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 (Frank, 2001; Kepner, 1987). 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 posttraumatic 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 (see Lee, 2008). 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 therapies 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. (2003), in which the powerful investigator allegiance effect in psychotherapy research predicts 92.5% 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 (Ablon, Levy, & Katzenstein, 2006; Westen et al., 2004). 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, especially 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 & 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 outcomes (immediate, intermediate, and final) and three levels of processes (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.

Greenberg and various colleagues (see Strümpfel, 2006) have conducted a number of experiments—too numerous to cite individually—in which using the Gestalt therapy two-chair technique resulted in a greater depth of experience than empathic reflection alone and was effective for resolving unfinished emotional issues with significant others. Pre- and posttesting showed that general distress was reduced, and there was