What do Gestalt therapists do in the clinic? The expert consensus
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Abstract: What it is that Gestalt therapists do in the clinic that is different from other therapists? What is it, in other words, that makes Gestalt therapy Gestalt, and distinguishes it from other psychotherapeutic modalities? This article describes the process of finding an expert consensus about these questions as part of the process of developing a ‘fidelity scale’ for Gestalt therapy. Using a Delphi study, eight key concepts that characterise Gestalt therapy were identified, together with the therapist behaviours that reflect those concepts.

Key words: Gestalt, fidelity scale, Delphi study, developing awareness, working relationally, working in the here and now, phenomenological practice, working with embodiment, field sensitive practice, contacting processes, experimental attitude.

When I (Madeleine) attended the AAGT conference in Asilomar, California in September 2014, one of my main goals was to persuade some of the participants there to be involved in a study that would try to find an answer to the following questions: What it is that Gestalt therapists do in the clinic that is different from other therapists? What is it, in other words, that makes Gestalt therapy Gestalt, and distinguishes it from other psychotherapeutic modalities? Perhaps most dauntingly, my aim was to try to answer these questions through a process that depended on there being a consensus among experts in Gestalt therapy (GT).

At first, when I spoke to people at Asilomar, there was resistance to the very notion that it was possible to define GT in this way. Later, came warnings about the impossibility of there ever being a consensus in a tradition that is so rich in disagreement and differentiation as GT. But more fundamentally, there were the underlying questions: Why would you want to do this? What would be the point of it?

As I was preparing to write this article, a client returned to me a back issue of the British Gestalt Journal that I had lent her several months before. Opening it up, I found myself reading a note that Malcolm Parlett wrote in 2007. The note provided some of the answers to this last question. Commenting on the diversity within the GT community, Parlett suggested that if you were to investigate or dissect any Gestalt term, principle, idea or method a great deal of theoretical difference and confusion would be revealed.

Parlett was concerned that this enormous disparity between Gestalt thinkers threatened the possibility of securing the GT ‘brand’ in the wider therapeutic community:

I am thinking of students and trainees who have few stable guidelines after the elementary stage and other experienced professionals who want to grasp quickly what Gestalt offers. If we want to take care of our collective contact boundary with ‘interested but not Gestalt educated others’, then surely we have to find more consensual rubrics for describing the approach, so we do not put off or confuse this group but rather attract and intrigue them. One need here is to return to practice more, to what we do, and to spelling out our understanding. (2007, p. 54)

Parlett’s concern, in other words, was that the wide-ranging divergence of opinion about method and theory within the Gestalt community was a threat to the future of GT. Unless the Gestalt community could agree about what GT was, then it would be difficult to continue to attract students to the ‘brand’, or to explain what GT is to others.

Around the same time that Parlett was calling for greater consensus about the practice of GT, other researchers in the GT world recognised the need to develop an evidence base to establish that GT is an effective form of psychotherapy (Brownell, 2014; Burley, 2014; Barber, 2009). But before we can tell whether or not GT works, we first need to have a measure for determining whether or not the therapy that a particular therapist is delivering can properly be described as ‘Gestalt therapy’ (Perepletchikova, 2011; Waltz et al., 1993). And in order to have such a measure,
we must be able to describe what Gestalt therapists do in the clinic that can be distinguished from non-Gestalt forms of treatment.

This then, as I explained to those I met at Asilomar, was what I was going to try to do. The aim was to develop a measure—a ‘fidelity scale’—that an independent rater could use to determine how faithful therapy being delivered by a therapist is to the methods that characterise GT. The rationale and methodology for the development of such a scale were extensively discussed by Fogarty, Bhar and Theiler (2015). At the very least, development of the scale required the identification of the key principles and concepts of GT; and the ‘operationalisation’ of those principles and concepts in the form of observable therapist behaviours that reflect them.

Usually, fidelity scales are based on pre-existing treatment manuals (Perepletchikova, 2011; Waltz et al., 1993). However, GT has never had a manual, and many experts argue that it would be impossible to create one (Mann, 2010; McConville, 2014; Wollants, 2008; Yontef and Jacobs, 2013). In the absence of a manual, an alternative way to develop a scale is to use the Delphi method. In the Delphi method, statements (such as a description of a therapist behaviour) are submitted to a panel of experts, and treated as valid if endorsed by a consensus of 80% or more.

When reading GT’s rich, vast and diverse body of literature, it is sometimes difficult to imagine that there could be a consensus about anything within GT, and certainly difficult to imagine that experts in GT could agree about the clinical behaviours that characterise Gestalt therapists and that distinguish them from therapists trained in other modalities. Despite these difficulties, in the absence of a manual, the Delphi method seemed to offer a viable and parsimonious path to the development of a fidelity scale for GT. Whether the Delphi method would work depended on whether there was enough consensus in the GT community about what it is to be a Gestalt therapist. Whether, in other words, a panel of GT experts would agree with Dave Mann that although ‘no two Gestalt therapists will be the same ... both will be recognisable as Gestalt therapists’ (2010, preface, p. xi).

The Delphi method

The Delphi method is an established method for consensus building that poses a series of questionnaires to collect data from a panel of experts about real-world practices (Linstone and Turoff, 1975). The Delphi method involves a group of experts making private, independent ratings of agreement on a series of statements. Experts are also invited to comment on the statements and there are opportunities to offer amendments and modifications in every phase of the Delphi process. Once ratings are received and collated, a summary is fed back to the panel members, who then complete a second round of rating and feedback (Hart et al., 2009). The Delphi method has been widely used in Information Technology and in the field of education to determine prototypical practices for new technologies and practices (Carley et al., 2006; Clayton, 1997). More recently it has been adopted by the health sector in establishing benchmark practices for identifying and treating various disorders (de Villiers et al., 2005; Falzon et al., 2014; Hart et al., 2009).

In contrast to other data gathering and analysis techniques, the Delphi invites participants to engage in a process of multiple iterations, in which feedback and analysis from the first questionnaire is integrated into subsequent questionnaires until a consensus of 80% agreement is reached on each item. Consequently, in the Delphi process participants may have the opportunity to augment or modify their initial position in relation to the analysis and feedback provided by other panel members and communicated by the researcher who facilitates the Delphi process.

The flexibility of the Delphi method and the fact that it provided an opportunity for a wide range of views to be expressed and collated seemed the most appropriate method to develop a consensus about GT and how it might be operationalised in clinical practice.

Participants in the Delphi study

The process of gathering participants for the study began at the AAGT conference in Asilomar, California in 2014. At that meeting, over fifty members of the AAGT were presented with the proposal for the Delphi and invited to participate, or otherwise to suggest participants who may be able to contribute to the study. Despite initial resistance to the notion of a fidelity scale, and many cautions about the difficulties of creating such a consensus in the GT tradition that is so rich in disagreement and differentiation, participants began to warm to the idea, and to understand the importance of such a scale in the face of the demands for evidence-based practice (EBP) in institutional training and the wider health systems (Burley, 2014; Brownell, 2008, 2014; Frew, 2013; Gold and Zahm, 2008; O’Leary, 2013).

The opportunity to meet face to face with so many GT practitioners at the beginning of the process was foundational for this study, as it provided a basis for the lived experience of GT and grounded the cyberspace technology of the project in that experience. Experts for the Delphi had to have either been a GT trainer; edited a GT journal; published books or refereed-journal articles on GT; or been a director of a GT centre. The Asilomar
conference was inevitably North American-centric. However, Asilomar was only the starting point for the invitation of potential participants. After Asilomar, I approached people who were familiar with other regions where Gestalt was practised – such as Eastern and Western Europe and Latin America – to suggest people in those regions who met the selection criteria. The people invited to participate were intended to provide a reasonable representation of contemporary experts in GT theory and practice. Is the representation perfect? Of course not. One obvious limitation of the Delphi is that the study was conducted in English. Given that limitation, it is no surprise that although the list of participants includes experts from many countries, cultures and language, more than half the participants are English speakers. However, parts of the research project have already been translated into German, Russian and Spanish; and in the long run, it will not only be interesting to see whether the study can be validated in the English-speaking world, but whether it can be validated in other languages and cultures as well.

Drafting the survey

Preparing the survey items for the Delphi was a daunting task. A veritable library of resources has been written about GT theory and practice. However, finding commonalities amongst this vast body of literature became easier as the project progressed. Eight key concepts emerged repeatedly: increasing awareness, working relationally, working in the here and now, phenomenological practice, working with embodiment, field sensitive practice, working with contacting processes, and experimental attitude. Nevertheless, dividing GT into eight discrete concepts felt slightly artificial, because any given moment in a clinical session is likely to include several of these concepts operating simultaneously. Descriptions of the concepts were based on an extensive literature review as well as operating simultaneously. Descriptions of the concepts session is likely to include several of these concepts slightly artificial, because any given moment in a clinical contactng processes, and experimental attitude. Nevertheless, dividing GT into eight discrete concepts felt slightly artificial, because any given moment in a clinical session is likely to include several of these concepts operating simultaneously. Descriptions of the concepts were based on an extensive literature review as well as operating simultaneously. Descriptions of the concepts session is likely to include several of these concepts

Describing observable behaviours was even more challenging, as behaviours characteristic of one concept (e.g. phenomenological practice) might just as easily be exemplary of another concept (e.g. working in the here and now).

In this study, the first round of the Delphi was used to develop and refine descriptions of the key concepts and associated therapist behaviours. The refined therapist behaviours were then submitted to the participants in the second round of the Delphi. Therapist behaviours that are endorsed by a consensus of participants in the second round will form the basis of a draft Gestalt Therapy Fidelity Scale (GTFS).

Sending the survey

In the first round, prospective panel members were sent a link to an online survey in which they were presented with descriptions of the eight key GT concepts and associated therapist behaviours. They were asked to rate on a five-point scale whether they agreed with the proposed title and concept description of the eight key concepts of GT in clinical practice. Participants were invited to provide feedback on the name of the concept, whether they thought it was foundational for GT clinical practice, and whether there were any modifications or omissions that needed to be addressed. Participants were also given descriptions of therapist behaviours and asked whether they agreed that each of these behaviours reflected one of the key GT concepts. Finally, participants were given the opportunity to make their own suggestions as to how best to operationalise the key GT concepts.

The moment before the first ‘send’ button was pressed was like jumping out of an aeroplane (albeit with a parachute and instructor). A leap into the unknown: were people going to respond? Would they be offended by the brevity and condensation of GT into such discrete items? Would they recognise the behaviours as distinctively Gestalt? Were the differences and conflicts within GT about to surface beyond any hope of consensus?

Beyond expectation, the participation from the international Gestalt community was overwhelmingly collaborative. Over sixty experts from around the globe participated, and I feel deeply grateful for their considered feedback and willingness to stay engaged in the consensus building process. Participants included:

Europe: Austria – Nancy Amendt-Lyon; Belorussia – Elena Iasaja; Czech Republic – Anton Polak, Jan Roubal; Denmark – Hanne Hostrup; France – Vincent Beja, Gonzague Masquelier, Jean-Marie Robine; Germany – Willi Butollo, Rosemarie Wulf; Italy – Gianni Francesetti, Margherita Spagnuolo Lobb; Russia – Maria Lekareva, Illia Mstibovskyi, Rezeda Popova; Sweden – Seán Gaffney, Ia Martensson Astvik; United Kingdom – Sally Denham-Vaughan, Toni Gilligan, Phil Joyce, Dave Mann, Malcolm Parlett, Peter Philippson, Christine Stevens.

Middle East: Israel – Nurith Levi.

Asia: Japan – Norioshi Okada.

Latin America: Argentina – Myriam Sas de Guiter; Chile – Pablo Herrara Salinas; Mexico – Heather Keyes, Myriam Munoz Polit.

North America: Canada – Leslie Greenberg; United States – Lena Axelsson, Dan Bloom, Phil Brownell, Victor Daniels, Mark Fairfield, Bud Feder, Iris Fodor, Ruella Frank, Eva Gold, Elinor Greenberg, Mary-Ann Kraus, Lynne Jacobs, Jay Levin, Mark McConville, Joe

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Oceania: Australia – Susanna Goodrich, Noel Haarburger, Tony Jackson, Judy Leung, Alan Meara, Brian O’Neill, Phoebe Riches, Richie Robertson, Claire Taubert, Greer White; New Zealand – Anne McLean.

These participants responded with such clarity and willingness that the iterative process of the Delphi was surprisingly short. In the first round of the Delphi, participants were presented with descriptions of eight key concepts and thirty-five associated therapist behaviours. In light of the feedback received, several therapist behaviours were eliminated, and many more were redrafted. The twenty-five remaining and redrafted therapist behaviours were used to create a mock-up of a draft GTFS.

The first mock-up was taken to a seminar with Bob and Rita Resnick at the Relational Centre in Sydney in early November 2015. Live work and videos were compared with items in the mock-up of the draft GTFS. The work presented by the Resnicks aligned with the mock-up, but further analysis was required. Videos of live work by Gordon Wheeler (APA Series 1 – Systems of Psychotherapy), Erv Polster (work with the unmotivated client), Fritz and Laura Perls, recent work by Serge Ginger, Gonzague Masquelier, and work available on YouTube were analysed. Videos of live work with Lynne Jacobs and Gary Yontef were obtained by consent from supervisees and colleagues to extend further the analysis of the draft GTFS. Finally, the process of analysing the mock-up of the draft GTFS against videos of live work from other therapeutic modalities led to further refinement of the scale.

From the outset of this project it was recognised that dividing GT into differing concepts was challenging because of the fact that GT is a holistic approach that cannot easily be delineated into a list of techniques or skills. Similarly, dividing therapist behaviours into discrete items fails to take account of the fact that in every clinical moment several therapist behaviours may be operating at once. Conversely, no single session of GT will necessarily require each of the therapist behaviours that define GT. Nonetheless, the mock-up of the draft GTFS sought to identify the core therapist behaviours that characterise most sessions of clinical GT.

In the second round of the Delphi, the panel (including several experts who had not participated in the first round) were presented with this refined list of twenty-five therapist behaviours, and asked whether in their view each of these behaviours reflected one of the eight key GT concepts. While I have not yet completed my analysis of the results of the second round of the Delphi, at the time of writing it appears that there will be enough consensus about the therapist behaviours for there to be a viable GTFS.

What follows is a description of each concept, redrafted in light of the feedback given by the participants in the first round of the Delphi, together with some discussion of that feedback. I have also included the twenty-five therapist behaviours that were submitted to the second-round panel.

Developing awareness

Description of the concept

The aim of GT is to develop awareness and promote awareness of awareness. This does not mean simply developing insight or introspection, but exploring experience as physical and emotional beings making sense of our world and our relationship to others and the environment. The therapist supports awareness for the client and his life world and the process by which awareness is developed. In this way awareness can be seen to increase self-regulation. Awareness includes sensory and bodily experience as well as cognitive and emotional awareness. GT identifies three zones of awareness: inner (feeling states), outer (contact functions: behaviour, speech and actions), and middle (thoughts, judgments, ideas). Each of these zones of awareness and their relationship to each other and the wider field is developed through the major concepts that will be explicited below:

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

Given that the aim of developing awareness is central to all GT concepts, no specific therapist behaviours were identified for this concept.

Feedback

There were three comments about this concept that were not fully integrated into the descriptions reproduced in this article (as they were not representative of most views) but remain important to mention. The first comment related to a perennial theme within GT theory: whether the central concept is contact or awareness. The second comment related to the ‘zones of awareness’ that some felt were outmoded in contemporary GT. The third comment related to the objection that awareness can be perceived as awareness for its own sake (e.g. egotism, self-commenting) rather than developing awareness towards a therapy of action spontaneity and growth (which are clearly the objectives of GT). Fortunately, the comments really only applied to the
descriptions of the key concepts, rather than the associated therapist behaviours.

Working relationally

Description of the concept

Relational perspectives have become central to contemporary GT practice. A relational approach is grounded in a contextualist framework in which human experience is shaped by context. Hence the concept of working relationally is not only focused on the therapeutic alliance, but underscores the meaning-making paradigm for GT. A contextualist framework is paradigmatic in working with the nuances of emotional process, therapist–client interaction, and enduring relational themes.

The therapeutic alliance draws on the concepts of ‘inclusion’, ‘confirmation’ and ‘presence’. ‘Inclusion’ requires the therapist to do more than empathically listen and attune to her clients. The therapist leans into the client’s experience such that she connects with the client’s existence as if it were a sensation within her own body. This is not a merging with the client, but a sensitivity that enables a visceral encounter between therapist and client. Inclusion integrates the therapist’s awareness of her responses to the client with a deeply attuned appreciation of the ‘otherness’ of the client’s experience.

‘Confirmation’ involves a profound acceptance of the immediate existence and potential of the client. The therapist does not control the therapeutic encounter. There is no therapist goal or agenda (except that of increasing the client’s awareness). This does not mean that the therapist mirrors or agrees with everything that the client brings to the session. The therapist is committed to the dialogue and this includes genuine moments of dissonance, which are made transparent. The therapist is part of the relational field. This entails commitment to change, not only for the client, but also for the therapist.

The balance between this gently focused inclusion and commitment to the co-created space of the therapy session requires ‘presence’. ‘Presence’ is evident in a grounded and assured quality in the therapist. Equally, ‘presence’ entails a willingness to be uncertain, to work with ‘creative indifference’ and to offer support to the client’s expressive capacity. This lends an intrinsic ethical quality to the clinical encounter in which shared meaning-making between the client and therapist is developed through an open exchange about how the therapist and client are affected by each other.

Shame and other disruption affective states can also be triggered within the therapeutic relationship for a range of reasons including when the therapist is attending to one aspect of the client’s situation, without maintaining attention for another co-existent (but possibly un-named) aspect of his situation. These ruptures are evident in the withdrawal of the client from the process. It is important for the therapist to attend to ruptures in the therapeutic relationship through offering support and investigating the contribution that the therapist might make in co-creating a shame experience in therapy.

Participants in the second round of the Delphi were asked whether the following therapist behaviours reflect this concept:

- The therapist follows the client attentively, tracking the awareness process and the client’s experience, not following a predetermined agenda.
- The therapist responds non-judgmentally to the client, creating the conditions that allow for the most effective client expression.
- The therapist demonstrates a willingness to be uncertain and to work with creative indifference.
- The therapist draws on her relationship with the client as the ground for challenge and growth.
- The therapist seeks to identify and repair any ruptures in the relationship.

Feedback

Several themes emerged in the feedback on this concept. Firstly, a relational stance is central to most humanistic approaches. However, what is specific in GT is the way the therapist recognises that she is a part of the client’s field and can be often – as the Other of the situation – his figure of interest. Thus, in GT we often work with/on the clinical relationship. Secondly, many participants wanted the term ‘dialogic inclusion’ to be used instead of ‘working relationally’. But as the question of Buber’s centrality to GT remains debated, it was decided to retain the term relational, whilst leaning into Buber’s notions of presence, confirmation and inclusion. Thirdly, there was some opposition to a ‘Rogerian’ flavour in the original description and the GT stance of differentiation and challenge, and this led to some revisions in the description of the concept, as reproduced above. Finally, there was much discussion about the proposition that the therapist does not set an agenda. While most agreed with this as a basis for GT, there was deliberation about the role of the therapist in co-creating the therapeutic space. Most agreed that some kind of interpretation from the therapist is always informing the contact with the client, but some were wary of a top-down approach. In the therapist behaviours submitted to the second round of the Delphi study, a balance was struck between inevitable tension and recognition that the importance of field sensitivity would inflect the specific situation in each unique therapeutic encounter.
Working in the here and now

Description of the concept

Immediate experience is the essential material for healing and growth in GT. Laura Perls observed that the actual experience of any situation does not need to be explained or interpreted: it can be directly contacted, felt and described in the here and now. This is because the act of remembering the past or anticipating the future occurs in the present. Therefore, in the clinical encounter, references to the past or future are brought back to the present: focusing on what and how the client perceives his situation now. As Gestalt therapists, we concentrate on ‘what is’ rather than ‘what was’ or ‘what will be’, not because we wish to ignore a person’s history or his future intentions. For example, in the case of sexual abuse the focus is primarily on how the abuse is being communicated now.

The therapist and client work together on the immediacy of a situation: exploring the many dimensions of the present behaviour or affect. This is particularly the case when the behaviour or affect is habitual or causes suffering. Exploration of moment-to-moment awareness of the present situation can assist in understanding the choices inherent in the broader context of the client’s life space. The past may be considered relevant to this exploration, when the immediate situation is thematic of habitual or past experiences. However, the emphasis is always on the immediate encounter, such that if a client wishes to relate an event from the past the therapist would enquire about how it feels to tell that story now.

Working in the present supports the client to ‘stay with’ his situation rather than shift or change it. This concept is reflected in the paradoxical theory of change that maintains that the focus of the therapy is not to change, but to embrace as fully as possible all aspects of an experience, by increasing awareness of that experience. The aim is not to change, but paradoxically to stay the same, and to engage more fully in that experience. Once full acceptance is reached, then change follows that process of acceptance.

Feedback on this concept revolved around the question of observation, which was too removed from the inter-

Participants in the second round of the Delphi were asked whether the following therapist behaviours reflect this concept:

- The therapist enquires about the client’s immediate presentation.
- The therapist supports the client to stay with what is happening in the encounter between them, by enquiring and seeking to extend awareness about immediate sensation, affect, cognitions and somatic presentations.
- The therapist supports the client to accept and deepen his awareness of his presenting issue rather than trying to change it.

Phenomenological practice

Description of the concept

Phenomenological practice is more than simply validating the client’s subjective experience. It involves exploring the life world situations that the client brings to each session. This requires attunement to the id of the situation through enquiry and support for descriptive language that captures the embodied and sensate aspects of experience. This process may be guided by the method of moving from the general to the particular and avoiding abstraction. By using this method, the therapist and client are able to grow into the situation that they are exploring together and to observe which elements settle into the foreground against the background of the total situation. The main point is to stay as close as possible to the client’s experience and to stay with and deepen ‘what is’ for the client.

This experiential focus takes place in the context of three major precepts of phenomenological investigation: bracket, describe, observe. The first precept is the rule of epoche, which entails bracketing the question of truth or falsehood of any interpretations of reality. The second precept is the rule of description, which discourages interpretations and promotes experience–close detailing of the immediate and concrete aspects of a situation. The third precept is the rule of equalisation. This rule requires the therapist to treat all observed data as equally important without assigning value or structuring a hierarchy.

Participants in the second round of the Delphi were asked whether the following therapist behaviours reflect this concept:

- The therapist supports the client to describe and deepen and become more present to his experience.
- The therapist articulates the different perspectives/experience of the therapist and client.
- The therapist encourages the client to widen his choices rather than establishing a program for change.
- The therapist shares (where appropriate) her own experiences that relate to the client’s experience.

Feedback

Feedback on this concept revolved around the question of observation, which was too removed from the inter-
Working with embodiment

Description of the concept

Attention to the body is a major focus for GT. From its inception, GT has been informed by Wilhelm Reich’s insight that past emotional experiences are carried in habitual bodily tensions. Some therapists might pay attention to the body through introducing somatic experiments. But even without introducing the possibility to exaggerate a somatic habit, or trying a different way of holding the body, GT increases awareness of the way in which the physicality of the client is engaged in relating to the therapist and his wider environment. This approach is both mutual and shame sensitive. The therapist develops awareness of her own body process during the session, and this co-creates an embodied field, which is supportive to the bodily life experience of the client. Shame can often desensitise the body, and encouraging rapid release of physical expression can be overwhelming. So it is important to grade an embodied approach to therapeutic work. Observation of breath (without trying to change breathing patterns) is an example of the GT approach to embodiment.

Therapists may seek to increase a client’s awareness of a particular movement or gesture through an invitation to exaggerate, or pay attention to that gesture. Therapists may invite a client to put words to a pain in the body. Connecting embodiment with thought and feelings is essential, as GT does not explore and increase somatic awareness for its own sake.

Touch is not required in working with embodiment, though it can be used to communicate empathy, or to offer support.

Participants in the second round of the Delphi were asked whether the following therapist behaviours reflect this concept:

- The therapist makes observations and enquires about the client’s embodiment (including breathing).
- The therapist invites the client to identify sensations, feelings, emotions, thoughts or images that emerge as a consequence of attending to somatic experiences.
- The therapist invites the client to engage with his body through experiment.

Feedback

Feedback on this concept pointed to a tendency to neglect the relational aspect of embodiment in the clinical alliance. The therapist calibrates her own presence and embodiment to support and/or resonate with the client’s kinaesthetic experience. Therapists heighten the awareness and ability of clients both to sense their own embodied process and resonate with others. For example, the therapist might say ‘I have a sinking feeling in my body as you say that. I wonder what it’s like for you?’

Field sensitive practice

Description of the concept

Field theory is considered to be the scientific basis of GT and is fundamental to GT philosophy and method. Field theory is a way of analysing causal relations, such that any event or experience is the result of many factors in which every emerging figure of interest emerges from the ground of a person’s life space. Figure and ground are not seen as separate entities but as embedded elements of the person’s organism/environmental field.

Field approaches focus on observing, describing, and explicating the exact structure of whatever is being studied in terms of its organisation, contemporaneity, uniqueness, possible relevance and changing process. There are three important aspects of ‘field’ in GT. First, the experiential field, where the client’s perceptions and immediate subjective experience are explored at the level of self-awareness. Second, the relational field between the client and the therapist. Third is the wider field including social, historical, cultural context (or life space) in which the client is situated.

Participants in the second round of the Delphi were asked whether the following therapist behaviours reflect this concept:

- The therapist investigates the ground (or context) from which the client’s presenting figure emerges.
- The therapist supports the client to identify how his perception of his environment and prior relationships and needs organise current experience.
- The therapist supports the client to identify the uniqueness of his experience.

Feedback

Feedback on this concept was less varied than other concepts. On the whole, most seemed satisfied with the original description though some attempt was made to integrate a more holistic and interconnected approach to the field, including the systemic idea that one experience or behaviour cannot be isolated from the rest of the elements of the field. The therapist beha-
...vions reflecting this concept attempt to include the clinical practice in which the therapist recognises herself as 'a function of a field', as defined by the current field with the client, and uses her awareness as information about the current field formation.

Working with contacting processes

Description of the concept

In GT, awareness can be increased by focusing on styles of contact. The contact cycle is one of the key concepts in GT’s understanding of how the organism reaches towards the environment and engages in the (full or partial) satisfaction of needs and attendant meaning-making. As the client moves towards another (or towards a satisfaction of a need by reaching out towards the environment) there are certain characteristics of this movement that the Gestalt therapist is trained to identify as contact processes. Initially only four stages of contact were described: fore-contact, contact, final contact, and post-contact. These terms were later developed into a heuristic tool: the cycle of contact/awareness/experience. This cycle describes the ‘ideal’ interactive process of contact and withdrawal of organism and environment as involving sensation, awareness, mobilisation of energy, action, contact, satisfaction (assimilation), and withdrawal.

This cycle can be useful in tracking the experience of figure formation and identifying relational patterns where a client may become habitually stuck. Early GT thinkers suggested that psychological disturbances resulted from interruptions to this cycle, which when completed satisfactorily is regarded as ‘healthy’ self-regulation. Seven major styles of interruption to contact were identified: desensitisation, deflection, egotism (self spectatorship), introjection (swallowing rules or norms without consideration), retroflection (turning an impulse back on the self), projection (disowning qualities of the self and attributing them to others), and confluence. More recent GT thinkers revised this notion of interruptions as individualistic and inconsistent with field theory and refigured the contact cycle as styles of moderation to the flow of contact that might be adopted in any given organism/environment. Whether a contact style is useful or dysfunctional will depend upon the context in which it occurs. The seven interruptions to contact were refuged on a paired continuum:

- desensitisation – hypersensitivity
- deflection – staying with
- egotism - spontaneity
- introjection – questioning/rejecting
- retroflection – expressivity
- projection – owning
- confluence – differentiation

Through this continuum, every creative adjustment to the environment is considered a form of self-regulation at the contact boundary. Observations about contact style are not based on the content that a client brings to the session, but on the way in which he brings it (or not), including the way he brings (or does not bring) himself to the therapist. The contact style emerges from the relationship between the therapist and the client. It is not a one-person event.

This formulation of patterns of contact and creative adjustments has been further elaborated by European and North American writers. They suggest that the Gestalt therapist develops the ability to sense how the client’s intentions for contact move and shift so as to perceive the sense of an absence at the contact boundary of the therapeutic encounter. This involves cooperation between client and therapist to facilitate a new synthesis of awareness and create new meaning by focusing on experiential information that was previously not yet figural.

Participants in the second round of the Delphi were asked whether the following therapist behaviours reflect this concept:

- The therapist works with the client’s interactional patterns as they emerge between client and therapist.
- The therapist and the client identify the figure together.
- The therapist co-creates a space in which the client and therapist explore how they are impacting each other.
- The therapist identifies experiential processes that have not yet been named or overted and explores the impact of this on her awareness.

Feedback

This was the concept that attracted the most varied and passionate feedback from participants. At one stage I suggested to one of my supervisors (Leanne O’Shea) that the feedback was so engaging that a conference on the topic of contact in GT would be very lively (and potentially lethal, she added!). The main objections arose from the intra-psychic, individualistic paradigm that underscored the models of contact that were developed post-Perls, Hefferline and Goodman (1951). It was difficult to retain the theoretical importance of these models whilst also retaining the more contemporaneous and relational GT approach in which the contact style is emergent from the dyad, not from the client. Many participants emphasised the importance of recognising that contact always occurs in an organism/environment relationship.
Experimental attitude

Description of the concept

Awareness can also be explored through working with an experimental attitude. Experiments are introduced from material that emerges in the therapeutic encounter. Experiments are co-created by the client and therapist and are graded for risk and challenge in a way that supports the client’s capacity to engage with and deepen into his awareness. The therapist supports an experience where the client tries out new behaviour, potentially leading to new meaning-making and deeper awareness. The therapist is sensitive to the potential that an experiment may be shaming or rupturing of the relationship. The therapist works with the client to integrate material that emerges from the experiment. The result of the experiment produces a fresh figure of clarity for the client (a new awareness arises).

Experiments include:

- An invitation to exaggerate, minimise, repeat or reverse a bodily gesture or behaviour.
- Empty chair work: either with an aspect of self, or with a person with whom the client is relating.
- Working with unfinished situations from the past by focusing on the internal structure of the therapeutic alliance.
- Guided visualisation.
- Staying at the impasse.
- Directing awareness to breath or bodily movement or sensations.
- Creating a safe emergency.
- Introduction of art materials, movement, music or imagery.

Participants in the second round of the Delphi were asked whether the following therapist behaviours reflect this concept:

- The therapist uses material that emerges in the therapeutic encounter as the basis for introducing experiments to develop the client’s awareness.
- The therapist grades the experiment by eliciting feedback from the client regarding the degree of challenge and support that the client perceives.
- The therapist supports the client to integrate learning and awareness that emerges from an experiment.

Feedback

Most participants agreed that an experimental attitude is an essential and differential element of GT. This is only the case where the experimental attitude is a process rather than a method or technique (as some modalities have taken up the empty chair as a technique and decontextualised it from the relational foundations of GT). Thus, the whole of GT is experimenting – experimenting with contacting, presence, self-disclosure, embodiment, challenge, support, where the Gestalt therapist holds an experiential stance and works with clients to develop experiments.

Validation of the scale

Preliminary analysis of the responses to the second round of the Delphi study suggests that it is likely to result in a working document containing descriptions of therapist behaviours that the expert panel agree characterise the specificity of GT in clinical practice. The analysis will be completed in time for the EAGT/AAGT conference in Taormina, Sicily, and may be the subject of a postscript to this article in a subsequent issue of the BGJ.

Once the analysis of the results of the Delphi study has been completed, the next stage in the development of the GTFS will involve the validation and reliability of the scale. This stage involves raters being trained in the use of the draft GTFS, rating recordings of sessions from two groups. The first group will be videos of clinical work by therapists trained in (and purporting to practise) GT. The second group will be videos of clinical work by therapists not trained in (and not purporting to practise) GT. The hypothesis to be validated is simple: those trained in (and purporting to practise) GT should rate higher on the GTFS than those not trained in (and not purporting to practise) GT. Once the scale is validated it can be used for clinical trials (including post hoc analysis) and for training purposes.

This has been a wonderful project to be engaged in. I have deeply appreciated the warmth and encouragement from the Gestalt community and have sometimes welcomed the many challenges along the way. Research can often be a lonely path, but this project has offered connection, and most importantly a means towards consensus that our community needs in order to thrive.

Notes

1. The full reference list for the Delphi study is too long for print publication, but it can be accessed via the BGJ website (www.britishgestaltjournal.com), or be obtained by contacting the first-named author.

2. There were three further participants who elected to not be named.

References


What do Gestalt therapists do in the clinic?


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