Gestalt Therapy

A Guide to Contemporary Practice

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Philip Brownell completed a doctoral program in clinical psychology from George Fox University in which he was trained as a scientist-practitioner. Following completion of his Psy D, he completed six years of post-graduate level training in Gestalt Therapy through the Portland Gestalt Therapy Training Institute and worked as a Mental Health Therapist for four years on the Intensive Care Unit of a dual-diagnosis psychiatric facility. Dr. Brownell is the Editor of the *Handbook for Theory, Research, and Practice in Gestalt Therapy*, which is being translated into several languages. He has facilitated the gestalt-focused discussion group, Gstalt-L, for thirteen years, is co-chair of the AAGT's Research Task Force, and is actively engaged in supporting research focused on gestalt therapy. He is a licensed clinical psychologist, gestalt therapist, organizational consultant, and coach. He is seminary educated, an ordained clergyman, and President of the Gestalt Training Institute of Bermuda.

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Gestalt Therapy

A Guide to Contemporary Practice

PHILIP BROWNELL, MDiv, PsyD

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I dedicate this book to all the people who trained me in gestalt therapy; most profoundly that would be Maya Brand and Carol Swanson and my discussion partners at Gstalt-L. My gestalt training group with Maya and Carol broadened my view beyond my doctoral program and Gstalt-L broadened my view beyond my gestalt training group.

I also want to thank my wife, Linda, and my children, Matt, Zac, and Stasia, and my good friend Pat Roberts. Pat is a writer and lover of books and in many ways has been like a spiritual mother.

So, here's to good friends, stacks of books, and cups of coffee around which to talk about the Kingdom of God.

—Philip Brownell

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Foreword

It is raining in Bermuda as Phil Brownell writes the Preface to his comprehensive look at contemporary gestalt therapy. The rain fills cisterns all over his island and fills dry streams. It is fitting that this is how he begins his Preface since gestalt therapy is a metaphorical stream. Or rather, gestalt therapy is the convergence of many streams: streams that flowed from Europe, America, and Asia; converging streams of existentialism and pragmatism, phenomenology and hermeneutics, biology and psychology, social science and neuroscience, psychoanalysis and politics, the arts and sciences, Buddhism and Western theology. With such a broad headwater, no single view of gestalt therapy can be the final word on the subject. This is Dr. Brownell's encyclopedic overview, which is both traditional and original.

I have described gestalt therapy's development with the earthbound metaphor of water; Dr. Brownell characteristically looks to the heavens for his metaphor: "Gestalt therapy is not a supernova shining alone in the darkness. It is built from an assimilation…" (p. 35) Dr. Brownell's book describes today's gestalt therapy as a widely accepted theory and method (praxis).

This book is accessible as an introduction for the reader who has heard something about gestalt therapy and wants to know more. It is also a resource for the experienced gestalt therapist who needs a deeper understanding of gestalt therapy history, development, theory, and practice. He accomplishes this by offering a book that meets these varied needs of readers at different levels of interest, modality, and experience.

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In this Foreword I will situate Dr. Brownell's contribution within the history and the current world of gestalt therapy, from my own point of view, of course.

Dr. Brownell describes the founding of gestalt therapy some 60 years ago by Fritz Perls, Laura Perls, and Paul Goodman, who brought together their diverse European and American backgrounds to synthesize a new psychotherapeutic and social theory. He takes the reader through gestalt therapy's later development and makes gestalt therapy come alive by introducing actual practitioners who, in their own words, describe how they became gestalt therapists. Dr. Brownell offers his personal insights into gestalt therapy to show heretofore unexplored possible influences on its founders and original practitioners as they developed gestalt therapy. At all times, he is ecumenical in his presentation of the various contemporary approaches within gestalt therapy, offering the reader a sense of a world of differences in the gestalt therapy universe. The world of gestalt therapy is, and has always been, a world of differences. However at relative peace these various approaches may now be with one another, gestalt therapy's history was not without conflict.

The postwar years in the United States were a time of social conformity; this was reflected in the dominant psychotherapies, which encouraged individual adjustment to social pressures. Gestalt therapy "debuted" in 1951. This new modality offered reform of traditional or authoritarian modalities of psychotherapy that stressed a model of health based on adjustment to societal norms dictated by the psychotherapist himself (the therapist was most often a man).

To some people's perceptions, the established psychotherapies offered an often-cerebral process of social adjustment, while gestalt therapy offered an opportunity to release the creative potential of the person. Gestalt therapy presented a psychotherapy with creative novelty at its core and proposed an egalitarian psychotherapy relationship of more or less mutual partners. Most importantly, and famously, gestalt therapy accented a person's creative potential and supported individual difference, not conformity. It is no wonder that in its early days it attracted so many artists, social nonconformists, and miscellaneous "refugees" from then authoritarian mainstream

psychotherapies. The social complacency of conformity and the psychotherapies that supported it were begging to be challenged, to come under siege. Gestalt therapy would be the modality most identified with supporting this siege.

The 1960s was a time of social tumult; it was the time of this siege. "The human potential movement" and the social revolutions of the decade formed a synergy with the social and clinical values of gestalt therapy. Gestalt therapy became the unofficial "anti-Establishment" psychotherapy. Its popularity got ahead of itself. In the hands of popularizers and amateurs, "gestalt therapy" sometimes seemed to morph into often-unidentifiable variations and sometimes careless or reckless parodies of the original, serious psychotherapy. The reputation caused by this popularization, that is, the mistaken impressions that gestalt therapy is nothing but theatrical techniques that could be done to people, that mere emotional catharsis such as pillow banging and screaming was psychotherapy, that gestalt therapy is nothing but its techniques, and so on, is something gestalt therapy continues to have to correct. Dr. Brownell's book is an important contribution to gestalt therapy's ongoing work of addressing what remains of these false beliefs.

Claims of dilution as a consequence of gestalt therapy being outstripped by its popularity were further complicated by gestalt therapy's initial success among serious psychotherapists in the 1950s, too. Clinicians were eager to learn gestalt therapy as one of the modalities in the humanistic reformation of psychotherapy. There was an increasing demand to learn gestalt therapy quickly. Trainers from the original institute, The New York Institute for Gestalt Therapy, were invited to teach gestalt therapy around the country and soon across the world. These skilled trainers were under pressure to teach gestalt therapy as quickly as possible. There was a need to streamline the training of gestalt therapists, and indeed, to streamline the gestalt therapy.

Fritz Perls rejected the original model of gestalt therapy that he helped develop in New York. He developed a new, simple, more easily understandable and learnable version of gestalt therapy. His version of gestalt therapy became widespread and identified as gestalt therapy itself. Those in New York who continued to practice

and teach the model he rejected felt Perls's new version of gestalt therapy strayed too far from its source in the service of simplification. They insisted that gestalt therapy could not be taught quickly since it was a nuanced, phenomenological approach. Unfortunately, the tensions between what was known as the "East Coast Model," identified with Laura Perls in New York, and the "West Coast Model," identified with Fritz Perls in California, colored gestalt therapy's history.

As gestalt therapy spread, gestalt therapy institutes sprang up and flourished as people who were trained by the original trainers trained their own students. Newer conflicts emerged as institutes inevitably offered their own understandings of gestalt therapy to which other institutes objected, sometimes aggressively. The differences among various models, approaches, or perspectives within gestalt therapy proliferated over the decades. There was no peace among the adherents of the different models. Intramodality conflicts are not unique to the history of gestalt therapy. A glance at the history of psychoanalysis, for example, shows similar scuffles.

Over time, gestalt therapy itself continued to develop as a modality that embraces change. The fractionalization of gestalt therapy eased from the rigid defense of particular perspectives on gestalt therapy to inclusive notions that we each may have different points of view within a common heritage.

The streams of gestalt therapy that once flowed apart have come together. Naturally, different approaches to gestalt therapy remain and there are hearty disagreements. These energize gestalt therapy and assure its development.

Gestalt therapists meet in conferences with attendees from all over the world. There are transnational organizations such as the Association for the Advancement of Gestalt Therapy, an international community, to transcontinental organizations such as the European Association for Gestalt Therapy, Gestalt Australia and New Zealand, and the International Gestalt Therapy Association, which is primarily oriented toward the Spanish communities. There are many national and regional organizations as well. Gestalt therapy has its own journals such as *Gestalt Review*, *Studies in Gestalt Therapy: Dialogical Bridges*, *The British Gestalt Journal*,

and *Gestalt!* to name only the English language journals, and its own publishers (The Gestalt Press, The Gestalt Journal Press).

This brings me back to this book. Dr. Brownell's description of gestalt therapy is an example of the contemporary perspective in that he offers us a broad view of gestalt therapy itself. But this is not to say that he offers us a generic, one-size-fits-or-pleases-all model of gestalt therapy. To be sure, he offers an excellent survey of the basic, important concepts and offers illustrative clinical examples. The latter are crucial for any reader to be able to see how gestalt therapy is applicable across so many different dimensions of practice. Dr. Brownell excels in reaching out to the broadest audience of readers. At the same time, he offers the more informed reader an opportunity to see gestalt therapy from his own perspective.

Make no mistake about this. Just as in this Foreword I offer my own perspective on the history of gestalt therapy, Dr. Brownell does the same in this book. Readers may differ with my point of view here; and readers may sometimes differ with Dr. Brownell's. Gestalt therapy's liveliness often comes from its support of differences and its commitment to meeting one another on the basis of our differences. It is this liveliness that now characterizes gestalt therapy as its different perspectives continue to develop around the world. Each perspective is a special point of view from a different vantage point, yet each looks upon a world of shared experiences. Gestalt therapy continues to develop, like the stream with which I began this Foreword. Dr. Brownell's contribution adds to this development.

Dan Bloom

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Preface

As I put the finishing touches on this book it is raining in Somerset; it's raining all over Bermuda. That is good, because in Bermuda people catch their water as it rolls off limestone painted roofs and lands in cisterns beneath the houses. It's been dry here for weeks and we were just about ready to order a truckload of water.

When one's line of work goes dry, it's hard to imagine getting excited because everything seems stale, washed out, and bleached from overexposure. The same may be true of gestalt therapy. Many books have been written exploring one aspect or another, such as those of Perls, Hefferline, and Goodman (1951), Erving and Miriam Polster (1973), Joel Latner (1989), Gary Yontef (1993), Sylvia Crocker (1999), Jennifer MacKewn (1997), Gaie Houston (2003), Edwin Nevis (2000), and Ansel Woldt and Sarah Toman (2005) to name just a few in the English language. So why another one?

The most honest answer is because I wanted to write one. I wanted to include things in this book that I've been discussing with my friends and colleagues at Gstalt-L, an online community of gestalt theorists, trainers, trainees, and practitioners. For more than thirteen years it's been like a think tank where people have fought for their opinions and argued passionately and cogently for their ideas. Recently, Seán Gaffney (2009) indicated that his article in *Gestalt Review* came about in part due to such discussion at Gstalt-L. Because of the drama that can be seen there, some people report that they maintain a subscription to see what the characters are going to do next. It's like watching a soap opera. At any rate, some of the ideas expressed there over the years have not made it to print yet, and I want to give them voice in a different format.

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I also wanted to give myself the gift of writing. For me, writing is a learning experience. I frequently propose projects to publishers because I want to pursue a particular idea and learn from it. Then I go into research mode as I prepare to write. Even in the process of writing, as I thrash about with something, I discover resources I never knew existed and expand my world. I run sections of the manuscript past friends and colleagues to see how they play with them. Their responses help me calibrate what I'm doing.

Finally, I wanted to write a book that would inform people who are unfamiliar with gestalt therapy–perhaps to bring them a little water if what they already knew had gone dry. That is why, for this book, I have selected the mainframe of gestalt praxis—phenomenology, dialogical relationship, the field, and experiment. I don't want to blur that focus. There are many other things that could have been put into this book, but if a mental health professional wants to understand gestalt therapy, especially with a view to eventually becoming fully trained and to practice it, then the starting place is to grasp these four tenets. In addition, I knew from years of experience, both in private practice and in community mental health, that there are pragmatic concerns, if not sound professional protocols, that needed to be included. So, I chose the issues of assessment, treatment planning, and training.

My hope is to bring a little water to people who have become thirsty in their work, including established gestalt therapists. I've tried to keep the jargon to a minimum, but I realize it is necessary to use the terms that have meaning within the field in order to help those unfamiliar learn the necessary concepts. I've also included some subjects gestalt therapists have thus far neglected in the literature, as well as new slants on subjects that have already been covered.

I guess the last thing is that I speak from where I'm at. Where I'm at is partly due to where I've been. I'm the oldest of five children. I grew up in an alcoholic, dysfunctional family, and I went through years of therapy to deal with it. I've been a road manager for a rock band. I've been a neuropsychiatric technician in the United States Navy during a time of war. I've been a longhaired

counter-culture freak, and I've been a Jesus freak. I'm still a Jesus freak. I've been a seminary student. I've worn three-piece suits trying to fit in while working as a minister of children at a large, multi-staff church in central California, and I've been a laid-back pastor of a rural congregation along the north Tillamook coast in Oregon. I've ridden a motorcycle to work. I've been a liberal and I've been a conservative. Right now I'm what I like to call a *conliberative*. I'm the father of three great children, and I've been married three times. I've been a single parent. I've been homeless, and I've lived in beautiful, even luxurious, homes including the place from which I write at the moment, which is located atop a hill looking south and west across the expanse of the Atlantic Ocean.

Each therapist brings to his or her work as a professional his or her whole self. That means that if I am to be of help to others I must attend to myself, making sure that I'm grounded, balanced, available, and courageous enough to meet the courage that brought my clients to me in the first place. When I do that, I bring my *whole self* to that meeting. People get a whole person—an integrated person at peace. That is what I also hope the reader picks up on in this book, even though what they get is a huge dose of my mind grappling with various issues.

Philip Brownell
June 2009

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Acknowledgments

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Second I want to thank Dan Bloom and Peter Philippson who at various times read and commented on portions of the book. As always, we did not agree on everything, but that is the beauty of having people like this in one's life. No matter how much we may struggle over various things, no matter how different we are from one another, we find a common ground in our interest in gestalt therapy theory and practice. I have gone to war with Peter while conducting organizational business, but then I can turn the page and find in him a thoughtful and considerate thinker who will take what I write seriously and give his best shot at critical response. I respect that very much. Dan is much the same way, except in him I have found a man who thinks like me on crucial subjects and sometimes speaks directly and forcefully as I also tend to do. Neither of these men share my faith in Jesus, and what I find truly amazing and priceless is that we can talk with one another the way we do and can respect, if not love one another, in spite of what has separated other people.

Last, I want to acknowledge the sacrifice that my wife has made as I have worked on this book. I have been unavailable to her, and that has been difficult. While I worked hard writing, she worked hard waiting—waiting to get her husband back. And now the book is done; and now I am back.

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Introduction

This is a book about gestalt therapy, but it is not a book that tells everything there is to know about gestalt therapy. Some things are left out and other things are only treated in passing. Why? It is because I want to keep a focus on the core of gestalt therapy. To practice gestalt therapy, one must know these core concepts.

So the claim is that this book tells the reader what gestalt therapy is and that it can serve as a template or treatment manual.[1] However, this would only be a beginning for a true student of gestalt therapy. Vast sections on gestalt therapy's theory of self, especially as it relates to contact in the person-world/organism-environment field, are either left out or only mentioned in passing. Why is that? Because to utilize the core of gestalt therapy praxis will inexorably lead one into person-world/organism-environment self-formation. Self emerges from the action of the person in his or her world. Utilize the core, and all else will follow.

The primary audience for this book is practicing clinicians; counselors and psychotherapists who are working with people in a variety of settings (or those in training to do so). This would also extend to anyone interfacing with people in a helping profession such as nursing, the clergy, corrections, or social work.

During my internship at a large hospital on the southeast side of Portland, Oregon, I was an adjunct instructor at the Walla Walla School of Nursing. My purpose was to teach the nurses about the field of psychology during their rotation through the psychiatric units in the hospital. What I emphasized was making good contact with the patients they served instead of simply coming into a room, attending to the medical necessities, and charting. Contact is healing. Often, one of the greatest factors leading to positive outcomes

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can be the support that meaningful human contact can have for a patient during a stay in the hospital. Nurses can benefit from learning how to do gestalt therapy.

I was a line staff member at several residential treatment centers for children and adolescents. The line staff are the ones who spend most time with the residents. I realize now that I could have done a much better job if I had been trained in gestalt therapy back then, and that goes for my time as a pastor or minister to children as well. So, with a bit of hindsight, I contend that anyone in a position that requires working in groups and interfacing with other people could benefit from learning gestalt therapy.

There are people who train in gestalt therapy, however, with no intention of using it professionally. They just want to live by its philosophy. They like how it contributes to an existentially satisfying way of life and they want to know more about it and to use it as a discipline for living. This book is for those people as well.

Gestalt therapy is an experiential approach and must be learned in experiential training groups (an explanation of this will be included in chapter 11). But the reader can gain a foothold in obtaining the expertise needed to practice gestalt therapy by reading this concise and practical guidebook written about complex clinical and interpersonal processes in mostly ordinary language even though the subjects in question do require reference to technical terms used in the field.

The practicing and experienced clinician, on the other hand, will recognize many of the elements covered in the book, but might know them under different titles and terms and might disagree with my conceptualizations. That's okay. I don't expect everyone to agree with all of my claims. However, I do believe this book will contribute to the establishment of a baseline in the core of gestalt praxis and extend into new ground on several facets of that core. This book, then, could provide self-study enrichment for those currently in practice. It would be appropriate for professional organizations of counselors and psychotherapists, formal academic programs and gestalt postgraduate-level training organizations. It could also be used as an ancillary text in any people-helping training program, including pastoral counseling programs in seminaries,

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school counselor training programs in college, and graduate programs for clinical social work.

Following an orientation to psychotherapy in chapter 1, chapters 2 and 3 address the question, "What is gestalt therapy?" These chapters grew from a conceptual statement of the theory of gestalt therapy to its practice and then into the actual community of gestalt practitioners. I realized the reader needed to sense *who* gestalt therapy was and not just *what* it was (the "who," and how they did what they did, helps define the "what"). So I contacted many of the people mentioned there and asked what attracted them to gestalt therapy in the first place, with whom they trained, and how they began training others. Chapter 3 gives a feel for how gestalt therapy spread throughout the world since its birth at the first gestalt training institute in New York in the early 1950s.

Part II of the book, How to Do Gestalt Therapy, presents the core of gestalt therapy praxis.

Chapter 4, "Deal with Personal Experience," covers the role of phenomenology in gestalt therapy and presents a modified phenomenological method that adapts a philosophical practice to a psychotherapeutic purpose. This is a mild corrective to many previous writings in gestalt therapy that called for the phenomenological method and pointed rightfully to Edmund Husserl, but did not distinguish between his projects and the domain of psychology.

Chapter 5, "Work the Therapeutic Relationship," first deals with the issue of *alterity*, an important concept for anyone working with people. It then goes into the nature of dialogical relationships and the concept of contact.

Chapter 6, "Use the Context of Life," addresses field theory in gestalt therapy, showing that gestalt therapy is not unique as a field-oriented approach. It orients the reader as to the place of phenomenal experience and relationship within a unified field that has both phenomenal and ontic dimensions.

Chapter 7, "Move to Action," deals with the experiential aspects of gestalt therapy, which are for some people what gestalt therapy is all about. It defines what a gestalt therapy experiment *is* and shows how experiment is integral to every other theoretical tenet.

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Chapter 8, "Practice a Unified Approach," describes how every part of gestalt therapy is related to and organized by the whole of gestalt therapy. Gestalt therapy is not multimodal; it is holistic and a unified praxis. It is not possible, while working with a client, to be phenomenal without being relational and field theoretic within a process that is experienced by both therapist and client. It's all of the same tapestry.

The last two parts of the book deal briefly with some clinical and professional matters: assessment, treatment planning and case management on the one hand and training, continuing education and professional associating on the other.

If I had to choose the top five books on gestalt therapy to recommend to an English-language reader, aside from this book, I would choose:

1. *Gestalt Therapy: Excitement and Growth in the Human Personality* (Perls et al., 1951)
2. *Gestalt Therapy Integrated: Contours of Theory and Practice* (Polster and Polster, 1973)
3. *Gestalt Therapy History, Theory and Practice* (Woldt and Toman, 2005)
4. *Handbook for Theory, Research, and Practice in Gestalt Therapy* (Brownell, 2008)
5. *Brief Gestalt Therapy* (Houston, 2003)

I chose the first book because it's the seminal book on the gestalt approach. In number 2 the Polsters moved the focus from individual experiencing to contact between one person and the environment or one person and another person, and that moved the emphasis to dialogue. Woldt and Toman (number 3) is a thorough and contemporary treatment of gestalt therapy that also does well by the classic theory behind it and it presents field theory as an encompassing tenet in the core of gestalt therapy. I chose number 4 (the book I edited with an international team of contributors) because it establishes the core of gestalt therapy as represented in this book, and it addresses the issue of research in the gestalt community, something absolutely necessary for gestalt therapists to undertake. Gaie

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Houston's description of gestalt therapy (number 5) used in a brief approach is particularly relevant to today's concern for cost reduction that does not reduce effectiveness as a by-product.

This book fits somewhere around numbers 3, 4, and 5 for relevance. My hope is that it will be clear and understandable to the novice and provocative enough for the seasoned gestalt therapist so as to help in the evolution of gestalt therapy praxis.

NOTES

1. Most gestalt therapists loathe the term "treatment manual," because it brings to mind a positivist approach to science and research they feel is out of place in gestalt therapy's worldview. I do not share that opinion. I think every treatment manual is a map and every gestalt therapist learns that the map is not the territory. A treatment manual is also a tool; it's just one kind of tool for a special job. Only an idiot would try to use one tool to do every job. Just so, a treatment manual is created for the purpose of guiding practice and to accomplish the job of random, controlled research studies. And I'm okay with that. A treatment manual, and certainly this book, is not a cookbook with recipes or a paint-by-numbers project that makes robots out of therapists, and it doesn't tell everything there is to know and do about any given clinical approach.

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PART I

Orientation

1 What Is Psychotherapy?

This chapter provides a working definition of psychotherapy, describes common factors present in all established approaches to psychotherapy, and explores the issue of whether or not psychotherapy is effective. In dealing with the evidence-based movement, it advocates for practice-based evidence that is more relevant to the clinical work mental health professionals do.

If you regard yourself as a mental health professional, then chances are you already think you know what psychotherapy is. You are either doing it now, have seen someone do it, have been a patient/client/customer in the process, or help manage it in some way. If you are just starting out, however, you might approach psychotherapy with wonder and excitement. You might also feel uneasiness about your future as a psychotherapist.

This chapter provides a description of psychotherapy as a general ground for the subsequent exploration of gestalt therapy in particular. Various types of psychotherapy are mentioned (i.e., individual, dyad, or group). Psychotherapy research is discussed, including those common factors identified as being effective to positive outcomes across all major clinical perspectives. Regarding evidence-based practice, forms of warrant are briefly discussed so as to identify the means by which justification is established and to

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orient toward "evidence" as warrant for the practice of any particular approach to psychotherapy.

THE TALKING CURE

If you were a bug on the wall in a therapy session, what might you see? You would see two people sitting in a room talking. You might see one of the people crying, fidgeting, speaking rapidly, or you might see two people sitting in relative quiet, but the tension in the room would throttle your senses. You might see three people in the room, or you might see a whole group. You might see a family in the room with the therapist acting like a policeman directing traffic.

Many people believe the concept of psychotherapy originated with Sigmund Freud in 1900 (Bankart, 1996), in his work titled *The Interpretation of Dreams* (since republished in numerous editions and translations). Others trace the origins of psychotherapy to the collaboration five years earlier between Josef Breuer and Freud, and the publication of their book *Studies in Hysteria*; Breuer's patient, Anna O., is said to have called the hypnosis she experienced "the talking cure" (Winick, 1997). Because of these associations, psychotherapy, "the talking cure," has been attributed largely to Sigmund Freud. With the advent of such a talking cure, the psychotherapist became the doctor of the *interior* (Cushman, 1992), and psychotherapy's focus became what takes place when two people sit down to speak with one another about one person's subjective experience. It is any form of treatment using verbal or nonverbal communication between a therapist and a patient/client/consumer that is understood to be a professional relationship (Winick, 1997).

The word *psychotherapy* is a compound word coming from two Greek words: *psychē* and *therapeuō*. Psychē means "soul" and therapeuō means "heal" or "cure"; the compound, therefore, refers to a process that heals the soul. Perhaps more difficult to put into a compound was another Greek word, *iaomai*. Therapeuō originally meant to serve a superior, and eventually it came to include curing a

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person of various ills. Iaomai was the more direct word for healing; it resulted in a person becoming *hugiēs*, or healthy. Iaomai included healings and cures from physical and psychological ills. Thus, the implication in the compound "psychotherapy" is that the therapist serves the client for the purpose of healing the client's soul and making him or her healthy, sensible, and of sound mind (Brown, 1976).

Psychotherapy is not a legal matter, even though it often has legal implications or focuses on someone's legal process. Psychotherapy is not just a conversation; it is a dialogue. Psychotherapy is not a medical procedure (even though clinical psychology bought into the medical model years ago), so no linear process of cause and effect is involved in the cure. Psychotherapy is not social work, so the emphasis is not on procuring community services, even though it may result in the client becoming more proactive and researching these same resources on his or her own. Psychotherapy is also not a game in which two people waste each other's time and energy; it is not a farce or a futile process.

When I was a neuropsychiatric technician for the U.S. Navy during the Vietnam War, I worked on a ward with a psychiatrist who was rumored to have been associated with Harvard before joining the ranks of the officers involved in the war effort. I knew nothing of analysis, but many of the other corpsmen were saying that making an appointment with this psychiatrist was "the thing to do," so I did. At the first appointment, he sat in one chair smoking a pipe, and I sat in another. We faced each other, but I had a hard time looking at him, because I did not want him to discover that I was basically on a joy ride. I said nothing, and he said nothing. Occasionally, we exchanged one-syllable trivialities. I recall making several appointments with him, but none of them went anywhere beyond what I have just described. There was not much talking in that version of the talking cure.

On the same unit, a civilian psychologist who had been driving down the coast to the Esalen Institute to train in gestalt therapy with Fritz Perls was conducting a "gestalt group." I was assigned to work with that group as a support to the psychologist, and I observed a lot of talking, but I also observed enactment as people were asked to "be your foot," "let your hand speak," and so on.

These were two ways of doing psychotherapy. In each case, a theory guided the method used, and the combination of theory and method produced a distinctive praxis. *Praxis* is the process by which a theory becomes animated in the actions of its adherents. Thus, the praxis of gestalt therapy is different from that of cognitive behavioral therapy (CBT), even though the gestalt therapist and the cognitive behavioral therapist may at times be doing what looks, to any reasonable observer, like the same thing. This would be the case in both approaches' use of mindfulness:

> Gestalt therapy, influenced by Zen Buddhism and Eastern thought since its inception, has always understood the importance of awareness and subjective experience (phenomenology), and understood the value of the experiential "felt sense" (as opposed to thinking and the conceptual), both important aspects of mindfulness. These concepts as well as gestalt therapy's understanding of the change process, and the importance of the acceptance of "what is" have recently been incorporated into other systems such as CBT and ACT. The mindfulness-based therapies (MBSR, MBCT) would therefore have some overlap with aspects of gestalt therapy, as there has now been a change in these approaches from cognition and behavior change to being with and acceptance of "what is." (E. Gold, personal communication, April 5, 2009 [used by permission])

Mindfulness is mindfulness, but gestalt therapy and cognitive behavioral therapy are two different theoretical systems.

Corsini and Wedding (2007), in their book surveying a number of approaches to psychotherapy, have claimed that, in general, the praxis of any form of psychotherapy is a learning process that concerns the way people think, feel, and act:

> All psychotherapies are methods of learning. All psychotherapies are intended to change people: to make them think differently (cognition), to make them feel differently (affection), and to make them act differently (behavior). Psychotherapy is learning. It may be learning something new or relearning something someone has forgotten; it may be learning how to

> learn, or it may be unlearning; paradoxically, it may be learning what one already knows. (p. 6)

Gerald Corey (2009) disagreed that a psychotherapist's chief goal is to change people, but he admitted that people come to psychotherapists in order to change and that change takes place. He further identified the relational aspects of psychotherapy that are integral to change:

> Psychotherapy is a process of engagement between two persons, both of whom are bound to change through the therapeutic venture. At its best, this is a collaborative process that involves both the therapist and the client in co-constructing solutions to concerns.… Therapists are not in business to change clients, to give them quick advice, or to solve their problems for them. Instead, counselors facilitate healing through a process of genuine dialogue with their clients. The kind of person a therapist is remains the most critical factor affecting the client and promoting change. (Corey, 2009, p. 6)

Writing in a practical way for those contemplating the services of a psychotherapist, Elaine Klonicki (2002) described psychotherapy as being in a relationship with a person specially trained to listen in a supportive and nonjudgmental fashion so as to guide one's personal discovery to relieve pain and restore emotional balance. She also asserted that psychotherapy teaches practical skills that help people become more successful. She contrasted and compared three similar activities—counseling, psychotherapy, and psychoanalysis—which she described as increasingly more involved and aimed at in-depth work with patients/clients/consumers: Counseling offers short-term opinion or advice, psychotherapy offers help for ongoing dysfunctional or ineffective patterns of behavior one has not been able to change on one's own, and psychoanalysis helps those whose patterns are so stubbornly reinforced outside of their awareness that they need several sessions a week to go deep enough to understand themselves.[1]

Psychotherapy takes place in dyads (the traditional one-to-one therapy), triads (what many call "couples" or "marital therapy"), small

groups, and families. Therapeutic principles are also employed by organizational consultants working with large groups and complex systems. Sometimes therapists work together in teams, especially when conducting group therapy. Sometimes a therapist will have an observing group of "consultants," who remain behind a mirror and call by phone to affect the process.

As mentioned previously, all psychotherapists are guided by a psychotherapeutic theory that can be thought of as a cognitive system defining how things are related and how things happen (Crocker, 2008). Even so-called eclectic or integrative psychotherapists use such cognitive systems, usually ones based on some form of personalized pragmatism and/or positivism. The theories that have found most allegiance and support, however, are cognitive behavioral, psychoanalytic, person-centered (or interpersonal), existential, and experiential. These systems include many subcategories, and elements of several of them can be reformulated into still other theories. Two examples are multimodal therapy and gestalt therapy. Gestalt theory is a revision of psychoanalysis (Freudian theory) that includes (but is not restricted to) elements of cognitive, behavioral, existential, and interpersonal theory. Gestalt theory is described more completely in chapters 4 through 8, but the point here is that therapists need some kind of theory to guide them, to avoid just wandering around in the client's story, trying different techniques, and giving advice in a loosely and intuitively subjective fashion.

FACTORS COMMON TO DIVERSE FORMS OF PSYCHOTHERAPY

All major approaches to psychotherapy share some characteristics—things that contribute to the effectiveness of psychotherapy in one way or another. These factors also help define psychotherapy. Thus, whether a psychotherapist follows a cognitive behavioral approach, a psychodynamic perspective, an interpersonal approach, transactional analysis, rational emotive behavioral therapy, reality therapy, a Jungian approach, or gestalt therapy, he or she will engage the client and some common factors will influence the outcome.

In the *Handbook for Theory, Research, and Practice in Gestalt Therapy*, I described the factors inherent to all approaches to doing psychotherapy, relating them to gestalt therapy as follows (an experienced gestalt therapist would immediately recognize these features as belonging to gestalt therapy theory and practice):

- **Client and Extra-Therapeutic Factors:** This is the field—all things having affect, especially the view of the field most associated with the life spaces of both client and therapist. These factors include what the client brings to therapy that bear on the process of therapy and the issues to be visited during that process. They include the client's cognitive-intellectual capacities and those elements of culture, history, financial resources, and legal impact that affect the course of therapy.
- **Therapist Qualities:** This relates to the therapist as an authentic person, the capacity of the therapist for contact, and his or her training and experience. It includes the life space of the therapist.
- **Relationship:** This concerns the relational qualities of the working alliance, and it relates directly to the gestalt therapy concepts inherent to dialogue—presence, inclusion, commitment to dialogue, and the creation of conditions permissive and conducive to dialogue.
- **Specific Method:** Certainly, this encompasses the aspects of theory referred to earlier, but more specifically it relates to gestalt therapy's reliance on a phenomenological method and experiment, for gestalt therapy is decidedly phenomenological and experiential.
- **Expectancy:** This relates to faith in the paradoxical theory of change; it is a faith position more generally as well, in that gestalt therapists trust the field will supply what is necessary (Brownell, 2008, pp. 98–99).

The most salient features of psychotherapy are those extra-therapeutic events and factors that the client and therapist bring to

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therapy. Some studies suggest these factors account for about 40% of positive outcomes, so what are they more specifically?

In Bermuda, where I write this, the extra-therapeutic factors affecting psychotherapy include the economic conditions. A slowdown in construction of new homes is the result of the dwindling workforce, as major companies have let some of their workers go. Extra-therapeutic factors in this case include tension between guest workers and Bermudians; race; the systemic dysfunction within some organizations which, like stubborn mold, keeps coming back no matter what you do; and clients' developmental, physical, and intellectual characteristics.

This is not an exhaustive list, but it will suffice. It illustrates how psychotherapy needs to deal with relevant factors in a current situation, which is a mix of spatial, environmental, and social contexts. At times it might be necessary to revisit one's childhood, but the current context is a more salient ingredient in psychotherapy; psychotherapy is therefore some kind of process, verbal and/or experiential, that in some way addresses the current experience of the client, the person who comes for help.

Psychotherapy is also an agreement between two people in which one is seeking help and will pay for it, and the other has wisdom, training, and experience to offer in facilitating the seeker's quest for answers, solutions, skill building, insight, and/or awareness. Thus, a contract is formed in which the provider gives informed consent about what he or she has to offer, its limits, and the conditions under which the psychotherapeutic process will be conducted.

All these things are involved in "the talking cure," no matter how much or how little actual talking takes place.

DOES PSYCHOTHERAPY "WORK"?

If something "works," then it attains an expected effect or outcome. It functions in a desired fashion. A bucket can be used to carry water, for example, but if it is riddled with holes, all the water flows out and the bucket does not "work." The question often asked (not

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so much any more, actually) is, "Does psychotherapy work?" Or is psychotherapy so riddled with holes that it cannot carry water? That question has been answered,[2] but there are facets to the answer, and they concern the basic issues of justification (is a certain type of psychotherapy—or even psychotherapy itself—warranted), types of outcomes research, evidence-based practice, and practice-based evidence. These concepts are treated only briefly here, but the reader may want to explore these issues in more depth at some other time.

Efficacy, Effectiveness, and Warrant

For the last 50 years or so, people have been concerned with the question of whether or not, or how much psychotherapy works. In the late 1980s and 1990s, the pace of outcomes research in the practice of psychotherapy picked up, and it was dominated by the term *efficacy*. Efficacy is a concept that grew out of the randomized trials used to test the cause-and-effect relationships between taking a medication and symptom reduction. The greater the desired effect, the greater the efficacy. In the late 1990s, some psychologists began to investigate the patient satisfaction associated with various kinds of treatments, not just medications, and their studies became associated with the term *effectiveness*. The greater the patient's/client's/consumer's satisfaction (in one form of such study), the greater the effectiveness. In addition to these concepts, the question of a methodology's efficiency also became increasingly of concern. Haynes and Johnson (2009) provide a succinct summary of all three concepts:

> *Efficacy* is the degree to which interventions result in positive outcomes in ideal settings. Ideal settings are often research laboratories or experimental conditions providing studies with a high degree of internal validity. … *Effectiveness* is the extent to which treatments provide positive patient outcomes in real-world settings. … *Efficiency* is the extent to which one treatment provides relatively better outcomes than other treatments. (Haynes & Johnson, 2009, pp. 302–303)

The term efficacy is usually reserved for statements of causality associated with randomized and controlled studies of manualized treatments and the systematic review of such clinical research using meta-studies of effect sizes. Effectiveness usually refers to feasibility in studies with measurable positive effects across broad populations in clinical situations. Efficacy studies emphasize internal validity and replicability, but effectiveness studies emphasize external validity and generalizability (Nathan, Stuart, & Dolan, 2003). Although randomized, controlled studies have become the standard for research providing evidence, their applicability to psychotherapy research has been questioned, and the issues intrinsic to this concern over their appropriateness further illustrate how psychotherapy contrasts with medical treatments:

> The controlled clinical trial method was initially designed by medical science for use in studies of medications. A physician administers a specific medication knowing it is the only medication being administered to compare the results with a placebo or standard of care condition. Unlike medication, psychotherapy cannot be administered in such pure form, and adherence is much more difficult to measure. The social nature of the interaction must be considered. The controlled clinical trial methodology is effective in investigating medical interventions for comparing psychotherapy to pharmacotherapy or their combination. It is limited however, when imposed on psychotherapy alone, which is an entirely different enterprise because of the complex and dynamic nature of social interaction. (Ablon & Marci, 2004, p. 667)

Warrant, on the other hand, is a philosophical and general term. It refers to the level of justification for any given action and has various bases (Brownell, 2008). Warrant, as a philosophical construct, stands behind all assertions and arguments pertaining to efficacy, effectiveness, and efficiency.

For instance, warrant can be based on personal experience and assertion. In this situation, a psychotherapist claims to know what he or she does is effective, because the therapist has seen the results in the clients' changed lives and general satisfaction.

A person might say, “I don’t need research to tell me this works; I know it works from watching my clients.” A person’s esteemed trainer might say, “Believe me. This stuff works!” Either statement would be a low level of justification, but a valid method of ascertaining whether or not warrant exists.

Warrant can also be based in *foundationalism*; that is, one belief is based on another more “foundational” belief. For instance, early analysts believed they should remain unobtrusive (and they believed they could actually do that) so as to present a blank slate on which the client could project in the therapy room; this was based on their belief that free association was the avenue to the unconscious and was obscured by transference, and that the unconscious is where the intrapsychic and psychosexual conflicts of neurosis lay. Foundationalism is usually rejected because it results in an infinite regress of beliefs, none of which, perhaps, can be independently supported.

Somewhat related is the *coherency* view of warrant, in which justification is achieved through a web of beliefs and the warrant is not subject to a linear regress but stands or falls as a unity. This view can be compared to a ship at sea that requires constant upgrading and maintenance to remain afloat. In the same way, a web of meaning is in a perpetual state of construction. Related to coherentist warrant is the web of factors and theoretical tenets created through the consilience that unites them.

Consilience is a unity of knowledge. A good theory unifies data and laws from diverse domains; one classic example is the successful unification of Kepler’s laws and Galileo’s laws by means of Newton’s theory (Niiniluoto, 2007). Newton established a larger category that accounted for the observations of Kepler and Galileo, thus assimilating them into his theory. William Whewell asserted that coherence is a type of consilience, in that coherence extends the hypothesis to colligate a new class of phenomena without having to adjust the hypothesis to make it fit (Snyder, 2006).

For example, if the cognitive approach of imaginal desensitization is shown to be effective and that approach shares the characteristics of the gestalt use of imagination in experimental enactment (a consilience of praxis between the two perspectives, CBT and

gestalt), then part of a coherent web forms, and the fact that people coming at a phenomenon from two different perspectives arrive at virtually the same procedure, construct, theory, and so on suggests they have independently discovered the same approach. In this case, not only would the research support both the CBT and gestalt versions of the shared intervention, but the consilience between the theories would also suggest warrant on the basis of coherence.

Another basis for warrant is in evidence. *Evidentialism* in psychotherapy claims that unless there is conclusive evidence for the efficacy of a certain practice, one lacks warrant and should not engage in that practice. Stated more positively, warrant is attained through conclusive evidence. Unfortunately, all evidence is partial; evidence is inconclusive, even though it can sometimes be quite compelling. There is always error. Effect sizes fall short of perfection. Only relative evidence is available and therefore only relative certainty is attainable.

Even so, warrant is linked to evidence-based practice of psychotherapy through concern for efficiency and effectiveness. The use of any particular approach to psychotherapy is warranted on the basis of the various kinds of evidence different types of research generate. If an approach is said to be evidence-based, it is deemed to be warranted on the basis of evidentialism. It may be that more can be said about warrant based on coherentism and consilience in the future, but that remains to be seen. Finally, if the evidence supporting one approach indicates it is more effective than another approach, then the more effective approach is more efficient and relatively more warranted.

Evidence-Based Practice

The concerns for efficacy, effectiveness, and efficiency are at the heart of the movement for evidence-based practice in psychotherapy. The two considerations that loom largest in any particular intervention or approach to psychotherapy are "does the treatment work—a question of its efficacy, which is most related to internal validity, and does it generalize or transport to the local setting where it is to be used—a question of its effectiveness, which is most related to external validity" (Brownell, 2008).

According to the American Psychological Association, evidence-based practice in psychology is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences (APA, 2006). That task force identified multiple forms of support as "evidence." The range of research designs that contribute to the body of knowledge relevant to evidence-based practice includes:

> … clinical observation, qualitative research, systematic case study, single-case experimental designs to examine causal factors in outcome with regard to a single patient, process-outcome studies to examine mechanisms of change, effectiveness studies in natural settings, random controlled treatments and efficacy studies for drawing causal inferences in groups, and meta-analysis for observing patterns across multiple studies and for understanding effect sizes. (Brownell, 2008, p. 94)

In addition to this list, some have argued for the need to remain sensitive to, and make a place for, the clinical judgment of experienced clinicians (Zeldow, 2009) and to make the clinical setting a natural laboratory (Borckhardt et al., 2008; Brownell, 2008; Fago, 2009; Westen & Bradley, 2005) for the production of practice-based evidence. Clinical judgment and reasoning have been defined by Shapiro, Friedberg, and Bardenstein (2006) as a mix of informed analysis and decision making leading to case planning based on such things as research findings, client observation, consideration of etiology, credible clinical theories, compelling authors and trainers, as well as past experience in the use of various techniques.

Practice-Based Evidence

Practice-based evidence has been characterized as a bottom-up process of gathering data that relies on the experience of practicing clinicians to inform treatment (Dupree, White, Olsen, & Lafleur, 2007). Practice-based research networks (PBRNs) have been used among clinician-researchers across diverse organizations in preventive medicine, because these PBRNs increase external validity and the generalizability of results. They are useful.

Psychotherapists who track the quality of their own work and who use sound research methodology, such as single-case, timed research designs, to do so provide themselves with evidence that surpasses assertion based on personal experience and declaration based on foundationalism. They also produce a form of evidence that is critical to the evidence-based movement, and that is practice-based evidence. It is precisely what is in question in studies of the effectiveness of psychotherapy or any particular kind of psychotherapy, and it qualifies as a valid form of research design that many believe rightfully stands beside random, controlled trials (Borckhardt et al., 2008). Among the factors making this approach appealing is the fact that it can be carried out at the clinical level without a major cost and relatively nonintrusively. It is a psychotherapist-friendly method of generating outcomes research that can then be analyzed to assess typical patterns for an individual therapist's practice, including the effectiveness of the psychotherapy that therapist used.

CONCLUSION

Psychotherapy is a general term referring to a process of treating psychological pain and functional ineffectiveness. Thus, it is related to one's individual, subjective experience and focuses on such forms of distress as depression, anxiety, disruptions of thinking, dissatisfaction with one's body, compulsive repetition that seems out of control, psychosis, and extreme mood disturbance. Psychotherapy addresses one's functional effectiveness, taking into consideration such factors as organizational capacity, conscientiousness, agreeableness, and openness to experience, and it has been shown to be a warranted response to pain and dysfunction with a relatively high degree of effectiveness.

The term psychotherapy is often used interchangeably with "counseling." It represents the meeting of two people, one of whom is trained and asserts competence and the other who comes to address pain or discomfort and functional decline. These two individuals form a therapeutic or professional agreement in which the therapist offers services for which the client agrees to pay. Because

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of the nature of this relationship, ethical and legal guidelines and parameters have been formulated over time to assist the therapist and to protect the patient/client/consumer. That is because the therapist has heightened influence with regard to the patient/client/consumer, and that person's level of vulnerability intensifies when a therapeutic relationship is deeply rooted.

Psychotherapists are guided by clinical and theoretical systems. They typically learn these in formal, academic graduate programs or postgraduate training institutions, and they are supervised in their practical experience by trained, competent, and licensed clinical supervisors. Often, their practices are regulated by certification and licensing boards in the jurisdictions in which they practice.

The various systems of psychotherapy (psychoanalytic, psychodynamic, cognitive, behavioral, cognitive behavioral, humanistic and existential, etc.) all have their literature bases. This book focuses on gestalt therapy, providing a practical guide for the mental health professional who would become competent to practice as a gestalt therapist.

NOTES

1. Corisni and Wedding (2007) would disagree that this kind of distinction can be made between psychotherapy and counseling, claiming the overlap is too great. Along the same lines, it is difficult to see much real difference between counseling and coaching; coaching, counseling, and psychotherapy now overlap extensively.
2. In the middle of the 20th century, several prominent researchers/writers questioned whether the benefits of psychotherapy exceeded what occurred naturally over time without treatment. Since then "thousands of well-controlled outcome studies … have been completed, reviewed, and meta-analyzed," resulting in the evidence that psychotherapy does, indeed, work; in fact, the evidence is so massive that the question now is which forms of therapy work better than others and under what conditions (Kazdin, 2008, p. 146).

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