersburg City Psychotherapeutic Center. Its object included 101 patients with depressive disorders. The characteristic features of depression for these patients were polymorphism of the clinical picture, absence of expression of signs of the depressive triad, prevalence of asthenic, anxious and vegetative disorders.

In order to avoid depressive disorders caused by non-psychogenic factors, the group of patients did not include: children under 18 and adults over 55; patients with depression within the framework of schizophrenia (F20), with schizotypical (F21) and delusional (F22) disorders, and also with schizoaffective disorders (F25), patients who had a history of convincing evidence of cerebral atherosclerosis or a neuroinfectious process; patients with severe somatic disorders, as well as any form of dependence on psychoactive substances; patients with depressions of endogenous origin.

Methods of research: Hamilton clinical scale, Beck depression questionnaire (BDI), the method for diagnosing the types of attitudes towards the disease (TOBOL), the symptomatic questionnaire of neurotic disorders, the questionnaire WOCQ "Ways of Coping" by Lazarus and Folkman, the technique for determining the level of subjective control, the methodology for assessing the quality of life SF-36, the methodology of the "Index of Life Style" for researching the parameters of psychological protection.

The adapted option of Gestalt therapy for the treatment of psychogenic depressions of the neurotic level was developed on the basis of the analysis of the mechanisms of mental adaptation of patients with neurotic depressions. Clinical efficacy of Gestalt therapy for this type of patients has

been demonstrated and the stability of positive results at catanmesis has been revealed.

The author's program included the following steps:

1. On the first diagnostic stage, patients were selected in accordance with the above criteria. The evaluation of the depression level and an introductory interview to identify the level of motivation for psychotherapy was carried out.
2. At the next introductory stage, there were 2-3 meetings to form a sustainable motivation of the patients to participate in a group Gestalt therapy and to reduce anxiety associated with the need for self-disclosure. Therein, awareness exercises, such as "identification with a symptom", "awareness of the body sensations", "awareness of inner dialogue", "awareness and transformation of guilt" were given.
3. The main stage of focused therapy consisted of 3-14 meetings. It was held in the traditional Gestalt therapy mode of individual therapy in a group: one of the participants worked with the leader for about 30 minutes, after which a feedback was given by the rest of the group. During the work the Gestalt therapist focused the attention on the emotional side of relationship, actual conflict and confrontation with the patient's regressive patterns. For this purpose the following principles and techniques of the Gestalt approach were used: observing the figure of the client; dialogue; suppressive and expressive techniques; amplification and reversion of roles; visualization; psychodrama of fantasies about future; techniques of "polar dialogue", "empty chair", "shuttle".
4. The final stage of group therapy consisted of debriefing. The patients formulated "home tasks" for themselves, aimed at further behavior change.

The specific feature of Gestalt therapy within the framework of this research was its orientation on a confrontation with a passive-avoiding style of psychological protection of patients, manifested in the tendency towards suppression and aggression.

As a result of passing this program the patients of the main group revealed an increase of motivation and of experiencing relationship controllability. The ability to solve the actual interpersonal conflicts productively increased. At the same time, the patients of the comparison group revealed strengthening of non-constructive patterns in the field of interpersonal, primarily, family relationships, as well as patterns of regressive dependence.

Thanks to dealing with the displaced actual conflicts of patients of the main group, the emotion of helplessness was reduced, they started to realize the connection of their state with a traumatic situation. There was also a decrease in average values of disadaptive psychological defenses, which testified to the reduction of tendencies towards deterrence and manifestation of more adaptive expression of aggression in situations of interpersonal conflict.

After the Gestalt therapy, the patients showed the increased ability to distance themselves from negative experiences through denial, which could lead to an increase of optimism and the ability to dissociate from depressive experiences. In addition, there was a decrease in the influence of depressive feelings on role functioning, which could reduce the dependence of patients on the limitations caused by the state of depression.

The results obtained generally indicate that Gestalt therapy can be recommended for use with patients with neurotic depressions who have an extemal locus of control.

The Research of the Influence of Gestalt Therapy on Manifestations of Infantile Aggression

In the research contained in the PhD thesis of Oksana Mavlyanova, lector at the department of child and family psychotherapy of the faculty of psychological counseling of Moscow City Psychological and Pedagogical University, Gestalt therapy was used for correction of non-constructive forms of aggression of primary school children (Mavlyanova, 2011).

219 children aged 7 to 9 years were taken part. Among them, four groups were formed with different forms of aggression: destructive-purposeful, destructive-non-goal-oriented, constructive and deficit ones.

Together with an expert consultant in the field of Gestalt therapy Natalya Kedrova, the author suggested that purposefulness of behavior and emotional competence can act as regulators of aggressive behavior and, therefore, contribute to the transformation of non-constructive forms of aggressive behavior into constructive ones.

The author developed and tested the correctional-developing program, oriented towards the development of personality. The program was implemented in the form of group Gestalt therapy work and consisted of ten lessons (one lesson lasted for 1 - 1.5 hours, frequency - once a week).

To test the program, two groups were formed: an experimental group of 60 children, and a control group consisted of 101 children. Ten closed subgroups were also formed, which included 9 to 13 people. All closed

subgroups consisting of approximately the same number of children with different forms of aggressive manifestations.

In groups of children with destructive-non-goal-directed and deficit forms of aggressive manifestations, showing a low level of purposefulness of behavior, a significant increase in the mean values for this parameter was noted (McNemar's test, $p<0.05$) after passing the correctional-developing program. For children with high level of aggression a significant decrease in the level of aggression was noted (Wilcoxon test, $p<0.05$) after going through the program. Children observations showed that in a group of children with the deficit form of behavior the frequency of verbal aggression had increased (McNemar's test, $p<0.05$). In the group with a constructive form of aggressive manifestation, changes in the level of purposefulness and the level of aggression were not revealed.

The author of the research concludes that the correction program based on the principles and methods of the Gestalt approach provides the means for developing emotional competence and purposeful behavior of children, which helps to stop non-constructive forms of their aggressive behavior.

The Research on Gestalt Therapy Efficacy in Treating Somatoform Disorders of the Gastrointestinal Tract

The thesis of Elena Tsareva, psychiatrist and head of the department in the Regional Clinical Psychoneurological Dispensary of the Tver city, investigates clinical and personal characteristics of patients suffering from somatoform disorders (F45) of the gastrointestinal tract (Tsareva, 2005). It suggests a complex model of Gestalt therapy for treatment of this pathology and studies its efficacy.

Such patients revealed the following psychological features: a significantly high subjective level of "complaint pressure" in the system of digestion organs; predominance of moderate values of personal and reactive anxiety; an average level of alexithymia; prevalence of mixed, anxious-hypochondriacal and hypochondriacal types of attitude towards the disease.

The developed model of complex Gestalt therapy, in contrast to the traditional one, is characterized by: concentrating mainly on topical intrapersonal conflicts associated with the symptom; clear structuring - identification of successive stages; using the techniques of body-oriented and art therapy at the initial stage as elements accelerating the cathartic response and facilitating identification and display of emotions; use of special techniques that take into account the patient's capabilities at each stage.

The Gestalt Therapy model applied has shown its overall clinical efficacy. So, immediately after the end of the course of treatment 90.1% of patients in the main group and only 51.8% of the patients in the control group experienced a practical recovery, i.e. there were no clinic manifestations of the disease. A follow-up research confirmed the efficacy and sustainability of the results achieved: practical recovery was observed with 90.6% of patients in the main group.

A comprehensive model of Gestalt therapy also contributed to normalization of the psychological characteristics of patients. After the treatment, the main group of patients showed a significant decrease in the overall "complaint pressure", the type of attitude towards the disease was harmonized in 49.2% of cases, the levels of reactive and personal anxiety, as well as the levels of alexithymia decreased, which began to correspond to the norm twice as often as in the control group.

The Research of the Possibilities of Influence of Gestalt Therapy on Sexuality

The research in PhD thesis of Nina Aizman, director of the Center for Practical Psychology of the Novosibirsk State Pedagogical University, is devoted to the analysis of the efficacy of different methods of psychological impact on sexuality (Aizman, 2012).

In total, 196 1st- and 5th-year university students were examined at the age of 17-18 and 21-22, 96 of them were included into the control group and 100 - into the experimental one.

To assess the different substantive characteristics of sexuality, the researcher used multifactorial personality questionnaire of R. Cattell (form C), adapted by A.N. Kapustina; the methodology "Researching masculinity and femininity of a person" by C. Bohm; the scale of the reactive and personal anxiety of C.D. Spielberger, adapted by Y.L. Khanin; the method of diagnosing the level of subjective feeling of loneliness of D. Russell and M. Ferguson; the researching method of gender identity (Schneider L.B.); test "Who am I?" (Kun M., McPartland T., modified by Rumiantseva T.V.); «Wiesbaden questionnaire to the method of positive psychotherapy and family psychotherapy» by N. Pezeschkian and H. Daidenbach; "The scale of basic beliefs" by R. Yanoff-Bullman modified by M.A. Padun, A.V. Kotelnikova.

Result processing was carried out by means of quantitative analysis using methods of mathematical statistics "Statistika-6.0" (factor analysis, Pearson's correlation analysis, the Mann-Whitney U-test, Fischer's F-criterion, Student's t-test, H-test of Kruskal-Wallis).

The conducted psychodiagnostic research has allowed to identify the substantial characteristics of sexuality to be formed, on the basis of factor analysis, the five components with total dispersion of 78.3%. The levels of formed sexuality singled out and the criteria for their diagnosis were used to analyze the efficacy of various methods of psychological influence on sexuality.

At the establishing stage of the experiment there were no statistically significant differences between the control and experimental groups. After the forming experiment in the experimental group, in comparison with the control group, differences in the distribution of features were revealed, including those in the structure of female sexuality.

The conclusions obtained about the efficacy of individual Gestalt therapy in comparison with the conversation method, based on principles of rationally-emotive therapy, are the following ones:

1) The obtained results do not allow to treat conversation as a method of development of all components of sexuality.
2) Method of Gestalt therapy aimed at promoting awareness of personal problems, dealing with internalized goals and psychotraumatic situations, allowed to form a more positive attitude of respondents to their parents. The method contributed to awareness of a relatively controllable world and of the events of one's own life, attention to one's own body, positive perception of one's own gender. There appeared an opportunity to address the emotional sphere in relation to the feeling of love, to reduce the subjective feeling of loneliness. Thus, the method of Gestalt therapy beneficially influenced the development of all components of sexuality.

The comparison of efficacy of the conversation method and Gestalt therapy shows that Gestalt therapy is more effective in correcting patterns of behavior formed within a family relations system when address the emotional sphere and in reducing the subjective feeling of loneliness.

A Comparative Research of the Efficacy of Gestalt Therapy and Other Methods of Psychotherapy for Patients with Neurotic Disorders in Respect to Different Cognitive Styles

The study conducted at the department of non-pharmaceutical therapy and clinical physiology of The First Moscow State Medical University

measured the efficacy of different methods of psychotherapy taking into account the cognitive style of patients (Beketov, Bozhko, Koshelev, 2007).

The experimental group included 340 patients (165 men and 175 women) at the age of 20 to 45, suffering from neurotic or stress-related disorders of non-psychotic character for at least 2 years. None of the patients had any previous experience of psychotherapy or received psychotropic drugs for at least five weeks before the start of treatment.

The criteria for participating in the research were as follows: detection of signs of agoraphobia, social phobia, isolated phobias, panic disorder, generalized anxiety disorder, obsessive compulsive disorder, posttraumatic stress on the basis of diagnostic ICD-10 tests. The exclusion criteria were: showing signs of organic disorders and psychoses on the basis of diagnostic ICD-10 tests, taking psychotropic drugs, as well as the presence of any clinically significant somatic pathology.

A clinical and psychological research was conducted, including pathopsychological examination, neuropsychological examination in case of presence of psychic functions' deficiency, psychometric testing: the MMIL test, "Pictogram" method, Bourdon's proof-reading test, Stroop's verbal and color interference test, the free object sorting test, the quality of life questionnaire, Hamilton scale for assessing anxiety and depression.

Statistical analysis was conducted as a correlation study of efficacy indicators of treatment, psychotherapeutic techniques and cognitive styles, comparison of treatment outcome in groups with different psychotherapeutic techniques and cognitive styles.

Patients were randomized to five approximately equal groups. Randomization was carried out by sex, age, level of education, diagnosis, test scores. In the 1st group of patients with neurotic disorders (68 patients) Gestalt therapy was performed, the second one (68 people) was given classical (directive) hypnotherapy, the 3rd one (69 people) - cognitive-behavioral psychotherapy, the 4th one (67 people) - short term psychodynamic psychotherapy, the 5th one (68 people) - unconscious audiosuggestive psychotherapy (UAS PT).

With Gestalt therapy, the emphasis was on increasing awareness for what was going on at the moment and confronting the patients with the present. The following methods were mainly used: a dialogue between parts of one's own personality, a projective game, identification of the opposite, exercises for imagination.

When conducting testing immediately after psychotherapy, in 70-73% of cases there was a regression of the symptoms manifested by the patients. There were no statistically significant differences in the data between the groups with different types of psychotherapy according to such measures of

efficacy as Hamilton scales for evaluating anxiety and depression, Bourdon's proofreading test or the quality of life questionnaire.

When performing a correlation analysis between such parameters of cognitive style as "narrow / wide range of equivalence" and psychotherapy efficacy indicator, the following correlations were revealed: in the Gestalt therapy group there appeared a statistically significant positive relationship between efficacy and "categorization", in the classical hypnotherapy group - between efficacy and "globalization", in the cognitive-behavioral group - between efficacy and "differentiation", there was a pronounced tendency for correlation with" detalization", the group of short term psychodynamic psychotherapy and UAS PT revealed a statistically significant positive link to "detalization".

When conducting a correlation analysis between such cognitive style parameters as "rigidity / flexibility of cognitive control" and psychotherapy efficacy, there were revealed the following correlations: in the Gestalt therapy group there was a statistically significant positive connection between efficacy and non-integration, in the groups of classical hypnotherapy and UAS PT - between efficacy and flexibility, in the cognitive-behavioral group - between efficacy and rigidity, in the group of short term psychodynamic psychotherapy there was a statistically significant positive association with the indicator of integration.

The authors of the research conclude that the efficacy of individual psychotherapy methods for neurotic and stress-related disorders depends on parameters of the patients' cognitive areas.

Difficulties and Prospects for Gestalt Therapy Efficacy Research

Based on the current realities of the state of Russian Gestalt therapy it is possible to mark a number of difficulties to overcome in the field of research. They are connected with the opportunities that are opening in the future. In our opinion, realizing these opportunities will help to concentrate the efforts to enhance Russian efficacy research. Naturally, these difficulties and prospects are to a large extent relevant not only for Russia.[3]

First of all, it is necessary to note that, if the tradition of Gestalt therapy in Russia is relatively new, then the modern research in general is only in its infancy. And this applies to all areas of psychotherapy and psychological

[3] Speaking of the prospects, we use part of the presentation, made by the authors at the conference "Exploring Practice-based Research in Gestalt Therapy" in Paris in 2017.

counseling. However, the interest in research is gradually increasing, although there are still too many obstacles to its implementation.

Methodological Difficulties

Substantial progress was made in the sphere of methodology recently, in particular, in Single Case Time Series (SCTS) design (Wong, Nash, Borckardt, Finn, 2016) applyied and developed by the team of the Gestalt International Collaborative Project (Herrera, Bergmann, Brownell, Roubal & Mstibovskyi, 2015a; Herrera et al., 2015b; Herrera, Roubal, Mstibovskyi & Brownell, 2017; Herrera, Mstibovskyi, Roubal, & Brownell, 2018).

Despite of this work it should be realized that no methodologies for carrying out efficacy research have yet been found that would reflect the holistic and diverse nature of Gestalt therapy adequately enough.

In our opinion, carrying out the quantitative analysis showing the outcome of Gestalt therapy with all evidence is extremely important, but one cannot do without researching the way this result is achieved in the course of therapy. This task requires developing methods of qualitative analysis, specific for the Gestalt approach, as well as selecting of suitable instruments out of the existing ones and describing their connection with the quantitative analysis. Here the research may create incentives for the development of the Gestalt therapy theory.

There is a shortage of methodological recommendations on conducting research and using the results in private practice by therapists, for group leaders and when teaching Gestalt therapy, so it would be very useful to create them.

Lack of Motivation and Meaning

Undoubtedly, many Gestalt therapists would like to get the results of the research and apply them to practice: we mean the strict evidence of the effectiveness of Gestalt therapy, a clearer vision of the outcome and process of therapy, recommendations for conducting therapy for separate groups of clients, etc. But hardly anyone can give a certain exact answer to the question: why do I need any research today?

We think that for Russian Gestalt therapy, the aim of research should be related to a marked improvement in activities in two areas: private practice and education. If research can help to make such an activity more fruitful, it will receive a large amount of supporters.

Moreover, in Russia there exist the same reasons for conducting research, which are typical for the whole Gestalt community, such as

university research, competition with other types of psychotherapy and the development of the Gestalt approach in general (Roubal, Francesetti, Brownell, Melnick, Zeleskov-Djoric, 2016).

Another aspect of this problem is the lack of motivation of the client to participate in the research, which is necessary since it requires his considerable additional work. In fact, the research process is an essential part of the relationship between the therapist and the client and the dialogue between them. This means "an interaction of non-independence and a matter of what they do together" (Brownell, 2010, p.113). Therefore, single case efficacy should be considered according to the laws of dialogue as a two-person field with the following properties: presence, acceptance and commitment (Brownell, 2010). The difficulty is that the presence in the research as well as acceptance of each other in the roles of its participants and commitment in what is happening should be also maintained outside sessions and for a fairly long time. In our opinion here, as in any dialogue, the client is required to make a serious decision to participate (Mstibovskyi, 2015) supported not only by the expected benefits, but also by understanding the meaning of the research personally for him and for the world in which he lives.

Organizational and Financial Difficulties

Nowadays Russian Gestalt institutes only begin to be interested in the development of research. A certain independence of the main centers of Gestalt therapy in Russia, which we have mentioned above, does not facilitate the free exchange of information about research either. Therefore, the organization of an international association and a problem-oriented network of researchers would be extremely useful here, as well as stimulation of institutes conducting research by international Gestalt associations.

In Russia, some Gestalt therapists and trainers work as psychologists in universities, which can significantly help organizing research. Under their guidance it is possible to write masters' or doctoral theses in the field of Gestalt therapy using modem methods of proving efficacy.

Whereas research on the efficacy of psychotherapy all over the world is mainly financially supported by grants, in Russia such examples in the field of Gestalt therapy are still unknown. Therefore, the problem of financing research or obtaining financial advantages when using its results is currently of particular interest here.

What Can Efficacy Research Do for the Future of Gestalt Therapy in General and for Each Gestalt Therapist?

1) It is an opportunity to pay more attention to the results, without distorting the processual nature of the therapy itself.

Gestalt therapists, undoubtedly, are oriented on the results at particular stages of their work, such as signing the contract, summarizing the session, analyzing their work, etc. But most of the time during the sessions this is unacceptable because it distorts the unpredictability of contact with the client and the natural course of the process of gestalt formation. At the same time clients are focused much more on the result than on the process of therapy.

Conducting research together with therapy helps to remove this imbalance, shifting the general focus of the therapist's attention beyond sessions to results. Thus, it becomes possible to find a common language with clients to a larger extent and to influence their motivation (and hopefully in the long run, to gain advantages in Gestalt therapy selling).

Moreover, quantitative measurement of the results and evaluation of the therapy factors affecting them gives a new level for the management of the therapy process in a similar way to various systems, for which quantitative feedback is necessary.

2) Achieving greater objectivity while maintaining respect for the subjectivity, individuality and uniqueness of the client, the therapist and their relationship.

It would seem that the place of objectivity in research is clear: demographic data on participants, the use of tried and tested instruments, and statistical analysis. But on a closer examination it turns out that on the one hand, a lot of instruments have already been created and it is not easy to choose among them the most suitable, and also to interpret its results. And on the other hand, there are still not enough tools reflecting the work specifics of Gestalt therapists in general and in certain areas. In addition, there are large and still unused opportunities to deepen objectivity through the choice of optimal design and the use of modern analysis methods.

At the same time, the issue of objectivity is extremely important, because objectivity fosters trust, both in the therapist and in the Gestalt Approach in general, and helps to successfully position Gestalt therapy among evidence based methods.

3) Better understanding of how Gestalt therapy actually works: what exactly its efficacy is composed of, and how it is achieved.

The efficacy of therapeutic influence on a client is usually measured by the value of Effect size. But this information is not enough without the description of the change mechanisms, the connection between quantitative and qualitative analyses. This is where a great possibility is created in the description of the essential processes of Gestalt therapy, in the development on the basis of this theory and work practice.

In the following we will concentrate on two things, which may seem as if they were still a long way down the road; however, the rapid progress in information science, brain neurophysiology and communication means can draw this future nearer.

4) There are opportunities to turn Gestalt therapy to a certain extent into an exact science by means of research, no matter how strange it may sound.

The exact sciences are known to use clearly defined concepts and hypothesis testing, as well as logical reasoning and reproducible experiments. Quantitative regularities are revealed and used. And this is exactly what we do in research.

Of course, Gestalt therapy remains a kind of art and will never be the same exact science as technology or physics, but it can move in this direction along with, for example, design or marketing.

Can this be applied directly in private or clinical practice? For example, with a new client at the first stage of the Single Case research, we can not only determine the expected outcome within the contract, but also predict the achievement of this outcome in statistical or other quantitative measures. At the same time, it becomes possible to take into account not only the client's therapeutic, but also his research diagnosis, which assesses the factors that influence the outcome.

After the completion of the therapy together with the research of this individual case it is possible to compare the prognosis with its implementation, and then record this case in a general research database.

5) We firmly believe Gestalt therapy can overtake other areas of psychotherapy over time in efficacy researches.

This point seems hard to agree with, as now, for obvious reasons, Gestalt therapy lags far behind psychoanalysis and CBT. But we are sure that it has one significant advantage - it has a deep internal connection with the modeling method (Mstibovskyi, 2010). After all, the experiment as one of the leading means of Gestalt therapy involves modeling of life situations, and many positions of Gestalt theory are brilliant models of real human relationships with other people.

In the field of psychotherapy research, the interdisciplinary scientific method of modeling is constantly used: for design, for measurements, for

analysis. But models are often used like patterns and in an unconscious way. In Gestalt therapy we can make it flexible, diverse and creative.

In fact, for any Gestalt therapist, modeling is familiar, although this fact is little realized and rationalized. The creation of the model as a simple, clear and completed reflection of the object by identifying its most significant features corresponds to the process of gestalt formation. And who would know and feel this process better than a Gestalt therapist does, being an expert in the area of contact, and the emergence of insights.

Therefore, Gestalt therapists have the potential to create in their studies new models designed specifically for this research problem, and flexibly combine them with ready-made models.

Research Currently in Progress

When preparing for the International Research Project on Spiritually Integrated Psychotherapy (Brownell, Herrera Salinas & Zeleskov Djoric, 2017), a group of Gestalt therapists was formed in Russia, which to a large extent included the MIGAP trainers from different regions of the country. Many of them also work in universities and / or as leaders of Gestalt centers.

Since 2014 Gestalt International Collaborative Project SCTS design (Herera et al., 2015a, 2015b, 2017, 2018) has been carried out, Illia Mstibovskyi being member of its International coordination team. This work consists both in development of methods of analysis and carrying out calculations on ready-made cases, and in accumulating experience in applying this methodology to a Gestalt therapist's daily work. A distinctive feature of this research in Russia is that clients are taken from private practice with different diagnoses and problems.

The authors of the current chapter have completed and are preparing to publish the research of the outcome of a separate session of Gestalt therapy and its relationship with the quality of therapeutic alliance (Aralova & Mstibovskyi, 2015, 2017). This work was carried out on the basis of Southern Federal University and SRGI.

In this research the following goals were set:

- to look at individual sessions of Gestalt therapy and investigate how the clients assess the outcome of the session and also how the therapist and the client characterize the working alliance;
- to find a way of measuring the outcome, corresponding to the special characteristics of Gestalt therapy and
- to test the hypothesis that the session outcome is related to the quality of the working alliance.

We consider that the most important concerns of a Gestalt practitioner are the outcome of a separate session and the quality of the working alliance. It is also one of the focuses of our educational programs on Gestalt therapy in SRGI. In second place Gestalt therapists are interested in the results of the whole therapy, which, in our opinion, is best described by SCTS methodology.

The outcome of a separate session is a less researched area than the evaluation of the efficacy of therapy in general. At the same time, a detailed study of what is happening at each session just gives an opportunity to go deep into the specifics, both about the process during the sessions, and the individual results obtained by certain events during the session. Therefore, such methodology should be well combined, and it should complement the SCTS design.

Existing methods for evaluating the outcome of a separate session are useful, but not sufficient in order to take into account the special characteristics of Gestalt therapy, which prompted to develop a new measurement method for this purpose.

Thus, the following tasks of this study were set and achieved:

1) Create a new measurement method for assessing the outcome of a separate Gestalt therapy session;
2) Prove that its results are consistent and complement the results of the existing questionnaires in this field;
3) Check the research hypothesis that the client's assessment of the outcome of the session is related to the quality of the working alliance during this session;
4) Divide the sessions into sub-groups according to the level of efficacy;
5) Identify the sessions in which the working alliance is significantly worse than usual;
6) Predict the generalized characteristics of the outcome of the session on the basis of assessing the quality of the working alliance.

This methodology aims to transform the subjective judgments of clients about the outcome of a separate session to objective indicators; to verify and strengthen this objectivity with the help of a profound and thorough analysis; and to compare the objective indicators describing the outcome of the session and the quality of the working alliance. In this research were taken small steps towards developing Gestalt therapy into an exact science. In particular, it concerns modeling of the client's usual evaluation of a session, founding quantitative regularities of how the quality of the working

alliance is related to the client's evaluation of a separate session outcome, and the prediction of how the characteristics of the working alliance will affect the outcome.

This chapter attempts to see the general picture of the state of research concerning Gestalt therapy in Russia. It seems that a significant path has already been taken, but in order to strengthen the positions of Gestalt therapy and the scientific evidence of its efficacy, there is still much to be done.

References

Aizman, N. I. (2012). Эффективность различных методов психологического воздействия на сексуальность [Efficacy of Various Methods of Psychological Effect on Sexuality]. *National Psychological Journal*. No.1 (7), 107-112. Moscow, Russia: Moscow State University.

Aralova, M., Mstibovskyi, I. (2015, September). *Unique Characteristics of Working Alliance in Relation to the Client's Subjective Evaluation of the Outcomes of a Separate Session of Gestalt Therapy.* Paper presented at the 8th European Conference of Society for Psychotherapy Research, Klagenfurt, Austria.

Aralova, M., Mstibovskyi, I. (2017, May). *The outcome of a separate GT session, and its relationship with the quality of working alliance.* Paper presented at the International Conference "Exploring practice-based Research in Gestalt-therapy," Paris, France. Abstract retrieved from http://www.gestalt-research.com/wp-content/uploads/2016/04/Abstracts.pdf.

Beketov, Y.A., Bozhko, S.A., Koshelev, V.V. (2007). Взаимосвязь эффективности различных видов психотерапии с параметрами когнитивного стиля пациентов при лечении невротических расстройств [Interrelation of the Efficacy of Different Types of Psychotherapy with the Parameters of the Cognitive Style of Patients in the Treatment of Neurotic Disorders]. *Vestnik Novykh Meditsinskikh Tekhnologiy*, V. XIV, No. 2, 133-134. Tula, Russia: Tula State University.

Brownell, P. (2010). *Gestalt therapy: A guide to contemporary practice.* New York, NY: Springer Publishing Company.

Brownell, P., Herrera Salinas, P., Zeleskov Djoric, J. (2017, May). *International Practice Based Research Network: Exploring Process, Outcome, and Emergent Spirituality in Gestalt Therapy*. Paper presented at the International Conference "Exploring practice-based Research in Gestalt-therapy," Paris, France. Abstract retrieved from http://www.gestalt-research.com/wp-content/uploads/2016/04/Abstracts.pdf.

Dolgopolov, N. B. (2015). *Избранные статьи по гештальт-терапии, психодраме и футуропрактике* [Selected Articles on Gestalt Therapy, Psychodrama and Futuropractice]. Moscow, Russia: Moscow Institute of Gestalt and Psychodrama.

Herrera, P., Bergmann, J., Brownell, P., Roubal, J., Mstibovskyi, I. (2015a, June). *Single case time series (SCTS). A framework for international research in Gestalt Therapy.* Paper presented at the 46th International Annual Meeting of Society for Psychotherapy Research, Philadelphia, USA.

Herrera, P., Brownell, P., Roubal, J., Bergmann, J., Mstibovskyi, I., Glanzer, O., Pfleiderer, S. (2015b, September). *Single Case, Timed Series (SCTS) Design Efficacy Studies of Psychotherapy of Depression: The Experience of the International Project on Gestalt therapy.* Paper presented at the 8th European Conference of Society for Psychotherapy Research, Klagenfurt, Austria.

Herrera, P., Mstibovskyi, I., Roubal, J., Brownell, P. (2018). Researching gestalt therapy for anxiety in practice-based settings: A single case experimental design. *Revista Argentina de Clinica Psicologica, Practice Oriented Research Special Issue*. 27(2), 321-352.

Herrera, P., Roubal, J., Mstibovskyi, I., Brownell, P. (2017, May). *The creation of an international practice-based research network in Gestalt Therapy*. Paper presented at the International Conference "Exploring practice-based Research in Gestalt-therapy", Paris, France. Abstract retrieved from http://www.gestalt-research.com/wp-content/uploads/2016/04/Abstracts.pdf.

Hlomov, D. N., Kaliteevskaya, E. R. (2008) *Философия гештальт-подхода* [Philosophy of the Gestalt Approach]. Moscow, Russia: Moscow Gestalt Institute.

Kedrova, N. B. (2015). *Азбука Эмоций* [The ABC of Emotions]. Rostov-on-Don, Russia: Phoenix.

Lebedeva, N. M., Ivanova, E. A. (2005). *Путешествие в Гештальт: теория и практика* [A Journey to Gestalt: Theory and Practice]. Saint-Petersburg, Russia: Rech'.

Lekareva, M. P. (1999). *Анализ изменения Я-концепции студентов-психологов в процессе изучения основ гештальт-терапии* [Change analysis of I-concepts of Psychology Students in the Process of Studying the Basics of Gestalt Therapy]. (Doctoral dissertation). Retrieved from http://www.dissercat.com/content/analiz-izmenenii-ya-kontseptsii-studentov-psikhologov-v-protsesse-izucheniya-osnov-geshtalt.

Mavlyanova, O. V. (2011). Факторы трансформации неконструктивных форм агрессивного поведения в конструктивные [Factors of transformation of unconstructive forms of aggressive behavior into constructive]. *Electronic Journal "Psychological Science and Education" www.psyedu.ru* No. 4, 140-150. Moscow, Russia: Moscow State Psychological and Pedagogical University.

Mstibovskyi, I. A. (2010). Моделирование в гештальт-терапии [Modeling in Gestalt Therapy]. *Journal of a Practical Psychologist*. No. 6, 91-122. Moscow, Russia: IG "Sotsial'nye nauki".

Mstibovskyi, I. A. (2015). Диалог как поступок [Dialogue as a deed]. *Journal of a Practical Psychologist*. No. 5, 20-35. Moscow, Russia: IG "Sotsial'nye nauki".

Nemirinkiy, O. (2013). Gestalt Approach in Psychosomatic Disorders. In G. Francesetti, M. Gecele and J. Roubal (Eds.) *Gestalt therapy in clinical practice*, pp. 565-582. Milano, Italy: FrancoAngeli.

Roubal, J., Francesetti, G., Brownell, P., Melnick, J., Zeleskov-Djoric, J. (2016) Bridging practice and research in Gestalt Therapy. In J. Roubal (Ed.) *Towards a research tradition in gestalt therapy*, pp. 1-15. Newcastle upon Tyne, UK: Cambridge Scholars Publishing.

Tretyak, L. L. (2007) *Гештальт-подход в патогенетической психотерапии психогенных депрессий невротического уровня* [Gestalt Approach in Pathogenetic Psychotherapy of Psychogenic Depressions of Neurotic Level]. (Doctoral dissertation). Retrieved from http://www.dissercat.com/content/geshtalt-podkhod-v-patogeneticheskoi-psikhoterapii-psikhogennykh-depressii-nevroticheskogo-u.

Tsareva, E. V. (2005) *Клиника, диагностика и психотерапия соматоформных расстройств желудочно-кишечного тракта* [Clinic, Diagnostics and Psychotherapy of Somatoform Disorders of Gastrointestinal Tract]. (Doctoral dissertation). Retrieved from http://www.dissercat.com/content/klinika-diagnostika-i-psikhoterapiya-somatofommykh-rasstroistv-zheludochno-kishechnogo-trak.

Wong, A. J., Nash, M. R., Borckardt, J. J., Finn, M. T. (2016) A guide to conducting case-based, time-series research in gestalt therapy:

Integrating research and practice in clinical setting. In J. Roubal (Ed.) *Towards a research tradition in gestalt therapy*, pp. 116-129. Newcastle upon Tyne, UK: Cambridge Scholars Publishing.

CHAPTER NINETEEN

TEACHING AND CONDUCTING GESTALT RESEARCH IN CHILE

PABLO HERRERA SALINAS

I remember my first direct experience of Gestalt, in Santiago de Chile, back in 2003. Before, I had seen a couple of books in my father's library and took a class in my undergraduate psychology studies. But I had never really *experienced* gestalt therapy.

It was the first day of a three-year training. We were 30 students who had never met before. Some psychologists, many with different occupations. After we presented ourselves in a very standard fashion, the facilitator asked us to do something unusual: *tell our class mates what you didn't like about them*. We had just met each other and this directive went directly against Chilean politeness, but if the great *Nana Schnake* said it, we had to do it. So we went along with it.

After everyone had spoken, Nana read to all of us what we disliked about the others. She then asked us which of these negative traits we recognized in ourselves, and which we definitely didn't possess. Finally, she created a *role* or character who personified the traits we disliked in others and didn't possess in ourselves. And we had to come the next day to class disguised as that character and interact with the others in that role for a few hours.

I had to be an old-fashioned macho man, narcissist, aggressive and womanizer. *And I loved it!*

It was in 2003, and in these years I've been to hundreds of hours of therapy and workshops. And that role has played a huge part on my development path ever since. It has been like a backbone, or a guiding light that helps me focus on the important aspects that I need to integrate.

But this is not about my personal experience, so let's rewind a little bit and talk about the history of Gestalt therapy in Chile. Just for a little context, so then we can share a bit about our present and what we are doing towards the future.

A Little Bit of History and Context

Before I begin, a word of warning: for a thorough overview of the history of GT in Chile, there is an excellent chapter written by one of its founding fathers (Huneeus, 2013). In order to avoid repeating what he already wrote, I'll talk just briefly about our history and focus more on the current developments of the Gestalt Institute of Santiago. Also, describing our current situation, I'll try to convey a more subjective feeling of how it is to practice, teach, learn and do research in GT today.

Gestalt in Chile is the offspring of the polyamorous trio of Claudio Naranjo, Nana Schnake and Francisco Huneeus (not literally a polyamorous trio, although Nana and Francisco were a couple for 10 years), all of them psychiatrists educated in the 1950s. They are over 80 years old but still publishing and working actively. Claudio Naranjo learned with Frederick Perls and has written countless Gestalt books focused on spirituality, Enneagram, and recently education. Adriana "Nana" Schnake (my teacher) founded the Gestalt Institute of Santiago, developed a model and technique to work therapeutically with physical illnesses, and has conducted group therapy workshops in the Chiloé island for decades, besides creating our institute and deeply influencing Latin American Gestalt. Francisco Huneeus founded the "Cuatro Vientos" editorial, translating and publishing almost every gestalt therapy book available in Spanish speaking countries.

Naranjo studied Gestalt in the 60s with Perls and Jim Simkin at Esalen, and introduced Gestalt Therapy in Chile at the end of that decade. Francisco was working on neurobiology and Nana was studying the therapeutic use of psychedelic drugs at the university hospital. However, after learning about Gestalt and having their university work interrupted by the state de coup in 1973, Nana and Francisco Huneeus founded "Cuatro Vientos" editorial in 1975, being the first to translate Perls work into Spanish and aiming to be a kind of "open university" that spreads ideas to promote personal and collective well-being into our society. Despite (or perhaps because of) the oppressive political context, Cuatro Vientos' books were a runaway success, making Gestalt literature available to a wide audience, far beyond healthcare professionals. As a matter of fact, all my first books on Gestalt were ones I "borrowed" from my father's library, who is an engineer but attended Nana's workshops and was interested in personal development literature. Nana and Francisco were also the first to teach and disseminate GT in Argentina in 1974, and also helped its inception in Peru, Brazil and Spain in 1978.

After the initial boom in the 70s our founding fathers have continued to publish books. Nana has published mostly on her innovative work with

physical illnesses and Naranjo has published on several topics like patriarchy (1993, 2010), gestalt techniques (1990, 2003), meditation and spirituality (1999, 2012, 2014), emotional education (2002), and enneagram (1996, 1999, 2000). He has also founded the SAT (seekers after truth) institute, which organizes psycho-spiritual workshops based on Óscar Ichazo's enneagram work. However, newer generations have not been so productive in terms of published material. There is only one Gestalt book written in Chile that is not by our founding fathers, and it is one on Group therapy written by Marina Varas, Nana's daughter and head of the Gestalt Institute of Santiago.

That leads us to our present situation.

Gestalt Therapy in Chile: How Are We Doing?

How to summarize our current situation in a few words? Using Facebook terminology, *it's complicated.*

On one hand, *we are doing fine*: (1) we have the Gestalt Institute of Santiago founded by Nana Schnake and now headed by her daughter and son in law (Marina Varas and Antonio Martínez), where I work as head of research; (2) We have the very active Cuatro Vientos editorial continuing to publish books on Gestalt and other related topics (however, almost all the current work is international, with extremely few Chilean publications); (3) We have two of the few Spanish speaking master's degree programs in the world that teach Gestalt (one solely focused on Gestalt, and one that includes it as part of a humanistic program); (4) Every year the Gestalt teaching program at the Santiago Institute is full with 30 new students, mostly psychologists; (5) Nana and Naranjo are widely known in Chile, not exclusively by mental health professionals; (6) Gestalt and humanistic therapy are practiced by many therapists and are not outlawed by the healthcare industry.

On the other hand, *we are not doing so well.* A couple of objective facts: (1) 90% of the GT trainees in our institute never finish their dissertations and therefore never graduate or publish anything that could be read by colleagues or the general public; (2) we are losing ground in the academia and many lectures on Gestalt and humanistic therapy have banished from university classrooms. Also, some personal anecdotes: (3) When I first asked about Gestalt to a professor at the university (a psychoanalyst) back when I was studying my psychology degree, he said dismissively that it was "the aborted child of psychoanalysis." (4) When I told a trusted humanistic psychology professor that I wanted to go to Nana's group workshop in Anchimalén, he advised strongly against it, because "they break your

defenses there and don't help you get up again;" (5) My psychology students at the Universidad de Chile are surprised to know that humanistic therapists don't just rely on incense and hugging and have actual therapy techniques and theory (!?).

Speaking to international colleagues and knowing the dire situation gestalt therapy is having in Germany, Australia and other latitudes, I'd say Gestalt in Chile is like Asterix's village in Roman occupied France. It's alive and healthy, with movement inside, but quite isolated, gradually losing ground and subject to a lot of prejudice and ill will from outsiders. Also, the key figures are too old for us to continue to rely on them to do the hard work of publishing, speaking to the media, etc.

I don't know if this is the same in other countries, but I think GT's emphasis on taking care of one's needs, rebelling against societal musts and insistence on "cutting our heads" is strongly related to our student's not finishing their thesis, us not wanting to do research or write, and in general being comfortable with our private practices, without doing the hard work required to go out and have a bigger impact outside our therapy rooms. When I see some of my psychology colleagues stressed, overworked and caffeine dependent, I think they need a bit of inner critic dialogues or they need to listen to their bodies some more. But then I notice how they organize many seminars in my university, they publish more, and they appear in the newspapers, and I begin to think that maybe that's a necessary price they pay to have an impact, to influence and help our ill society. And I start to question if I should work more, or be more demanding of our students, in order to get Gestalt out of the therapy room and into the lives of more people in need.

Alas, I begin to divert from the topic at hand.

On second thought... I'm not diverting, I'm diving right into our next section. Because what I discussed in the last paragraph was the question about opposite values and needs: work and stress and caring about others versus relaxation and peace and taking care of one's needs. It's a classic polarity conflict. And that's precisely what I wanted to talk about now.

How Do We Practice Gestalt in Chile?

Until last year, I really couldn't answer this question. Because before I met other Gestalt therapists from different countries, I naively thought we practiced "Gestalt." Not "Chilean Gestalt" or "Latin American Gestalt." However, talking to colleagues from Czech Republic, Italy, Germany and other countries has shown me different emphases, different descriptions of what doing Gestalt therapy is. Also, researching for this chapter I learned

from Francisco Huneeus that the linguistic barrier has deeply influenced gestalt therapy in hispanic countries. For example, the classic gestalt therapy book by Perls, Hefferline & Goodman (1951) was only translated to Spanish in 2002, and as most therapists in Chile and Spanish speaking countries don't read English, our brand of Gestalt has been mostly shaped by Perl's "west coast" work (specifically the Gestalt books published by Cuatro Vientos). This is markedly different than what I could notice talking to several European colleagues.

So, how do we do Gestalt Therapy in Chile? Our main focus of intervention is the client's main polar conflict. What aspects of their experience and personality do they accept, embrace and own? Which ones do they disown or want to eradicate? Using dialogue, dreamwork, projections (among other techniques), we observe that patients are identified with part of their experience and behavior and reject or think that they don't posses the opposite traits. The client's main polarity conflict is almost always the ground in which the current figure appears, and we consider the therapy to be incomplete and only symptomatic if the therapist doesn't work at the character level, helping integrate the rejected or inhibited polarity.

Although this has been familiar to most international gestaltists I have spoken to, they have told me they put the emphasis of their work on other topics. For example, other Gestalt colleagues give a lot of importance to the relational aspect of Gestalt theory, almost in a systems theory manner, or similarly to relational psychoanalysis. For others, the focus is on the interruptions of contact. And the most surprising thing is that something so obvious for us, the concept of polarities, is not emphasized in other training institutes, and seldom theorized.

The concept of *polarities* or *polarization* doesn't appear often in Gestalt therapy literature. Some Gestalt authors have written about it explicitly (see Yontef 1993, Zinker 1976, or Johnson 1992), but Perls never mentioned it in his books. However, it can be indirectly traced back to his thinking. For example, Perls (1974) mentions Friedlander's concept of *creative indifference* as a state in which a person has the freedom to reach both opposite behavioral poles. He also speaks about how, when we are neurotic, we develop a rigid and predictable *character*, losing our ability to creatively adapt to the demands of the situation. As he says, "all control, even internalized external control–'you should'–interferes with the healthy organismic functioning. There is only one thing that must control: the situation" (Perls, 1974, p. 31). Another related idea is the one about *holes* in the personality: experiences and personal resources that are not available because the neurotic has projected them as a way of resolving the basic *society vs self* conflict. The only time he describes a specific polar conflict

is when he talks about the *top dog vs under dog* conflict. Later, he explicitly states that the aim of Gestalt therapy is to "increase human potential through the integration process" (Stevens, 1978).

I have proposed a definition for polarities (Herrera, 2016), trying to capture the essence of what we do here at the Santiago institute and how we work with them, inspired on the concept of *conflict splits* by Greenberg (1979). They can be defined as "conflict splits, personified using two opposite characters, each expressing different cognitive, emotional and behavioral processes. The specific characters are selected because at least one of those characters exhibits processes that are being systematically interrupted by the patient in different contexts, thus making unavailable certain resources and limiting the patients experience and creative adaptation. The characters names and specific traits can change during the therapy, but we assume that they represent basic ways of being in the world and will "show up" in symptoms, dreams and interpersonal conflicts, until those processes stop, being systematically interrupted, or the patient changes their context and doesn't need those inhibited resources anymore".

To "diagnose" the main polar conflict, we observe the systematic interruptions in the client's contact processes to explore what is missing in their experience, what is being left out, what is being rejected or pushed back. We explore this aiming to understand the client from their own lived experience, in a non-judgmental manner and being respectful for the clients freedom of choice. Using this information we often discuss this polar pair with the patient, discussing if he or she is willing to integrate this previously neglected pole. Then, we often use two chair dialogue and other techniques to help the patient embody the "other" polarity, and then establish dialogue and cooperation between both poles (in my case, we named it "the caveman vs the diplomat").

We are also very careful in that identifying with previously unknown aspects of the self should not lead to a reversal of polarities (e.g. The "strong responsible woman" that after therapy shifts and now becomes "carefree and dependent," now rejecting her responsible pole). Also, we take great lengths to ensure that the patient fully embodies the disowned pole, so the role playing and dialogue is not only at an intellectual level. Treating these two parts of the self (dominant & rejected) as polar opposites helps us because it makes them easier to differentiate. This helps the patient personify them and engage in dialogue.

Similarly to Johnson's Polarity Map model, we regard each pole, each *way of being*, as having both egosyntonic and egodystonic components, and that is one key reason for polarization. As an example, let's analyze the different components in the diplomat vs caveman polar conflict:

	Caveman	Diplomat
Egosyntonic	- Setting boundaries. - Having energy. - Directing others.	- Minimizing conflict. - Getting along with others. - Giving a "cool" impression.
Egodystonic	- Hurting others. - Making others angry and vindictive. - Losing control.	- Being regarded as "passive". - Being weak. - Stressing.

So, for a sustainable integration of the disowned polarity is that the patient must learn and experience two complementary things:

1. To enjoy the positive, egosyntonic aspects of the disowned polarity.
2. To tolerate sometimes suffering the negative, egodystonic aspects of the disowned polarity.

The logic of this argument is that it's impossible to *always* choose the most appropriate response to a particular context (and if it was possible, it would require too much processing power for our limited brains). So, even though we would like to behave in a perfect way in every situation, sometimes we will err though excess, and other times through restraint. We are polarized when we can't tolerate one of these errors, and thus avoid at all cost any behavior that would lead us to that horrible result.

Continuing with the example: this patient doesn't allow himself to be a "caveman" because he avoids *at all costs* the potential negative consequences of being like that (e.g. Losing control or making others vindictive). Also, because he avoids that kind of behavior he is not able to enjoy the positive aspects of that polarity. On the contrary, he is used to tolerating the negative aspects of being a "diplomat" (e.g. feeling passive, or weak), and also he is able to enjoy the positive aspects of that polarity.

The change towards tolerating the egodystonic aspects of the disowned polarity can be eased with reframing techniques (e.g. "If others get vindictive when you set boundaries, maybe they are not true friends; because true friendship tolerates minor frustration and conflict). However, it probably will require exposing the patient to unpleasant feelings and experiences that he has been systematically avoiding. Another way of facilitating this is helping the patient contact the enjoyable consequences of integrating that pole.

Some specific techniques that helps us in the integration path are the two-chair dialogue between the 2 polarities, two chair work with another person who personifies a rejected pole, and the kind of role playing work I described at the beginning of the chapter.

Also, in the spirit of integrating polarities, we strive to reach a balance between east and west coast Gestalt traditions. This means that although our training programs are fundamentally experiential (a welcome relief after a 90% theoretical psychology training at the universities), we still retain some scientific influence from our psychiatrist founding fathers. Also, a few of our teachers are also part of the Existential Analysis training program (founded by Alfred Laingle), so existentialism is a big part of our background. One specific way in which existentialism informs our practice and complements our focus on polarities is with the concept of the *existential vision*, an implicit construction of the world, the person, and their relationship that lies in the ground, as an unconscious assumption from which polarity conflict emerges. So, many times it's not enough to integrate the client's polarities, as it's also crucial to explore and expand the *existential vision* or awareness of the field.

For example, I had a client who presented 2 main polarities: the dominant pole was weak, afraid and small, and the inhibited one was strong, big and assertive. During the first period of therapy she integrated both and started feeling better, but she still had problems, specially trusting her boyfriend. We noticed that she was relating to him from the strong pole, because she felt powerless from the weak or sensitive one. But exploring further, we understood that she perceived him as dangerous, and she had learned to be afraid of abusive relationships and of the world in general. So, in the context of a dangerous world and a potential abuser in her bed, she had 2 options: be weak and afraid (as her mother) or defend herself and be strong and not trust and have a relationship with low intimacy and constant friction (as she had in the present). So, if she remained constrained to that existential vision, she only had those two flawed options. Later, she opened to question and widen her perception of the world and of romantic partners, daring to trust and not be always so emotionally and bodily defensive.

Specific Theoretical and Technical Contributions

In this section I'll mostly focus on Nana Schnake's "Holistic approach to health and disease". There are other important contributions, specially by Claudio Naranjo. However, most of his work has been developed and published in the USA and hasn't had a profound influence on Chilean Gestalt. I would argue that his most well-known contribution in Chile has

been his work integrating Gestalt with the Enneagram personality types and with spiritual practices. He continues the Sufi Enneagram tradition as transmitted by the mystics Gurdieff and Oscar Ichazo, providing a welcome complement to Riso and Hudson's Enneagram work (2001). He uses the Enneagram to describe typical neurotic identifications of the Ego, which need to be transcended. Using the already presented polarity terminology, we could say that if we transcend our ego identifications, we can achieve the ideal state of *creative indifference* and are free to act according to our organismic needs and the present situation.

Nana Schnake's pioneering work with Body Dialogues

Nana's holistic approach to health and disease and body dialogue technique is a specific contribution from Chilean Gestalt, being applied by therapists, psychologists and physicians in Chile, Mexico, Brazil and Spain. Nana has written 3 books on the topic (1995, 2002, 2007), which sadly haven't been translated to english, so her approach is not known to colleagues outside the Spanish speaking world.

The holistic approach assumes that body and mind cannot be neatly divided, so illnesses don't have isolated causes. It also feeds from modern physics ideas about "the whole being in the part" (Wilber, 1997) and of non causal relations between phenomena. The main thesis is that each human being has some traits and way of being in the world (not static, but more or less stable), and that way of being in the world pervades and affects the whole organism. Also, each organ or system in our body has certain physiological functions that determine its "way of being". For example, lungs don't move independently, so they are "passive" in their function; the skin is sensitive and protective, etc. Finally, the method asserts that if the person rejects some aspects of her way of being, she is rejecting also intrinsic aspects of the natural functioning of the organ, making it more vulnerable to infection, illness or damage. For example, if I reject my "passive" polarity or trait, I could adversely affect the proper functioning of my lungs. So, the illness is not fought as an enemy, assuming instead that it can give us a valuable message about our integration path.

Based on this theoretical assumption, the method aims to help the patient to be aware of the parts of the ill organ or system that she is rejecting or denying in herself, and use the organ as a guide to integrate those aspects. It is directly related to polarity work, using the organ as a way of contacting the neglected pole. It doesn't pretend to replace traditional western medicine, but anecdotal results show that sometimes the technique helps overcome the disease, other times it helps slow down its progress and other

times it's "just" an effective method of facilitating the integration of client's polarities.

Describing the technique itself, it is a two-chair work between the person and the ill organ or system. Here I'll give a brief overview, as the technique has been explained in detail in Nana's books (1995, 2002, 2007). First the dialogue is oriented towards the traits or aspects of the organ that the person is rejecting in herself. Then, the focus turns to helping the client accept and not fight the organ with its characteristics. Finally, the therapist helps the client become the organ and thus embody those previously rejected traits. During the process the therapist often serves as an auxiliar ego, becoming the organ or the client during the dialogue. After the body dialogue has ended the client leaves with an important awareness but still with the task to integrate that polarity or trait into her life. So, the organ dialogue often is conducted in the context of a psychotherapeutic process, not as an isolated single-session technique.

I'll give a concrete example: Francisca is a thiry-year old woman who has a skin disease in which she grows hard layers of dandruff in her scalp (and sometimes her face). This disease began over 20 years ago, a week after her father died. At the beginning of the dialogue with her skin, the therapist noticed she didn't acknowledge its protective function. Then, the therapist in the role of the skin told Francisca that she could protect her and always would. Later they started talking about the onset of the illness and Francisca shared how she felt helpless and unprotected when her father died. Finally during the dialogue she concluded that the message of the illness was: "you can protect yourself, and comfort yourself, now that your father is gone". They noticed that she tended to pair off with protective men, and the therapist told Francisca that as she developed and integrated her protective part, the illness would give in.

The method is mature and has been applied for three decades. Now we're moving onto a different stage. We want to explore it scientifically. How effective is it? Why does it work? Are there contra-indications? We don't want Nana to be an infallible guru and the body dialogues her 10 commandments. We want to challenge its assumptions and study it with a curious and critical stance.

In the next section I'll tell you about the specific research projects we are developing. Here I'll just share some preliminary thoughts. I assume sometimes the method works, as I've been told by my colleagues that have used it (I'll tell you a secret: I've never used it after my GT training 12 years ago!). But how does it work? What are the specific change mechanisms? On one hand, it helps the patient to experience a rejected polarity. Sometimes it's difficult to get clients to accept some part of themselves that

feels foreign, but having them be an organ is easier, because the organ is obviously part of themselves. Also, speaking to the organ helps the client be more accepting with it and with the illness, reducing inner struggle and stress. We know emotional stress tends to make symptoms worse, so maybe the integration of polarities and reduction of frustration and anger towards the body and illness reduces stress and symptoms…

A final idea is that this method can empower the client but also, if applied without common sense and empathy, can bring enormous guilt to the client, who can feel as though his illness is his own fault (because he's narcissistic, doesn't accept limits, too independent, etc.). I've heard patients who end up worse after an intervention like this, so it's important to be aware of this danger.

Now let me tell you about our current research situation.

Research

In 2013, Huneeus stated that "there has been no empirical research in gestalt therapy in Chile to date." In the GT community research was a bad word, and "empirical research" a two-word combo that could make any gestaltist's stomach turn.

Today, in 2017, "empirical research" is like lettuce or carrots: not something that we long to eat, but good food nonetheless, and healthy too. And it doesn't make our stomach turn.

We had an aversion to research and now we have three relatively big projects underway, with several master's degree dissertations, presentations in international meetings and 2 journal publications being written. And it all started with a serendipitous combination of factors. I'll list them because knowing them can be useful for other colleagues who want to facilitate this transition in their institutions:

- Know-how: An improbable combination of GT and research training. I am the only Chilean that I know that had a 3-year GT training and also a PhD on psychotherapy research. Plus, our director has no research training but a strong and historic interest in the topic, and his leadership has been essential to make research an institutional project, not a personal one.
- A shared vision: a sense of purpose to fuel our motivation. Five years ago a German colleague (Otto Glänzer) visiting his daughter came to Chile and told us that GT in Germany was dying, and it was in part due to lack of empirical studies. That was the wake-up call. We wanted to collaborate to protect something valuable to us: Gestalt.

Also, we wanted to make it grow, to challenge it and to improve it. But the main motivation was more basic: to take care of something that we loved.

- Manpower: untapped resources. We didn't have funds to do research, but we had an institute with students who had to do their master's degree thesis. They often didn't complete their work, and when they did, it only served as dead weight on a bookshelf. So, we designed a lot of didactic material to make our students *want* to participate in our research project, because it was easier, had more guidance, and they noticed they could make a contribution. After a few years, we have been able to collect enormous amounts of data without spending a single peso, helping many students finish their work and graduate with their diploma.

Enough preamble. What projects are we working on?

1. The creation of an instrument to identify client's main polar conflict and rate its integration level. This project is directly inspired by Hans Strupp's ideas about PTO (problem treatment outcome) coherence (Strupp, 1988he). He claims that often in psychotherapy research the measures and instruments we use are not consistent with the way we work in the therapy process, and neither with what we aim to accomplish with our clients. So, for example, we end up doing research using DSM–5 for diagnosis, the Beck Depression Inventory for measuring outcome, and focusing on Gestalt techniques during the therapy with the aim of integrating client's polarities. This outcome measure aims to help fill that gap. We are currently testing the first version of the instrument.
2. A series of projects aiming to test the efficacy of Nana's body dialogue method and test the proposed theoretical change mechanisms. As noted before, so far there's no empirical research on Nana's approach. Our project will start testing its results with a few patients with uterine myoma, observing if the intervention helps with their physical symptoms and their polarity integration. We will also explore the theoretical hypothesis that it is this polarity integration the main change mechanism for the potential medical changes. After this initial study we plan on doing more research to explore the approach on different illnesses and more patients.
3. An international collaborative project to study process and outcome in Gestalt Therapy. Finally, we are spearheading a series of case studies using single case experimental design and time-series

analysis. In these, each client is compared with herself (pre-therapy versus post-therapy) and we collect detailed data daily during the whole process, including video recording of all sessions. This allows us to meticulously observe the change process, for example noting turning points during the therapy, or comparing specially productive and unproductive sessions. This methodology is affirmed by the American Psychological Association to assess if a therapy is efficacious for a specific problem, helping us become empirically supported with all that it implies. Also, by yielding detailed process information, this method helps us understand how change occurs during the therapy process, challenging theoretical assumptions and also understanding why sometimes change doesn't happen. We have already more than 20 cases collected and 10 analyzed, each functioning as a master's degree thesis for one of the students in our training center.

4. Finally, we are working with an international team (Jan Roubal from Czech Republic, Philip Brownell from USA, Illia Mstibovskyi from Russia and Otto Glänzer from Germany) to form a wide, practice-based research network (PBRN) of colleagues that can use this methodology in their private practices and institutions. With this team we are working on two publications: one focused on GT efficacy for anxiety disorders, and another aiming to show this method to GT colleagues and motivate them to join our PBRN.

Conclusion and Future Challenges

Gestalt in Chile is in a transition period. When I started my training 14 years ago, my classmates were mostly non-psychologists learning for more personal than academic or professional reasons. Now, almost all trainees are psychologists whose motivation is strongly tied to having their psychotherapy accreditation, and some of the students even have academic or research interests. We're engaged in research projects and are presenting at international conferences, but still most psychology students think we only punch cushions and do incense therapy. We enjoy a constant flow of new students and our graduates are happy, but we seek external validation and impact as well. We honor the legacies and try to carry on what our forefathers built, but at the same time want go to further, challenge their hypotheses and explore moments of failure. This reliance or dependance on few key figures is one of our main problems. If three or four strategic people get sick or lose motivation, all that we have built would fall down. We still

haven't built a community strong enough to carry on our work if we lose key members.

We have few resources, but if we want to grow into the future we still need to do much more. We need to publish and create a writing and research-friendly culture. We need to transcend the language barrier. We need to reach international colleagues who have expressed interest in the single case collaboration project. We need to do process research with the enormous amount of data we have collected. We have done a lot with very little resources, but to grow we need government financing.

Let's stop to think about this last sentence for a minute. It's weird for a group of Gestalt therapists trained on a gestalt prayer/theory is elephantshit brand of Gestalt to claim that the future of our field requires us to do empirical research, publish and learn to make budgets to apply for government funding. More than weird, borderline heretic perhaps. There are good reasons why we have historically avoided all that. It's hard to write (even more in a second tongue). It's a pain in the ass to apply for funding, and to understand methodological papers. It's easy to fall into doing aimless and meaningless empirical research. It's easy to give in when facing criticism, apathy or contempt among our peers.

At the same time, we believe the future of Gestalt needs curiosity, exploration and an open mind towards what we assume we know. In these challenging times, we need self-confidence and self-criticism. We need fellows who love experiential training and loath research, and we also need fellows who love analyzing videos, doing calculations or writing for a bigger audience.

We need all this, because our world needs us to contribute beyond the walls of our training institutes or private practices. We have a message and an expertise that is worth sharing. So, this is not a political or strategic calculation, it's a matter of love and care for Gestalt and for our world.

References

Greenberg, L. S. (1979). Resolving splits: Use of the two-chair technique. *Psychotherapy: Theory, Research & Practice*, 16(3), 316.

Herrera, P. (2016). The construction of a gestalt-coherent outcome measure. In J. Roubal, P. Brownell, G. Francesetti, J. Melnick, & J. Zeleskov-Djoric (Eds.), *Towards a research tradition in gestalt therapy.* Newcastle upon Tyne: Cambridge Scholar Publishing.

Huneeus, F. (2013). Gestalt therapy in Chile. In E. O'Leary (Ed.), *Gestalt therapy around the world, pp. 317–323.* Oxford: John Wiley & Sons. http://doi.org/10.1002/9781118323410

Johnson, B. (1992). *Polarity management*. Amherst: Human Resource Development.
Naranjo, C. (1990). *La vieja y novísima gestalt: Actitud y práctica*. Santiago: Cuatro Vientos
Naranjo, C. (1993) *La agonía del patriarcado. Barcelona: Editorial Kairós*
Naranjo, C. (1996) *Carácter y Neurosis*. Vitoria: Ediciones La Llave
Naranjo, C. (1999) *Autoconocimiento transformador. Los eneatipos en la vida, la literatura y la clínica*. Vitoria: Ediciones La Llave
Naranjo, C. (2000) *El eneagrama de la sociedad*. Vitoria: Ediciones la Llave
Naranjo, C. (2002) *Cambiar la educación para cambiar el mundo*. Vitoria: Ediciones La Llave
Naranjo, C. (2003) *Gestalt de vanguardia*. Vitoria: Ediciones La Llave
Naranjo, C. (2010) *La mente patriarcal*. Barcelona: RBA Libros
Naranjo, C. (2012) *Ayahuasca, la enredadera del río celestial*. Vitoria: Ediciones La Llave
Naranjo, C. (2014) *Budismo dionisiaco*. Vitoria: Ediciones La Llave
Perls, F. S., Hefferline, R., & Goodman, P. (2002). *Terapia Gestalt: excitación y crecimiento de la personalidad humana*. Madrid: Ed. Sociedad de Cultura Valle-Inclán.
Perls, F. S. (1974). *Sueños y existencia*. Santiago: Cuatro Vientos.
Riso, D. R., & Hudson, R. (2000). *La sabiduría del eneagrama*. Barcelona: Urano.
Schnake, A. (1995). *Los diálogos del cuerpo*. Santiago: Editorial Cuatro Vientos.
Schnake, A. (2002). *La voz de síntoma*. Santiago: Cuatro Vientos.
Schnake, A. (2007). *Enfermedad, síntoma y carácter*. Santiago: Cuatro Vientos.
Wilber, K. (1987). El paradigma holográfico. Barcelona: Editorial Kairós.
Yontef, G. M. (1995). *Proceso y diálogo en Terapia Guestáltica*. Santiago: Cuatro Vientos.
Zinker, J. (1979). *El Proceso Creativo en la Terapia Guestaltica*. México, D.F.: Paidós.

CONCLUSION

In what now seems like a dream, a long time ago books and movies used to conclude with an announcement: "The End." We are in that space with this book. The chapters have presented various styles of writing, diverse opinions and assertions, and they have illustrated the issues involved with research from several vantage points. They speak for themselves.

My hope is that this book will provide thinking material and stimulate growth in the global gestalt research movement. The book is already long. I won't go on and on. Because this is the end.