

Gestalt Therapy

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This is a chapter from the popular text, [Current Psychotherapies](#), by Corsini and Wedding. It will provide an overview of history, basic concepts, a case example, and further suggested readings.

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OVERVIEW

Gestalt therapy was founded by Frederick "Fritz" Perls and collaborators Laura Perls and Paul Goodman. They synthesized various cultural and intellectual trends of the 1940s and 1950s into a new gestalt, one that provided a sophisticated clinical and theoretical alternative to the two other main theories of their day: behaviorism and classical psychoanalysis.

Gestalt therapy began as a revision of psychoanalysis (F. Perls, 1942/1992) and quickly developed as a wholly independent, integrated system (F. Perls, Hefferline, & Goodman, 1951/1994). Since gestalt therapy is an experiential and humanistic approach, it works with patients' awareness and awareness skills rather than using the classic psychoanalytic reliance on the analyst's interpretation of the unconscious. Also, in gestalt therapy the therapist is actively and personally engaged with the patient, rather than fostering transference by remaining in the analytic role of neutrality. In gestalt therapy theory, a process-based postmodern field theory replaced the mechanistic, simplistic, Newtonian system of classical psychoanalysis. The gestalt therapist uses active methods that develop not only patients' awareness but also their repertoires of awareness and behavioral tools. The active methods and active personal engagement of gestalt therapy are used to increase the awareness, freedom, and self-direction of the patient, rather than to direct patients toward preset goals as in behavior therapy and encounter groups.

The gestalt therapy system is truly integrative and includes affective, sensory, cognitive, interpersonal, and behavioral components. In gestalt therapy, therapists and patients are encouraged to be creative in doing the awareness work. There are no prescribed or proscribed techniques in gestalt therapy.

Basic Concepts

Holism and Field Theory

Most humanistic theories of personality are holistic. Holism asserts that humans are inherently self-regulating, that they are growth-oriented, and that persons and their symptoms cannot be understood apart from their environment. Holism and field theory are interrelated in gestalt theory. Field theory is a way of understanding how one's context influences one's experiencing. Field theory, described elegantly by Einstein's theory of relativity, is a theory about the nature of reality and our relationship to reality. It represents one of the first attempts to articulate a contextualist view of reality (Philippson, 2001). Field theory, born in science, was an early contributor to the current postmodern sensibility that influences nearly all psychological theories today. Schools of thought that emphasize dependence on context build upon the work of Einstein and other field theorists.

The combination of field theory, holism, and gestalt psychology forms the bedrock for the gestalt theory of personality.

Fields have certain properties that lead to a specific contextual theory. As with all contextual theories, a field is understood to be composed of mutually interdependent elements. But there are other properties as well. For one thing, variables that contribute to shaping a person's behavior and experience are said to be present in the current field, and therefore, people cannot be understood without understanding the field, or context, in which they live. A patient's life story cannot tell you what actually happened in his or her past, but it can tell you how the patient experiences his or her history in the here and now. That rendition of history is shaped to some degree by the patient's current field conditions.

An event that happened three years ago is not a part of the current field and therefore cannot affect one's experience. What *does* shape one's experience is how one holds a memory of the event, and also the fact that an event three years ago has altered how one may organize one's perception in the field. Another property of the field is that the organization of one's experience occurs in the here and now and is ongoing and subject to change based on field conditions. Another property is that no one can transcend embeddedness

in a field; therefore, all attributions about the nature of reality are *relative* to the subject's position in the field. Field theory renounces the belief that anyone, including a therapist, can have an objective perspective on reality.

The *Paradoxical Theory of Change* is the heart of the gestalt therapy philosophy (Beisser, 1970). The paradox is that the more one tries to become who one is not, the more one stays the same. Health is largely a matter of being whole, and healing occurs when one is made whole again. The more one tries to force oneself into a mold that does not fit, the more one is fragmented rather than whole.

Organismic self-regulation requires knowing and owning—that is, identifying with— what one senses, feels emotionally, observes, needs or wants, and believes. True growth starts with conscious awareness of what is occurring in one's current existence, including how one is affected and how one affects others. One moves toward wholeness by identifying with ongoing experience, being in contact with what is actually happening, identifying and trusting what one genuinely feels and wants, and being honest with self and others about what one is actually able and willing to do—or not willing to do.

When one knows, senses, and feels one's self here and now, including the possibilities for change, one can be fully present, accepting or changing what is not satisfying.

Living in the past, worrying about the future, and/or clinging to illusions about what one should be or could have been, diminishes emotional and conscious awareness and the immediacy of experience that is the key to organismic living and growth.

Gestalt therapy aims for self-knowledge, acceptance, and growth by immersion in current existence, aligning contact, awareness, and experimentation with what is actually happening at the moment. It focuses on the here and now, not on what should be, could be, or was. From this present-centered focus, one can become clear about one's needs, wishes, goals, and values.

The concepts emphasized in gestalt therapy are contact, conscious awareness, and experimentation. Each concept is described below.

Contact means being in touch with what is emerging here and now, moment to moment. *Conscious awareness* is a focusing of attention on what one is in touch with in situations requiring such attention.

Awareness, or focused attention, is needed in situations that require higher contact ability, situations involving complexity or conflict, and situations in which habitual modes of thinking and acting are not working and in which one does not learn from experience. For example, in a situation that produces numbness, one can focus on the experience of numbness, and cognitive clarity can emerge.

Experimentation is the act of trying something new in order to increase understanding.

The experiment may result in enhanced emotions or in the realization of something that had been kept from awareness. Experimentation, trying something new, is an alternative to the purely verbal methods of psychoanalysis and the behavior control techniques of behavior therapy.

Trying something new, without commitment to either the status quo or the adoption of a new pattern, can facilitate organismic growth. For example, patients often repeat stories of unhappy events without giving any evidence of having achieved increased clarity or relief. In this situation, a gestalt therapist might suggest that the patient express affect directly to the person involved (either in person or through role playing). This often results in the patient experiencing relief and in the emergence of other feelings, such as sadness or appreciation.

Contact, awareness, and experimentation have technical meanings, but these terms are also used in a colloquial way. The gestalt therapist improves his or her practice by knowing the technical definitions.

However, for the sake of this introductory chapter, we will try to use the colloquial form of these terms.

Gestalt therapy starts with the therapist making contact with the patient by getting in touch with what the patient is experiencing and doing. The therapist helps the patient focus on and clarify what he or she is in contact with and deepens the exploration by helping focus the patient's awareness.

Awareness Process

Gestalt therapy focuses on the awareness process—in other words, on the continuum of one's flow of awareness. People have patterned processes of awareness that become foci for the work of therapy. This focus enables the patient to become clear about what he or she thinks, feels, and decides in the current moment—and about how he or she does it.

This includes a focus on what does not come to awareness. Careful attention to the sequence of the patient's continuum of awareness and observation of nonverbal behavior can help a patient recognize interruptions of contact and become aware of what has been kept out of awareness. For example, whenever

Jill starts to look sad, she does not report feeling sad but moves immediately into anger. The anger cannot end as long as it functions to block Jill's sadness and vulnerability. In this situation, Jill can not only gain awareness of her sadness but also gain in skill at self-monitoring by being made aware of her tendency to block her sadness. That second order of awareness (how she interrupts awareness of her sadness) is referred to as awareness of one's awareness process.

Awareness of awareness can empower by helping the patient gain greater access to himself or herself and clarify processes that had been confusing, improving the accuracy of perception and unblocking previously blocked emotional energy. Jill had felt stymied by her lover's defensive reaction to her anger. When she realized that she actually felt hurt and sad, and not just angry, she could express her vulnerability, hurt, and sadness. Her lover was much more receptive to this than he was to her anger. In further work Jill realized that blocking her sadness resulted from being shamed by her family when, as a child, she had expressed hurt feelings.

The gestalt therapist focuses on the patient's awareness and contact processes with respect, compassion, and commitment to the validity of the patient's subjective reality.

The therapist models the process by disclosing his or her own awareness and experience.

The therapist is present in as mutual a way as possible in the therapeutic relationship and takes responsibility for his or her own behavior and feelings. In this way, the therapist can be active and make suggestions but also can fully accept the patient in a manner consistent with the paradoxical theory of change.

Other Systems

In the decades up to and including the 1970s, it seemed simple to compare gestalt therapy with other systems. There were three major systems: classical Freudian psychoanalysis, behavior therapy, and the existential and humanistic therapies. In the 1960s, gestalt therapy became the most visible of the humanistic existential therapies and a salient alternative to psychoanalysis and behavior modification. However, the theoretical boundaries supporting various schools of therapy have become less distinct over the ensuing decades.

Classical Freudian Psychoanalysis and Gestalt Therapy

At the heart of Freudian psychoanalysis was a belief in the centrality of basic biological drives and in the establishment of relatively permanent structures created by the inevitable conflict between these basic drives and social demands—both legitimate demands and those stemming from parental and societal neurosis. All human development, behavior, thinking, and feeling were believed to be determined by these unconscious biological and social conflicts.

Patients' statements of their feelings, thoughts, beliefs, and wishes were not considered reliable because they were assumed to disguise deeper motivations stemming from the unconscious. The unconscious was a structure to which the patient did not have direct access, at least before completing analysis. However, the unconscious manifested itself in the transference neurosis, and through the analyst's interpretation of the transference, "truth" was discovered and understood.

Psychoanalysis proceeded by a simple paradigm. Through free association (talking without censoring or focusing), the patient provided data for psychoanalytic treatment.

These data were interpreted by the analyst according to the particular version of drive theory that he or she espoused. The analyst provided no details about his or her own life or person. He or she was supposed to be completely objective, eschewing all emotional reactions. The analyst had two fundamental rules: the *rule of abstinence* (gratifying no patient wish) and the *rule of neutrality* (having no preferences in the patient's conflict).

Any deviation by the analyst was considered countertransference. Any attempt by the patient to know something about the analyst was interpreted as resistance, and any ideas about the analyst were considered a projection from the unconscious of the patient.

Although interpretation of the transference helped bring the focus back to the here and now, unfortunately, the potential of the here-and-now relationship is not realized in classical psychoanalysis because the focus is drawn away from the actual contemporaneous relationship, and the patients' feelings are interpreted as the result of unconscious drives and unresolved conflicts. Discussion in psychoanalysis is usually focused on the past and not on what is actually happening between analyst and patient *in the moment*.

This simple summary of psychoanalysis is not completely accurate, because Adler, Rank, Jung, Reich, Horney, Fromm, Sullivan, and other analysts deviated from core Freudian assumptions in many ways and provided the soil from which the gestalt therapy system arose. In these derivative systems, as in gestalt therapy, the pessimistic Freudian view of a patient driven by unconscious forces was replaced by a belief in

the potential for human growth and by appreciation for the power of relationships and conscious awareness. These approaches did not limit the data to free association; instead, they valued an explicitly compassionate attitude by the therapist and allowed a wider range of interventions. However, these approaches were still fettered by remaining in the psychoanalytic tradition. Gestalt therapy took a more radical position.

Behavior modification provided a simple alternative: Observe the behavior, disregard the subjective reports of the patient, and control problematic behavior by using either classical or operant conditioning to manipulate stimulus-response relationships. In the behavioral approaches the emphasis was on what could be measured, counted, and “scientifically” proved.

The behavioral approach was the inverse of the intrapsychic approach of Freudian psychoanalysis. Here-and-now behavior was observed and taken as important data in its own right, but the patient’s subjective, conscious experience was not considered reliable data.

A third choice was provided by gestalt therapy. In gestalt therapy the patient’s awareness is not assumed to be merely a cover for some other, deeper motivation. Unlike psychoanalysis, gestalt therapy uses any and all available data. Like behavior modification, gestalt therapy carefully observes behavior, including observation of the body, and it focuses on the here and now and uses active methods. The patient’s self-report is considered real data. And, in a departure from both behavior modification and psychoanalysis, the therapist and the patient co-direct the work of therapy.

Client-Centered Therapy, Rational Emotive Behavior Therapy, and Gestalt Therapy

Gestalt therapy and client-centered therapy share common roots and philosophy. Both believe in the potential for human growth, and both believe that growth results from a relationship in which the therapist is experienced as warm and authentic (congruent).

Both client-centered and gestalt therapy are phenomenological therapies that work with the subjective awareness of the patient. However, gestalt therapy has a more active phenomenological approach. The gestalt therapy phenomenology is an experimental phenomenology.

The patient’s subjective experience is made clearer by using awareness experiments. These experiments are often similar to behavioral techniques, but they are designed to clarify the patient’s awareness rather than to control her or his behavior.

Another difference is that the gestalt therapist is more inclined to think in terms of to an encounter in which the subjectivity of both patient and therapist is valued. The gestalt therapist is much more likely than a person-centered therapist to tell the patient about his or her own feelings or experience.

Gestalt therapy provides an alternative to both the confrontational approach of REBT and the nondirective approach of Carl Rogers. A person-centered therapist completely trusts the patient’s subjective report, whereas a practitioner of rational emotive behavior therapy (REBT) confronts the patient, often quite actively, about his or her irrational or dysfunctional ways of thinking. Gestalt therapy uses focused awareness experiments and personal disclosure to help patients enlarge their awareness. (During the 1960s and 1970s, Fritz Perls popularized a very confrontive model for dealing with avoidance, but this model is not representative of gestalt therapy as it is practiced today.)

Gestalt therapy has become more like the person-centered approach in two important ways. First, gestalt therapists have become more supportive, compassionate, and kind. In addition, it has become clear that the therapist does not have an “objective” truth that is more accurate than the truth that the patient experiences.

Newer Models of Psychoanalysis and Relational Gestalt Therapy

There have been parallel developments in gestalt therapy and psychoanalysis. Although the concept of the relationship in gestalt therapy was modeled on Martin Buber’s I-Thou relationship, it was not well explicated until the late 1980s (Hycner, 1985; Jacobs, 1996; Yontef, 1993). In its emerging focus on the relationship, gestalt therapy has moved away from classical psychoanalysis and drive theory, away from confrontation as a desired therapeutic tool, and away from the belief that the therapist is healthy and the patient is sick.

Psychoanalysis has undergone a similar paradigm shift, and the two systems have somewhat converged. This is possible in part because contemporary psychoanalytic theories (especially relational and intersubjective theories) have rejected the limitations of classical Freudian psychoanalysis. The new theories eschew reductionism and determinism and reject the tendency to minimize the patient’s own perspective. This movement brings psychoanalysis closer to the theory and practice of gestalt therapy. Gestalt therapy was formed in reaction to the same aspects of psychoanalysis that contemporary psychoanalysis is now rejecting.

Basic tenets now shared by contemporary psychoanalysis and gestalt therapy include the following: an emphasis on the whole person and sense of self; an emphasis on process thinking; an emphasis on subjectivity and affect; an appreciation of the impact of life events (such as childhood sexual abuse) on personality development; a belief that people are motivated toward growth and development rather than

regression; a belief that infants are born with a basic motivation and capacity for personal interaction, attachment, and satisfaction; a belief that there is no “self” without an “other”; and a belief that the structure and contents of the mind are shaped by interactions with others, rather than by instinctual urges. It is meaningless to speak of a person in isolation from the relationships that shape and define his or her life.

Cognitive Behavior Therapy, REBT, and Gestalt Therapy

The assumption that gestalt therapy does not engage with patients’ thinking processes is inaccurate. Gestalt therapy has always paid attention to what the patient is thinking.

Gestalt therapists, like their cognitive therapy colleagues, stress the role of “futurizing” in creating anxiety and, like REBT therapists, discuss the creation of guilt by moralistic thinking and thoughts of unreasonable conditions of worth (“shoulds”). Many of the thoughts that would be labeled irrational in REBT or cognitive behavior therapy have also traditionally been an important focus for gestalt therapy.

There is one major difference between contemporary gestalt therapy and REBT or cognitive behavior therapy. In modern gestalt therapy, the therapist does not pretend to know the truth about what is irrational. The gestalt therapist observes the process, directs the patient to observe his or her thoughts, and explores alternate ways of thinking in a manner that values and respects what the patient experiences and comes to believe.

HISTORY

Precursors

Gestalt therapy was less a font of substantial original “discoveries” than a groundbreaking integrative system for understanding personality and therapy that developed out of a seedbed of rich and varied sources. Fritz and Laura Perls, and the later American collaborators with whom they wrote, taught, and practiced from the 1940s through the 1960s (Isadore From, Paul Goodman, and others), swam in the turbulent waters of the twentieth-century revolutions in science, philosophy, religion, psychology, art, literature, and politics. There was tremendous cross-fertilization between intellectuals in all disciplines during this period.

Frankfurt-am-Main of the 1920s, where Fritz Perls got his M.D. and Laura Perls her D.Sc., was a center of intellectual ferment in psychology. They were directly or indirectly exposed to leading gestalt psychologists, existential and phenomenological philosophers, liberal theologians, and psychoanalytic thinkers.

Fritz Perls was intimately acquainted with psychoanalysis and in fact was a training analyst. However, Perls chafed under the dogmatism of classical psychoanalysis. For Perls, the revolutionary basic idea that Freud brought to Western culture—the existence of motivations that lay outside of conscious awareness—had to be woven into other streams of thought, particularly holism, gestalt psychology, field theory, phenomenology, and existentialism.

These intellectual disciplines, each in its own way, were attempting to create a new vision of what it means to be human. Their vision came to be called a “humanistic” vision, and gestalt therapy introduced that vision into the world of psychotherapy. Freudian analysts asserted the essential truth that human life is biologically determined, conflicted, and in need of constraint; the existentialists asserted the primacy of existence over essence, the belief that people choose the direction of their life, and the argument that human life is not biologically determined. Within psychoanalysis, Perls was influenced by the more “renegade” analysts, especially Otto Rank and Wilhelm Reich. Both Rank and Reich emphasized conscious experience, the body as “carrier” of emotional wisdom and conflicts, and the active process of engagement between the therapist and the patient in the here and now. Reich introduced the important notion of “character armor”—repetitive patterns of experience, behavior, and body posture that keep the individual in fixed, socially determined roles. Reich also thought that how a patient spoke or moved was more important than what the patient said. Rank emphasized the creative powers and uniqueness of the individual and argued that the client was his or her own best therapist. Like Fritz Perls, Rank stressed the importance of the experience of the here-and-now therapeutic relationship.

Providing a major source of inspiration to Fritz and Laura Perls were European continental philosophers who were breaking away from Cartesian dualism, arguing that the split between subject and object, self and world, was an illusion. These included the existentialists, the phenomenologists, and philosophers such as Ludwig Wittgenstein.

The new approach was influenced by field theory, the gestalt psychologists, the holism of Jan Smuts, and Zen thought and practice. This thinking was blended by Fritz Perls with the gestalt psychology of figure/ground perception, and with the strongly gestalt-psychology-influenced work of psychologists Kurt Goldstein and Kurt Lewin (Wulf, 1998).

In his first book, *Ego, Hunger and Aggression* (1942/1992), Perls described people as imbedded in a person-environment field; this field was developed by the emergence into consciousness of those needs that organized perception. Perls also wrote about a “creative indifference” that enables a person to differentiate according to what is really needed in a particular situation. With the differentiation emerges the experience of contrast and awareness of the polarities that shape our experience of ourselves as separate.

Perls thought of this as a Western equivalent to the Eastern practice of Zen (Wulf, 1998).

Fritz and Laura left Germany during the Nazi era and later fled Nazi-occupied Holland. They went to South Africa, where they started a psychoanalytic training center.

During this same period, Jan Smuts, South African prime minister in the 1940s, coined the term *holism* and wrote about it. In time, Fritz and Laura Perls left South Africa because of the beginning of the apartheid policies that Jan Smuts helped to initiate.

The fundamental precept of *holism* is that the organism is a self-regulating entity. For Fritz Perls, gestalt psychology, organismic theory, field theory, and holism formed a happy union. Gestalt psychology provided Perls with the organizing principles for gestalt therapy, as well as with a cognitive scheme that would integrate the varied influences in his life.

The word *gestalt* has no literal English translation. It refers to a perceptual whole or configuration of experience. People do not perceive in bits and pieces, which are then added up to form an organized perception; instead, they perceive in patterned wholes.

Patterns reflect an interrelationship among elements such that the whole cannot be gleaned by a study of component parts, but only by a study of the relationship of parts to each other and to the whole. The leading figures in the development of gestalt psychology were Max Wertheimer, Kurt Koffka, and Wolfgang Kohler.

Kurt Lewin extended this work by applying gestalt principles to areas other than simple perceptual psychology and by explicating the theoretical implications of gestalt psychology. He is especially well known for his explication of the field theory philosophy of gestalt psychology, although this concept did not originate with him. Lewin (1938) discussed the principles by which field theory differed from Newtonian and positivistic thinking. In field theory, the world is studied as a systematic web of relationships, continuous in time, and not as discrete or dichotomous particles. In this view, everything is in the process of becoming, and nothing is static. Reality in this field view is configured by the relationship between the observer and the observed. “Reality,” then, is a function of perspective, not a true positivist fact. There may be multiple realities of equal legitimacy.

Such a view of the nature of reality opens gestalt theory to a variety of formerly disenfranchised voices, such as those of women, gays, and non-Europeans.

Lewin carried on the work of the gestalt psychologists by hypothesizing and researching the idea that a gestalt is formed by the interaction between environmental possibilities and organismic needs. Needs organize perception and action. Perception is organized by the state of the person-in-relation and the environmental surround. A gestalt therapy theory of organismic functioning was based on the gestalt psychology principles of perception and holism. The theory of organismic self-regulation became a cornerstone of the gestalt therapy theory of personality.

The philosophical tenets of phenomenology and existentialism were popular during the Perlses’ years in Germany and in the United States. Gestalt therapy was influenced profoundly by the work of the dialogic existential thinkers, especially Martin Buber, with whom Laura Perls studied directly. Buber’s belief in the inextricable existential fact that a self is always a self-with-other was a natural fit with gestalt thinking, and his theory of the I-Thou relation became, through the teachings of Laura Perls, the basis for the patient-therapist relationship in gestalt therapy.

Beginnings

Although Fritz Perls’s earliest publication was *Ego, Hunger and Aggression* (1942/1992), the first comprehensive integration of gestalt therapy system is found in *Gestalt Therapy* (F. Perls et al., 1951/1994). This seminal publication represented the synthesis, integration, and new gestalt formed by the authors’ exposure to the intellectual zeitgeist described above. A New York Institute of Gestalt Therapy was soon formed, and the early seminar participants became teachers who spread the word to other cities by running regular training workshops, especially in New York, Cleveland, Miami, and Los Angeles.

Intensive study groups formed in each of these cities. Learning was supplemented by the regular workshops of the original study group members, and eventually all of these cities developed their own gestalt training institutes. The Gestalt Institute of Cleveland has made a special effort to bring in trainees from varied backgrounds and to develop a highly diverse faculty.

Gestalt therapy pioneered many ideas that have influenced humanistic psychotherapy.

For instance, gestalt therapy has a highly developed methodology for attending to experience phenomenologically, and for attending to how the therapist and patient experience each other in the therapeutic relationship. *Phenomenology* assumes the reality is formed in the relationship between the observed and the observer. In short, reality is interpreted.

The dialogic relationship in gestalt therapy derived three important principles from Martin Buber's thought. First, in a dialogic therapeutic relationship the therapist practices inclusion, which is similar to empathic engagement. In this the therapist puts himself or herself into the experience of the patient, imagines the existence of the other, feels it as if it were a sensation within his or her own body, and simultaneously maintains a sense of self. Inclusion is a developed form of contact rather than a merger with the experience of the patient. Through imagining the patient's experience in this way, the dialogic therapist confirms the existence and potential of the patient. Second, the therapist discloses himself or herself as a person who is authentic and congruent and someone who is striving to be transparent and self-disclosing. Third, the therapist in dialogic therapy is committed to the dialogue, surrenders to what happens between the participants, and thus does not control the outcome. In such a relationship, the therapist is changed as well as the patient.

Underlying most existential thought is the existential phenomenological method.

Gestalt therapy's phenomenology is a blend of the existential phenomenology of Edmund Husserl and the phenomenology of gestalt psychology.

Phenomenological understanding is achieved by taking initial perceptions and separating what is actually experienced at the moment from what was expected or merely logically derived. The phenomenological method increases the clarity of awareness by descriptively studying the awareness process. In order to do this, phenomenologists put aside assumptions, especially assumptions about what constitutes valid data. All data are considered valid initially, although they are likely to be refined by continuing phenomenological exploration. This is quite consistent with the gestalt therapy view that the patient's awareness is valid and should be explored rather than explained away in terms of unconscious motivation.

Although other theories have not fully incorporated the I-Thou relation, or systematic phenomenological focusing, they have been influenced by the excitement and vitality of direct contact between therapist and patient; the emphasis on direct experience; the use of experimentation; emphasis on the here and now, emotional process, and awareness; trust in organismic self-regulation; emphasis on choice; and attention to the patient's context as well as his or her "inner" world.

Current Status

Gestalt Institutes, literature, and journals have proliferated worldwide in the past 45 years.

There is at least one gestalt therapy training center in every major city in the United States, and there are numbers of gestalt therapy training institutes in most countries of Europe, North and South America, and Australia. Gestalt therapists practice all over the world.

Various countries and regions have begun to form umbrella organizations that sponsor professional meetings, set standards, and support research and public education. In the United States, there is the Association for the Advancement of Gestalt Therapy, with both national and international membership. This organization is not limited to professionals.

The association was formed with the intention of governing itself through adherence to gestalt therapy principles enacted at an organizational level. Regional conferences are also sponsored by a European gestalt therapy association, the European Association for Gestalt Therapy, and by an Australian and New Zealand association, GANZ.

Gestalt therapy is known for a rich oral tradition, and historically, gestalt writings have not reflected the full depth of its theory and practice. Gestalt therapy has tended to attract therapists inclined to an experiential approach. The gestalt therapy approach is almost impossible to teach without a strong experiential component.

Since the publication of a seminal book by the Polsters (Polster & Polster, 1973), the gap between the oral and written traditions of gestalt therapy has closed. There is now an extensive gestalt therapy literature, and a growing number of books address various aspects of gestalt therapy theory and practice. For many years there was only one English-language periodical devoted to gestalt therapy, *The Gestalt Journal*. There are now four English language gestalt journals: *The International Gestalt Journal* (formerly *The Gestalt Journal*), the *British Gestalt Journal*, the *Gestalt Review*, and the *Gestalt Journal of Australia and New Zealand*. The Gestalt Journal Press also lists a comprehensive bibliography of gestalt books, articles, videotapes, and audiotapes. This listing can be accessed through the Internet at www.gestalt.org. Gestalt therapy literature has also flourished around the world. There is at least one journal in most languages in Europe, North and South America, and Australia.

In addition to the books written in English, translated, and widely read in other countries, there have been important original theoretical works published in French, German, Italian, Portuguese, Danish, and Spanish. The past decade has witnessed a major shift in gestalt therapy's understanding of personality and therapy. There has been a growing, albeit sometimes controversial, change in understanding the relational conditions for growth, both in general and (especially) in the therapeutic relationship. There is an increased appreciation for interdependence, a better understanding of the shaming effect of the cultural value placed on self-sufficiency, and greater realization of how shame is created in childhood and triggered in interpersonal

relationships (Jacobs, 2005; Lee & Wheeler, 1996; Lee, 2004). As gestalt therapists have come to understand shame more thoroughly, and how shame is triggered, they have become less confrontive and more accepting and supportive than in earlier years.

PERSONALITY

Theory of Personality

Gestalt therapy theory has a highly developed, somewhat complicated theory of personality.

The notions of healthy functioning and neurotic functioning are actually quite simple and clear, but they are built upon a paradigm shift, not always easy to grasp, from linear cause-and-effect thinking to a process, field theory world view.

Gestalt therapy is a radical ecological theory that maintains there is no meaningful way to consider any living organism apart from its interactions with its environment— that is, apart from the organism-environment field of which it is a part (F. Perls et al., 1951/1994). Psychologically, there is no meaningful way to consider a person apart from interpersonal relations, just as there is no meaningful way to perceive the environment except through someone's perspective. According to gestalt therapy field theory, it is impossible for perception to be totally "objective."

The "field" that human beings inhabit is replete with other human beings. In gestalt theory, there is no self separate from one's organism/environmental field; more specifically, self does not exist without other. Self implies self-in-relation. Contact is an integral aspect of all experience—in fact, experience does not exist without contact—but it is the contact between humans that dominates the formation and functions of our personalities.

The field is differentiated by *boundaries*. The contact boundary has dual functions:

It connects people with each other but also maintains separation. Without emotional connecting with others, one starves; without emotional separation, one does not maintain a separate, autonomous identity.

Connecting meets biological, social, and psychological needs; separation creates and maintains autonomy and protects against harmful intrusion or overload.

Needs are met and people grow through contact with and withdrawal from others.

By separating and connecting, a person establishes boundary and identity. Effective self-regulation includes contact in which one is aware of what is newly emerging that may be either nourishing or harmful. One identifies with that which is nourishing and rejects that which is harmful. This kind of differentiated contact leads to growth (Polster & Polster, 1973). The crucial processes regulating this discrimination are awareness and contact.

The most important processes for psychological growth are interactions in which two persons each acknowledge the experience of the other, with awareness and respect for the needs, feelings, beliefs, and customs of the other. This form of dialogic contact is essential in therapy.

Organismic Self-Regulation

Gestalt therapy theory holds that people are inherently self-regulating and motivated to solve their own problems. Needs and desires are organized hierarchically so that one's most urgent need takes precedence and claims one's attention until this need is met. When this need is met, the next need or interest becomes the center of one's attention.

Gestalt (Figure/Ground) Formation

A corollary to the concept of organismic self-regulation is called gestalt formation.

Gestalt psychology has taught us that we perceive in unified wholes, and also that we perceive through the phenomenon of contrast. A figure of interest forms in contrast to a relatively dull background. For instance, the words on this page are a visual figure to the reader, whereas other aspects of the room are visually less clear and vivid until this reference to them leads the reader to allow the words on the page to slip into the background, at which time the figure of a table, chair, book, or soda emerges. One can only perceive one clear figure at a time, although figures and grounds may shift very rapidly.

Consciousness and Unconsciousness

A most important consequence of adapting gestalt psychology to a theory of personality functioning is that ideas about consciousness and unconsciousness are radically different from those of Freud. Freud believed the unconscious was filled with impersonal, biologically based urges that constantly pressed for release. Competent functioning depended on the successful use of repression and sublimation to keep the contents of the unconscious hidden; these urges could be experienced only in symbolic form.

Gestalt therapy's "unconscious" is quite different. In gestalt therapy theory, the concepts of awareness and unawareness replace the unconscious. Gestalt therapists use the concepts of awareness/unawareness to reflect the belief in the fluidity between what is momentarily in awareness and what is momentarily outside of awareness.

When something vital, powerful, and relevant is not allowed to emerge into foreground, one is unaware. What is background is, for the moment, outside of awareness, but it could instantly become the figure in awareness. This is in keeping with the gestalt psychology understanding of perception, which is the formation of a figure against a background.

In neurotic patients, some aspect of the phenomenal field is purposely and regularly relegated to the background. This concept is roughly similar to the Freudian dynamic unconscious. However, gestalt therapists do not believe in a "primary process" unconscious that needs to be translated by the therapist before it can be comprehensible to the patient.

Gestalt therapists maintain that what is being relegated to permanent background status reflects the patient's current conflicts as well as the patient's perspective on current field conditions. When a patient perceives the conditions of the therapy relationship to be safe enough, more and more aspects of previously sequestered subjective states can be brought into awareness through the therapeutic dialogue.

Health

The gestalt therapy notion of health is actually quite simple. In healthy organismic selfregulation, one is aware of shifting need states; that is, what is of most importance becomes the figure of one's awareness. Being whole, then, is simply identifying with one's ongoing, moment-by-moment experiencing and allowing this identification to organize one's behavior.

Healthy organismic awareness includes awareness of the human and nonhuman environment and is not unreflective or inconsiderate of the needs of others. For example, compassion, love, and care for the environment are all part of organismic functioning. Healthy functioning requires being in contact with what is actually occurring in the person-environment field. Contact is the quality of being in touch with one's experience in relation to the field. By being aware of what is emerging, and by allowing action to be organized by what is emerging, people interact in the world and learn from the experience.

By trying something new, one learns what works and what does not work in various situations. When a figure is not allowed to emerge, when it is somehow interrupt or misdirected, there is a disturbance in awareness and contact.

Tendency Toward Growth

Gestalt therapists believe that people are inclined toward growth and will develop as fully as conditions allow. Gestalt therapy is holistic and asserts that people are inherently self-regulating and growth-oriented and that people and their behavior, including symptoms, cannot be understood apart from their environment.

Gestalt therapy is interested in the existential themes of existence—connection and separation, life and death, choice and responsibility, authenticity and freedom. Gestalt therapy's theory of awareness is a bedrock phenomenological orientation toward experience derived from an existential and humanistic ethos. Gestalt therapy attempts to understand human beings by the study of experience. Meaning is understood in terms of what is experienced and how it is experienced.

Life Is Relational

Gestalt therapy regards awareness and human relations as inseparable. Awareness develops in early childhood through a matrix of relations that continues throughout life.

Relationships are regulated by how people experience them. People define themselves by how they experience themselves in relation to others. This derives from how people are regarded by others and how they think and behave toward others. In gestalt therapy theory, derived from Martin Buber, there is no "I," no sense of self, other than self in relation to others. There is only the "I" of the "I-Thou" or the "I" of the "I-[I]t." As Buber said, "All real living is meeting" (1923/1970, p. 11).

Living is a progression of needs, met and unmet. One achieves homeostatic balance and moves on to whatever need emerges next. In health, the boundary is permeable enough to allow exchange with that which promotes health (connecting) and firm enough to preserve autonomy and exclude that which is unhealthful (separation). This requires the identification of those needs that are most pressing at a particular time and in a particular environment.

Variety of Concepts

Disturbances at the Boundary

Under optimal conditions, there is ongoing movement between connecting and withdrawal.

When the experience of coming together is blocked repetitively, one is left in a state of *isolation*, which is a boundary disturbance. It is a disturbance because it is fixed, does not respond to a whole range of needs, and fails to allow close contact to emerge. By the same token, if the need to withdraw is blocked, there is a corresponding boundary disturbance, known as *confluence*. Confluence is the loss of the experience of separate identity.

In optimal functioning, when something is taken in—whether it is an idea, food, or love—there is contact and awareness. The person makes discriminations about what to take in and what meaning to attach to that which is taken in. When things (ideas, identity, beliefs, and so on) are taken in without awareness, the boundary disturbance of *introjection* results. Introjects are not fully integrated into organismic functioning. In order for one to integrate and be whole, what is taken in must be assimilated.

Assimilation is the process of experiencing what is to be taken in, deconstructing it, keeping what is useful, and discarding what is not. For example, the process of assimilation allows the listener to select and keep only what is useful from a lecture she or he attends.

When a phenomenon that occurs in one's self is falsely attributed to another person in an effort to avoid awareness of one's own experience, the boundary disturbance of *projection* occurs. When an impulse or desire is turned into a one-person event instead of a two-person event (an example is caressing oneself when one wants another person to do the [caressing]), there is the boundary disturbance of *retroflexion*. In each of these processes some part of the person is disowned and not allowed to become figural or to organize and energize action.

Creative Adjustment

When all the pieces are put together, people function according to an overarching principle called creative adjustment. "All contact is creative adjustment of the organism and the environment" (F. Perls et al., 1951/1994). All organisms live in an environment to which they must adjust. Nevertheless, people also need to shape the environment so that it conforms to human needs and values.

The concept of creative adjustment follows from the notion that people are growth-oriented and will try to solve their problems in living in the best way possible. This means solving the problem in a way that makes the fullest use of their own resources and those of the environment. Since awareness can be concentrated on only one figure at a time, those processes that are not the object of creative awareness operate in a habitual mode of adjustment until it is their turn to come into full awareness.

The term *creative adjustment* reflects a creative balance between changing the environment and adjusting to current conditions. Since people live only in relation, they must balance adjusting to the demands of the situation (such as societal demands and the needs of others) and creating something new according to their own, individual interests. This is a continual, mutual, reciprocal negotiation between one's self and one's environment.

The process whereby a need becomes figural, is acted on, and then recedes as a new figure emerges is called a *gestalt formation cycle*. Every gestalt formation cycle requires creative adjustment. Both sides of the polarity are necessary for the resolution of a state of need. If one is hungry, one must eat new food taken from the environment. Food that has already been eaten will not solve the problem. New actions must occur, and the environment must be contacted and adapted to meet the individual's needs.

On the other hand, one cannot be so balanced on the side of creating new experience that one does not draw on prior learning and experience, established wisdom, and societal mores. For example, one must use yesterday's learning to be able to recognize aspects of the environment that might be used as a source of food, while at the same time being creative in experimenting with new food possibilities.

Maturity

Good health has the characteristics of a good gestalt. A *good gestalt* consists of a perceptual field organized with clarity and good form. A well-formed figure clearly stands out against a broader and less distinct background. The relation between that which stands out (figure) and the context (ground) is meaning. In a good gestalt, meaning is clear.

Health and maturity result from creative adjustment that occurs in a context of environmental possibility. Both health and maturity require a person whose gestalt formation process is freely functioning and one whose contact and awareness processes are relatively free of excessive anxiety, inhibition, or habitual selective attention. In health, the figure changes as needed; that is, it shifts to another focus when a need is met or superseded by a more urgent need. It does not change so rapidly as to prevent satisfaction (as in hysteria) or so slowly that new figures have no room to assume dominance (as in compulsivity). When the figure and ground are dichotomized, one is left with a figure out of context or a context without focus (as in impulsivity) (F. Perls et al., 1951/1994).

The healthy person is in creative adjustment with the environment. The person adjusts to the needs of the environment and adjusts the environment to his or her own needs. Adjustment alone is conformity and breeds stagnation. On the other hand, unbridled creativity in the service of the isolated individual would result in pathological narcissism.

Disrupted Personality Functioning

Mental illness is simply the inability to form clear figures of interest and identify with one's moment-by-moment experience and/or to respond to what one becomes aware of. People whose contact and awareness processes are disrupted often have been shaped by environments that were chronically impoverished. Impoverished environments diminish one's capacity for creative adjustment.

However, even neurotic self-regulation is considered a creative adjustment. Gestalt therapists assume that neurotic regulation is the result of a creative adjustment that was made in a difficult situation in the past and then not readjusted as field conditions changed. For example, one patient's father died when she was 8 years old. The patient was terribly bereft, frightened, and alone. Her grief-stricken mother, the only adult in her life, was unavailable to help her assimilate her painful and frightening reactions to her father's death. The patient escaped her unbearable situation by busying herself to the point of distraction. That was a creative adjustment to her needs in a field with limited resources. But as an adult, she continues to use the same means of adjustment, even though the field conditions have changed. This patient's initial creative adjustment became hardened into a repetitive character pattern. This often happens because the original solution worked well enough in an emergency, and current experiences that mimic the original emergency trigger one's emergency adaptation.

Neurotic self-regulation tends to replace organismic self-regulation. Patients frequently cannot trust their own self-regulation, because repeated use of a solution from an earlier time erodes their ability to respond with awareness to the current self-in-field problem.

Organismic self-regulation is replaced by "shoulds"—that is, by attempts to control and manage one's experience rather than accepting one's experience. Part of the task of therapy is to create, in the therapy situation, a new "emergency" but a "safe emergency"—one that includes some elements reminiscent of the old situation (such as rising emotional intensity) but also contains health-facilitating elements that can be utilized (for instance, the therapist's affirming and calming presence). The new situation, if safe enough, can promote a new, more flexible and responsive creative adjustment.

Polarities

Experience forms as a gestalt, a figure against a ground. Figure and ground stand in a polar relation to each other. In healthy functioning, figures and grounds shift according to changing needs and field conditions. What was previously an aspect of the ground can emerge almost instantly as the next figure.

Life is dominated by polarities: life/death, strength/vulnerability, connection/ separation, and so on and on. When one's creative adjustments are flowing and responsive to current field conditions, the interaction and continually recalibrating balance of these polarities make up the rich tapestry of existence.

In neurotic regulation, some aspects of one's ground must be kept out of awareness (for instance, the patient's unbearable loneliness), and polarities lose their fluidity and become hardened into dichotomies. In neurotic regulation, a patient may readily identify with his or her strength but may, rather, ignore or disavow the experience of vulnerability.

Such selective awareness results in a life filled with insoluble conflicts and plagued by crises or dulled by passivity.

Resistance

The ideas of holism and organismic self-regulation have turned the theory of resistance on its head. Its original meaning in psychoanalysis referred to a reluctance to face a painful truth about one's self. However, the theory of self-regulation posits that all phenomena, even resistance, when taken in context, can be shown to serve an organismic purpose.

In gestalt theory, resistance is an awkward but crucially important expression of the organism's integrity. Resistance is the process of opposing the formation of a figure (a thought, feeling, impulse, or need) that threatens to emerge in a context that is judged to be dangerous. For instance, someone may choke back tears, believing that crying would expose himself or herself to ridicule, or someone who has been ridiculed in the past for showing any vulnerability may assume that the current environmental surround is harsh and unforgiving. The inhibited experience is resisted—usually without awareness. For example, a patient may have pushed all experience of vulnerability out of awareness; however, the experience of vulnerability still lives in the background, quietly shaping and shadowing the figure formation process. It cannot disappear, because it is but one side of a polarity that is part of life. Therefore, instead of a fluid polar

relationship between those two attributes, the patient develops a hardened dichotomy between strength and vulnerability and inevitably experiences anxiety whenever he or she feels vulnerable. The result may be a man who takes risks demonstrating great physical courage, but who is terrified by the thought of committing himself to a woman he loves. As the conflict is explored in therapy, he becomes aware that he is terribly frightened of his vulnerable feelings and resists allowing those feelings to be activated and noticed. The resistance protects him by ensuring that his habitual mode of self-regulation remains intact. When the original creative adjustment occurred, the identification with his strength and the banishment of his vulnerability were adaptive. Gestalt theory posits that he has “forgotten” that he made such an adjustment and so remains unaware that he even *has* any vulnerability that might be impeding his ability to make decisions in support of his current figure of interest, the commitment. Even when the patient becomes vaguely aware, he may not be sure that the current context is sufficiently different that he can dare to change his dichotomized adjustment. Repetitive experiments within the relative safety of the therapeutic relationship may enable him to contact his vulnerable side enough to re-enliven the polarity of strength/vulnerability such that he can resume a more moment-by-moment creative adjustment process.

Emotions are central to healthy functioning because they orient one to one’s relationship to the current field, and they help establish the relative urgency of an emergent figure. Emotional process is integral to the gestalt formation process and functions as a “self-signal” in a healthy individual. For instance, upon suddenly experiencing shame, the healthy person takes it as a sign that he or she should not persist in whatever he or she is doing. Unfortunately, the person whose self-regulation has been disrupted cannot experience shame as a signal but instead tends to be overwhelmed by it.

Contact and Support

“*Contact* is possible only to the extent that *support* for it is available. . . . *Support* is everything that facilitates the ongoing assimilation and integration of experience for a person, relationship or society” (L. Perls, 1992). Adequate support is a function of the total field.

It requires both self-support and environmental support. One must support oneself by breathing, but the environment must provide the air. In health one is not out of touch with the present set of self and environmental needs and does not live in the past (unfinished business) or future (catastrophizing). It is only in the present that individuals can support themselves and protect themselves.

Anxiety

Gestalt therapy is concerned with the process of anxiety rather than the content of anxiety (what one is anxious about). Fritz Perls first defined anxiety as excitement minus support (F. Perls, 1942/1992; F. Perls et al., 1951/1994). Anxiety can be created cognitively or through unsupported breathing habits. The cognitive creation of anxiety results from “futurizing” and failing to remain centered in the present. Negative predictions, misinterpretations, and irrational beliefs can all trigger anxiety. When people “futurize,” they focus their awareness on something that is not yet present. For example, someone about to give a speech may be preoccupied with the potentially negative reaction of the audience.

Fears about future failure can have a very negative effect on current performance.

Stage fright is a classic example in which physical arousal is mislabeled, and misattribution triggers a panic attack.

Anxiety can also be created by unsupported breathing. With arousal there is an organismic need for oxygen. “A healthy, self-regulating individual will automatically breathe more deeply to meet the increased need for oxygen which accompanies mobilization and contact” (Clarkson & Mackewn, 1993, p. 81). When people breathe fully, tolerate increased mobilization of energy, are present-centered and cognitively flexible, and put energy into action, they experience excitement rather than anxiety. Breath support requires full inhalation and exhalation, as well as breathing at a rate that is neither too fast nor too slow. When one breathes rapidly without sufficient exhaling, fresh, oxygenated blood cannot reach the alveoli because the old air with its load of carbon dioxide is not fully expelled. Then the person has the familiar sensations of anxiety: increased pulse rate, inability to get enough air, and hyperventilation (Acierno, Hersen, & Van Hasselt, 1993; 1992; F. Perls, 1942/1992; F. Perls et al., 1951/1994).

The gestalt therapy method, with its focus on both body orientation and characterological issues, is ideal for the treatment of anxiety. Patients learn to master anxiety cognitively and physically through cognitive and body-oriented awareness work (Yontef, 1993).

Impasse

An impasse is experienced when a person’s customary supports are not available and new supports have not yet been mobilized. The experience is existentially one of terror. The person cannot go back and does not know whether he or she can survive going forward.

People in the impasse are paralyzed, with forward and backward energy fighting each other. This experience is often expressed in metaphorical terms: void, hollow, blackness, going off a cliff, drowning, or being sucked into a whirlpool.

The patient who stays with the experience of the impasse may experience authentic existence—that is, existence with minimal illusion, good self-support, vitality, creativity, and good contact with the human and nonhuman environment. In this mode, gestalt formation is clear and lively, and maximum effort is put into what is important. When support is not mobilized to work through the impasse, the person continues to repeat old and maladaptive behaviors.

Development

Gestalt therapy has not, until recently, had a well-developed theory of childhood development, but current psychoanalytic research and theory support a perspective that gestalt therapists have held for quite a while. This theory maintains that infants are born with the capacity for self-regulation, that the development and refinement of selfregulatory skills are contingent on mutual regulation between caretaker and infant, that the contact between caretaker and infant must be attuned to the child's emotional states for self-regulation to develop best, and that children seek relatedness through emotionally attuned mutual regulation (Stern, 1985). Gestalt therapist Frank (2001) has used the research of Stern and others to formulate a comprehensive gestalt theory of development based on embodiment and relatedness. McConville and Wheeler (2003) have used field theory and relatedness in articulating their theories of child and adolescent development.

PSYCHOTHERAPY

Theory of Psychotherapy

People grow and change all through life. Gestalt therapists believe growth is inevitable as long as one is engaged in contact. Ordinarily, people develop increasing emotional, perceptual, cognitive, motoric, and organismic self-regulatory competence.

Sometimes, however, the process of development becomes impaired or derailed. To the extent that people learn from mistakes and grow, psychotherapy is not necessary.

Psychotherapy is indicated when people routinely fail to learn from experience.

People need psychotherapy when their self-regulatory abilities do not lead them beyond the maladaptive repetitive patterns that were developed originally as creative adjustments in difficult circumstances but that now make them or those around them unhappy. Psychotherapy is also indicated with patients who do not deal adequately with crises, feel ill equipped to deal with others in their lives, or need guidance for personal or spiritual growth.

Gestalt therapy concentrates on helping patients become aware of how they avoid learning from experience, how their self-regulatory processes may be closed-ended rather than open-ended, and how inhibitions in the area of contact limit access to the experience necessary to broaden awareness. Of course, awareness is developed through interactions with other people. From the earliest moment of a person's life, both functional and dysfunctional patterns emerge from a matrix of relationships.

Psychotherapy is primarily a relationship between a patient and a therapist, a relationship in which the patient has another chance to learn, to unlearn, and to learn how to keep learning. The patient and the therapist make explicit the patterns of thought and behavior that are manifest in the psychotherapy situation. Gestalt therapists hold that the patterns that emerge in therapy recapitulate the patterns that are manifest in the patient's life.

Goal of Therapy

The only goal of gestalt therapy is awareness. This includes achieving greater awareness in particular areas and also improving the ability to bring automatic habits into awareness as needed. In the former sense, awareness refers to content; in the latter sense, it refers to process, specifically the kind of self-reflective awareness that is called "awareness of awareness." Awareness of awareness is the patient's ability to use his or her skills with awareness to rectify disturbances in his or her awareness process. Both awareness as content and awareness as process broaden and deepen as the therapy proceeds. Awareness requires self-knowledge, knowledge of the environment, responsibility for choices, selfacceptance, and the ability to contact.

Beginning patients are chiefly concerned with the solution of problems, often thinking that the therapist will "fix" them the way a physician often cures a disease. However, gestalt therapy does not focus on curing

disease, nor is it restricted to talking about problems. Gestalt therapy uses an active relationship and active methods to help patients gain the self-support necessary to solve problems. Gestalt therapists provide support through the therapeutic relationship and show patients how they block their awareness and functioning. As therapy goes on, the patient and the therapist turn more attention to general personality issues. By the end of successful gestalt therapy, the patient directs much of the work and is able to integrate problem solving, characterological themes, relationship issues with the therapist, and the regulation of his or her own awareness.

How Is the Therapy Done?

Gestalt therapy is an exploration rather than a direct attempt to change behavior. The goal is growth and autonomy through an increase in consciousness. The method is one of direct engagement, whether that engagement is the meeting between therapist and patient or engagement with problematic aspects of the patient's contacting and awareness process. The model of engagement comes directly from the gestalt concept of contact.

Contact is the means whereby living and growth occur, so lived experience nearly always takes precedence over explanation. Rather than maintaining an impersonal professional distance and making interpretations, the gestalt therapist relates to the patient with an alive, excited, warm, and direct presence.

In this open, engaged relationship, patients not only get honest feedback but also, in the authentic contact, can see, hear, and be told how they are experienced by the therapist, can learn how they affect the therapist, and (if interested) can learn something about the therapist. They have the healing experience of being listened to by someone who profoundly cares about their perspectives, feelings, and thoughts.

What and How; Here and Now

In gestalt therapy there is a dual focus: a constant and careful emphasis on *what* the patient does and *how* it is done and also a similar focus on the interactions between therapist and patient. What does the patient do to support himself or herself in the therapy hour in relation to the therapist and in the rest of his or her life?

Direct experience is the primary tool of gestalt therapy, and the focus is always on the here and now. The present is a transition between past and future. Not being primarily present-centered reflects a time disturbance—but so does not being able to contact the relevant past or not planning for the future.

Frequently patients lose their contact with the present and live in the past. In some cases, patients live in the present as though they had no past, with the unfortunate consequence that they cannot learn from the past. The most common time disturbance is living in anticipation of what could happen in the future as though the future were now.

Now starts with the present awareness of the patient. In a gestalt therapy session, what happens first is not childhood but what is experienced *now*. Awareness takes place *now*.

Prior events may be the object of present awareness, but the awareness process is *now*.

Now I can contact the world around me, or *now* I can contact memories or expectations.

"Now" refers to *this moment*. When patients refer to their lives outside of the therapy hour, or even earlier in the hour, the content is not considered *now*, but the action of speaking *is* now. We orient more to the now in gestalt therapy than in any other form of psychotherapy. This "what and how; here and now" method frequently is used to work on characterological and developmental themes. Exploration of past experience is anchored in the present (for example, determining what in the present field triggers this particular old memory). Whenever possible, methods are used that bring the old experience directly into present experience, rather than just recounting the past.

There is an emerging awareness in gestalt therapy that the best therapy requires a binocular viewpoint:

Gestalt therapy requires technical work on the patient's awareness process, but at the same time it involves a personal relationship in which careful attention is paid to nuances of what is happening in the contact between therapist and patient.

Awareness

One of the pillars of gestalt therapy is developing awareness of the awareness process. Does the awareness deepen and develop fully—or is it truncated? Is any particular figure of awareness allowed to recede from the mind to make room for other awarenesses—or does one figure repeatedly capture the mind and shut out the development of other awareness?

Ideally, processes that need to be in awareness come into awareness when and as needed, in the ongoing flow of living. When transactions get complex, more conscious self-regulation is needed. If this develops and a person behaves mindfully, the person is likely to learn from experience.

The concept of awareness exists along a continuum. For example, gestalt therapy distinguishes between merely *knowing* about something and *owning* what one is doing. Merely knowing about something marks the transition between that something's being totally out of awareness and its being in focal awareness. When people report being aware of something and yet claim they are totally helpless to make desired changes,

they are usually referring to a situation in which they *know about* something but do not fully feel it, do not know the details of how it works, and do not genuinely integrate it and make it their own. In addition, they frequently have difficulty imagining alternatives and/or believing that the alternatives can be achieved and/or knowing how to support experimenting with alternatives.

Being fully aware means turning one's attention to the processes that are most important for the person and environment; this is a natural occurrence in healthy self-regulating.

One must know what is going on and how it is happening. What am I needing and what am I doing? What is needed by others? Who is doing what? Who needs what? For full awareness, this more detailed descriptive awareness must be allowed to affect the patient—and he or she has to be able to own it and respond in a relevant way.

Contact

Contact, the relationship between patient and therapist, is another pillar of gestalt therapy.

The relationship is contact over time. What happens in the relationship is crucial. This is more than what the therapist says to the patient, and it is more than the techniques that are used. Of most importance is the nonverbal subtext (posture, tone of voice, syntax, and interest level) that communicates tremendous amounts of information to the patient about how the therapist regards the patient, what is important, and how therapy works.

In a good therapy relationship, the therapist pays close attention to what the patient is doing moment to moment and to what is happening between the therapist and the patient. The therapist not only pays close attention to what the patient experiences but also deeply believes that the patient's subjective experience is just as real and valid as the therapist's "reality."

The therapist is in a powerful position in relation to the patient. If the therapist regards the patient with honesty, affection, compassion, kindness, and respect, an atmosphere can be created in which it is relatively safe for the patient to become more deeply aware of what has been kept from awareness. This enables the patient to experience and express thoughts and emotions that she or he has not habitually felt safe to share. The therapist is in a position to guide the awareness work by entering into the patient's experience deeply and completely. Martin Buber refers to "inclusion" as feeling the experience of the other much as one would feel something within one's own body, while simultaneously being aware of one's own self.

There is some tension between the humane urge of the therapist to relieve the patient's pain and the indispensable need of the patient for someone who willingly enters into and understands his or her subjective pain. The therapist's empathic experience of the patient's pain brings the patient into the realm of human contact. However, trying to get the patient to feel better is often experienced by a patient as evidence that the patient is acceptable only to the extent that he or she feels good. The therapist may not intend to convey this message, but this reaction is often triggered when the therapist does not abide by the paradoxical theory of change.

Experiment

In client-centered therapy the phenomenological work by the therapist is limited to reflecting what the patient subjectively experiences. In modern psychoanalytic work, the therapist is limited to interpretations or reflections. These interventions are both in the gestalt therapy repertoire, but gestalt therapy has an additional experimental phenomenological method. Put simply, the patient and therapist can experiment with different ways of thought and action to achieve genuine understanding rather than mere changes in behavior. As in any research, the experiment is designed to get more data. In gestalt therapy, the data is the phenomenological experience of the patient.

The greatest risk with experiments is that vulnerable patients may believe that change has been mandated. This danger is magnified if a therapist's self-awareness becomes clouded or if she or he strays from a commitment to the paradoxical theory of change. It is vitally important in gestalt therapy that the therapist remain clear that the mode of change is the patient's knowledge and acceptance of self, knowing and supporting what emerges in contemporaneous experience. If the therapist makes it clear that the experiments are experiments in awareness and not criticism of what is observed, the risk of adding to the patient's self-rejection is minimized.

Self-Disclosure

One powerful and distinguishing aspect of gestalt therapy is that therapists are both permitted and encouraged to disclose their personal experience, both in the moment and in their lives. Unlike classical psychoanalysis, in gestalt therapy data are provided by both the patient and the therapist, and both the patient and the therapist take part in directing therapy through a process of mutual phenomenological exploration. This kind of therapeutic relationship requires that therapists be at peace with the differences

between themselves and their patients. In addition, therapists most truly believe that the patient's sense of subjective reality is as valid as their own. With an appreciation of the relativity of one's subjectivity, it becomes possible for therapists to disclose their reactions to patients without *requiring* that patients change. These conversations, entered into with care and sensitivity, are generally quite interesting and evocative, and they often enhance the patient's sense of efficacy and worthiness.

Dialogue is the basis of the gestalt therapy relationship. In dialogue, the therapist practices inclusion, empathic engagement, and personal presence (for example, selfdisclosure).

The therapist imagines the reality of the patient's experience and, in so doing, confirms the existence and potential of the patient. However, this is not enough to make the interaction a real dialogue.

Real dialogue between therapist and patient must also include the therapist surrendering to the interaction and to what emerges from that interaction. The therapist must be open to being changed by the interaction.

This sometimes requires the therapist to acknowledge having been wrong, hurtful, arrogant, or mistaken.

This kind of acknowledgment puts therapist and patient on a horizontal plane. This sort of open disclosure requires personal therapy for the therapist to reduce defensiveness and the need to pridefully maintain his or her personal self-image.

Process of Psychotherapy

People form their sense of self and their style of awareness and behavior in childhood.

These become habitual and often are not refined or revised by new experiences. As a person moves out of the family and into the world, new situations are encountered and the old ways of thinking, feeling, and acting are no longer needed or adaptive in new situations. But the old ways persist because they are not in awareness and hence are not subject to conscious review.

In gestalt therapy the patient encounters someone who takes his or her experience seriously, and through this different, respectful relationship, a new sense of self is formed. By combining the gestalt therapy relationship with phenomenological focusing techniques, the patient becomes aware of processes that previously could not be changed because they were out of awareness. Gestalt therapists believe the contact between therapist and patient sets the stage for development of the capacity to be in contact with one's shifting figures of interest on a moment-by-moment basis.

Gestalt therapy probably has a greater range of styles and modalities than any other system. Therapy can be short-term or long-term. Specific modalities include individual, couple, family, group, and large systems. Styles vary in degree and type of structure; quantity and quality of techniques used; frequency of sessions; confrontation versus compassionate relating; focus on body, cognition, affect, or interpersonal contact; knowledge of and work with psychodynamic themes; emphasis on dialogue and presence; use of techniques; and so forth.

All styles of gestalt therapy share a common emphasis on direct experience and experimenting, use of direct contact and personal presence, and a focus on the what and how, here and now. The therapy varies according to context and the personalities of both therapist and patient.

Gestalt therapy starts with the first contact between therapist and patient. The therapist inquires about the desires or needs of the patient and describes how he or she practices therapy. From the beginning, the focus is on what is happening now and what is needed now. The therapist begins immediately to help clarify the patient's awareness of self and environment. In this case the potential relationship with the therapist is part of the environment.

The therapist and prospective gestalt therapy patient work together to become clear about what the patient needs and whether this particular therapist is suitable. If there seems to be a match between the two, then the therapy proceeds with getting acquainted.

The patient and therapist begin to relate to and understand each other, and the process of sharpening awareness begins. In the beginning it is often not clear whether the therapy will be short- or long-term or even whether, on further examination, the match between patient and therapist will prove to be satisfactory. Therapy typically begins with attention to the immediate feelings of the patient, the current needs of the patient, and some sense of the patient's life circumstances and history.

A long social history is rarely taken, although there is nothing in gestalt theory to prevent it. Usually, history is gathered in the process of therapy as it becomes relevant to current therapy work and at a pace comfortable for the patient.

Some patients start with their life story, others with a contemporaneous focus. The therapist helps patients become aware of what is emerging and what they are feeling and needing as they tell their stories. This is done by reflective statements of the therapist's understanding of what the patient is saying and feeling, and by suggestions about how to focus awareness (or questions that accomplish that same goal).

For example, a patient might start telling a story of recent events but not say how he was affected by the events. The therapist might ask either what the patient felt when the reported event happened or what the patient is feeling in telling the story. The therapist also might go back over the story, focusing on recognizing and verbalizing the feelings associated with various stages in the story.

The therapist also makes an assessment of the strengths and weaknesses of patients, including personality style. The therapist looks for specific ways in which the patient's self-support is either precarious or robust. Gestalt therapy can be adapted and practiced with virtually any patient for whom psychotherapy is indicated. However, the practice must be adapted to the particular needs of each person. The competent gestalt therapist, like any other kind of therapist, must have the training and ability to make this determination. A good therapist knows the limits of his or her experience and training and practices within these limits. Treatment usually starts with either individual or couples therapy—or both. Group therapy is sometimes added to the treatment plan, and the group may become the sole modality for treatment. Fritz Perls claimed that patients could be treated by gestalt group therapy alone. This belief was never accepted by most gestalt therapists and is thoroughly rejected today. Gestalt group therapy complements individual and couples work but does not replace it. Gestalt therapists work with people of all ages, although specialized training is required for work with young children. Gestalt therapy with children is done individually, as part of Gestalt family therapy, and occasionally in groups (Lampert, 2003; Oaklander, 1969/1988).

Mechanisms of Psychotherapy

All techniques in gestalt therapy are considered experiments, and patients are repeatedly told to "Try this and see what you experience." There are many "gestalt therapy techniques," but the techniques themselves are of little importance. Any technique consistent with gestalt therapy principles can and will be used. In fact, gestalt therapy explicitly encourages therapists to be creative in their interventions.

Focusing

The most common techniques are the simple interventions of focusing. Focusing ranges from simple inclusion or empathy to exercises arising largely from the therapist's experience while being with the patient. Everything in gestalt therapy is secondary to the actual and direct experience of the participants. The therapist helps clarify what is important by helping the patient focus his or her awareness.

The prototypical experiment is some form of the question "What are you aware of, or experiencing, right here and now?" Awareness occurs continuously, moment to moment, and the gestalt therapist pays particular attention to the *awareness continuum*, the flow or sequence of awareness from one moment to another. The gestalt therapist also draws attention to key moments in therapy. Of course, this requires that the therapist have the sensitivity and experience to recognize these moments when they occur. Some patients feel abandoned if the therapist is quiet for long periods; others feel it is intrusive when the therapist is active. Therefore, the therapist must weigh the possible disruption of the patient's awareness continuum if he or she offers guiding observations or suggestions against the facilitative benefit that can be derived from focusing. This balance is struck via the ongoing communication between the therapist and patient and is not solely directed by the therapist.

One key moment occurs when a patient interrupts ongoing awareness before it is completed. The gestalt therapist recognizes signs of this interruption, including the nonverbal indications, by paying close attention to shifts in tension states, muscle tone, and/or excitement levels. The therapist's interpretation of the moment is not presumed to be relevant or useful unless the patient can confirm it. One patient may tell a story about events with someone in his life and at a key moment grit his teeth, hold his breath, and not exhale. This may turn out to be either an interruption of awareness or an expression of anger. On another occasion, a therapist might notice that an angry look is beginning to change to a look of sadness—but a sadness that is not reported. The patient might change to another subject or begin to intellectualize. In this case the sadness may be interrupted either at the level of self-awareness or at the level of expression of the affect. When the patient reports a feeling, another technique is to "stay with it." This encourages the patient to continue with the feeling being reported and builds the patient's capacity to deepen and work through a feeling. The following vignette illustrates this technique (P = Patient; T = Therapist).

P: [Looks sad.]

T: What are you aware of?

P: I'm sad.

T: Stay with it.

P: [Tears well up. The patient tightens up, looks away, and becomes thoughtful.]

T: I see you are tightening. What are you aware of?

P: I don't want to stay with the sadness.

T: Stay with the not wanting to. Put words to the not wanting to. [This intervention is likely to bring awareness of the patient's resistance to vulnerability. The patient might respond "I won't cry here—it doesn't feel safe," or "I am ashamed," or "I am angry and don't want to admit I'm sad."]

There is an emerging awareness in gestalt therapy that the moments in which patients change subjects often reflect something happening in the interaction between therapist and patient. Something the therapist says

or his or her nonverbal behavior may trigger insecurity or shame in the patient. Most often this is not in the patient's awareness until attention is focused on it by the therapist and explored by dialogue (Jacobs, 1996).

Enactment

The patient is asked to experiment with putting feelings or thoughts into action. This technique might be as simple as encouraging the patient to "say it to the person" (if the person involved is present) or might be enacted using role playing, psychodrama, or gestalt therapy's well-known empty-chair technique.

Sometimes enactment is combined with the technique of asking the patient to exaggerate.

This is not done to achieve catharsis but is, rather, a form of experiment that sometimes results in increased awareness of the feeling.

Creative expression is another form of enactment. For some patients creative expression can help clarify feelings in a way that talking alone cannot. The techniques of expression include journal writing, poetry, art, and movement. Creative expression is especially important in work with children (Oaklander, 1969/1988).

Mental Experiments, Guided Fantasy, and Imagery

Sometimes visualizing an experience here and now increases awareness more effectively than enacting it, as is illustrated in the following brief vignette (P = Patient; T = Therapist).

P: I was with my girlfriend last night. I don't know how it happened but I was impotent. [Patient gives more details and history.]

T: Close your eyes. Imagine it is last night and you are with your girlfriend. Say out loud what you experience at each moment.

P: I am sitting on the couch. My friend sits next to me and I get excited. Then I go soft.

T: Let's go through that again in slow motion, and in more detail. Be sensitive to every thought or sense impression.

P: I am sitting on the couch. She comes over and sits next to me. She touches my neck. It feels so warm and soft. I get excited—you know, hard. She strokes my arm and I love it. [Pause. Looks startled.] Then I thought, I had such a tense day, maybe I won't be able to get it up.

One can use imagery to explore and express an emotion that does not lend itself to simple linear verbalization. For example, a patient might imagine being alone on a desert, being eaten alive by insects, being sucked in by a whirlpool, and so forth. There are infinite possible images that can be drawn from dreams, waking fantasy, and the creative use of fantasy.

The gestalt therapist might suggest that the patient imagine the experience happening right now, rather than simply discussing it. "Imagine you are actually in that desert, right now. What do you experience?" This is often followed by some version of "Stay with it."

An image may arise spontaneously in the patient's awareness as a here-and-now experience, or it may be consciously created by the patient and/or therapist. The patient might suddenly report, "Just now I feel cold, like I'm alone in outer space." This might indicate something about what is happening between the therapist and the patient at that moment; perhaps the patient is experiencing the therapist as not being emotionally present.

Imagery techniques can also be used to expand the patient's self-supportive techniques.

For example, in working with patients who have strong shame issues, at times it is helpful for them to imagine a Metaphorical Good Mother, one who is fully present and loving and accepts and loves the patient just as he or she is (Yontef, 1993).

Meditative techniques, many of which are borrowed from Asian psychotherapies, can also be very helpful experiments.

Body Awareness

Awareness of body activity is an important aspect of gestalt therapy, and there are specific gestalt therapy methodologies for working with body awareness (Kepner, 1987; Frank, 2001). The gestalt therapist is especially interested in patterns of breathing. For example, when a person is breathing in a manner that does not support centering and feeling, he or she will often experience anxiety. Usually the breathing of the anxious patient involves rapid inhalation and a failure to fully exhale. One can work with experiments in breathing in the context of an ordinary therapy session. One can also practice a thoroughly body-oriented gestalt therapy (Frank, 2001; Kepner, 1987).

Loosening and Integrating Techniques

Some patients are so rigid in their thinking—a characteristic derived from either cultural or psychological factors—that they do not even consider alternative possibilities. Loosening techniques such as fantasy,

imagination, or mentally experimenting with the opposite of what is believed can help break down this rigidity so that alternatives can at least be considered.

Integrating techniques bring together processes that the patient either just doesn't bring together or actively keeps apart (splitting). Asking the patient to join the positive and negative poles of a polarity can be very integrating ("I love him and I abhor his flippant attitude").

Putting words to sensations and finding the sensations that accompany words ("See if you can locate it in your body") are other important integrating techniques.

APPLICATIONS

Who can we help?

Because gestalt therapy is a process theory, it can be used effectively with any patient population the therapist understands and feels comfortable with. Yontef, for instance, has written about its application with borderline and narcissistic patients (1993). If the therapist can relate to the patient and understands the basic principles of gestalt therapy and how to adjust these principles to fit the unique needs of each new patient, the gestalt therapy principles of *awareness* (direct experience), *contact* (relationship), and *experimenting* (phenomenological focusing and experimentation) can be applied. Gestalt therapy does not advocate a cookbook of prescribed techniques for specialized groups of individuals. Therapists who wish to work with patients who are culturally different from themselves find support by attending to the field conditions that influence their understanding of the patient's life and culture (for example, see Jacobs, 2000). The gestalt therapy attitude of dialogue and the phenomenological assumption of multiple valid realities support the therapist in working with a patient from another culture, enabling patient and therapist to mutually understand the differences in background, assumptions, and so forth.

Both gestalt therapy philosophy and gestalt therapy methodology dictate that *general principles must always be adapted for each particular clinical situation*. The manner of relating and the choice and execution of techniques must be tailored to each new patient's needs, not to diagnostic categories *en bloc*. Therapy will be ineffective or harmful if the patient is made to conform to the system rather than having the system adjust to the patient.

It has long been accepted that gestalt therapy in the confrontive and theatrical style of a 1960s Fritz Perls workshop is much more limited in application than the gestalt therapy described in this chapter. Common sense, professional background, flexibility, and creativity are especially important in diagnosis and treatment planning. Methods, emphases, precautions, limitations, commitments, and auxiliary support (such as medication, day treatment, and nutritional guidance) must be modified with different patients in accordance with their personality organization (for example, the presence of psychosis, sociopathy, or a personality disorder).

The competent practice of gestalt therapy requires a strong general clinical background and training in more than gestalt therapy. In addition to training in the theory and practice of gestalt therapy, gestalt therapists need to have a firm grounding in personality theory, psychopathology and diagnosis, theories and applications of other systems of psychotherapy, knowledge of psychodynamics, comprehensive personal therapy, and advanced clinical training, supervision, and experience.

This background is especially important in gestalt therapy because therapists and patients are encouraged to be creative and to experiment with new behavior in and outside of the session. The individual clinician has a great deal of discretion in gestalt therapy. Modifications are made by the individual therapist and patient according to therapeutic style, personality of therapist and patient, and diagnostic considerations. A good knowledge of research, other systems, and the principles of personality organization are needed to guide and limit the spontaneous creativity of the therapist. The gestalt therapist is expected to be creative, but he or she cannot abdicate responsibility for professional discrimination, judgment, and proper caution. Gestalt therapy has been applied in almost every setting imaginable. Applications have varied from intensive individual therapy multiple times per week to crisis intervention.

Gestalt therapists have also worked with organizations, schools, and groups; they have worked with patients with psychoses, patients suffering from psychosomatic disorders, and patients with post-traumatic stress disorders. Many of the details about how to modify gestalt techniques in order to work effectively with these populations have been disseminated in the oral tradition—that is, through supervision, consultation, and training. Written material, too abundant to cite, has also become available.

Treatment

Patients often present similar issues but need different treatment because of differences in their personality organization and in what unfolds in the therapeutic relationship. In the following two examples, each of the two patients was raised by emotionally abandoning parents.

Tom was a 45-year-old man proud of his intelligence, self-sufficiency, and independence.

He was not aware that he had unmet dependency needs and resentment. This man's belief in his self-sufficiency and denial of dependency required that his therapist proceed with respect and sensitivity. The belief in self-sufficiency met a need, was in part constructive, and was the foundation for the patient's self-esteem. The therapist was able to respond to the patient's underlying need without threatening the patient's pride (P = Patient; T = Therapist).

P: [With pride.] When I was a little kid my mom was so busy I just had to learn to rely on myself.

T: I appreciate your strength, but when I think of you as such a self-reliant kid, I want to stroke you and give you some parenting.

P: [Tearing a little.] No one ever did that for me.

T: You seem sad.

P: I'm remembering when I was a kid . . . [Tom evoked a sympathetic response in the therapist that was expressed directly to the patient. His denial of needing anything from others was not directly challenged. Exploration led to awareness of a shame reaction to unavailable parents and a compensatory self-reliance.] Bob was a 45-year-old man who felt shame and isolated himself in reaction to any interaction that was not totally positive. He was consistently reluctant to support himself, conforming to and relying totally on others. Previous empathic or sympathetic responses only served to reinforce the patient's belief in his own inadequacy.

P: [Whiny voice.] I don't know what to do today.

T: [Looks and does not talk. Previous interventions of providing more direction had resulted in the patient following any slight lead by the therapist into talk that was not felt by the patient.]

P: I could talk about my week. [Looks questioningly at therapist.]

T: I feel pulled on by you right now. I imagine you want me to direct you.

P: Yes, what's wrong with that?

T: Nothing. I prefer not to direct you right now.

P: Why not?

T: You can direct yourself. I believe you are directing us now away from your inner self. I don't want to cooperate with that. [Silence.]

P: I feel lost.

T: [Looks alert and available but does not talk.]

P: You are not going to direct me, are you?

T: No.

P: Well, let's work on my believing I can't take care of myself. [The patient had real feelings about this issue, and he initiated a fruitful piece of work that led to awareness of abandonment anxiety and feelings of shame in response to unavailable parents.]

Groups

Group treatment is frequently part of an overall gestalt therapy treatment program. There are three general models for doing gestalt group therapy (Frew, 1988; Yontef, 1990). In the first model, participants work one-on-one with the therapist while the other participants remain relatively quiet and work vicariously. The work is then followed by feedback and interaction with other participants, with an emphasis on how people are affected by the work. In the second model, participants talk with each other with emphasis on direct here-and-now communication between the group members. This model is similar to Yalom's model for existential group therapy. A third model mixes these two activities in the same group (Yontef, 1990). The group and therapist creatively regulate movement and balance between interaction and the one-on-one focus. All the techniques discussed in this chapter can be used in groups. In addition, there are possibilities for experimental focusing that are designed for groups. Gestalt therapy groups usually start with some procedure for bringing participants into the here and now and contacting each other. This is often called "rounds" or "check in."

A simple and obvious example of gestalt group work occurs when the therapist has each group member look at the other members of the group and express what he or she is experiencing in the here and now. Some gestalt therapists also use structured experiments, such as experiments in which participants express a particular emotion ("I resent you for . . .," "I appreciate you for . . ."). The style of other gestalt therapists is fluid and organized by what emerges in the group.

Couples and Families

Couples therapy and family therapy are similar to group therapy in that there is a combination of work with each person in the session and work with interaction among the group members. Gestalt therapists vary in where they prefer to strike this balance. There is also variation in how structured the intervention style of the therapist is and in how much the therapist follows, observes, and focuses the spontaneous functioning of the

couple or family. Partners often start couples therapy by complaining and blaming each other. The work at this point involves calling attention to this dynamic and to alternative modes of interaction. The gestalt therapist also explores what is behind the blaming. Frequently, one party experiences the other as shaming him or her and blames the other, without awareness of the defensive function of the blaming.

Circular causality is a frequent pattern in unhappy couples. In circular causality, A causes B and B causes A. Regardless of how an interaction starts, A triggers a response in B to which A then reacts negatively, without being aware of his or her role in triggering the negative response. B likewise triggers a negative response by A without being aware of his or her role in triggering the negative response. Circular causality is illustrated in the following example.

A wife expresses frustration with her husband for coming home late from work every night and not being emotionally available when he comes home. The husband feels unappreciated and attacked, and at an unaware level, he also feels ashamed of being criticized. The husband responds with anger, blaming the wife for not being affectionate. The wife accuses the husband of being defensive, aggressive, insensitive, and emotionally unavailable. The husband responds in kind. Each response in this circle makes it worse. In the worst cases, this circular causality can lead to total disruption in the relationship and may trigger drinking, violence, or sexual acting out.

Underneath the wife's frustration is the fact that she misses her husband, is lonely, worries about him working so hard, really wants to be with him, and assumes that he does not want to be home with her because she is no longer attractive. However, these fears are not expressed clearly. The husband might want to be home with his wife and might resent having to work so hard but might also feel a need to unwind from the stress of work before being emotionally available. The caring and interest of each spouse for the other often get lost in the circular defensive/offensive battle.

Often blaming statements trigger shame, and shame triggers defense. In this kind of toxic atmosphere, no one listens. There is no true contact and no repair or healing. Expressing actual experience, rather than judgments, and allowing oneself to really hear the experience of the spouse are first steps toward healing. Of course, this requires that both of the partners know, or learn, how to recognize their actual experience. Sometimes structured experiments are helpful. In one experiment the couple is asked to face each other, pulling their chairs toward each other until they are close enough to touch knees, and then instructed to look at each other and express what they are aware of at each moment. Other experiments include completing sentences such as "I resent you for . . ." or "I appreciate you for . . ." or "I spite you by . . ." or "I feel bad about myself when you. . . ."

It is critical in couples therapy for the therapist to model the style of listening he or she thinks will enhance each spouse's ability to verbalize his or her experience, and to encourage each partner to listen as well as to speak. The various experiments help to convey to patients that verbal statements are not something written in stone but are part of an ongoing dialogue. The restoration of dialogue is a sign that therapy is progressing. As described in the earlier section on psychotherapy, patients may move into various treatment modalities throughout treatment. They may have individual therapy, group therapy, or couples therapy, and they may occasionally participate in workshops. It is not unusual for patients to make occasional use of adjunctive workshops while engaged in ongoing individual therapy.

Gestalt therapists tend to see patients on a weekly basis. As more attention comes to be focused on the therapist-patient relationship, patients are eager to come more often, so some gestalt therapists see people more often than once a week. Many gestalt therapists also run groups, and there are therapists who teach and conduct workshops for the general public. Others primarily teach and train therapists. The shape of one's practice is limited only by one's interests and by the exigencies of the work environment.

Evidence

Can Gestalt Therapy Be Evidence-Based?

There is research evidence that gestalt therapy is effective. But what constitutes relevant "evidence"? In 1995 the APA Division of Clinical Psychology published a list of "empirically validated treatments." The task force enshrined only one kind of evidence, randomized controlled trials (RCT). RCT studies the techniques of different types of therapy for removal of the symptoms of particular disorders. This paradigm requires the random assignment of patients to experimental and control groups, blinded raters, manualization of techniques, elimination of the effects of "extraneous" factors (such as the relationship and the personality qualities of the therapist), and orientation to the removal of psychiatric symptoms. This is a paradigm that studies disorders and techniques, rather than persons and the whole process of therapy.

RCT is not a suitable research approach for Gestalt therapy, which is a complex system based on the centrality of the dialogue between therapist and patient and on the joint creation of "experiments" useful for that individual person in a specific situation and moment. In the gestalt framework, therapy evolves or

emerges; it is not planned out in advance. It is oriented to the whole person and his or her life, rather than to symptom removal alone.

Of course, the APA list endorsed short-term behavioral and cognitive-behavior approaches, because the RCT paradigm operates in terms of assumptions derived from the philosophic/epistemological approach of these therapies (Freire, 2006; Westen, Novotny, & Thompson-Brenner, 2004). In response to protests over limiting the evidence to RCT, the concept morphed into “empirically supported treatments” and then into “evidence-based practice.” Although “evidence-based” is a more inclusive term that includes a wider range of types of research, some still consider RCT evidence to be the “gold standard” and give less credence to other types of evidence. When qualitative research—research not governed by the RCT protocol—is included, there is considerable evidence of the efficacy of gestalt therapy.

Any research that oversimplifies or reduces the gestalt therapy system in order to get more controlled data may yield important information, but it cannot validate or invalidate the efficacy of the actual practice of gestalt therapy. Any method that reduces the curative factors of the therapeutic relationship to “extraneous” status is inappropriate for use in validating gestalt therapy. RCT measures what is easy to measure (Fox, 2006), but it does not well reflect the complexity of actual practice.

Manualizing gives controlled data, but Westen and colleagues (2004) ask what supports these particular data as a valid measure of the effectiveness of therapy. In fact, in a series of meta-analyses, Elliott, Greenberg, and Lietaer (2004) re-analyzed studies comparing humanistic and behavior therapies on the basis of the school of therapy to which the researchers belonged. The factor of the allegiance of a research group proved to be so decisive that there were no further differences between the schools of therapy when it was taken out of the calculations. It appears that the more symptom tests are included in the study, compared to more holistic questions, the more likely the study is to favor behavior therapy (Strümpfel, 2004, 2006). This is consistent with the work of Luborsky et al. (1999, 2002, 2003), in which the powerful investigator allegiance effect in psychotherapy research predicts 92.5 percent of the outcome (Westen, Novotny, & Thompson-Brenner, 2004, p. 640).

It has become clear that RCT starts with the bias of the behaviorist philosophy and designs the criteria and method of data collection from within that bias. The positivist, reductionistic philosophic assumptions of this paradigm are contrary to experiential therapies, including gestalt therapy, psychoanalysis, and humanistic-existential therapies in general (Freire, 2006). Fox goes so far as to assert, “all that has been demonstrated is that EBT, in the form of manualized, brief treatments, are easier to evaluate with RCT methodologies . . . than several other treatments widely used by psychologists—and several of these ‘other’ treatments have tons of scientific evidence to support them. . . .” (Fox, 2006).

In spite of this bias, Strümpfel claims, on the basis of his meta-analysis and review of the literature, that in no case of clinical comparison between gestalt therapy and CBT were there significant differences, except for one study in which process-experiential/Gestalt therapy led to a greater improvement in mastery of interpersonal problems than cognitive-behavior therapy (Strümpfel, 2006). Given that gestalt therapy is not a symptom-focused approach to treatment, it is remarkable that it has been shown to be as effective as CBT in removing symptoms (Strümpfel, 2004).

RCT research gains statistical power by controlling “impure” treatments; clinicians gain clinical power by not remaining pure to a “brand-name” protocol (Westen et al., 2004). In actual practice, clinicians use interventions that laboratory research would disallow because they belong to another “brand name.”

Although they are prevented from using cognitive-behavioral interventions in research, gestalt therapists and psychodynamic therapists include these techniques in their offices (Westen et al., 2004; Ablon, Levy, & Katzenstein, 2006). By the same token, cognitive-behavior therapists faced with patients with personality dysfunction often explore the dynamic roots of difficulties. Gestalt therapists are interested in developing research models that are sensitive to the complexities of clinical work and that can obtain evidence, specially of the medium and long-term effects of various aspects of practice. This has led to a substantial increase in new studies (Strümpfel, 2006). Activity promoting research is also described on gestalt therapy listserves and in journals. There is even a new book that instructs readers on conducting research in gestalt therapy practice (Barber, 2006).

Validation of Therapeutic Relationship and Experiential Techniques

Gathering empirical data on therapeutic relationships is an alternative approach to research on therapy effectiveness (Norcross, 2001, 2002). This approach focuses on enumerating those principles of therapeutic relationship that are empirically supported. This stream of work brings together decades of research on the importance of the quality of the therapeutic contact and alliance, and it documents principles that have been shown to be effective. The evidence from research in this paradigm is more appropriate and useful for gestalt therapy, and in fact Gestalt therapy can be said to practice within the principles of this line of research.

Ideally, assessments of the effectiveness of psychotherapy practice and theory would have to emphasize both the factors of relationship and the factors of technique (Goldfried and Davila, 2005; Hill, 2005). The

effectiveness of combining experiential techniques and a good relationship has been robustly demonstrated by Les Greenberg and associates, who have conducted, over 25 years, a large series of experiments in which process and outcome studies are brought together with attention to context and to the combination of technique and relationship factors. Many of their research reports relate specific interventions with three types of outcome (immediate, intermediate, and final) and three levels of process (speech act, episode, and relationship) (Greenberg, 1991; Greenberg & Paivio, 1997; Greenberg, Rice, & Elliott, 1993).

Greenberg continues to conduct research with increasing sophistication in what he calls process-experiential therapy. This is an active experiential therapy that he describes as an amalgam of a Rogerian client-centered relationship and gestalt therapy techniques. Greenberg gives evidence of the power of combining a technique with a relational focus, confirming a central tenet in gestalt therapy. We consider this a form of contemporary, relational gestalt therapy and include it in our evidence of the effectiveness of gestalt therapy (Strümpfel, 2006; Strümpfel & Goldman, 2001). For purposes of research, we consider relational gestalt therapy equivalent to Greenberg's process-experiential therapy, except that gestalt therapy practice uses a much wider range of techniques than have so far been studied in his program. Although the evidence from a manualized approach (such as Greenberg's use of the empty-chair technique) gives very useful data, it cannot validate or invalidate gestalt therapy, because it is inconsistent with the central tenets of that therapy. On the other hand, his research that combines technique with measures of the efficacy of aspects of the therapy relationship is highly consistent with a gestalt therapy approach.

Greenberg, Elliott, and Lietaer (1994) reviewed 13 studies comparing experiential therapies with cognitive and behavioral treatments using meta-psychological statistics and found that the cognitive and behavioral interventions were slightly more effective.

However, when the seven studies compared directive experiential (process-experiential) therapy with cognitive or behavioral treatment, there was a small, statistically significant difference in favor of the directive experiential approach. This indicates that the directive experiential approach was more effective than either a pure client-centered approach lacking active phenomenological experimentation or the cognitive and behavioral treatments.

The same group has conducted a number of experiments in which using the gestalt therapy two-chair technique resulted in a greater depth of experience than empathic reflection alone (Greenberg, 1982; Greenberg & Dompierre, 1981; Greenberg & Higgins, 1980; Greenberg & Rice, 1981). Paivio and Greenberg (1992) demonstrated that the empty-chair dialogue was effective for resolving unfinished emotional issues with significant others. Pre- and post-testing showed that general distress was reduced, and there was a reduction in unfinished business. The two-chair technique has been shown to be effective in healing internal splits because of an increase in the depth of experiencing (Greenberg & Higgins, 1980). Research shows that the two-chair technique is effective in softening the "harsh internal critic" (Greenberg, 1980). Being harsh, critical, or self-rejecting prevents healing and growth. Greenberg also has demonstrated that conflict resolution using the two-chair dialogue occurs via deeper experiencing of previously rejected aspects of self. This confirms gestalt therapy's paradoxical theory of change.

Research that is relevant, realistic, and valid for gestalt therapy would need to account for the importance of the therapeutic relationship and also for the full range of interventions that are integral to the gestalt therapy method. Limiting the therapist's interventions in order to achieve scientific precision would achieve uniformity for the research at the expense of misrepresenting the gestalt therapy methodology. It would also contradict the main tenets of humanistic psychology (Cain & Seeman, 2001). Specific techniques such as the empty-chair and two-chair techniques can be conveniently studied. However, these tools are not representative of all patients or of the range of techniques used in gestalt therapy. Some patients are too inhibited to use the empty chair effectively or cannot generate enough affect to do so. A wide range of techniques that accomplish the same function can be used in clinical practice. One advantage of gestalt therapy is that the therapist has support for using a great variety of techniques within the context of a cohesive theoretical framework.

Neurology, Childhood Development, Affect and Gestalt Therapy

Recent research results in neurology and infant development support the gestalt therapy viewpoint on the importance of the here and now and the inseparability of emotion and thought. (Damasio 1995, 1999; Stern, 2004). In addition, gestalt therapy's inclusion of work with the body in the methodology of psychotherapy gives it an added power that ideally would be included in the evaluation of psychotherapy efficacy but is not included in most psychotherapy research (Strümpfel, 2006).

Reviews and Meta-Analyses

Cain and Seeman (2001) review issues of validation of humanistic therapies, including gestalt therapy. They cite relevant research and describe the general results using Carl Rogers's words: "The facts are friendly" (Rogers, 1961/1995, p. 25). The research on gestalt therapy was reviewed by Yontef (1995).

Strümpfel reviews data from 74 published research studies on therapeutic process and outcome re-analyzed in 10 meta-analyses and added his own calculations (Strümpfel, 2006). Tests of efficacy were carried out on data for approximately 4,500 patients treated in clinical practice. Of these, approximately 3,000 were treated with gestalt therapy and 1,500 were control subjects. He also shows 431 sources of evidence that include single case reports. The studies included patients with multiple diagnoses; including such patients is consistent with usual clinical practice, but most laboratory-based studies exclude them in order to get more precise data (Strümpfel, 2006; Westen et al., 2004).

Strümpfel discusses comparisons conducted by Elliott (2001) and Elliott et al. (2004) and points out that, relative to the number of measurements undertaken, significant results were found more frequently for the humanistic therapies than for the behavioral and (even more clearly) the psychodynamic approaches. This summary of the data contradicts claims that the behavioral therapies have been demonstrated to be superior.

The variety of different patients, diagnoses, and settings of these studies taken as a whole is evidence for the effectiveness of gestalt therapy even with highly impaired patients. It confirms the effectiveness of Gestalt therapy adapted to a wide range of clinical disorders (such as schizophrenia, personality disorders, affective and anxiety disorders, substance dependencies, and psychosomatic disorders) and administered in psychosocial preventive health settings. The treatment effects were shown to be stable in the long term. Psychiatric patients with various diagnoses showed significant improvements in their main symptoms, in personality dysfunctions, self-concept, and interpersonal relationships after treatment with Gestalt therapy. The patients themselves evaluated the therapy as very helpful. Assessments by nursing staff indicated improvements in the patients' contact and communications functioning (Strümpfel, 2006).

The effects were largest for gestalt therapy with symptoms of depression, anxiety, and phobias. Studies showed the efficacy of gestalt and social therapy to drug-dependent patients, with a long-term abstinence rate of 70 percent. There was also a reduction in symptoms of depression and an improvement in personality development. Studies showed a 55 percent reduction in pain and in the use of medication with functional disorders.

There was also evidence that gestalt therapy is effective for school children with achievement difficulties, for parents who experience their children as having problems, for couples, in preventive health care, and for pregnant women undergoing preparation for delivery (Strümpfel, 2006).

Seventeen studies had follow-up data from 1/2 to 3 years after the end of therapy.

The effects of the therapy were stable in all cases except one, in which treatment was administered for only a few hours in a group. Other studies demonstrated that patients in gestalt therapy learned strategies to cope successfully with recurrent symptoms (Strümpfel, 2006). Schigl (cited in Strümpfel, 2004, 2006) did follow-up studies with several hundred patients of gestalt and experiential therapy. Of these, 63 percent reported attaining their initial goals completely or to a great extent. Use of psychotropic medication was reduced by half and use of tranquilizers by 75 percent.

In one study an independent research group evaluated the findings of an evaluation conducted by particular clinics (Barghaan et al., 2002, and Harfst et al., 2003, both cited in Strümpfel, 2006). Based on follow-up data on 117 cases, a comparison was made between patients treated with a combination of psychodynamic and gestalt therapy, psychodynamic therapy, and/or behavior therapy. The authors reported that gestalt therapy had improvements with larger-than-average effect sizes on various psychosocial and physical measures.

Similarly, Strümpfel (2006) reports on the meta-analysis by Elliott et al. (2004) of 112 studies.

Of the various humanistic approaches, process-experiential/gestalt therapy approaches tended to have the largest effect sizes.

One interesting result found by Strümpfel is that psychiatric patients receiving cognitive-behavior therapy sought social contacts more frequently, but patients were better able to maintain these contacts when treated with a combination of gestalt therapy and transactional analysis. Strümpfel conducted further exploratory analyses and found indications that the particular effectiveness of Gestalt therapy lies in the domain of social/relational/interpersonal functions. Clinical studies support the finding that gestalt therapy leads to particularly marked improvement in establishing personal contact, in sustaining relationships, and in managing aggression and conflicts (Strümpfel, 2004, 2006).

The therapeutic method of guiding clients toward their immediate self-experiencing in the process and promoting emotional activation, which was developed in gestalt therapy, has proved to be an effective mode of therapeutic work. According to a meta-analysis by Orlinsky, Grawe, and Parks (1994), the experiential confrontation process, defined as directing attention to the patient's experience and behavior that are directly activated in the session, is a strong predictor for positive therapeutic outcome.

The active Gestalt therapy interventions have proven to be suitable for intensifying qualities of experience within the therapy session and today can be associated with improved conflict resolution . . . and a reduction in symptoms and problems. In light of these findings and the data on the breadth of its application and efficacy, a number of previous appraisals of Gestalt therapy, e.g., regarding restricted applicability, can

be revised. (Strümpfel, 2006) Psychotherapy comparison studies have provided evidence that the effects of Gestalt therapy are comparable to those of other forms of therapy—or even better (Strümpfel, 2006). To conclude this section, we suggest a word of caution about using research evidence when endeavoring to understand and evaluate therapeutic efficacy, whether by comparing different approaches or by assessing the value of therapy as a healing enterprise. Any treatment dyad and treatment process has vastly more complex meanings than can possibly be measured. Added to the mix is the fact that each therapist is unique and can practice well only by working within a framework matched to his or her personality. Therefore, even if research suggests most generally that, say, gestalt therapy is very well suited to support a patient's strivings for enduring relationships, if the therapist is not attracted to working with close attention to moment-by-moment emotional experience, then he or she would probably need to work in another framework in order to be at all helpful to his or her patients. In fact, it is possible that therapists' comfort within their orientations may prove to be a more significant factor for positive outcomes than their specific orientations. Our current research results are limited, as always, by the questions we ask and by the research tools available to us.

Psychotherapy in a multicultural world

The founders of Gestalt therapy were all cultural/political outsiders. Some were Jews, and some of them were immigrants – including Fritz and Laura Perls – who had fled persecution in Europe. Some were gay. All were interested in developing a process-oriented theory that could provide support and encouragement for people to explore their own life paths, even if those life paths did not fit neatly within extant cultural values. Thus, instead of establishing content goals for successful therapy (e.g. achievement of genital sexuality), they established a process goal: awareness.

Gestalt therapists throughout the world have been involved with, and written about, their involvement in multicultural and intercultural projects, be they the provision of mental health services or community organization or organizational consulting (Bar-Yoseph, 2005). Heiberg (2005) interviewed non-European immigrants and residents of Norway about their experiences and found that shame and a shaming process constantly infused their interactions with members of Norway's dominant culture. Almost all of his respondents had been in therapy with withe therapists, and the Gestalt patients spoke most enthusiastically of the chance to explore their experience – especially their shame – on their own terms rather than being analyzed and interpreted. Gaffney (2008) wrote about the subtle and gross difficulties of providing supervision in the divided society of Northern Ireland. Bar-Yoseph (2005) edited a collection of articles by Gestalt therapists engaged in various multicultural endeavors. Articles by American therapists are included. A thread in almost all the literature in that efficacious multicultural interaction requires that the therapist recognize the implications of his or her social/cultural/political situatedness. There are two reasons for this. First, such awareness helps the therapist to relativize his or her own cultural norms so has to help to navigate the inevitable strong emotional reactions that emerge when coming into intimate contact with profoundly different and sometimes disturbing world-views. Second, awareness of the difference between the relative insider status of being a professional and the often marginalized status of the cultural outsider is crucial for opening up meaningful dialogue with one's client. Billies (2005), Jacobs (2005a), and McConville (2005) elaborate this point in exploring what it means to be a white therapist in racially divided America. All of the authors referred to field theory as a strong support for phenomenological experiential explorations with their clients. They also emphasize that attention to the contacting and awareness processes and how these processes are shaped by field conditions enhanced the capacity of the therapist and the clients to make creative adjustments in their work together.

Another strongly emphasized dimension of Gestalt therapy is the dialogical attitude, and humble attitude that includes a willingness to be affected and changed by the client. In dialogue, the therapist learns from the patient about the patient's culture. This attitude enables the therapist to learn more about his or her own biases, and it also fosters contacting that is often experienced by the client of empowering.

CASE EXAMPLE

Background

Miriam often spoke in a flat voice, seemingly disconnected from her feelings and even from any sense of the meaningfulness of her sentences. She had survived terrifying and degrading childhood abuse, and now, some 35 years after leaving home, she had the haunted, pinched look of someone who expected the abuse to begin again at any moment. She could not even say that she wanted therapy for herself, because she claimed not to want or need people in her life. She thought that being in therapy could help her to develop her skills as a consultant more fully. Miriam was quite wary of therapy, but she had attended a lecture given

by the therapist and had felt a slight glimmer of hope that this particular therapist might actually be able to understand her.

Miriam's experiential world was characterized by extreme isolation. She was ashamed of her isolation, but it made her feel safe. When she moved about in the world of people, she felt terrified, often enraged, and deeply ashamed. She was unrelentingly self-critical. She believed she was a toxic presence, unwillingly destructive of others. She was unable to acknowledge wants or needs of her own, for such an acknowledgment made her vulnerable and (in her words) a "target" for humiliation and annihilation. Finally, she was plagued by a sense of unreality. She never knew whether what she thought or perceived was "real" or imagined. She knew nothing of what she felt, believed that she had no feelings, and did not even know what a feeling was. At times these convictions were so strong that she fantasized she was an alien. Miriam's fundamental conflicts revolved around the polarity of isolation versus confluence. Although she was at most times too ashamed of her desires to even recognize them, when her wish to be connected to others became figural, she was overcome with dread. She recognized that she wanted to just "melt" into the other person, and she could not bear even a hint of distance, for the distance signaled rejection, which she believed would be unbearable to her. She was rigidly entrenched in her isolated world. A consequence of her rigidity was that she was unable to flow back and forth in a rhythm of contact and withdrawal. The only way she could regulate the states of tension and anxiety that emerged as she dared to move toward contact, with the therapist and others, was to suddenly shrink back in shame, retreat into isolation, or become dissociated, which happened quite often. Then she would feel stuck, too ashamed and defeated to dare to venture forward again. She was unable to balance and calibrate the experience of desiring contact while at the same time being afraid of contact.

The following sequence occurred about four years into therapy. Miriam was much better at this point in being able to identify with and express feeling, but navigating a contact boundary with another person was still daunting. She had begun this session with a deep sense of pleasure because she finally felt a sense of continuity with the therapist, and she reported that for the first time in her life, she was also connected to some memories.

The air of celebration gave way to desperation and panic later, as therapist and patient struggled together with her wishes and fears for a closer connection to the therapist.

In a conversation that had been repeated at various times, Miriam's desperation grew as she wanted the therapist to "just reach past" her fear, to touch the tiny, disheveled, and lonely "cave girl" who hid inside. Miriam felt abandoned by the therapist's "patience" (Miriam's word).

P: You're so damn patient!

T: . . . and this is a bad thing? [Said tentatively.]

P: Right now it is.

T: Because you need . . .

P: [Pause.] Something that indicates *something*. [Sounding frightened and exasperated, and confused.]

T: What does my patience indicate to you right now?

P: That I am just going to be left scrambling forever!

T: It sounds like I am watching from too far away—rather than going through this with you—does that sound right?

P: Sounds right . . .

T: So you need something from me that indicates we will get through this together, that I won't just let you drown. [Said softly and seriously.]

[A few minutes later, the exploration of her need for contact and her fear has continued, with Miriam even admitting to a wish to be touched physically, which is a big admission for her to make. Once again Miriam is starting to panic. She is panicked with fear of what may happen now that she has exposed her wish to be touched. She fears the vulnerability of allowing the touch, and she is also panicky about being rejected or cruelly abandoned. The therapist has been emphasizing that Miriam's wish for contact is but one side of the conflict, and that the other side, her fear, needs to be respected as well. The patient was experiencing the therapist's caution as an abandonment, whereas the therapist was concerned that "just reaching past" the patient's fear would reenact a boundary violation and would trigger greater dissociation.]

T: . . . so, we need to honor *both* your fear and your wish. [Miriam looks frightened, on the verge of dissociating.] . . . now you are moving into a panic—speak to me . . .

P: [Agonized whisper.] It's too much.

T: [Softly.] yeah, too much . . . what's that . . . "it's too much"?

P: Somehow if you touch me I will disappear. And I don't want to—I want to—I want to use touch to *connect*, not to disappear!

T: Right, OK, so the fear side of you is saying that the risk in touching is that you'll disappear. Now we have to take that fear into account. And I have a suggestion— that I will move and we sit so that our fingertips can be just an inch or so from each other—and see how that feels to you. Do you want to try? [Therapist moves as patient nods assent. Miriam is still contorted with fear and desperation.] Okay, now, I am going to touch one of your fingers—keep breathing—how is that?

P: [crying] How touch-phobic I am! I shift between “it feels nice” and “it feels horrid!”

T: That is why we have to take this slowly. . . . Do you understand that . . . if we didn’t take it slowly you would have to disappear—the horror would make you have to disappear [all spoken slowly and carefully and quietly] . . . do you understand that . . . so it’s worth going slowly . . . your fingers feel to me . . . full of feeling?

P: Yes . . . as if all my life is in my fingers . . . not disappeared here, warm . . .

The patient attended a weeklong workshop the next week, after which she reported, with a sense of awe, that she had stayed “in her body” for the whole week, even when being touched. Since this session this patient has reported that she feels a greater sense of continuity, and as we continue to build on it (even the notion of being able to “build” is new and exciting), she feels less brittle, more open, more “in touch.” As more time has passed, and we continue to work together several times per week, long-standing concerns about feeling “alien” and about being severely dissociated and fragmented have begun to be resolved. The patient feels increasingly “human,” able to engage more freely in intimate participation with others.

SUMMARY

Gestalt therapy is a system of psychotherapy that is philosophically and historically linked to gestalt psychology, field theory, existentialism, and phenomenology. Fritz Perls, his wife Laura Perls, and their collaborator Paul Goodman initially developed and described the basic principles of gestalt therapy. Gestalt therapists focus on contact, conscious awareness, and experimentation.

There is a consistent emphasis on the present moment and on the validity and reality of the patient’s phenomenological awareness. Most of the change that occurs in gestalt therapy results from an I-Thou dialogue between therapist and patient, and gestalt therapists are encouraged to be self-disclosing and candid, both about their personal history and about their feelings in therapy.

The techniques of gestalt therapy include focusing exercises, enactment, creative expression, mental experiments, guided fantasy, imagery, and body awareness. However, these techniques themselves are relatively insignificant and are only the tools traditionally employed by gestalt therapists. Any mechanism consistent with the theory of gestalt therapy can and will be used in therapy.

Therapeutic practice is in turmoil, in a time when the limitations associated with managed care have encroached on clinical practice. At a time of humanistic growth in theorizing, clinical practice seems to be narrowing, with more focus on particular symptoms and an emphasis on people as products who can be fixed by following the instructions in a procedure manual.

The wonderful array of gestalt-originated techniques for which gestalt therapy is famous can be easily misused for just such a purpose. We caution the reader not to confuse the use of technique for symptom removal, however imaginative, with gestalt therapy. The fundamental precepts of gestalt therapy, including the paradoxical theory of change, are thoroughly geared toward the development of human freedom, not human conformity, and in that sense, gestalt therapy rejects the view of persons implied in the managed-care ethos.

Gestalt practice, when true to its principles, is a protest against the reductionism of mere symptom removal and adjustment; it is a protest for a client’s right to develop fully enough to be able to make conscious and informed choices that shape her or his life.

Since gestalt therapy is so flexible, creative, and direct, it is very adaptable to short-term as well as long-term therapy. The direct contact, focus, and experimentation can sometimes result in important insight. This adaptability is an asset in dealing with managed care and related issues of funding mental health treatment. In the 1960s, Fritz Perls prophesied that gestalt therapy would come into its own during the decade ahead and become a significant force in psychotherapy during the 1970s. His prophesy has been more than fulfilled.

In 1952, there were perhaps a dozen people actively involved in the gestalt therapy movement. Today there are hundreds of training institutes here and abroad, and there are thousands of well-trained gestalt therapists practicing worldwide. Unfortunately, there are also large numbers of poorly trained therapists who call themselves gestalt therapists after attending a few workshops and do not have adequate academic preparation. It behooves students and patients who are interested in exposure to gestalt therapy to inquire in depth about the training and experience of anyone who claims to be a gestalt therapist or who claims to use gestalt therapy techniques.

Gestalt therapy has pioneered many useful and creative innovations in psychotherapy theory and practice that have been incorporated into the general psychotherapy field.

Now gestalt therapy is moving to further elaborate and refine these innovations. The principles of existential dialogue, the use of direct phenomenological experience for both patient and therapist, the trust of organismic self-regulation, the emphasis on experimentation and awareness, the paradoxical theory of change, and close attention to the contact between the therapist and the patient all form a model of good psychotherapy that will continue to be used by gestalt therapists and others.

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Hycner, R., & Jacobs, L. (1995). *The healing relationship in gestalt therapy: A dialogic, self psychology approach*. Highland, NY: The Gestalt Journal Press.

Hycner and Jacobs's book is the most thorough description of the gestalt theory of the therapist-patient relationship in the literature. It articulates the attitude and praxis of an I-Thou orientation as it would be applied in gestalt therapy.

There are extensive case examples presented by both authors. The book also reaches outside of gestalt theory for insights from contemporary psychoanalysis, so it has a more specific slant than the other books and probably is best suited for the advanced reader. It would also be of interest to readers who wish to integrate psychoanalytic ideas with a humanistic clinical approach.

Kepner, J. (1993). *Body process: Working with the body in psychotherapy*. San Francisco: Jossey-Bass.

Kepner's book can be read by people who may have no particular interest in gestalt therapy but want to work effectively with patients while attending to body process as well as verbal communication. It is a beautiful illustration of the holistic approach that gestalt therapy espouses. Kepner describes how to attend to body process, both observed and experienced, and how to weave work with bodily experience into ongoing psychotherapy. Readers will also get an idea how the therapist's creativity, coupled with the readiness of the patient, can yield fertile gestalt awareness experiments.

Polster, E., & Polster, M. (1973). *Gestalt therapy integrated*. New York: Vintage Books.

This is one of the most readable and enjoyable therapy books around. There are many illustrative vignettes for people who want to get a sense of what gestalt therapy is like in practice. The book is written at the level of clinical theory and covers the basics of gestalt therapy: process, here and now, contact, awareness, and experiments. The writing is so lively that the reader is bound to come away with a feel for the gestalt therapy experience as practiced by some of its finest senior practitioners. A later, equally insightful and rich collection of readings by the Polsters is available in Roberts, A. (Ed.). (1999). *From the Radical Center*, Cleveland, OH: Gestalt Institute of Cleveland Press.

Wheeler, G. (2000). *Beyond individualism: Toward a new understanding of self, relationship and experience*. Hillsdale, NJ: Gestalt Press/Analytic Press.

The author manages to walk the reader, in a simple, lucid, and evocative manner, through the paradigm shift that gestalt therapy brings to the field of psychotherapy. He offers illustrative experiments along the way. The reader cannot help but have his or her experience of living changed by this book. This book, coupled with the clinical flavor of the Polsters' book *Gestalt Therapy Integrated* (see above), provides a well-rounded beginning for the interested clinician.

Yontef, G. (1993). *Awareness, dialogue and process: Essays on gestalt therapy*. Highland, NY: The Gestalt Journal Press. A compendium of articles written over a span of 25 years.

Some of the articles are for those who are new to gestalt therapy, but most are for the advanced reader. The essays are sophisticated probes into some of the thornier theoretical and clinical problems that any theory must address.

The book comprehensively traces the evolution of gestalt theory and practice and provides a theoretical scaffolding for its future.

CASE READINGS

Feder, B., & Ronall, R. (1997). *A living legacy of Fritz and Laura Perls: Contemporary case studies*. New York: Feder Publishing.

This edited collection provides a look at how different clinicians work from a gestalt perspective. The variety of styles encourages the reader to find his or her own.

Hycner, R., & Jacobs, L. (1995). Simone: Existential mistrust and trust. *The healing relationship in gestalt therapy: A dialogic, self-psychology approach* (pp. 85–90). Highland, NY: The Gestalt Journal Press.

Hycner, R., & Jacobs, L. (1995). Transference meets dialogue. *The healing relationship in gestalt therapy: A dialogic, self-psychology approach* (pp. 171–195). Highland, NY: The Gestalt Journal Press.

The first case is an example drawn from a workshop conducted in Israel; the second is an interesting case report by a psychoanalytically oriented gestalt therapist, including verbatim transcripts of three sessions. The second case is analyzed in a panel discussion by two gestalt therapists and two psychoanalysts in Alexander, Brickman, Jacobs, Trop, & Yontef. (1992), *Transference meets dialogue*. *The Gestalt Journal*, 15, 61–108.

Lampert, R. (2003). *A child's eye view: Gestalt therapy with children, adolescents and their families*. Highland, NY: The Gestalt Journal Press.

Case material is provided throughout this book.

Perls, F. S. (1992). Jane's three dreams. In *Gestalt therapy verbatim* (pp. 284–310). Highland, NY: The Gestalt Journal Press.

Three dreams are presented verbatim. The third dream work is a continuation of unfinished work from the second dream. Portions of this case are also found in D. Wedding and R. J. Corsini (Eds.). (2005). *Case studies in psychotherapy*. Belmont, CA: Wadsworth.

Perls, L. P. (1968). Two instances of gestalt therapy. In P. D.

Purlsglove (Ed.), *Recognition in gestalt therapy* (pp. 42–68). New York: Funk and Wagnalls. [Originally published in 1956.]

Laura Perls presents the case of Claudia, a 25-year-old woman of color who comes from a lower-middle-class West Indian background, and the case of Walter, a 47-year-old Central European Jewish refugee.

Simkin, J. S. (1967). *Individual gestalt therapy* [Film]. Orlando, FL: American Academy of Psychotherapists. 50 minutes.

In this tape of the eleventh hour of therapy with a 34-year-old actor, emphasis is on present, nonverbal communications leading to production of genetic material. The use of fantasy dialogue is also illustrated.

Simkin, J. S. (1972). The use of dreams in gestalt therapy. In C. J. Sager and H. S. Kaplan (Eds.), *Progress in group and family therapy* (pp. 95–104). New York: Brunner/Mazel.

In a verbatim transcript, a patient works on a dream about his youngest daughter.

Stammmer, F. (Ed.). (2003). The IGJ Transcript Project. *International Gestalt Journal*, 26(1), 9–58.

In this intriguing project, British gestalt therapist Sally Denham-Vaughan provides a brief summary of her work with a patient and then an extended transcript of a session. Four therapists from Europe and the United States offer their commentaries on the session, and then Denham-Vaughan replies. The result is not only a good example of a gestalt therapy process but also a lively discussion of some points of interest and controversy in gestalt therapy. [Reprinted in D. Wedding & R. J. Corsini. (2008). *Case Studies in Psychotherapy*. Belmont, CA: Brooks/Cole–Thomson Learning.]

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