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EVIDENCE CENTRE
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Is Gestalt therapy more effective than other therapeutic approaches?

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SUMMARY STATEMENT:

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REQUEST:

Is Gestalt therapy more effective than other therapeutic approaches?

REQUESTED BY:

Kate Ward, Social Worker, Department of Social Work, Berwickwide Community Health Service

SUMMARY OF FINDINGS:

- We identified two randomised controlled trials (RCTs), one pseudo-randomised controlled study and four comparative studies with concurrent controls that compared Gestalt therapy to another therapeutic approach or no therapy.
- The studies were conducted for the following conditions/situations: depressive disorders, unresolved emotional issues with a significant other, inmates and childbirth training.
- The studies compared Gestalt therapy to the following: cognitive group therapy, no therapy, attention-placebo treatment, discussions of human behaviour, free group activities (sports, hobbies etc) and respiratory autogenic training.
- The outcomes assessed were: emotional arousal, depression, anxiety, self-concept, state of relationships, symptom distress, self-ratings, body image, locus of control, health workers ratings, duration of labour and type of delivery.
- Six of the seven studies reported that Gestalt therapy resulted in an increase in some positive outcomes when assessed against comparators.
- The studies were of variable quality. The main potentials for bias were lack of randomisation, the intervention and control groups differing at baseline, loss to follow-up and small sample sizes.

METHODOLOGY

Search Strategy

The Centre for Clinical Effectiveness defined the 'best available evidence' as that research we can identify that is least susceptible to bias. We determine this according to predefined NHMRC criteria (see Appendix 1).

First we search for systematic reviews, evidence-based clinical practice guidelines, or health technology assessments, and randomized controlled trials. If we identify sound, relevant material of this type, the search stops. Otherwise, our search strategy broadens to include studies that are more prone to bias, less generalisable, or have other methodologic difficulties. We include case-control and longitudinal cohort studies in our critical appraisal reports. While we cite observational and case series studies, and narrative reviews and consensus statements, in our reports we do not critically appraise them. Some studies can produce accurate results but they are generally too prone to bias to allow determination of their validity beyond their immediate setting.

Details of Evidence Request:

Patients (subjects):	Possible psychological therapy candidates
Interventions :	Gestalt therapy
Comparison:	No therapy or other therapeutic approaches
Outcomes:	Emotional health and well-being

Search terms:

(See Appendix 2 for exact search strategy)

The following search terms were used to scour electronic databases and websites:

Intervention-related:	Gestalt therapy, gestalt, therapy

Resources Searched

We searched the following databases and Internet websites:

- Cochrane Library CD-ROM- Issue 1 2001
- Best Evidence (OVID)- 1991 to January/ February 2001
- Medline (OVID)-1966 to December Week 4, 2000
- CINAHL (OVID)- 1982 to January 2001
- Current Contents (OVID)- 1993 Week 26 to 2001 Week 10
- Pre-Medline- February 28, 2001
- PsychINFO (OVID)- 1967 to February Week 1, 2001
- SocioFile (OVID)- 1974 to February 2001

Refinements, Searching & Reporting Constraints:

We included items of evidence that were available to us on March 1, 2001. We included articles that were published since 1990. We applied the following inclusion and exclusion criteria:

Inclusion Criteria

- Primary studies comparing Gestalt therapy to no treatment or another therapeutic approach.

Exclusion Criteria

- Level IV evidence (case series or case studies)
- Expert opinion
- Qualitative studies
- Papers that compared one patient only to another patient
- Papers comparing training videos of different therapeutic approaches
- Non-English studies
- Articles published prior to 1990

RESULTS:

From our sources we identified 41 pertinent articles. We obtained the abstracts for these articles and applied the inclusion and exclusion criteria, leaving us with eight articles which we categorised as follows:

Table 1. Study designs of included articles

Study Design	Number included
Systematic reviews or meta-analyses	**1**
Evidence-based clinical practice guidelines	0
Randomised controlled trials	**2**
Pseudo-randomised controlled trials	**1**
Controlled trials, cohort or case-control analytic studies	**4**
Total	**8**

Articles were excluded for the following reasons:

Table 2. Reasons for exclusion

Reason for Exclusion	Number of Studies
Level IV evidence (case studies, descriptive studies, pre-post studies)	26
Comparison of training videos of different therapeutic approaches	2
Qualitative studies	3
Non-English	2
Total	**33**

We are reasonably confident these studies represent the most relevant findings published to date.

EVIDENCE SUMMARIES

Evidence summaries are in the form of spreadsheets reproduced at the end of this report. Each spreadsheet contains the article citation, the study design with level of evidence available according to NHMRC guidelines (2000), patient description, scientific validity of the article, results, and pertinent remarks from the authors and Centre for Clinical Effectiveness reviewer.

Findings

Description

Seven studies were identified, two of which were randomised controlled trials (RCTs; Rosner et al 2000, Cook 2000), and one which was pseudo-randomised (Paivio and Greenberg 1994). The remaining four studies were all comparative studies with concurrent control groups (Clance et al 1994, Serok and Levi 1993, Lobb 1992, O'Leary and Page 1990; Table 3).

All interventions were of Gestalt therapy even if it was presented and applied in a slightly different manner in some of the studies. The variations of Gestalt therapy that were applied included: focussed expressive group psychotherapy, short term Gestalt therapy group intervention, empty chair dialogue, Gestalt group activities and Gestalt person centred group work. Gestalt therapy was compared to: cognitive therapy, attention placebo, discussion of human behaviour, no therapy, group activities and respiratory autogenic training (Table 3).

The papers were published in the decade from 1990 to the year 2000. They were all written in English and reported research conducted in the United States, Canada, Germany, Italy and Israel (Table 3). The primary outcomes measured by the studies were emotional arousal, depression, anxiety, self-concept, state of relationships, symptom distress, self-ratings, body image, locus of control, health workers ratings, duration of labour and type of delivery (Table 3).

Table 3 Description of collected articles

First Author and Year of Publication	Study Design	Location	Intervention	Control	Outcomes
Rosner et al 2000[1]	Randomised Controlled Trial	Germany	Focussed expressive group psychotherapy (a manualised form of Gestalt therapy) (n=21)	Cognitive Therapy (n=17)	Nature and intensity of emotions
Cook 2000[2]	Randomised Controlled Trial	United States	Short term Gestalt therapy group intervention (unknown sample size)	Wait-list control group (unknown sample size)	Adolescent depression inventory, anxiety scales, self-concept
Paivio and Greenberg 1995[3]	Pseudo randomised Controlled Trial	Canada	Empty-chair dialogue intervention, drawing on Gestalt therapy techniques (n=17)	Psycho-educational group (attention-placebo minimal treatment condition) (n=17)	General symptom distress, unfinished business, interdependence, self-rating
Clance et al 1994[4]	Comparative study with concurrent controls	Unknown	Gestalt therapy (n=15)	Discussions of human behaviour (n=15)	Body image, self-concept
Serok and Levi 1993[5]	Comparative study with concurrent controls	Israel	Gestalt group activities (n=9)	Free group activities (sports, hobbies etc) (n=9)	Locus of control, social workers observations
Lobb 1992[6]	Comparative study with concurrent controls	Italy	Gestalt therapy training (n=100)	Respiratory autogenic training (n=100) No training (n=50)	Integration of childbirth behaviour, physiology of labour, frequency of psycho-physical blocks, duration of labour, memory of event
O'Leary and Page 1990[7]	Comparative study with concurrent controls	United States	Person-centred Gestalt group (n=7)	No therapy (n=7)	Awareness, responsibility, anger, my real self, my ideal self, fear, love guilt, future, past, self-acceptance

The studies were for the following conditions/ situations: depressive disorders, unresolved emotional issues with a significant other, inmates and childbirth training (Table 4). Inclusion criteria often involved achievement of a certain score (e.g. depression score). Patients were excluded in some studies if they were currently taking psychiatric medication or if they were severely functionally impaired. Two studies did not state exclusion criteria .

The number of subjects included in each study ranged from 14 to 250 with a total of 384 patients (Table 4). The mean age of subjects included in the studies was not always reported and some studies reported a mean age for the intervention and comparison groups separately. For those studies reporting a mean, age varied from 22 to 45 years. Two studies only included female subjects (Cook 2000; Lobb 1992) and one study only included male subjects (Serok and Levi, 1993). The duration of follow-up varied between studies from five weeks to one year (Table 4).

Table 4: Description of studies

First Author and Year of Publication	Description of subjects	Number of subjects	Mean age of subjects (SD)	Gender of subjects (female: male)	Length of follow up
Rosner et al 2000[1]	Patients with major depressive disorder	38	45.8	21:17	20 weeks
Cook 2000[2]	Self-reported depressed female high school students	Not stated	10th to 12th grade high school	All female	5 weeks
Paivio and Greenberg 1995[3]	People with unresolved emotional issues with significant others	34	Group A- 40 (8.15) Group B- 42 (11.81)	22:12	1 year
Clance et al 1994[4]	Undergraduate university students	30	Experimental group 22	18:12	Not stated
Serok and Levi 1993[5]	Male inmates	18	Not stated	All male	15 weeks
Lobb 1992[6]	Pregnant women requesting childbirth training	250	Range 16 to 35	All female	Not stated
O'Leary and Page 1990[7]	Doctoral and masters counselling students	14	Experimental group 31 Control group 34	8:6	6 weeks

Background

Frederick Perls was the originator and developer of the Gestalt approach to psychotherapy. He had as his central concept the theory that the organism continually is striving to maintain a balance that is continually disturbed by the organism's needs and regained by gratification of those needs (Clance et al 1994). Gestalt therapy consists, in part, of a process of heightened awareness so the person's natural functioning can reinstate itself (Clance et al 1994). It is concerned with, and focussed on, the present and aims to enhance personal growth, expand self-awareness, accept responsibility for who one is and what one is doing and enable one to make choices (Serok and Levi, 1993). Gestalt therapy focuses on experiencing the integration of cognitive, emotional and physiological components that compose gestalt (Serok and Levi, 1993).

Gestalt therapy views the restriction of unwanted emotions (especially anger) as central to the development of psychopathology. According to this perspective, general emotional intensity and the arousal of these emotions must be activated in order to obtain lasting relief of the symptoms of emotional disorder (Rosner et al 2000).

One of the major affective tasks in therapy specified by Greenberg and his colleagues is the resolution of "unfinished business". Empty-chair dialogue intervention has been devised to allow subjects to engage in an imaginary dialogue with the significant other. This is designed to access restricted feelings allowing them to run their course and be restructured in the safety of the therapy environment (Paivio and Greenberg, 1995). Gestalt therapy is a different approach from many other psychological therapies that seek to reduce emotional intensity along with the intensity of symptoms.

Whilst Gestalt can be a primary therapeutic orientation, other therapists may also incorporate Gestalt techniques or philosophy into their work.

Some of the positive effects that clients have attributed to the Gestalt approach include increased levels of self-actualisation and personal effectiveness, maximum development of personality potential and the expansion of awareness and of experiencing (Clance et al 1994).

In general, there has not been a great deal of research evaluating the effectiveness of Gestalt therapy.

Results

The randomised controlled trial by Rosner et al (2000) reported no significant difference in anger/emotions arising as a result of gestalt therapy compared to cognitive therapy. The study by Cook (2000) found that the Gestalt group had lower scores following treatment for depression and anxiety and higher scores for self-concept than the control group. A pseudo-randomised study reported that the empty chair dialogue group achieved significantly greater improvement than the psychoeducational group on all outcome measures (Paivio and Greenberg, 1995).

Clance et al (1994) report that Gestalt therapy resulted in significant positive changes in body image compared to a control group. Male inmates had a higher internal locus of control following Gestalt therapy than the group participating in free activities (Serok and Levi, 1993). Women who were trained in Gestalt therapy experienced a more integrated positive birth and shorter labour compared to women trained in respiratory methods or not at all (Lobb 1992). In the study by O'Leary and Page (1990) students receiving person centred gestalt group work increased their scores for future and love significantly more than the no therapy group.

Depression

Two studies evaluated the effect of Gestalt therapy on depression, one in high school girls (Cook 2000) and the other in patients with major depressive disorder (Rosner et al 2000). One study used focused expressive psychotherapy (Rosner et al 2000) and the other a short term Gestalt group intervention (Cook 2000).

No significant differences were found in the frequency of expressing either anger or positive emotions between Gestalt and Cognitive therapy ($\chi^2[4]=5.02$, $p=0.29$). There were no significant differences between rating of emotional qualities (Rosner et al 2000). In high school girls there were significantly lower scores on the Reynolds Adolescent Depression Inventory (RADS) and on the Revised Childrens Manifest Anxiety Scale (RCMAS) following Gestalt therapy compared to the control group. There were significantly higher scores on the Piers Harris Children's Self-Concept Scale (PHSCS) for Gestalt therapy compared to the control group.

Unresolved emotional issues with significant other

The empty chair dialogue (ECD) intervention (drawing on Gestalt therapy techniques) was compared to a psychoeducational group (PED) with an attention-placebo minimal treatment condition (Paivio and Greenberg, 1995). The experimental group reported significantly greater reductions in symptom and interpersonal distress following therapy compared to the control group (symptom $F[1,31]=10.07$, $p=0.005$; distress $F[1,31]=17.53$, $p=0.000$). The Gestalt group reported less distress and more change on identified problems post treatment than the control group (target complaints $F[1,31]=15.18$, $p=0.001$; change $F[1,31]=31.56$, $p=0.000$). The experimental group reported more resolution of unfinished business than the control group following therapy ($F[1,31]=30.33$, $p=0.000$). The ECD group reported perceiving the other as significantly less hostile after therapy than the PED group ($p=0.03$). On average, the ECD clients perceived themselves as less hostile in the relationship after treatment ($F[1,31]=5.55$, $p=0.02$). The ECD group reported a significantly greater increase of self-affiliation or self-acceptance at post treatment than the PED group ($F[1,31]=4.36$, $p=0.04$). Results indicated that the ECD group maintained gains four months after therapy.

Body Image

One study used undergraduate university students as study subjects to assess the effect of Gestalt therapy on body image (Clance et al 1994). Gestalt therapy resulted in a significant positive change in a subjects attitude toward his/her body and self (pre-test/post test difference means Gestalt group X=33.4; control group X=15.2, p<0.04).

There was a significant gender effect (Body Cathexis- Self Cathexis [BC-SC] difference scores male X=37.91; female X=15.27, p<0.007). Gender and treatment factors did not interact significantly. There were mean gains for males in Body Cathexis (BC) post test (control X=129.56; experiment X=145.4, p<0.02) but mean gain for their Self Cathexis scores post test were not significant (control X= 133.59; experiment X= 136.25). In opposite fashion, females showed no significant change on the BC mean (control X= 136.2; experiment X=139.2, p<0.99), but showed higher SC post test mean scores (control X=130.02; experiment X=13.2, p<0.04).

There were no significant changes in scores for Draw-a-person human figure drawing test (male control X=12.18; experiment X=14.16; female control X=18.0; experiment X=18.38).

Semantic differential concepts

One study applied person-centred group Gestalt therapy with postgraduate university students to assess semantic differential concepts such as anger, fear, love, guilt and self acceptance (O'Leary and Page, 1990). Members of the experimental group increased their scores significantly more than the control group participants between the pre-test and post-test on the potency scale of the following concepts: future, love and gestalt therapy. There were no significant differences between the means of the control and experimental group members on any of the evaluative scales.

Male Inmates

One study applied Gestalt group activities to a group of male inmates and compared results with another group of inmates who received an equivalent amount of free activities of their choice (Serok and Levi, 1993). After Gestalt group activities, prisoners external locus of control (LOC) is significantly lower, or their internal locus of control is higher. The mean locus of control score for the Gestalt group prior to therapy was 8.77 (SD 2.43) and after therapy their mean score was 0.22 (SD 3.27). The difference was statistically significant (t= -3.78, p=0.45). Mean LOC for the control group was 8.44 (SD 2.9) prior to the study and 7.7 (SD 1.92) at the end of the study. This difference was not statistically significant (t= 0.84, p=3.30).

Pregnant women and childbirth

One study assessed the impact of Gestalt therapy on childbirth compared to respiratory autogenic training (RAT) or no training (Lobb 1992). The average duration of labour and delivery for the experimental group was four hours less than for women without training and two hours less than women in the RAT group. The experimental group received fewer caesarean sections. The perception of contractions was less painful for the Gestalt group than that of the women in the no training and RAT groups. The perception of self during labour and delivery was more positive for the Gestalt group than for the no training and RAT groups. The Gestalt group reported more confidence in their parental

function than the no training and RAT groups. The Gestalt group reported lower confidence in the health structure than the other two groups. There were no significant differences in opinion of training for the RAT and Gestalt groups.

Methodology

Randomised Controlled Trial

Authors report that two studies (Rosner et al 2000; Cook 2000) were randomised. We are, however, unsure of the method of randomisation, and hence subjects may not have been truly randomised to the two groups (Table 5). No sample size (power) calculations were performed at the commencement of the study to determine how many patients would be needed to detect a significant difference between the groups. In one of the studies (Rosner et al, 2000) the two groups were treated equally and in the other one group actually received no therapy at all (Cook 2000). It could be argued that it was not actually the therapy that made the difference but other factors such as attention. The Cook (1999) study was only reported in an abstract format which made it difficult to determine all potential biases.

There are also a number of serious limitations. For both of these studies the groups may not have been similar at baseline. One study provided no details of loss to follow up (Cook, 2000; Table 5). The reliability and validity of the scales used to measure outcomes were not reported for either study. For the Rosner et al (2000) study the two therapists administering the intervention may have differed in how they delivered the therapy. The result may be dependent on the therapist rather than the type of therapy used.

Pseudo-randomised Controlled Trial

Patients were allocated to groups in this study (Paivio and Greenberg 1995) using an alternate allocation method which is not truly random (Table 5). If groups are not randomised then background characteristics which may influence the outcome may not be evenly distributed between the two groups. All patients were accounted for. The two groups differed in how they were treated with the intervention group receiving 12 individual session and the control group receiving three sessions. This means that any difference between the two groups may not be able attributable to the intervention alone.

There were clear study inclusion criteria. The scales and inventories used had reliability and validity assessed. A strict protocol was in place to ensure that therapists conformed to a certain procedure and quality. The two groups were similar at the commencement of the trial for gender, age, education, previous therapy and marital status. There was a potentially small sample size and no power calculations were performed. It is possible that there was not sufficient power to detect the true difference between the groups.

Comparative Study with Historical Controls

Four of the included studies were comparative studies. Comparative studies are subjected to a number of potential biases. These four studies (Clance et al 1994, Serok and Levi 1993, Lobb 1992, O'Leary and Page et al 1990) were not randomised. In two of the studies all patients were accounted for (Serok and Levi1993, O'Leary and Page 1990) and in the other two there was no description of subjects who dropped out or failed to complete the studies (Table 5).

It is important in an intervention study that the two groups are treated equally in every way except the intervention so that any difference between the groups can be attributed to that intervention. One study failed to provide details to enable us to make this assessment (Lobb 1992). One study did treat groups equally (Serok and Levi1993) and the other two treated subjects in each group slightly differently. For one study the

women in the control group did not receive any form of intervention (O'Leary and Page et al 1990) and in the other the two groups received a very different structure and number of sessions (Clance et al 1994).

Groups should be similar at the beginning of the trial so that any differences at the completion of the trial can be attributed to the intervention. In the study by Clance et al (1994) the groups were similar for gender but were drawn from different populations with participation compulsory for only one of the groups. In the study by Serok and Levi (1993) the groups were similar for the main outcome measure which was locus of control. We were unable to determine if groups were similar in one study (Lobb 1992) and in the other study (O'Leary and Page 1990) the control group was older, although subjects were matched for age, gender and type of program.

There were clear study exclusion criteria for only two of the studies (Clance et al 1994, Serok and Levi 1993). Sample size calculations were not performed for any of the studies so we cannot be certain that they had sufficient power to detect a difference between the groups. The groups were self selected for all four studies and may not be representative of the sample from which they were drawn. This may limit the generalisability of the results.

Further profiles of these studies are provided in the attached Evidence Summary table.

Table 5 Quality and methodology of included studies

First author and Year of Publication	Study Design	Randomisation	Concealment of allocation	Masking	All patients accounted for
Rosner et al 2000 [1]	Randomised Controlled Trial	✔	?	?	✔
Cook 2000[2]	Randomised Controlled Trial	✔	?	?	?
Paivio and Greenberg 1995[3]	Pseudorandomised Controlled Trial	×	×	×	✔
Clance et al 1994[4]	Comparative study with concurrent controls	×	×	×	?
Serok and Levi 1993[5]	Comparative study with concurrent controls	×	×	×	✔
Lobb 1992[6]	Comparative study with concurrent controls	×	×	×	?
O'Leary and Page 1990	Comparative study with concurrent controls	×	×	×	✔

× this criterion was not met
✔ this criterion was met
? we are unable to determine if this criterion was met

ARTICLES CRITICALLY APPRAISED FOR THIS REPORT

Level II evidence- randomised controlled trials

1. Rosner R, Beutler LE and Daldrup RJ (2000). Vicarious emotional experience and emotional expression in group psychotherapy. Journal of Clinical Psychology 56**:** 1-10.

2. Cook DA (2000). Dissertation Abstracts International 60(08B), p4210, U Kentucky, US.

Level III-1- pseudo-randomised controlled trial

3. Paivio SC and Greenberg LS (1995). Resolving "unfinished business": efficacy of experiential therapy using empty-chair dialogue. Journal of Consulting & Clinical Psychology 63**:** 419-425.

Level III-2- comparative study with concurrent controls

4. Clance PR, Thompson MB, Simerly DE *et al.* (1994). The effects of the Gestalt approach on body image. Gestalt Journal 17**:** 95-114.

5. Serok S and Levi N (1993). Application of Gestalt therapy with long-term prison inmates in Israel. Gestalt Journal 16**:** 105-127.

6. Lobb MA (1992). Childbirth as re-birth of the mother. The Gestalt Journal XV**:** 7-38.

7. O'Leary E and Page R (1990). An evaluation of a person-centred gestalt group using the semantic differential. Counselling Psychology Quarterly 3**:** 13-20.

ARTICLES NOT CRITICALLY APPRAISED

Non- English

Bretz HJ, Heekerens HP and Schmitz B (1994). [A meta-analysis of the effectiveness of gestalt therapy]. Zeitschrift fur Klinische Psychologie, Psychopathologie und Psychotherapie 42**:** 241-260.

Rosner R, Frick U, Beutler LE *et al.* (1999). Course of depression in different psychotherapies - an application of hierarchical linear models. Zeitschrift fur Klinische Psychologie 28**:** 112-120.

Level IV evidence- descriptive studies, case studies, pre-post studies

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Keller JW, Brown G, Maier K *et al.* (1995). Use of dreams in therapy: a survey of clinicians in private practice. Psychological Reports 76: 1288-1290.

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Lazarus AA (1995). Different types of eclecticism and integration - lets be aware of the dangers. Journal of Psychotherapy Integration 5: 27-39.

Lynch JE (1998). Factors influencing choice of clinical specialty in a sample of Gestalt therapists. Gestalt Journal 21: 73-80.

Mahrer AR, White MV, Howard MT *et al.* (1991). Practitioner methods for heightening feeling expression and confrontational strength. Psychotherapy in Private Practice 9: 11-25.

O'Leary E and Nieuwstraten IM (1999). Unfinished business in gestalt reminiscence therapy: A discourse analytic study. Counselling Psychology Quarterly 12: 395-411.

Parlett M and Hemming J (1996). In Handbook of individual therapy.(Ed, Dryden W) Sage Publications, Inc, London, England UK, pp. 194-218.

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Sicoli LA and Hallberg ET (1998). An analysis of client performance in the two-chair method. Canadian Journal of Counselling 32: 151-162.

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Tyler N (1995). Redecision therapy and multiple personality disorder. Transactional Analysis Journal 25: 367-369.

Viney LL (1994). Sequences of emotional distress expressed by clients and acknowledged by therapists: are they associated more with some therapists than others? British Journal of Clinical Psychology 33: 469-481.

Qualitative studies

Hershbell AS (1998). U St. Thomas (St. Paul), USA.

Imes S (1998). In Touch in psychotherapy: Theory, research, and practice.(Eds, Smith EWL and Clance PR) The Guilford Press, New York, NY, USA, pp. 170-200.

Schoenberg P (2000). Kent State U., US.

Comparison of training videos of different therapeutic approaches

Aspinall SY and Fodor IG (1999). Clinical films as training tools: A comparison of REBT and Gestalt therapy with children. Gestalt Review 3: US: Analytic Press.

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APPENDIX 1

Copyright

Disclaimer

The information in this report is a summary of that available and is primarily designed to give readers a starting point to consider currently available research evidence. Whilst appreciable care has been taken in the preparation of the materials included in this publication, the authors and Southern Health do not warrant the accuracy of this document and deny any representation, implied or expressed, concerning the efficacy, appropriateness or suitability of any treatment or product. In view of the possibility of human error or advances of medical knowledge the authors and Southern Health cannot and do not warrant that the information contained in these pages is in every aspect accurate or complete. Accordingly, they are not and will not be held responsible or liable for any errors of omissions that may be found in this publication. You are therefore encouraged to consult other sources in order to confirm the information contained in this publication and, in the event that medical treatment is required, to take professional expert advice from a legally qualified and appropriately experienced medical practitioner.

Levels of Evidence

As defined by "How to use the evidence: assessment and application of scientific evidence" (National Health & Medical Research Council, Canberra, 2000):

Level I	Evidence obtained from a systematic review (or meta-analysis) of all relevant randomised controlled trials.
Level II	Evidence obtained from at least one randomised controlled trial.
Level III	
-1	Evidence obtained from pseudo-randomised controlled trials (alternate allocation or some other method).
-2	Evidence obtained from comparative studies (including systematic reviews of such studies) with concurrent controls and allocation not randomised, cohort studies, case control studies or interrupted time series with a control group.
-3	Evidence obtained from comparative studies with historical control, two or more single-arm studies or interrupted time series without a parallel control group.
Level IV	Evidence obtained from case series, either post-test or pretest/ post-test.

APPENDIX 2

Search Strategy

	Search Terms- MEDLINE, CINAHL, Best Evidence, Current Contents, PreMedline, PsychINFO, SocioFile
1	exp Gestalt Therapy/
2	gestalt.tw
3	therapy.tw
4	2 and 3
5	1 or 4
6	limit 10 to yr=1990-2001

Evidence Summary Therapy Is Gestalt therapy more effective than other therapeutic approaches?	**Study 1** Rosner R, Beutler LE, Daldrup RJ. (2000) Vicarious emotional experience and emotional expression in group psychotherapy. Journal of Clinical Psychology 56(1):1-10	**Study 2** Cook DA. (1999) Gestalt treatment of adolescent females with depressive symptoms: a treatment outcome study (girls, high school students, group therapy). Dissertation Abstracts International 60(8B): 4210
STUDY DESIGN & NHMRC LEVELS OF EVIDENCE	Randomised Controlled Trial Level II	Randomised Controlled Trial Level II
DESCRIPTION: Subjects, Interventions, Comparisons, Outcomes, Inclusion & Exclusion Criteria	**Patients:** Patients with Major Depressive Disorder **Intervention:** Focussed expressive psychotherapy (FEP; a manualised form of Gestalt therapy) in a group **Comparison:** Cognitive Therapy in a group **Outcomes:** The nature and intensity of emotions experienced, scores on the Clients Emotional Arousal Scale-revised (CEAS-r), and Non-verbal Arousal Instrument (NAI). **Incl & Excl Criteria:** Patients were included if they had a diagnosis of a major depressive disorder, a score of 16 or more on the 17-item Hamilton Rating Scale for Depression, and a willingness to discontinue other pharmacological and psychological treatments.	**Patients:** Depressed female high school students at a rural school **Intervention:** Short term Gestalt therapy group intervention **Comparison:** Wait-list control group **Outcomes:** Reynolds Adolescent Depression Inventory (RADS) scores, Revised Children's Manifest Anxiety Scale (RCMAS) scores and Piers Harris Children's Self-Concept Scale (PHCSS) scores. **Incl & Excl Criteria:** Included if 10^{th}-12^{th} grade, female, attending the specific rural high school and scored a certain level on the RADS.
VALIDITY: Methodology, rigour, selection, opportunity for bias	**Randomisation:** Yes, method not specified **All patients accounted for:** Yes, no significant differences were found between those in the study versus those who dropped out. **Patients treated equally:** Yes **Similar groups:** Uncertain, data not provided. **Potential for bias:** No sample size (power) calculations were performed.	**Randomisation:** Yes, method not specified **All patients accounted for:** No details provided of loss to follow up **Patients treated equally:** Patients in the control group did not receive any form of therapy. **Similar groups:** Uncertain, no details are provided. **Potential for bias:** We are uncertain of the sample size and the characteristics of the two groups prior to the study.
RESULTS: Generally favourable or unfavourable, specific outcomes of interest, estimate of experimental effect and precision if appropriate	The first hypothesis was the FEP and CT would differ, with FEP giving rise to more anger and CT giving rise to more positive emotions. No significant differences in the frequency of expressing either anger or positive emotions for the two therapies (χ^2 [4]=5.02, p=0.29). CT-observing clients expressed more positive emotions and more negative feelings than FEP-observing clients (χ^2 [4]=15.69, p<0.01). FEP clients did not feel significantly more anger. There were no significant differences between the two groups when comparing active clients. The second hypothesis was that the active clients and the observing clients would experience similar and parallel feelings within the two treatments but different feelings between the treatments. Ratings of emotional qualities revealed a parallel process for only 6 of 35 comparisons, which was non-significant. The correlation between average intensities of emotional expression for active and observing clients was non significant.	Significant differences were found between the pre-and post-test scores for all treatment groups on all measures. Following treatment participants demonstrated significantly lower scores on the RADS and RCMAS, and significantly higher scores on the PHCSS. Significant differences were also found between the experimental and control groups at the post-assessment for depressive symptoms, as measured by the RADS. No significant differences were found between 5 week follow-up scores and the post-test scores on the RADS for the experimental group suggesting that treatment effects were maintained at follow-up.

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AUTHORS COMMENTS: Risk/benefit, limitations	"While the types of emotions generally experienced by CT clients and FEP clients did not differ significantly, differences in the subgroups of active and observing group members were found. This indicated that the process assumptions made by the respective treatments were only valid for the actively participating clients and not for the observing group members. Emotional contagion as a process ."	All participants receiving Gestalt group treatment intervention had significantly lower post-test versus pre-test scores on the RADS and RCMAS, and significantly higher post-test scores on the PHCSS. The Gestalt group demonstrated fewer depressive symptoms following intervention than the control group.
REVIEWER'S COMMENTS: Risk/benefit, methodology, conclusions	Strengths: • Reliability and validity of instruments was assessed • The raters, rated the sessions blindly Weaknesses: • The groups may have varied significantly at baseline • The segment randomly selected for assessment for each participant may not be representative of their overall therapy experience • The two therapists may have differed in other ways than their therapeutic approach • The sample size may not have been sufficient to detect a difference between groups	Strengths • Subjects were randomly allocated to one of the two groups • There was a good follow up period Weaknesses • The groups may not have been similar at the start of the trial • The study may not have had sufficient power to show true differences between the groups • We have no details of loss to follow-up • There is a potential placebo effect with the intervention group receiving "something" and not the control group. • The reliability and validity of the selected scales was not reported

Evidence Summary Therapy Is Gestalt therapy more effective than other therapeutic approaches?	**Study 3** Paivio SC, Greenberg LS. (1995) Resolving "Unfinished Business": Efficacy of experiential therapy using empty-chair dialogue. Journal of Consulting and Clinical Psychology 63(3): 419-425	**Study 4** Clance PR, Thompson MB, Simerly DE et al. (1994) The effects of the gestalt approach on body image. The Gestalt Journal XVII(1): 95-114
STUDY DESIGN & NHMRC LEVELS OF EVIDENCE	Pseudo-randomised Controlled Trial Level III-1	Comparative study with concurrent controls Level III-2
DESCRIPTION: Subjects, Interventions, Comparisons, Outcomes, Inclusion & Exclusion Criteria	**Patients:** People with unresolved emotional issues with a significant other (person) **Intervention:** Empty-chair dialogue intervention (ECD), drawing on Gestalt therapy techniques. **Comparison:** Psychoeducational group (PED), an attention-placebo minimal treatment condition. **Outcomes:** General symptom distress, distress arising from interpersonal sources, target complaints, unfinished business resolution scale scores, degree of interdependence and affiliation in a relationship, rating of current therapeutic experience. **Incl & Excl Criteria:** Included if over 18 years, absence of current psychosocial treatment, absence of medication that affects mood, absence of drug and alcohol problems, absence of current self-harm potential or other crisis, absence of current involvement in a violent relationship. They were included if they met the criteria for the presence of unfinished business as the clinically predominant issue. Subjects were excluded if severely functionally impaired.	**Patients:** Undergraduate university students **Intervention:** Gestalt therapy **Comparison:** Control group involving discussions on the study of human behaviour. **Outcomes:** Body Cathexis- Self Cathexis (BS-CS) scores, Draw-A-Person (DAP) human figure drawing test. **Incl & Excl Criteria:** Included if eligible to be seen as a counselling centre client, suitable presenting issues for work within a time-limited experiential group modality, willingness to meet at scheduled group times.
VALIDITY: Methodology, rigour, selection, opportunity for bias	**Randomisation:** No, clients were alternately assigned to the two groups **All patients accounted for:** Yes **Patients treated equally:** The intervention group received 12 individual sessions, whereas the control subjects received 3 group lecture/discussions. **Similar groups:** Yes, for gender, age, education, previous therapy and marital status. **Potential for bias:** No sample size (power) calculations were performed prior to the study.	**Randomisation:** No **All patients accounted for:** No information of loss to follow up is provided **Patients treated equally:** The sessions were structured differently for the two groups. The control group received typical lecture series class work, whereas the Gestalt group received eight group sessions. **Similar groups:** Yes for gender. Groups were drawn from different populations. Students from the department who were interested in Gestalt were enrolled in the intervention group. The control group included the whole introductory psychology class for whom participation was compulsory. The two groups were, however, matched on BC-SC scores. There was no further analysis of baseline characteristics. **Potential for bias:** No samples size (power) calculations were performed prior to the study.

Evidence Summary Therapy Is Gestalt therapy more effective than other therapeutic approaches?	**Study 3 (cont…)** Paivio SC, Greenberg LS. (1995) Resolving "Unfinished Business": Efficacy of experiential therapy using empty-chair dialogue. Journal of Consulting and Clinical Psychology 63(3): 419-425	**Study 4 (cont…)** Clance PR, Thompson MB, Simerly DE et al. (1994) The effects of the gestalt approach on body image. The Gestalt Journal XVII(1): 95-114
RESULTS: Generally favourable or unfavourable, specific outcomes of interest, estimate of experimental effect and precision if appropriate	The ECD group reported significantly greater reductions than the PED group on symptom and interpersonal distress after therapy (symptom F[1,31]=10.07, p=0.005; distress F[1,31]=17.53, p=0.000). The ECD group reported less distress and more change on identified problems at post treatment than the PED group (target complaints F[1,31]=15.18, p=0.001; change F[1,31]=31.56, p=0.000). The ECD group reported greater unfinished business resolution at post treatment than the PED group (F[1,31]=30.33, p=0.000). The ECD group reported perceiving the other as significantly less hostile after therapy than the PED group (p=0.03). On average the ECD clients perceived themselves as less hostile in the relationship after treatment (F[1,31]=5.55, p=0.02). The ECD group reported a significantly greater increase of self-affiliation or self-acceptance at post treatment than the PED group (F[1,31]=4.36, p=0.04). Results indicated that the ECD group maintained gains for four months after therapy.	Gestalt therapy resulted in a significant positive change in a subjects attitude toward his/her body and self (pre-test/post test difference means Gestalt group X=33.4; control group X=15.2, p<0.04). When analysing males and females separately there was a significant sex effect (BC-SC difference scores male X=37.91; female X=15.27, p<0.007). Sex and treatment factors did not interact significantly. There were mean gains for males in BC post test (control X=129.56; experiment X=145.4, p<0.02) but mean gain for their SC scores post test were not significant (control X= 133.59; experiment X= 136.25). In opposite fashion females showed no significant change on the BC mean (control X= 136.2; experiment X=139.2, p<0.99), but showed higher SC post test mean scores (control X=130.02; experiment X=13.2, p<0.04). There were no significant changes in scores for DAP (male control X=12.18; experiment X=14.16; female control X=18.0; experiment X=18.38)
AUTHORS COMMENTS: Risk/benefit, limitations	"Results indicated that the experiential therapy achieved clinically meaningful gains for most clients and significantly greater improvement than the psychoeducational group on all outcome measures. Treatment gains for the experiential therapy group were maintained at follow-up."	"Gestalt therapy and awareness training do affect measurable and significant positive change in group participants' attitudes toward body and self. Further, Gestalt therapy has different effects on male and female subjects."
REVIEWER'S COMMENTS: Risk/benefit, methodology, conclusions	Strengths • Clear inclusion/ exclusion criteria • There were procedures in place to assess adherence of therapists to protocol and quality of therapy • Scales and inventories were assessed for reliability and validity • Groups were similar at baseline • The results were assessed for clinical significance as well as statistical significance Weaknesses • The sample was recruited through volunteerism, and is not representative of any sub group within the population • The subjects were not truly randomly allocated to groups • The two groups differed in the frequency and delivery of their treatments • Possible contribution of therapist effects	Strengths • Good description of the intervention • Subjects were matched at baseline for BC-SC scores Weaknesses • The included subjects may not be representative of the group from which they were drawn • The study was not randomised • There is potential loss to follow up • The groups were drawn from different populations • The control group were introductory psychology students, the intervention groups was interested students in the department. • Subgroup analyses were performed using very small numbers of subjects

<table>
<tr><td>Evidence Summary Therapy

Is Gestalt therapy more effective than other therapeutic approaches?</td><td>Study 5

Serok S, Levi N. (1993) Application of Gestalt therapy with long-term prison inmates in Israel. The Gestalt Journal XVI(1): 105-127</td><td>Study 6

Lobb MS. (1992) Childbirth as re-birth of the mother. The Gestalt Journal XV(1): 7-38</td></tr>
<tr><td>STUDY DESIGN & NHMRC LEVELS OF EVIDENCE</td><td>Comparative study with concurrent controls
Level III-2</td><td>Comparative study with concurrent controls
Level III-2</td></tr>
<tr><td>DESCRIPTION:
Subjects, Interventions, Comparisons, Outcomes, Inclusion & Exclusion Criteria</td><td>Patients: Volunteering male inmates from Israel
Intervention: Gestalt group activities
Comparison: Free group activities (sports, hobbies etc)
Outcomes: Rotters Locus of Control Inventory (LOC), social workers observations
Incl & Excl Criteria: Excluded if mentally ill, or retarded, chronic drug addicts, or those unable to communicate in Hebrew.</td><td>Patients: Pregnant women requesting childbirth training
Intervention: Gestalt therapy
Comparison: Respiratory Autogenic Training (RAT) and no training groups (NT)
Outcomes: Duration of labour and delivery, type of delivery, women's perception of labour and delivery, women's confidence in her own parental function in her partner's and in the health structure, the woman's perception of the usefulness of the course of training
Incl & Excl Criteria: None stated</td></tr>
<tr><td>VALIDITY:
Methodology, rigour, selection, opportunity for bias</td><td>Randomisation: No
All patients accounted for: Yes
Patients treated equally: Yes
Similar groups: Yes for LOC scores. Other details could not be presented due to issues around confidentiality.
Potential for bias: No sample size (power) calculations were made prior to the study</td><td>Randomisation: No
All patients accounted for: Unable to determine
Patients treated equally: Uncertain
Similar groups: Uncertain
Potential for bias: We do not have enough details to determine whether the groups were comparable at the start of the trial, and whether women were treated equally in all ways except the intervention.</td></tr>
<tr><td>RESULTS:
Generally favourable or unfavourable, specific outcomes of interest, estimate of experimental effect and precision if appropriate</td><td>LOC scores<table><tr><td></td><td>Mean-Pre (SD)</td><td>Mean-Post (SD)</td><td>P value</td></tr><tr><td>Gestalt</td><td>8.77 (2.43)</td><td>0.22 (3.27)</td><td>0.45 sig</td></tr><tr><td>Control</td><td>8.44 (2.90)</td><td>7.70 (1.92)</td><td>3.30, non-sig</td></tr></table>After Gestalt group activities, inmates external LOC was significantly lower (or their internal LOC was higher).</td><td>The average duration of labour and delivery on the experimental group was four hours less than that of women without training and two hours less than women in the RAT group. The experimental group received fewer caesarean sections. The perception of contractions was less painful for the Gestalt group than that of the women in the NT and RAT groups. The perception of self during labour and delivery was more positive for the Gestalt group than for the NT and RAT groups. The Gestalt group reported more confidence in their parental function than the NT and RAT groups. The Gestalt group reported lower confidence in the health structure than the other two groups. There were no significant differences in opinion of training for the RAT and Gestalt groups.</td></tr>
<tr><td>AUTHORS COMMENTS:
Risk/benefit, limitations</td><td>"Gestalt group activity suggests an active therapeutic atmosphere that leads to positive results. For the population that is reluctant to identify with the normative social value system, as well as for a population with limited verbal skills, these Gestalt methods seem to be suitable, and we recommend applying them to similar groups. However further research is required."</td><td>Authors conclude that hypotheses were confirmed. "The primary hypothesis was that the pregnant women prepared by the method illustrated here (Gestalt) would reveal, in comparison with women trained by other methods (RAT) or not trained at all (NT), a more integrated childbirth behaviour, demonstrated by: a) a more physiological labour, without psycho-physical blocks and therefore shorter, and b) a more positive memory of the event."</td></tr>
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REVIEWER'S COMMENTS: Risk/benefit, methodology, conclusions	Strengths • Subjects in each group were roughly matched on LOC scores Weaknesses • Sampling was not representative of all inmates. Only the highest scoring LOC subjects were included • Study was not randomised • The LOC was not validated in Hebrew • We are unsure if groups were similar at baseline • Only one outcome was measured	Strengths • Good description of the intervention • The study had control groups Weaknesses • The group was self-selected and therefore not representative of all pregnant women • The groups were not randomised • The groups may not have been similar at the start of the trial • Women in each group may have been treated differently • Unclear if women were lost to follow-up • Uncertain if study had sufficient power

Evidence Summary Therapy Is Gestalt therapy more effective than other therapeutic approaches?	**Study 7** O'Leary E, Page R. (1990) An evaluation of a person centred gestalt group using the semantic differential. Counselling Psychology Quarterly 3(1): 13-20
STUDY DESIGN & NHMRC LEVELS OF EVIDENCE	Comparative study with concurrent controls Level III-2
DESCRIPTION: Subjects, Interventions, Comparisons, Outcomes, Inclusion & Exclusion Criteria	**Patients:** Doctoral and masters students in counselling **Intervention:** Person-centred gestalt group **Comparison:** No therapy **Outcomes:** The evaluative and potency scales of the semantic differential concepts, awareness, responsibility, gestalt therapy, anger, my real self, my ideal self, fear, love, guilt, past, future and self-acceptance. **Incl & Excl Criteria:** None stated
VALIDITY: Methodology, rigour, selection, opportunity for bias	**Randomisation:** No **All patients accounted for:** Yes **Patients treated equally:** Yes, although the intervention group received something whereas the control group did not. **Similar groups:** The control group was slightly older. Groups were matched on age, sex and type of programme in which they were enrolled. **Potential for bias:** Small sample size, possible placebo effects.
RESULTS: Generally favourable or unfavourable, specific outcomes of interest, estimate of experimental effect and precision if appropriate	Members of the experimental group increased their scores significantly more than the control group participants between the pretest and post-test on the potency scale of the following concepts: future, love and gestalt therapy. There were no significant differences between the difference means of the control and experimental group members on any of the evaluative scales.
AUTHORS COMMENTS: Risk/benefit, limitations	"The results of this research showed that person centred gestalt groups can offer the skilled facilitator a viable means of facilitating the personal growth of graduate students. The attitudes of students who participated in these groups changed on several semantic differential scales including the potency scales of gestalt therapy, love and future. None of the scores on the evaluative scales used in this research were altered significantly."
REVIEWER'S COMMENTS: Risk/benefit, methodology, conclusions	Strengths • Reliability and validity of the semantic differential has been well established • Groups were matched on age, sex and type of program in which they were enrolled • There was no loss to follow up Weaknesses • The groups were not randomised • The sample may not be representative • Possible placebo effects as the control group did not receive any form of treatment • Study may not have had sufficient power to detect a difference between the groups