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Two risks and a third way: what research for Gestalt therapy?

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Abstract: In this article the author explains the possible future for Gestalt therapy in view of the evolution of the regulatory context and the appearance of the contextual model resulting from the evolution of research in psychotherapy. This future oscillates between marginalisation or even outright disappearance and dissolution into a vast, integrative, outcome-based current. The author argues that both the values inspiring the Gestalt therapeutic posture and the mode of intervention based on the therapist's affective resonance are worth defending and even disseminating more widely than today. He then draws the outlines of a Gestalt research that allows Gestalt therapy to be legitimised by being recognised as offering evidence-based treatments and to continue to develop as an original and innovative modality.

Keywords: psychotherapy research, Gestalt therapy research, evidence-based, contextual model, effectiveness, EAGT, EAP.

As Gestaltists we are probably all convinced that our modality is valid and operative. We all have many stories of clients who have been able to significantly change their lives after having worked with us. There is no doubt in our minds. But what is obvious to us is not necessarily obvious to others; our stories are just our stories. They are too singular and insufficiently objective to be convincing. And let us not forget that Gestalt therapy is still often perceived as a cathartic technique in which the client is jostled ... as if nothing had happened since Friedrich Perls' last group sessions.

Until recently we could be satisfied with our own certainties. We did not have to convince anyone but ourselves and our clients. But times change.

Today, substantiating our stories, documenting them accurately and methodically and thus demonstrating that Gestalt therapy is a valid and effective modality has become a major challenge. This is what I will try to present.

In this article, I will outline my perception and analysis of the field before drawing lines of action for our community. This subject is both highly technical and extremely political. I hope to make it accessible without too much reducing its complexity.

Regulatory pressure and the risk of marginality

The first thing we need to consider is the societal context. The chronic slowdown in economic growth and the unbridled voracity of financial capitalism have dried up the budgets allocated to public services and therefore to the various health systems. This has dramatic consequences for the management of the current Covid-19 pandemic.

Faced with these financial constraints, health system managers have logically questioned the effectiveness of psychotherapeutic care. They naturally sought this information from scientists specialising in these matters. Today, however, these experts are mainly cognitivists and behaviourists with a medical background. And they rely on a vast body of research that legitimises them and makes their opinions credible. This results in reports or recommendations that effectively exclude all therapies that have not sufficiently demonstrated their effectiveness in terms of scientific demonstration (INSERM[1] report in France, NICE[2] in England, APA[3] and NIMH[4] in the USA).

Research has therefore become the basis for political decisions.[5]

The consequence of this is that almost everywhere practice is regulated, the modalities authorised or reimbursed are generally CBT – the majority in almost all faculties of psychology; psychoanalysis – still influential in some universities; and systemic and family therapy which occupies a singular niche. The big losers are humanistic therapies.

Why is that? Because they are poorly represented in the universities, have not proved their effectiveness and often have even lost interest and been diverted from any research in psychotherapy. Thus Gestalt therapy is currently in difficulty in the United Kingdom, Spain,

Belgium, Poland, Germany, but also in the United States (where it is increasingly marginal) and France (where it is totally discredited by psychologists) (Béja et al., 2018).

What threatens in these contexts of increasing regulation of therapeutic practices is the pure and simple disappearance of Gestalt therapy as a modality accessible to the greatest number of people. We would only be able to practise in a very marginal way and, in some countries, we even run the risk of being accused of illegal practice of psychotherapy.

The contextual model and the risk of identity loss

Wampold's contextual model

The second element we need to take into account is the state of research and what the future holds for the profession of psychotherapists. Although the debate between cognitive-behavioural scientists and those who belong to humanistic and psychoanalytic approaches is not over, it has become clear that differences in effectiveness between modalities are marginal (Luborsky, Singer and Luborsky, 1975; Luborsky et al., 2002). Currently, there is a growing consensus that effectiveness depends mainly on factors that are common[6] to all modalities, i.e. mainly on the therapeutic relationship and its components. Thus, the quality of the therapeutic alliance is today the best predictor of the outcomes of a therapy (Orlinsky et al., 2004; Norcross and Wampold, 2011).

Moreover, there are therapists who systematically and significantly have better results than their colleagues, regardless of the modalities and perhaps even the types of clients they receive (Castonguay and Hill, 2017). This means that the therapist is ultimately more important than the treatment (Belasco and Castonguay, 2017).

These two statements, taken together, can profoundly transform the landscape of psychotherapy. Bruce Wampold, a renowned American researcher, has drawn conclusions from these achievements, which are no longer hardly contested today, and he has proposed the contextual model (Wampold and Imel, 2015) as an alternative to the medical model. In particular, he argues that since modalities have less impact on outcomes than the individual therapist, it is the therapist – not the modality or treatment – who must prove its effectiveness. It is moreover on this clinical basis of regular evaluation that the therapist will be able to improve his efficiency and measure his evolution; it will no longer be enough to apply a treatment based on evidence (Briffault, 2018).

It is therefore a model that departs from the medical model currently advocated by CBT and is beginning to compete with it. However, it leads to a weakening of therapeutic modalities, including Gestalt therapy (Briffault, 2018). Indeed, if they are still necessary to give the practitioner a form of conceptual framework and assurance, they are no longer justified by anything other than the therapist's personal preference alone. Thus, in the long run, modalities may disappear in favour of a therapy guided essentially by the result. What lies in wait is to lose our Gestalt specificity and to have to melt into a globalising and eclectic supra-modality.

EAP policy

This type of 'Wampold-style' model based on factors common to all modalities is of interest to professional groups that do not defend a theory. In the EAP (European Association for Psychotherapy) – an association in which many humanistic modalities participate, including Gestalt therapy – the current political effort is to fight for the recognition of the profession of psychotherapist as independent from that of psychologist. The effect of this policy is, once again, to insist on what the different modalities have in common rather than on their singularities, and to promote forms of good practice which should be based, essentially, on the therapist's ability to critically integrate the most relevant results of psychotherapy research. In the background, what is likely in the long run to impose itself, in line with the contextual model defended by Wampold, is an eclectic model of therapy in the form of a toolbox in which there are one or more research validated treatments per type of symptom presented.

The research effort currently promoted by EAP is also in this direction: it consists of collecting as many case studies as possible in a database managed by a Belgian university. For the time being, no methodology is proposed or recommended for the modalities that would allow, with a small number of cases, to demonstrate their effectiveness.

Following the EAP policy does not help us in the recognition of Gestalt therapy by the public authorities. On the contrary, the quest for independence for the profession risks pushing the authorities to regulate the practice, to our detriment, as in Germany.[7]

Moreover, such a policy leads us towards this type of globalising therapy and makes us run the risk of amalgamating Gestalt therapy with modalities that are foreign to us and do not necessarily share our values.

The need and interest in inventing our future: the third way

What are we going to decide? To preserve our originality, to develop, explain and justify it with the

help of research work and to be dynamic enough to have an existence of our own in a contextual model 'à la Wampold'? Or do we gradually disappear by merging into a broad integrative movement that would follow an evidence-based good practice guide that would have been developed without us? Or do we accept being marginalised?

We could be quite happy with either of these solutions. After all, if there are other ways of doing therapy than our own and they work, why would we want to fight at all costs, if not for community survival reflexes? And if we are disappearing while others replace us just as well, why is that a problem?

Do we believe that our modality is the best, that our interventions are superior, that our clients are always satisfied? And could we not, based on our experience as therapists and with the help of a few training seminars, put all of us in a 'Wampold' model?

If we have to fight, in my opinion, it is for something that deserves it. So we need to look at what, in our approach, is original and worth fighting for. For my part, I am perfectly convinced that our values, our theory and our methods of intervention deserve an even bigger audience than they do today.

As Gestalt therapists we have an anthropology built on a principle of equality, the contestation of all forms of domination as well as confidence in the potential for individual and collective growth. It is this confidence that drives us to create the conditions for a sufficiently supportive environment for our clients to develop as they wish rather than us pushing them to change. To make this anarchist-inspired anthropology work, we have extended the intuitions of our founders and developed deeply involved, cooperative modes of intervention based on field theory and affective resonances; our approach to situations is thus profoundly aesthetic (Robine and Béja, 2018); and our fundamental theory, based on the process of meaning-making within the organism–environment dipole, is simple and elegant.

Of all the therapeutic factors examined by researchers, those with the greatest influence are empathy and the ability to collaborate (Anderson et al., 2009; Wampold and Imel, 2015). This suggests that, properly applied, our modality is leading – at least in some important respects – in the way the therapist's person is involved and put to work in therapy.

Gestalt therapy harbours a treasure that is potentially at the service of all. In fact, if it has not been adequately developed, it has long been plundered. On the contrary, I hope that it will bear fruit.

We therefore have to draw a third way that allows our posture to endure and, even more, to spread more widely. This is even more necessary if we want to promote university-level training. There are, before us, stories to be built and ideas to be put forward. It begins by telling us another story about research; a story that is less threatening and more exciting. And this other story must continue by bringing our Gestalt singularity to this field of psychotherapy research; both to validate our modality in the face of regulatory pressure in many countries and also to legitimise our presence in this field and to share our perspectives on psychopathology and intervention.

Elements for a Gestalt therapy research policy

Reflecting on, doing and teaching research are therefore strategic activities. But this research can only be compatible with our values. And, given our means and availability, it also implies creating collaborations and networking with researchers based at the university.

The medical model: a controversial model

For a long time, however, we were faced with a major difficulty: research in psychotherapy was mainly carried out following a medical model that reduced the patient to his or her symptoms and therapy to the administration of a treatment. This was at the antipodes of our posture and could in no way account for what we were doing in Gestalt therapy. But research is itself traversed and subjected to the same contradictions and tensions as society as a whole. Medical thought is confronted with humanist thought but ideological arguments are put to the test of facts.

The initial question of whether psychotherapy works, and whether it works better than psychotropic drugs, was initially treated in the same way as in pharmacology. That is, Randomised Controlled Trials[8] (RCTs) were conducted. RCTs (the golden standard for validating cause and effect relationships) were a tool of choice for CBTs, which found a methodology that appeared to be very scientifically sound and that corresponded perfectly to the principle on which they were built: for each symptom (generally diagnosed by DSM criteria) there is a treatment to apply. An impressive number of scientific studies have thus been carried out, profoundly validating and legitimising CBTs in the eyes of the academic world and justifying rapidly growing research budgets and academic positions. This methodology was so favoured that all naturalistic studies justifying the efficacy of a modality – such as the one conducted by Christine Stevens et al. (2011) for Gestalt therapy – could be considered worthless.

However, many researchers question the validity of RCTs in the field of psychotherapy. If, due to the strict control of the different variables involved, the internal validity of RCTs is strong, their external validity is

weak: what seems to work in the laboratory may turn out to be completely undetectable, or even false, in real practice where conditions are very different.[9] How much credence should be given, under these conditions, to results showing greater effectiveness of one modality over another?

It was also argued that the result of a therapy cannot be assimilated to the reduction of symptoms alone, but must take into account other criteria, such as Antonovsky's sense of coherence (SOC) (Eriksson and Lindström, 2007) or the change felt after psychotherapy (CHAP) (Sandell, 1987, 2016).

Efficiency research – methodologies compatible with our anthropology

Taking these various criticisms into account, the APA (American Psychological Association) set up a new, more clinically sensitive reference system in 2005,[10] called 'Evidence Based Practice' (EBP).[11]

This shift by the APA is of great importance for humanistic therapies, which can now demonstrate their effectiveness without having to use RCTs. This standard reintroduces the case study approach by distinguishing certain rigorous and very specific methodologies that measure the effectiveness of treatment. Indeed, it validates the use of single case methodologies with experimental (or quasi-experimental) designs[12] (Horner and Carr, 2005) to conduct efficacy studies in real clinical practice. These methodologies belong to the category of the Single Case Time Series (Kazdin, 1983). They are compatible with our anthropology (Wong and al., 2016) and can be conducted in real naturalistic practice. A first conclusive study has already been conducted by our colleague Pablo Herrera in Chile for anxiety disorders (Herrera and al., 2018). We need to carry out others, making a very clear distinction between Single Case Time Series (SCTS) methodologies that allow us to prove the effectiveness of the treatment or therapeutic modality used, and simple Single Case Study (SC) methodologies that do not.

Research questions relevant to Gestalt therapy

Second, we need to test the effectiveness of our modes of intervention as well as the clinical relevance of our theory on psychopathology and on the processes of change. As an example of the questions we might ask ourselves, research has already shown that therapist responsiveness[13] (Snyder and Silberschatz, 2017) and the ability to create collaboration (Anderson et al., 2009) are essential ingredients for change. What, then, about the adjusted use of the therapist's affective resonances in the therapeutic relationship that we argue is our primary tool? How effective is it? Are we mistaken or are we precursors?

Let us already note that, both for efficacy studies by the SCTS and for the studies we have to conduct on the relevance of our posture, we now have the means, thanks to the Gestalt Therapy Fidelity Scale (GTFS)[14] created by Madeleine Fogarty (Fogarty, Bhar and Theiler, 2020), to justify the adherence of therapists to Gestalt therapy and therefore to study our practice by legitimately attributing the results to our modality. Without this scale we would lose credibility.[15]

What are the implications for the training of Gestalt therapists?

Finally, we have to work on the transformation of our training. It must in fact convey the major debates and the main results of research in psychotherapy as well as the methodologies compatible with our anthropology. Above all, however, it must develop a critical and informed viewpoint among therapists who have specifically to take into account Gestalt reflection and contributions in this field through the existing literature and the conferences[16] and seminars[17] organised by the Gestalt-therapy international community. There is now in our modality a whole corpus of Gestalt articles both about research (such as this article) and research results that therapists and students should read and know how to consult.[18]

Moreover, it would be desirable that students also do some research on their own practice. This allows them to acquire a greater reflective capacity, which is now known to be one of the major qualities of effective therapists (Lecomte et al., 2004).

What policy, then, for the EAGT?

A bit of history

It is to mobilise our community around these tasks that I have been working for a dozen years now. It is in my capacity as chair of the EAGT Research Committee (RC) that I have been invited to make this contribution.

As one of the bearers of this vision that research is a useful and now necessary requirement for Gestalt therapy and one of the actors who have worked nationally and internationally to encourage our community to get involved in it, I am pleased to see that research has now become a real subject of interest.

This is evidenced by the growing number of research-focused articles from the BGJ, the recent books dedicated to it (Roubal, 2016; Béja and Belasco, 2018; Brownell, 2019) and the two major research projects that have emerged since the first research conference in Cape Cod in 2013: these are the establishment of a Gestalt methodology for conducting both qualitative and quantitative studies with SCTS – such as the one conducted by Pablo Herrera (2018) – and the

establishment of a fidelity scale that was piloted by Madeleine Fogarty (Fogarty et al., 2015, 2016; Fogarty, Bhar and Theiler, 2020).

These two projects have enabled the establishment of a genuine international cooperation for a possible insertion of Gestalt therapy into the stream of evidence-based practices. A stronger sense of global community was born. This is, in my opinion, a valuable asset on which we must build.

The future

The EAGT RC, after having successfully raised awareness in the European community, in particular through the Rome seminar in 2014 and the Paris conference in 2017, is now working, in conjunction with the General Board and the Executive Committee, to build a comprehensive European policy to guide and support the collective effort. Taking into account all the contextual elements that we have just mentioned, it seems important that this policy supports the Gestalt community in countries where it is in difficulty, that it promotes Gestalt therapy towards the whole academic world and that it prepares our practitioners for the future that is taking shape. This means that, in my opinion, it should have the following three main strategic goals.

First of all it is to produce research results in our respective countries that help to convince decision-makers of the effectiveness of our modality. To this end, I think it is appropriate and necessary to set up, with the help of university researchers, ambitious projects that follow the methodology of the SCTS.

It is also desirable that we participate in international scientific discussions and that we explain and argue our clinical modes of intervention and what we believe to be the levers of change in Gestalt therapy. It is indeed important to evaluate their relevance and, if possible, to highlight their interest in the eyes of all our colleagues of other modalities.

Finally, we must make sure that young practitioners in Gestalt therapy, while remaining honest and respectful of our anthropology, can succeed in a context that seems to be moving gradually and at different speeds, depending on the country, towards a systematic evaluation of the practice.

Concretely, in order for this strategy to make sense in the long term, it involves the EAGT RC and the entire community:

- to gradually introduce a solid introduction to research in Gestalt therapy into the training courses of our institutes, using all the existing documents and the tools that will be put in place. This requires the RC to help the institutes to work in this direction, in particular with the support of seminars such as the one which was to take place in Warsaw at the end of March 2020 and which, because of the Covid-19 pandemic, had to be postponed.
- to put in place a set of tools that will soon be available to the research practitioners of our modality (database, networking platform, collection of resources).
- to coordinate, launch and support research projects in partnership with university researchers.

It is this policy that we seek to promote in the EAGT Research Committee.

Notes

1. INSERM: Institut national de la Santé et de la recherche médicale, France – Health and Medical Research National Institute.
2. NICE: National Institute for Health and Care Excellence, UK.
3. APA: American Psychological Association. This powerful association has a leading role in defining good practices in psychotherapy. Its advices and criteria defining treatments validity are influential references on the politics of health systems in North America and worldwide.
4. NIMH: National Institute of Mental Health, USA. The lead federal agency for research on mental disorders.
5. Under the leadership of mainly CBT-oriented researchers, APA's Clinical Psychology Division 12 argued in 1995 in the Chambless Report that 'no treatment will work for all problems, and it is essential to verify which treatments work for which types of problems', and published a first draft officially listing empirically validated treatments, later referred to as Empirically Supported Treatments (ESTs). No treatment or modality of humanistic inspiration was included in this list of eighteen 'well-established' treatments and only one (EFT for couples) was listed as 'probably effective'.

   This list, although quickly reviewed and extended (Chambless et al., 1996; 1998), was a clear line between two types of treatments: those that both had a manual for the symptom under study and could be the subject of symptomatic efficacy studies – mainly through randomised clinical trials – and the others, then called 'experimental treatments' (La Roche and Christopher, 2009). This of course influenced reimbursement policy and very quickly led to controversy in the research community (Chambless and Ollendick, 2001).
6. Common factors are those found in all therapies; they are the characteristics of the therapist, the client and the relationship between them.
7. This is very clearly the recent case in Germany, where psychotherapy has just been recognised as an independent profession (by a law adopted on 26 September 2019): this has been accompanied by a regulation of reimbursed practices from which all humanistic therapies, including Gestalt therapy, are excluded.
8. RCTs are protocols that compare two groups that are homogeneous in terms of demographic and symptomatological characteristics and are given two different treatments (one of which may be a placebo, for example). This approach, which controls the variables involved fairly rigorously (only one symptom per patient entering the study with a definite diagnosis) allows reliable causal relationships to be established (internal validity): if, in a statistically significant way, the group tested has better results than the control group, the treatment

tested can be said to be more effective than the other. This way of testing causality relationships is considered the 'golden standard' in medical research.

9. In real practice, known as naturalistic setting, the population of patients treated is often different from that entering RCTs, both demographically and symptomatically, where the disorders are complex and interrelated, while the 'real' therapists are professionals and not university students. Moreover, out of necessity or lack of training, they generally administer treatment more flexibly and therefore less rigorously.
10. Levant Report, July 2005.
11. Evidence Based Practice (EBP) is defined as 'the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences' (APA, 2006, p. 273). The uniqueness of patients was now taken into account, with the therapist's role being to choose a valid and appropriate treatment for the client.
12. Single Case Time Series (SCTS) must be distinguished from single case studies. The former are constructed in such a way that they can be used for statistical analysis to compare the client to himself or herself and to establish causal relationships, even on a single case. The SCTS therefore make it possible to prove the effectiveness of the treatment or therapeutic modality used, which is not the case with simpler single case studies. Five studies of the SCTS type conducted by three different researchers and involving a total of twenty cases with the same clinical problem now allow the treatment to be declared Evidence Based (Horner and Carr, 2005).
13. Responsiveness or, better, 'attuned responsiveness' is the therapist's ability to respond in an adjusted manner to the client, to maintain empathic contact with him or her and to understand his or her experience. This ability is crucial to respond appropriately to both large and small alliance breakdowns (Stiles, Honos-Webb and Surko, 1998).
14. The Gestalt Therapy Fidelity Scale (GTFS): a set of observation criteria which, if they are present in sufficient numbers in a session, qualify the session as 'Gestalt'. Most of the treatments considered valid by APA have a fidelity scale to affirm that the treatment being studied is indeed the one that is actually administered.
15. I am not unaware of the very sharp criticisms (Hosemans, 2019; Hosemans and Philippson, 2019) of Madeleine Fogarty's work. In my view, these criticisms are based on the legitimate fear that Gestalt practice will be confined to a grid of observable behaviours, and on our collective inability to clarify and agree on what Gestalt intervention consists of. In this context and in the absence of any intervention manual, the GTFS simply says that, on an observed session, if enough criteria are met, then, in the current state of Gestalt practice and with a low risk of error, one can qualify the therapist's behaviour as Gestalt. It does not say that if there are no or few criteria met, the work observed is not Gestalt. Above all, it does not say anything about the feeling, the reflection and the know-how that guide, step by step, the therapist's work with his client.

    So I would temper these fears a lot. The GTFS is for me a first work which has the great merit to exist and which I believe is necessary to verify more amply the value of the discrimination it addresses. As for these criticisms, I hope that they will not sterilise the discussion and that they will give rise to further work.
16. Gestalt therapy research conferences have been organised every two years since 2013: Cape Cod (USA) (2013, 2015), Paris (France) (2017), Santiago (Chile) (2019). The next one is scheduled to take place in Hamburg (2021).
17. The EAGT Research Committee has organised a seminar in Rome (2014) on research methodologies and is planning a series of future seminars. The next one, which was planned for Warsaw (March 2020), was postponed due to Covid-19.
18. In order to understand and promote research in Gestalt therapy, one can refer to the websites of the conferences, to the Gestalt database currently being set up, as well as to Gestalt books and articles on the subject.

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