Creating a Fidelity Scale for Gestalt Therapy

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Author’s note. This paper is based on a presentation at the 9th International GANZ Conference in Brisbane, October 2014. I have tried not to alter it too much, but am uncomfortably aware that there are augmentations and additions that I was tempted to include, particularly since attending the 2nd International Gestalt Research Conference in Cape Cod in May 2015. However, I have been encouraged to stay as close to the original presentation as possible. Suffice to say that there is currently a lot more research going on in Gestalt than this article suggests, and the collaborative environment at that conference bodes well for the future of Gestalt therapy.

Theories are wholes, unifications of numerous facts. Sometimes a simple theory has to be corrected when new factors, not fitting into the original conception, are discovered. Sometimes so many additions have to be provided that we come to a confusing complexity instead of a working hypothesis. When such a situation arises we have to pause and seek a reorientation, look for new common factors that can simplify the scientific outlook. (Perls, 1947)

Introduction

The demand for psychotherapies to be accountable in evidence-based practice (EBP) is mounting, particularly in western countries (Burley, 2014; Brownell, 2008; Frew, 2013; Gold & Zahm, 2008; O’Leary, 2013; Guidano & Miller, 2013). In order for Gestalt therapy (GT) to participate in EBP a Treatment Fidelity (TF) scale must be developed. Treatment fidelity (TF) refers to the extent to which the treatment was implemented as intended and is foundational for unambiguous interpretations of obtained results. TF fundamentally operationalizes the theoretical basis of a treatment orientation by describing the key therapist behaviours that both represent the orientation, and distinguish that orientation from others. Without an adequate TF procedure, it is impossible to know whether the results reflect
the treatment as designed or treatment as actually delivered or whether other variables (such as treatment settings, patients, therapists) account for therapeutic change (Perepletchikova, 2011; Waltz, Addis, Koerner & Jacobson, 1993).

Recommendations on the way TF is established, assessed, evaluated, and reported have been suggested and stratified into a staged continuum (Perepletchikova, 2011). Developing TF for GT is difficult, due to the diverse theoretical tradition of GT, its phenomenological foundation, the process focus of GT training and practice and the fact that there is no manual for GT. Hence it is has been proposed that in order to honour the rich diversity of theory and practice in GT, the development of a TF for GT might take the form of a Delphi Study. The following article describes the background to the development of such a study which will be undertaken under the supervision of Assoc.Profs. Sunil Bhar and Stephen Theiler at Swinburne University.

**Definition**

A fidelity scale provides a means by which an independent rater is able to determine how accurately therapy delivered by a therapist approximates the therapeutic method they intend to deliver. The purpose of developing a treatment fidelity scale for Gestalt Therapy is primarily for use in research studies; however, it is anticipated that the scale may also be useful in training settings to assess therapist development and provide feedback to therapists receiving Gestalt supervision.

**Why does Gestalt Therapy need a fidelity scale?**

A recent survey found that, among members of the American Psychological Association’s (APA) Division 29 who responded, 4 percent ascribed to a Gestalt theoretical orientation (Norcross and Rogan, 2013). This is an increase from previous surveys: in 2001 it was 1.5 percent; in 1991, 2 percent; and in 1981, 3 percent. The recent rise in the number of psychotherapists who professionally identify as Gestalt orientated is promising. However, the low percentages also reflect the views of Gestalt writers who are concerned that Gestalt will not survive market forces such as managed health care and the requirements of Evidence Based Practice (EBP) (Burley, 2014; Brownell, 2008; Frew, 2013; Gold & Zahm, 2008; O’Leary, 2013).
The threat posed to Gestalt therapy (GT) by a managed health care system raises a paradox. Should a system of therapy that was created in a hermeneutic fashion, deliberately in defiance of a regulatory system (Perls, Hefferline & Goodman, 1951) now be organised within the stringent world of managed health care and EBP? Related to this issue is the professionalization process that is occurring in many international contexts. The first implication of this professionalization process is the requirement that mental health practitioners become licensed and accredited (Frew, 2013; O’Leary, 2013). The second implication is that in order to professionalize Gestalt practitioners, an evidence base for GT must be developed. In order to develop this evidence base a clarion call has been put out to garner support for Gestalt research (Brownell, 2014; Burley, 2014; Joyce & Sills, 2010).

What Gestalt research already exists?

Mark McConville (2014) observes that GT is frequently dismissed or overlooked because Gestalt practice is under-represented in mainstream scientific research. The dearth of articles on Gestalt practice in psychology journals is often noted, but it represents a conundrum for many Gestalt thinkers. McConville is not alone in his concern that the framework for EBP is reductive and fails to account for the phenomenological basis of GT (McConville, 2014; Wollants, 2008; Yontef & Jacobs, 2013). Many Gestalt writers fear that the adoption of a scientific paradigm (with its measurement bias) would mean that the phenomena under study are likely to be framed in a fashion not conducive to their measurement (McConville, 2014; Yontef & Jacobs, 2013). This argument is also expressed in the wider psychodynamic community, where there is criticism of Randomized Control Trials (RCTs) on the basis that the trials concentrate on symptom reduction as a primary measure of effectiveness; and that RCTs are designed to prove that one form of treatment intervention is more efficacious than another, even though the number of variables in each treatment cannot be reduced to a size manageable in an RCT (Wampold, 2001). Further research has also demonstrated that RCTs are influenced by researcher allegiance, whereby studies conducted by advocates of a particular treatment tend to favour that treatment (Wampold, 2001).

There is a view that limiting the therapist’s interventions in order to achieve scientific precision would achieve uniformity for the research at the expense of misrepresenting the Gestalt methodology (Yontef & Jacobs,
2013). There are also significant challenges in determining adherence to the creative and experimental core of Gestalt practice, with its foundational commitment to an authentic, “felt”, relational experience between therapist and patient (Wheeler & Axlesson, 2015).

Hence most Gestalt researchers advocate forms of qualitative research that embrace the phenomenological foundation of Gestalt (Barber, 2006; Brownell, 2008; McConville, 2014). For example, although Phil Brownell’s enthusiasm for research is informed by a contemporary philosophy of science that is a product of naturalism, critical realism and post-positivism, his research methods are quasi-empirical. Brownell advocates a practice-based evidence that takes a bottom up approach to research by starting with clinical observation of what works in therapy (that is ideally co-determined by the client and the therapist). In this sense Brownell’s work is closely aligned with Paul Barber’s (2009) argument against the pursuit of a single truth in research praxis, and the development of the “practitioner-researcher”.

The endeavour to find a research methodology that fits with the Gestalt paradigm relates to philosophical differences in research traditions, in particular, the philosophy of science debate between naturalists and anti-naturalists. Phenomenology is an anti-naturalist system in terms of the philosophy of science. Those researchers whose framework is grounded in naturalism embrace the scientific method, and those whose paradigm is anti-naturalism embrace the phenomenological method. This division is often mirrored in the division between quantitative or qualitative research.

The body of research that reaches beyond qualitative studies into quantitative research, and that is often cited to shore up the evidence base for Gestalt, includes the studies conducted by Les Greenberg and associates and the meta-analysis by Strümpfel (2006). Over the past 25 years, Les Greenberg and associates have conducted a large series of experiments in which process and outcome studies are brought together with attention to context and to the combination of technique and relationship factors. Many of their research reports relate specific interventions with three types of outcome (immediate, intermediate and final) and three levels of process (speech act, episode and relationship) (Greenberg, 1980; Greenberg, 1991; Greenberg, Rice & Elliott, 1993; Greenberg, Elliott, & Lietaer, 1994; Greenberg & Paivio, 1997). Although these experiments include well-known Gestalt techniques, such as two chair work and “here and now experiments”, the “branding” of Greenberg’s work has moved from Process Experiential Therapy (PET), (Greenberg, Rice & Elliot,
to Emotion Focused Therapy (EFT), (Greenberg, Warwar & Malcom, 2008; Greenberg, 2014). Though both of these therapeutic methods explicitly acknowledge Gestalt as a precursor, they are differentiated from Gestalt, as they do not cover all the methods and theoretical bases of GT. Given their stated similarity with Gestalt, the results of Greenberg’s and associates’ work do suggest that Gestalt Therapy may be efficacious; but given the differences, their results fall short of establishing that it is.

Uwe Strümpfel (2006) conducted a meta-analysis that compared GT with Cognitive Behavioural Therapy (CBT). Like many meta-analyses that have sought to demonstrate the effectiveness of psychotherapy compared to CBT, Strümpfel’s results found an equivalence between treatment modalities. He found that there was no statistical difference between the methods when looking at the overall level of treatment (Strümpfel, 2006). Nonetheless, the conclusion drawn by Strümpfel was that these results contributed to the reasons why GT has been disenfranchised in Germany, because of the dearth of research that had been published to establish the efficacy of GT.

Strümpfel cautioned that due to the increasing linkage between research evidence and public policy, and the growing movement toward treatment guidelines, GT was in danger of becoming marginalized, not just in Germany, but worldwide. Strümpfel’s summary of GT research is a valid and significant contribution to the Gestalt research field. However, given the number of studies in his meta-analysis that examined Gestalt in combination with process-oriented psychotherapy and focused-expressive psychotherapy (including studies by Greenberg and associates), the findings of his investigation simultaneously shore up the trajectory of a common factors approach and offer promise for research focused specifically on the potential efficacy of Gestalt.

Brownell’s (in press) survey of Gestalt research underscores the support offered to GT by humanistic psychotherapy. Brownell highlights the online list (Elliott & Hendricks, 2013) of abstracts describing gestalt-oriented research. There are 19 abstracts on the list (many of which are written in German, and were included in Strümpfel’s meta-analysis). He suggests that these studies provide a general impression of the value of gestalt therapy in dealing with various subjects.

A more recent research project conducted in Britain also found promising results supporting an evidence base for the efficacy of GT. The Clinical Outcomes in Routine Evaluation system (CORE) was used to
evaluate and measure outcomes in counseling and psychotherapy services in the United Kingdom. From a database of 50,000 clients, 135 clients were identified as having been treated by Gestalt therapists. Using the CORE method, GT was found to be as effective as other treatment modalities (Stevens, Stringfellow, Wakelin & Waring, 2011). Again these results are promising, but they also raised some serious questions about Gestalt research. In particular, Stevens and colleagues struggled with the task of determining what therapeutic behaviours differentiated Gestalt from other psychotherapy methods (Stevens et al, 2011).

Common factors approach

The common factors approach has been widely embraced by the psychotherapy research community (Gaudiano & Miller, 2013). This approach seeks to identify those aspects of therapy that are shared by almost all therapeutic orientations. Common factors have been categorized differently by researchers. (Frank & Frank, 1991; Lambert & Bergin, 1994; Wampold, 2011). The main components relate to therapist qualities and therapeutic alliance, mobilization of client and extra-contextual factors, promoting hope and expectancy of change, collaborative goal setting, ritualized procedures to work toward that goal, eliciting feedback, explanation for treatment grounded in a patient’s belief system, and a healing setting (Frank & Frank, 1991; Wampold, 2011; Kohrt, 2014). The common factors approach underscores the effectiveness of psychotherapy across a wide range of disorders and clinical populations (Gaudiano & Miller, 2013), and concludes that in contrast to no intervention, psychotherapy is effective in symptom relief and decreases suffering, thereby making a positive difference to people’s lives.

The common factors approach has identified key features of the therapy experience that are central to effective outcomes. However, in clinical practice and research, it is difficult to disentangle common factors as distinct processes. Consequently the identified features have trended towards the therapeutic relationship and client expectancy, rather than treatment modality (Wampold, 2011).

However, not all research finds equivalence between treatment modalities (Asay & Lambert, 1999). Norcross, Beutler & Levant (2005) report that empirically supported treatments (ESTs) typically produce outcomes superior to those of non-empirically supported treatments. Norcross and Lambert (2006) found that treatment modality accounted for eight per cent of total variability in treatment outcomes. Of the four
major variables in outcome research – relationship, therapist, patient and modality – treatment modality variables are more significant in determining outcome than therapist variables, but less significant than relationship variables (a common factor) and patient variables (which account for 30% of total variance in psychotherapy outcomes (Norcross & Lambert, 2006).

Consequently, the focus on common factors runs the risk of collaborating in the disappearance of an evidence base for the efficacy of Gestalt. This is because the common factors approach fails to account for the specific elements of what works in therapy. In order to increase the evidence for GT’s efficacy, it is important to develop a scale that can be used to isolate the mechanisms that “work” in therapy and that are specific to GT.

**What might Gestalt research look like going forward?**

Gestalt therapists sometimes bemoan the fact that the Gestalt tradition is mined by newer modalities, such as Dialetical Behavioural Therapy (Lineman, et al, 1999), Acceptance and Commitment Therapy (ACT), (Singleton, 2010) and EFT, that have gone on to establish an evidence base and are consequently taught in universities (Frew, 2013) and receive funding and recognition through mental health schemes (O’Leary, 2013). If GT could establish its own evidence base, this would help GT both to claim its tradition and methods for itself and receive the recognition and funding that these newer modalities are receiving.

In order to establish this evidence base, GT needs both qualitative and quantitative methodologies. This is not only because mixed methods designs have more potency, but also because these two approaches are essentially different tools that accomplish different things and should be used accordingly. It is insufficient to try to establish the efficacy of GT with a strictly qualitative approach (Fischer, 2012). 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). Research that is relevant, realistic and valid for GT would need to account for the importance of the therapeutic relationship and also for the full range of interventions that are integral to the GT method.

In order to do this effectively, some departure from the common factors approach is required (Tschacher, Jungham, & Pfammater, 2014). The common factors approach dilutes specific techniques, and given that specific techniques, skills and concepts are what differentiates one therapeutic
method from another, a common factors approach will not be effective in supporting the establishment of GT as an EBP. Instead, what is needed is an approach that focuses on a treatment modality’s “specific factors”. The term specific factors is generally meant to refer to the core, theory-specified techniques or methods that are prescribed for a given treatment modality (Castonguay & Holtforth, 2005). For example, although the therapeutic alliance is a common factor, in GT the practice of dialogic inclusion (central to the therapeutic alliance) is underpinned by a post-Cartesian paradigm, not shared by other modalities. So, is the measure of the therapeutic relationship as conducted in a Gestalt framework also different?

Creating a fidelity scale for Gestalt Therapy

In order to participate effectively in RCTs, a scale is required in order to establish that the method practiced by the therapist is indeed the method that they claim to be delivering. The establishment and adoption of a validated fidelity scale for ACT has been one of the major reasons for the increased acceptance and promotion of this therapeutic modality over the past 5 years (Smout et al., 2010).

The assessment of treatment integrity (TI) is critically important to the interpretation of results from clinical trials, as it is impossible to validly assess the effect of a treatment without considering whether or not that treatment has been delivered in a manner consistent with its design. Recent reviews of the relation between interpretations and outcome in dynamic psychotherapy indicate that the competent delivery of interpretations such as their accuracy or fidelity to the method that the therapist is intending to deliver determine outcomes is essential in determining the results of RCTs (Perepletchikova & Kazdin, 2005).

Fidelity incorporates the concepts of both model adherence and competence, where “adherence” refers to using interventions prescribed by the model and “competence” refers to executing those interventions skillfully (Waltz, Addis, Koerner, & Jacobson, 1993; Perepletchikova 1993). As part of a general effort to secure treatment fidelity over the last fifteen years, psychotherapy researchers have been developing specific treatment manuals that operationalize therapy (Barber, Crits-Christoph & Luborsky, 1996; Perepletchikova, 2011). The rationale is that in order to contrast different psychotherapies in a clinical trial, one needs to ensure that the delivered treatment is as close as possible to the intended treatment (treatment integrity) without being “contaminated” by other approaches.
(treatment differentiability). Because clinical trials are designed to compare modes of treatment rather than therapists’ abilities, adherence and competence need to be maximized and therapist variance minimized through therapist selection, intense training, close supervision, and evaluation. While adherence is undeniably important, it is also critical that treatment be delivered skillfully. This necessity has led to the development of measures that focus on therapists’ competence (Waltz et al, 1993; Webb et al, 2010).

Gestalt Therapy does not have a treatment manual. Therefore, developing a fidelity scale based on manualised treatment is not currently possible. The gold standard for fidelity scales is the Cognitive Behavioural Therapy Rater Scale (CTRS), (Young & Beck, 1980). The CTRS was based on Beck’s book CBT for Depression (Beck, 1978). Given the efficacy and wide use of the CTRS in RCTs, and the fact that it was not based on a manual, the CTRS provides a good model upon which to base the development of a similar scale for GT.

However, GT is not limited to a single book on depression. There is a veritable library devoted to Gestalt philosophy and theory. Most Gestalt researchers know how difficult it is to get a group of Gestalt practitioners to agree upon what therapist behaviours determine the essence of the GT approach. As Peter Phillipson commented at the 2014 AAGT conference at Asilomar, California, “Gestalt was established in a co-created environment of competition and difference”. Often the broad resources of GT make it difficult to identify actual therapeutic interventions. Despite this, there are many in the Gestalt community who are calling for a loosening of the “anti-mainstream, diagnostic taboo in humanistic psychotherapy” in order to reach scientific standards of research criteria (Butollo, 2013; Brownell, 2008, 2014; Burley, 2013). Developing a fidelity scale does not reduce all therapists to a rigid set of techniques to which they must necessarily conform. Rather it creates a prototype for a therapeutic method. As Dave Mann (2010) suggests, no two Gestalt therapists will be the same, but both will be recognizable as Gestalt therapists - when was the last time you saw two identical oak trees! To develop the GTFS that is true to Gestalt foundations, some consensus from the Gestalt community must be sought to determine what characterizes Gestalt and differentiates it from other modalities.
Creating a Fidelity Scale For Gestalt Therapy

How will a fidelity scale for GT be developed?

Extant efforts to describe therapist activity in GT include the “unit of work” (Wyman, 1998), the Polsters’ (1973) description of the structure of a contact episode (interaction between client and therapist) and more recently Gary Yontef’s succinct description of the paradigm of GT (Yontef, 2007). These models have been adopted by training centres around the world but none have yet been developed for EBP. There are neither proscribed nor prescribed techniques in GT (Mann, 2010; Yontef & Jacobs, 2013) however the therapeutic tasks of the Gestalt approach can be organized according to the key theoretical concepts of GT. The determination of these key concepts can be derived from an extensive literature review, confirmed by means of a “Delphi” study, and validated through the use of video sessions. The first step in the Delphi study is to describe key concepts of GT and then illustrate those concepts through descriptions of therapeutic behaviours, which effectively operationalize key concepts of the Gestalt approach.

The draft operationalization of clinical GT is being presented at the Gestalt International Research Conference in Cape Cod in May 2015. Feedback from participants at that conference will be integrated into a survey format that will be sent to Gestalt experts around the world. Gestalt experts are identified by (a) having published authored at least 3 books or peer-reviewed articles (b) by being a director of a key international centre for at least 6 years, or (c) being an editor of a major journal for at least 6 years. These experts will be invited to form the panel for a Delphi method of collaboration in determining private, independent ratings of agreement on a series of statements seeking to operationalize GT. Once ratings are received and collated, a summary will be fed back to the panel members, who will then complete a second round of rating. Several rounds may be required, in order to determine a reliable consensus. The output from the Delphi process includes statements about which there is substantial consensus in ratings. Once a reliable consensus has been reached the fidelity scale will be ready for validation. And that is the topic of a future collaboration.
References


Biography

Madeleine has been working as a psychotherapist in private practice in Melbourne for the past 15 years. She recently completed honours in psychology and was surprised to find that Gestalt therapy rarely featured in university courses, and was even more absent in psychology journals. Madeleine is currently undertaking her PhD in psychology at Swinburne, where she had hoped to do a comparative study involving Gestalt therapy. It was then that she learnt of the need for a fidelity scale for Gestalt. This project has enlivened her practice and introduced her to the depth and richness of Gestalt thinkers both past and especially present.

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