a reduction in unfinished business. They have also shown the technique to be effective in healing internal splits because of an increase in the depth of experiencing and from 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. Recent research shows the approach effective in treating depression and maintaining the improvement (Ellison, Greenberg, Goldman, & Angus, 2009) and effective in treating individuals who have been emotionally injured by significant others (Greenberg, Warwar, & Malcom, 2008).

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 adds 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, 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%. There was also a reduction in symptoms of depression and an improvement in personality development. Studies showed a 55% reduction in pain and in the use of medication with functional disorders.

There was also evidence that Gestalt therapy is effective for schoolchildren 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% reported attaining their initial goals completely or to a great extent. Use of psychotropic medication was reduced by half and use of tranquillizers by 75%.

In one study cited by Strümpfel (2006), an independent research group evaluated the findings of an evaluation conducted by particular clinics. 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 white 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 common thread in almost all of the literature is 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 as 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 emphasized 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 client to make creative adjustments in their work together.

Another strongly emphasized dimension of Gestalt therapy is the dialogical attitude, a 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 as 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 4 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, dishevelled, 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 prophecy 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 who 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.

ANNOTATED BIBLIOGRAPHY

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 A. Roberts (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.

Woldt, A., & Toman, S. (2005). *Gestalt therapy: History, theory and practice.* Thousand Oaks, CA: Sage Publications.
Edited collections of articles on various topics are a tradition in Gestalt therapy. For instance, there are collections on Gestalt therapy practice in groups, shame, couples therapy, relationality, cultural issues, etc. Most edited collections in any field are uneven in quality, containing some gems and some lackluster pieces; however, they tend to be worthy reads because they acquaint the reader with multiple viewpoints extant in the area of interest. This particular edited collection of articles with accompanying discussions, thought questions, and experiments can serve as a textbook in that it covers much of the domain of Gestalt therapy. It is useful especially for students and their teachers and is a good foundation before moving on to some of the current controversies and specialized topics of conversation in Gestalt therapy.

Yontef, G. (1993). *Awareness, dialogue and process: Essays on Gestalt therapy.* Highland, NY: 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: 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: 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. *Gestalt Journal, 15,* 61–108.

Lampert, R. (2003). *A child's eye view: Gestalt therapy with children, adolescents and their families.* Highland, NY: 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: 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 & R. J. Corsini (Eds.). (2005). *Case studies in psychotherapy.* Belmont, CA: Brooks/Cole.

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 11th 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 & 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.

Staemmler, 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. (2011). *Case studies in psychotherapy.* Belmont, CA: Brooks/Cole.]