Dear Editor,

Thank you for the invitation to reply to Peter Philippson’s letter, and thank you to Peter for his considered engagement on this important question of what distinguishes Gestalt therapy (GT) as a clinical practice.

The Gestalt Therapy Fidelity Scale (GTFS) is intended to provide a measure by which to assess the extent to which the therapy that a therapist is delivering is GT (Fogarty et al., 2015). The assessment of treatment fidelity is an essential component of psychotherapy trials and foundational for Evidence Based Practice (EBP) (ibid.). The GTFS was developed through a Delphi Study that established a consensus between over sixty GT experts (including Philippson himself (Fogarty et al., 2016)). The Delphi Study resulted in a 20-item scale that can be used by an independent rater to assess a 30-minute video of a clinical session.

While acknowledging the consensus basis of the GTFS, Philippson argues that it reflects an outdated paradigm of ‘a one-person psychology of attunement to the client as a given’, rather than a ‘modern intersubjective Gestalt therapy’, based on ‘an exploration of self, other and pathology emergent in our contacting’. Philippson refers to his previous argument that there is a ‘third stage’ of GT training (which not all reach) in which therapists ‘learn to focus on the level of who-am-I-with-you and who-are-you-with-me’. In his critique of the GTFS, he argues that it fails to capture this intersubjective, relational dimension of GT (Philippson, 2017a; 2017b, pp. 57–58).

However, like all fidelity scales, the GTFS is limited by the conventions that apply to fidelity scales (Perepletchikova, 2011; Waltz et al., 1993): if an interaction cannot be observed by an independent rater, then it cannot be included in a fidelity scale. The participants in the Delphi Study were asked whether the GTFS failed to capture any of the essential aspects of GT, and to suggest items for inclusion. None of those experts (including Philippson) were able to offer anything that represented the intersubjective dimension that Philippson argues is missing from the GTFS. Philippson has still not suggested such an item.

Why might this be the case? Perhaps Philippson and others are overcome by the obstacle that I faced when formulating the items for the GTFS: how does one operationalise the ‘exploration of self, other and pathology emergent in our contacting’ (Philippson, 2017b, p. 57)? It is difficult to do so within the limitation of observable therapist behaviours. The real question is whether, despite this limitation, the GTFS still captures the specific ways in which the ‘intersubjective matrix’ is co-created in a clinical session of Gestalt?

Philippson’s felt sense is that the GTFS fails in this regard. However, he makes that claim without having participated in the validation study, and therefore without having any direct experience in assessing the extent to which the observable behaviours in GTFS do somehow account for the intersubjective dimension of GT. By contrast with Philippson, many of the participants in the validation studies reported that the items in the GTFS do capture the relational dynamic of a clinical session of GT. This may not be surprising, given that items 4, 15 and 17 in the scale are specifically intended to capture the relational dimension of GT:

4. The therapist draws on their relationship with the client as the ground for challenge and growth.

15. The therapist works with the client’s interactional patterns as they emerge between client and therapist.

17. The therapist co-creates a space in which the client and therapist explore how they are impacting each other.

Philippson criticises these items as being based on ‘the old “separate and independent minds” sort of intersubjectivity’ (2017b, p. 57); but does not suggest any alternative items that avoid this problem. Instead, Philippson proposes an entirely different research basis for GT: neuroscience (but again, without making any concrete suggestions about the form or direction such research might take).

It is exciting and comforting that neuroscience may eventually confirm what GT has always claimed. However, to find neurological evidence for the intersubjective matrix that Daniel Stern and others recognise (along with GT practitioners) as the crucible for change in psychotherapy would require complex instruments for the measurement of pre- and post-testing for therapist and client, in session and between sessions. It would also require that many sessions with different clients and therapists be measured. Furthermore, in addition to being extremely expensive, neuroscience also works from the paradigm of fidelity scales. That is, before one can credit any particular neurological manifestation to the fact that the therapist is practising GT, one must first establish that the therapist was indeed practising GT. And the only way of establishing that is through a fidelity scale!

Or perhaps Philippson is suggesting that instead of a fidelity scale, neuroscience itself can be used to
distinguish GT from other modalities. What might such research look like? Perhaps the ‘brain waves’ of a Gestalt therapist and client would be measured before, during and after a clinical session; similar measurements would be taken in relation to therapists working in other experiential psychotherapy modalities; and these measurements would then be compared to see whether there was something distinctive about the brain wave patterns manifested in a clinical session of Gestalt therapy. If such a distinctive ‘Gestalt’ pattern was found, then that pattern could be used to determine whether a particular therapist was delivering Gestalt, by again measuring the brain waves of therapist and client before, during and after a clinical session and seeing whether they conformed to the Gestalt pattern. Perhaps, one day, this will be possible. In the meantime, or for those without access to the necessary equipment, the GTFS provides a simple, low-tech measure for determining treatment fidelity that is the standard requirement for establishing EBP.

I am also concerned that Stern’s use of the example of the ‘safe emergency’ from GT may result in psychotherapy extracting this technique from the holistic foundation of GT and using it in clinical practice, in the same way that the ‘empty chair’ was mined from GT and practised as a technique outside the framework of dialogic relating, in the here and now, phenomenologically, through embodied experience, with field sensitive practice towards contact, with an experimental attitude. If this mining of GT practices continues, then GT’s holistic approach will remain outside the evidence-based practice of psychotherapy and psychology.

By contrast, the GTFS attempts to represent the clinical practice of GT holistically, and to preserve the experiential hermeneutic as an embodied, immediate and field-dependent system. Contemporary focus on the relational dyad endorses a central tenet of GT from PHG. But GT is a modality that embraces somatic, aesthetic and experimental practices that may not be included in other clinical practices that are also organised around the ‘intersubjective matrix’. Focus on this central aspect of GT does not necessarily distinguish GT from other modalities, nor does it capture the holistic practice of GT.

The results of the validation studies currently underway indicate that raters in many different countries around the world are able to distinguish GT from non-GT and to recognise GT across the variance of practitioners demonstrating very different styles of therapy. Philippson has called for the GTFS to be contrasted to DBT and PCT as comparison groups. This is a wonderful research project that I would be happy to support.

For now, the GT community can be proud of the collaboration that resulted in the creation of the GTFS, and the results of the validation studies that have focused our attention on the common ground of our practice. In 2007, Malcolm Parlett commented on the diversity within the Gestalt community. He suggested that almost any Gestalt term, principle, idea or method could be investigated and dissected, revealing much theoretical difference and confusion. He felt that this wide range of disparity between Gestalt thinkers threatened the possibility of generating sufficient consensus and collective wisdom to secure the Gestalt ‘brand’ in the wider therapeutic community (Parlett, 2007).

Parlett’s call for more accessible practice-based materials that describe Gestalt in the clinic has been answered to some extent by several subsequent publications (Francesetti et al., 2013; Francesetti, 2105a, 2015b; Joyce and Sills, 2009; Mann, 2010; Wheeler and Axelson, 2015). Differences between these authors continue to emerge nonetheless (O’Leary, 2013). The GTFS represents an international Gestalt community consensus on what constitutes Gestalt in clinical practice.

The results of the validation studies will soon be published. Once this occurs, further research and development for GT will be enabled. This will provide an opportunity to further investigate the question of whether the ‘intersubjective matrix’ is represented by the GTFS. Research creates evidence. Critique raises questions that generate research. Again, I take this opportunity to thank Peter Philippson for his critique and his questions, the Editor for the opportunity to respond to that critique, and to all who have been involved in the development and validation of the GTFS for their collaboration in this research.

References


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