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The Three Perspectives Diagnostic Model (How Can Diagnostics Be Used In The Gestalt Approach And In Psychiatry Without An Unproductive Competition)

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Abstract

Gestalt therapists need to conceptualize their clinical work in order to intentionally differentiate their approach to different clients. Diagnosing is a natural and necessary part of the therapeutic process. However, it is a difficult task to build a coherent diagnostic system in Gestalt therapy, because Gestalt therapists use (and often combine) different perspectives of looking at the clinical situation. This article helps distinguish three common points of view of the Gestalt approach: the Field Theory Perspective, the Contextual Perspective and the Psychopathology Perspective. Adopting these perspectives consciously allows the therapist to take advantage of each of them and let them supplement each other to map the complex therapeutic situation more vividly. The author uses his psychiatric background to present the Three Perspectives Diagnostic Model which allows an avoidance of competition between the Gestalt approach and the medical approach.

1. Introduction

Imagine you are walking in a park and you notice a sculpture. You look at it, sense and explore it. Then you go around it and look at it from a different place. It is the same sculpture and yet you perceive it differently now. Then you change place again and look at the sculpture from some other perspective. One perspective is not enough to meet the sculpture.

This metaphor of a sculpture is used here for a clinical situation and

diagnosis. The following text wants to avoid a competition of perspectives. The text does not deny there is an epistemological conflict between medical and Gestalt approaches. However, it does not want the conflict to lead into an unproductive fight: "The sculpture should be seen from this perspective!". Instead, the text offers the observer a tool for being more aware from which place he is observing and what perspective other places can offer.

1.1. Psychotherapeutic Diagnosis and Case Formulation

When I meet a client in a psychotherapy situation, I experience contact with him, I listen and watch. And different questions arise and vanish: What is happening here? What does the therapeutic situation say about the client and about me in the moment? What symptoms do I see? Then, often, the client also tells me about the context of his life and I start to recognize relational patterns; I wonder if I recognize these patterns here in the therapeutic situation, too. My questions try to cast light on the therapeutic situation from different angles, different perspectives. This way my awareness and understanding have more dimensions and correspond more to the rich complexity of the situation. In this article, I want to present my exploration of the different perspectives from which I can look at a clinical situation. It is important not only to ask questions and form a hypothesis but also to be aware from what point of view I am asking.

When a therapist meets a client, he[1] encounters an enormous amount of information about his client. It comes from various sides – through the therapist's senses (hearing, seeing, etc.), from the therapist's own emotional and bodily experiences, from the therapist´s immediate thoughts and intuitive insights, from the therapist's previous personal and professional experiences that come to mind during the meeting, from the theoretical concepts and assumptions that a therapist has assimilated during his education. For processing all this information a therapist needs filters and concepts that help him organize it in a meaningful way. This is necessary for good therapy – for contact which is healing and not re-traumatising, for identifying realistic treatment aims and procedures, and also as the foundation for responsible creativity on the part of the therapist.

There is a distinct effort present today in the various psychotherapeutic approaches to elaborate a method which would enable the assessment of an individual client and facilitate the clinical psychotherapeutic treatment he receives using theoretical concepts. There is an effort to create **psychotherapeutic diagnostics** (e.g. Bartuska et al., 2008). This, as opposed to medical diagnostics, is not a fixed system of boxes into which clients are meant to be put. Psychotherapeutic diagnostics is a system of clues helping the

therapist to continuously orientate himself in the ongoing therapeutic process and to create a useful map of a therapeutic situation. The therapist creates this map aware of the fact that it is merely a simplification of reality and that he himself is a part of this landscape under examination. While remaining in a relationship with his client, the therapist watches the ongoing change of a unique therapeutic process and consequently adjusts his description of a situation in cooperation with his client. In this respect, psychotherapeutic diagnostics is related to another frequently used term, which is **case formulation**.

Accordingly, Gestalt literature follows this trend although the Gestalt approach is not much visible in psychotherapeutic overview publications. It is crucial for Gestalt therapy not to fix its eyes only upon itself but to engage in more of a mutually inspiring dialogue with other approaches. According to the theory of Gestalt therapy, the individual is defined and grows by the processes occurring at the contact boundary with his surroundings. Consequently, the Gestalt approach itself is defined and developed on its borders (Roubal, 2010), both in contact with other psychotherapeutic approaches and also with the medical world. To further illustrate this, I recommend two new publications where Gestalt authors can find a great deal of inspiration from other psychotherapeutic approaches.

The book *Psychotherapeutic Diagnostics* (Bartuska at al., 2008) describes the diagnostic approach of varied psychotherapeutic schools and the broader context of assessment in psychotherapy. It is based on the following principal questions (Pritz, 2008): How can we describe diagnostic processes in psychotherapy? Is it possible to describe different methods of diagnostics used by varied psychotherapeutic systems and thus set the stage for a conjoint diagnostic practice? In the book, the Gestalt approach is represented only by a largely theoretical chapter on diagnostics in Gestalt Theoretical Psychotherapy (Stemberger, 2008) and by a very brief chapter on the same subject in Integrative Gestalt Psychotherapy (Höll, 2008). Unfortunately, neither one of the two texts offers a sufficiently comprehensive and practically applicable conceptualisation.

The second edition of the *Handbook of Psychotherapy Case Formulation* (Eells, 2007) presents case formulation as a method of organising complex information about the client, to extrapolate the individual treatment, to observe the changes and to transform the theory and research into clinical practice (Eells, 2007). The book purveys an overview of case formulations in diverse psychotherapeutic approaches that are then compared throughout the conclusion in the search for common ground. It includes a valuable chapter dealing with the topic of case formulation in Emotion-Focused Therapy (Greenberg, Goldman, 2007), which is embedded within client-centered and

Gestalt therapy. The Gestalt approach is not directly represented, however[2].

I want to present here a proposal that focuses primarily on diagnostics in Gestalt therapy. Its aim is to supplement the former as well as the newest Gestalt literature on the topic (e.g. Mackewn, 1999; Fuhr at al., 2000; Joyce and Sills, 2006; Francesetti and Gecele, 2009; Brownell, 2010; Dreitzel, 2010) and thus contribute to the developing formation of the Gestalt diagnostics system. Such a system would then accurately benefit both "inwards" and "outwards". It would serve Gestalt therapists as a tool in their daily practice. It would also present a comprehensive image of the Gestalt therapy diagnostic approach to the other psychotherapeutic schools and contribute to the search for common ground with them.

1.2. Personal Experience with Diagnosing[3]

When I was still a student of medicine, preparing for my examinations in psychiatry, I spent a great deal of time memorizing the diagnostic criteria ICD10, describing in detail the psychopathology of patients. Later on, during my work on the psychiatric ward I saw how easily the diagnosis may be bent and somewhat adjusted. That was perhaps the origin of my later ongoing suspiciousness of diagnostics. I heartily loathe the image of the "psychopathologist" placing the client's soul on the autopsy desk to look for what is wrong with it. I did not want to take part in the objectification and pathologising of people whom I encountered in the psychiatric hospital. I did not want to reduce living and changeable human beings to a set of petrified psychopathological symptoms. I did not want my own I and the client's You to "freeze into a thing among things" (Buber, 1996) for each other.

I have perhaps remained in psychiatric practice only thanks to finding another way of thinking about my clients. I was eager to grasp the psychotherapy approach, especially the Gestalt one, which looks at symptoms as a means of creative adjustment in relationships. However, after this enthusiastic phase (my time of "psychotherapy conversion"), disillusionment followed. When I thought of my clients in the complex terms of the field theory paradigm, I was not understandable to my colleagues from the psychiatric ward so I had to return to general psychopathological terms to communicate with them. The worst part was that I no longer believed in psychiatric diagnostic terminology and thus I could not benefit from it. I noticed I was losing my accurate, sharp diagnostic approach.

I looked at my clients through field theory glasses and saw their selves as a changeable system of contacts, their symptoms interconnected with all the other elements of the field and myself as taking part in co-creating their

symptoms here and now. I could make good contact with my clients, but I was not a good diagnostician. I encountered my freshly built introjects: "You should not see the client as an object!", "Do not focus on problems, on what is not working!", "You should head towards an I-You meeting!", "Focus on the 'in between'!" and others. I found out that when I left the objectivising and pathologising approach of medical diagnostics behind, I started to lose a sharp diagnostic view - the one which, from a distance, consciously grasps the fine details of clients' mental functioning. Thus, I also lost the way of intentionally and conceptually differentiating between approaches to clients with different kinds of suffering.

I want to use my experience as a "Gestalt informed" psychiatrist. Through this article I would like to explain my view that even a Gestalt therapist might benefit from using the sharp and precise approach of diagnostic labelling – the objectifying, pathologising approach, and the I-it perspective on the client. I would also like to show how to avoid becoming restricted by such an approach and stay open to the relational and process-oriented perspective of the Gestalt approach.

2. Gestalt Approach and Diagnostic Assessment

2.1. Basic Assumptions and History

Gestalt diagnosis is not pointed at fixed conclusions (Brownell, 2010) but serves as a flexible and momentary working hypothesis (Höll, 2008), which enables the therapist to orientate himself in a clinical situation and to consider accurate therapeutic strategies. Diagnosis is most useful when kept descriptive, phenomenological and flexible (Joyce and Sills, 2006). In addition to this, the Gestalt therapist co-creates and continuously corrects the diagnosis through dialogue with the client. Gestalt therapy is based on the assumption that the therapist who is formulating a diagnosis represents an inseparable part of the actual web of relations and, thus, the phenomena of the interaction between the therapist and the client are important objects of the therapist´s explorative interest.

Every experience is random, changeable, amorphous and chaotic in the moment of its birth (Melnick, 1998). A basic human tendency is to organise each experience into a meaningful structure. We organise our experience of the presence of other people in the same way – we give name to our experience, we give it a structure. As our experience is very changeable and difficult to grasp, we are prone to project the assessment of our experience onto the people around us. We constantly label our surroundings: "the guy´s had a bad night",

"you look good", "she is a bit too carefree". These and all other commonly used assertions might be seen as lay diagnosis, applied to label people around us. Diagnosing[4] within psychotherapy is distinct from such everyday running flows of labelling as the therapist employs it with the client's benefit in mind and constantly reflects on the process of formulating a diagnosis.

Throughout history, Gestalt therapists either shunned diagnosis[5] or they strived to create its specific Gestalt version (Brownell, 2010). The Gestalt approach has traditionally stood against the objectifying, pathologising and depersonalised labelling of people (Perls et al., 1951), widely used in medicine and early psychoanalysis. Different theoretical conclusions were emphasized, based on the interconnection of the field phenomena and the uniqueness of the life story of each person. However, in describing clinical cases, the Gestalt approach was still not able to emancipate itself from the concept of medical diagnostics. When we read, for example, descriptions of "introjectors" or "retroflectors" (Perls et al., 1951; Polster and Polster, 1974), or of people who somehow interrupt the contact cycle (Zinker, 1978), it is a similarly objectifying and pathologising perspective, only using different diagnostic labels. (However, unlike medical diagnostics, the diagnostic description in this case is not static but reflects the process and thus signifies the possibility of change.)[6]

On the other hand, there has always been a need present in the Gestalt approach to deal with typology for the sake of the therapist´s orientation and choice of intervention (Perls et al., 1951). Gestalt therapists realize that diagnosing cannot be avoided and so the choice, here, is either to do it inadvertently and negligently, or thoughtfully and with full awareness (Yontef, 1993). They are aware of the risk that they would treat the diagnosis instead of the client and their approach would become depersonalized and anti-therapeutic. On the other hand, rejecting diagnostics and differences among people can bring about similar effects (Delisle in Gilbert, Evans, 1999).

Therefore, there are attempts to constitute a diagnostic system (e.g. Delisle, 1991; Swanson and Lichtenberg, 1998; Melnick and Nevis, 1998; Baalen, 1999; Fuhr et al., 2000; Francesetti and Gecele, 2009; Dreitzel, 2010) which would help therapists with orientation. These are attempts to create a classification which would enable therapists to categorize their clinical experience in accordance with their clients'. Terms from both general psychopathology and the theory of Gestalt therapy are applied for this purpose. Authors often try to combine them, which is quite difficult as psychopathological and Gestalt terminology each originate in different paradigms. Partial, clearly defined models from Gestalt therapy theory are often used for diagnostics, such as the contact cycle and the styles of contact. The contribution of this procedure lies in its clarity and articulation, which enhances the teaching and supervision of

the Gestalt approach, whilst also making Gestalt methods easily embraceable for therapists of other psychotherapeutic orientations.

There is a risk, though, that models based, for example, on the contact cycle or the contact styles might retreat from the theoretical basis of Gestalt therapy. It seems that they might become infected by the paradigm of medical psychopathology – they objectify and pathologise the client. There is hardly any difference in, for example, labelling the client as "depressive" or as someone who "is interrupting the contact cycle between the stage of mobilization of energy and action by retroflection". Both cases eliminate the vital contribution of the Gestalt approach, which is openness towards encounter and reliance upon the process. Brownell (2010) poses a question: "How do we speak *about* the client without doing damage *to* the client?"

Gestalt therapists are aware of this risk and emphasize the relationship context and its subjective meaning for the client in phenomena marked as psychopathological. This is to emphasize that certain phenomena cannot be separated or isolated from others and that it is not possible to marginalize how the diagnosis itself is substantially influenced by the person who does the diagnosing.

Nevertheless, the concept of a therapist's subjective perspective taken to the end disables the formation of any general categories or clues. Another disadvantage is its great complexity, which disallows simple conceptualization and comprehensible explanation among students or supervisees, as well as other co-operating specialists (psychiatrists, general practitioners, social workers). Gestalt therapy then appears as a kind of fuzzy, unclear approach and easy simplifications in the form of shortcuts can appear - such as that "everything is happening in the field", or that "all is constantly in process". Obviously such general statements are of no use in practice.

So, how to preserve clarity, comprehensibility and diagnostic accuracy whilst remaining faithful to the original paradigm of the Gestalt approach? I present, here, the T*hree Perspectives Diagnostic Model* designed to provide a clear diagnostic assessment of a clinical case that would enable differentiated therapeutic approaches to clients with varied clinical characteristics. I find this diagnostic model most useful in my own practice as well as in Gestalt training and supervision, because it overcomes the dichotomy of medical and Gestalt models.

Existing Gestalt diagnostic systems focus first on describing the **content of diagnosis** – they focus on **what** Gestalt therapists might diagnose. The content of diagnosis is formed by both structures (described with nouns) and processes (described with verbs). This article supplements them by focusing on the very **process of diagnosing** – on **how** we diagnose, at what stage of the therapeutic

process diagnosing takes place and what its regularities are.

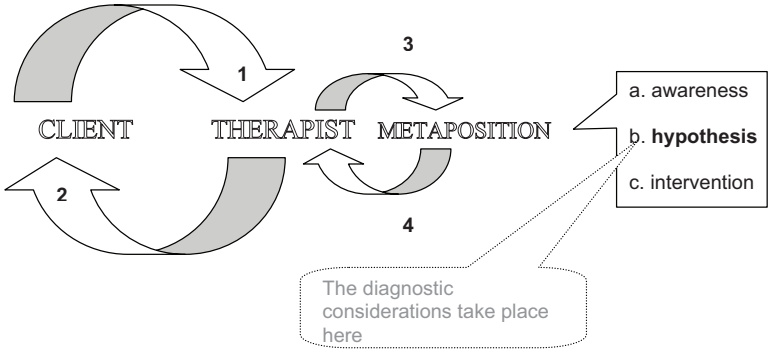
2.2. Metaposition

Through diagnosing we create distance in order to orientate ourselves and to gain a greater overview of the situation. The greater is the overview, the smaller is the contact and vice versa. Diagnostic manuals such as DSM IV or ICD 10 represent one extreme. A diagnosing expert with a maximum "objectivising" level of distance assesses every detail of the object under observation and does not try to make contact with the client. Moments of full I-You contact (Buber, 1996) in the process of therapy represent the other extreme. At such moments, the therapist plunges into being-togetherness with the other person to the maximum extent and does not try to orientate himself in the situation. He does not label either the other or himself from the I-it position. He does not diagnose, he encounters.

For psychotherapeutic work, maintaining just one of these extreme positions is unsustainable. We either do not establish contact with the client, or get lost in the stream of the encounter. In practice, in the course of the psychotherapeutic process we move up and down the scale between these polarities. We find ourselves either closer to the diagnosing pole or the pole of encounter, depending on what is needed at the moment. It is this capacity to move flexibly and in accordance with the actual situation from the level of meeting the client to the level of metaposition and back that represents the core psychotherapeutic skill.

For a better description of the therapist's position in the process of diagnosing I use and adapt the model which Ernst Knijff (2000) calls "the therapeutic dance".

Figure 1: Metaposition of the therapist



The client and the therapist mutually respond to each other (*see Arrow 1 and 2*). They "act" and "re-act" back, they co-create fixed gestalts. The therapist is trained to temporarily step out of these fixed gestalts by using his awareness. He is aware of the patterns forming the process of the therapeutic relationship. Thanks to his awareness he takes a position above the level of reacting and adopts a "metaposition" (*see Arrow 3*). There, he is mapping his awareness (a.), forming therapeutic hypotheses (b.), and considering possible interventions (c.). While being in metaposition, the therapist relates to the client through the observational I-it mode (Buber, 1969). Then he comes back and is ready and fully present to meet the client again (*see Arrow 4*); he is then back in the dialogical mode, which is open to I-You encounters (*see Arrow 2*). I emphasise that this article is focused on the therapist's diagnostic considerations in the "metaposition", namely the stage of forming therapeutic hypothesis (*see **b.** hypothesis*).

There is a continuous exchange of interactions between the client and the therapist, both verbal and non-verbal. On the content level, it is a matter of the mutual transfer of information; on the level of process, it is a matter of the mutual pattern of relating. The therapist encounters the client and gains **information** from different sources. One of the sources is observation of the client – how he looks, what his bodily structure is, what expression he is putting on, what he is wearing, how he talks etc. Further information is obtained from anamnestic data, either given directly by the client himself or drawn from other sources (medical reports from the client's general practitioner, his psychiatrist, or his relatives). We learn about the client's family, the possible history of similar difficulties among his relatives, the quality of relationships within his family, the client's previous and present social situation, the character of his existing relationships, the duration and development of his suffering, the kind of treament he has already been subjected to etc.

However, the therapist and the client exchange more than just information. They mutually react and, to a great extent, replay their usual **patterns of relating**, or fixed gestalts. It is a necessary stage of the therapeutic process, for which the therapist does not have to criticise himself. On the contrary, he personally experiences how the relational field in which the client lives is organised. All that the therapist experiences and what he does is a function of the field and might be used as diagnostic information (Roubal, 2009). The therapist uses his awareness – that is his own feelings, thoughts, physical perceptions and impulses in the client's presence – as another source of information. Collecting all this information is especially important in the initial stage of therapy. This article focuses on the next step – the process of diagnosing that structures and classifies the information.

The therapeutic situation differs from regular non-therapeutic communication in the way that the therapist employs his ability to take up a metaposition in favour of the client. In a metaposition the therapist steps out of interaction with the client and observes the therapeutic situation from a distance. There, he makes space for orientation. He classifies his observations, his **awareness** – what he perceives through his senses and what he experiences himself (predominantly the inner and outer zone of awareness according to Perls (1969)). He considers the gained information and creates working **hypotheses** (predominantly the middle zone of awareness according to Perls (1969)). Hypotheses are different ways in which the therapist understands and assigns meaning to the ongoing therapeutic process. Metaposition is also a place where the therapist considers possible **interventions**. Intervention could be anything that the therapist delivers on the basis of his awareness – a question, a supportive "*hmm*", a frustrating silence, an offer of experiment and so forth.

This stepping-up to the observer's position could take a second during a therapeutic session, a few minutes after the session has finished when the therapist is writing up his notes, or a longer period during supervision. While classifying information, forming hypotheses and considering interventions, the therapist derives benefit from not only his cognitive capacity but also his informed and cultivated intuition[7]. In the upcoming part of this text we will focus on just one stage of the whole process, namely the **stage of forming the hypotheses**, during which the diagnostic considerations of the therapist are articulated.

3. Three Perspectives Diagnostic Model

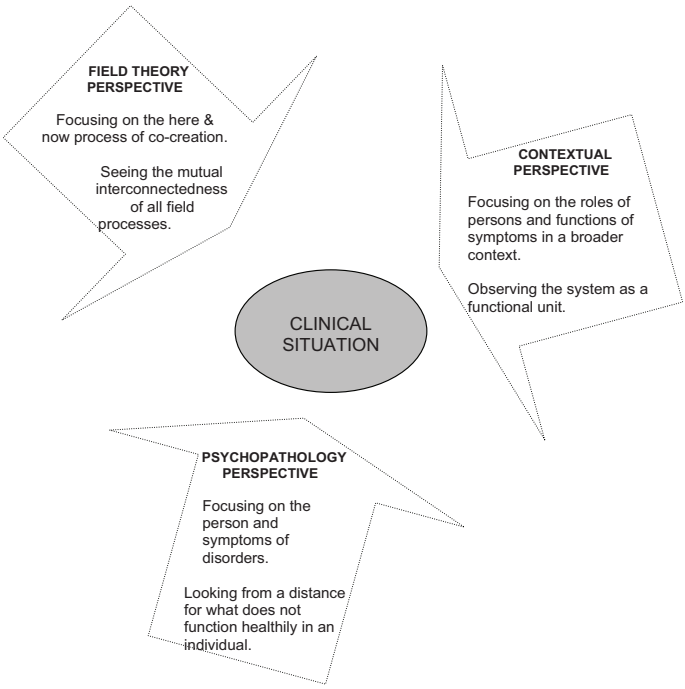
Diagnosis must be multidimensional to fit as closely as possible the map of the complex territory which a therapist enters when meeting a client. Forming a multidimensional diagnosis decreases the risk of treating our own concept instead of fully engaging with a living person; it enables us to listen to the needs of the client with regard to the different dimensions of his life (developmental, current relational, spiritual etc.).

When meeting a client, a therapist has a complex experience. He can form a multidimensional diagnosis by using different points of view, flexibly changing perspectives from which he observes his client´s process and the therapeutic situation. He can look at the clinical situation from a Gestalt perspective or medical perspective or some other. It is important that these perspectives are not treated as hierarchical, as one higher or better than the other. In the following suggested *Three Perspectives Diagnostic Model*, the perspectives do not compete with each other but rather supplement each other to form together a

multidimensional diagnosis. It is most important that the therapist recognizes the perspective from which he is diagnosing at a given moment. If he were to confuse the different perspectives, it would make it impossible for him to benefit from each of them.

The following model describes the three perspectives most frequently used by Gestalt therapists (see Figure 2). A therapist might start from any of them, but he must be aware from which perspective he is observing and which perspective he is not employing. He changes flexibly between them and gradually uses the viewpoints of the three diagnostic perspectives. He works with the diagnostic description of a case partly alone after the session has ended, while he is recording it in writing, partly during supervision, and also directly in the course of the session (while in metaposition). He also has the option to sensitively and safely bring in his diagnostic reflections during the conversation with the client and they thus can enlarge the awareness of the present situation together. Therapist and client can then explore, test and transform the diagnosis continuously. This type of diagnosing is of a dialogical nature.

Figure 2: Three Perspectives Diagnostic Model



The picture shows the three possible diagnostic perspectives frequently adopted by Gestalt practitioners. During the process of formulating a diagnosis, a therapist is aware from which position he is actually looking at the client and at the therapeutic situation. The model is cyclic; a therapist fluidly changes the perspectives to obtain a complex, multidimensional diagnostic picture.

3.1. Psychopathology Perspective

Is it possible for a Gestalt therapist to see his client as, for example, depressive, obsessive or borderline? I think it is, if the therapist keeps the psychopathology diagnosis as a hypothesis and knows he is looking at the therapeutic situation from just one of several possible perspectives. The *Psychopathology Perspective* results from a clinical situation: the therapist observes the client and forms hypotheses about him from the I-it perspective. We may say that he takes up the Newtonian paradigm, which is rooted in the assumption of objective[8] observation of the phenomenon; he treats the client as a classical medical practitioner. He relates his observations to his formerly gained knowledge and so creates the *Psychopathology Perspective*.

Psychopathology perspective: focus on what is not working healthily

- The therapist is asking: **What symptoms do I observe?**[9]
- The therapist is looking at the client as at an object; he is critically and comprehensively looking for what is not working in a healthy way with the client.
- The therapist is applying his knowledge of general medical psychopathology and theoretical models of the Gestalt approach (and possibly of other psychotherapeutic systems).
- The therapist is attempting to diagnose the symptoms in the most accurate way possible.
- The therapist does not worry that he "should" be focused on the relationship, the process of creative adjustment, the field theory perspective or the co-creation of symptoms at the present moment. He puts these Gestalt introjects away, brackets them for the moment.

The *Psychopathology Perspective* of diagnosis describes the dysfunctional characteristics of the client using both general psychopathological and Gestalt terminology. The therapist discriminates and labels the client´s difficulties,

forming hypotheses on how they appeared and how they are maintained onward. The therapist observes the client as an object on the I-it level of a relationship. As he does so, he accepts the initial perspective of the client himself, who also usually observes himself as if he were observing an object at the beginning of the therapy and relates to others on the "it-it" level (Gilbert and Evans, 1999). The present therapeutic relationship becomes the subject of diagnosing and therapy (Francesetti and Gecele, 2009).

From this perspective, the therapist may take the liberty of using rather "improper" thinking and terminology, from the Gestalt point of view. He consciously pathologises the client, he "objectifies" his diagnostic position. The therapist asks himself questions related to **medical classification systems:** *"What symptoms do I observe? Do I note psychotic, depressive, anxious or other symptoms in the client? Do I see any displays of personality disorder?"* The therapist can also make use of metaphors or partial Gestalt models (contact styles, contact cycle, functions of the self, polarities, fixed Gestalts and so forth). Some possible questions the therapist poses are: *"What contact styles is the client using and how is he applying them to prevent fluent contact and the accomplishment of his needs? How is the contact cycle deformed? At what stage does the client interrupt the cycle? Which stages does he skip?"* The therapist also focuses on the client's history and poses questions such as: *"What developmental needs have not been satisfied? What trauma has the client suffered? What relationship deficiency has he brought from his childhood and how does it affect his self-concept?"* A Gestalt therapist might use the diagnostic systems of other psychotherapeutic approaches here (such as psychodynamic, cognitively behavioural or transactionally analytic (Bartuska et al., 2008)), if they help him in creating a clear picture of the client´s situation.

The *Psychopathology Perspective* is focused on the disorders and dysfunctional strategies of the client. The advantage of such an approach is that the therapist obtains a clear and distinct image of the client's suffering. (Therefore, it is greatly advantageous at the intake-interview or while mapping a critical situation.) At the same time, the therapist has the possibility of validating his thoughts with the client, to diagnose in a **dialogical** way. He might pose questions such as: *"What troubles you the most?", "What diagnosis or labels did you get in the past and what is your opinion of them?", "What do you think – why are you having these troubles? How do you understand the situation?"*

3.1.1. The Psychopathology Perspective: Diagnostic Case example

To illustrate the *Three Perspective Diagnostic Model*, I present an abbreviated case study from my practice.[10] In order to develop this part of a complex

diagnosis (constructed from the Psychopathology Perspective) I gather information from the anamnestic interview with the client, from observation and from my own awareness, and look at it from the *Psychopathology Perspective.*

Martin (49 years of age) enters therapy because of panic/anxiety attacks that have appeared during the last 8 months irregularly, about once a week and with no apparent cause. He lives in a small town with his wife. His two sons (24 and 21 years of age) are away from home in full-time education and he sees them very little. He is an office worker. He suffers from chronic backache and is slightly overweight; otherwise, he is perfectly healthy. He has never been treated for psychological conditions and apart from the panic attacks suffers from no other mental disease. He states that his present relationships are in good order except for the fact that he and his wife are going through a minor crisis due to her short romantic involvement with another man. Martin has no siblings, his mother died of cancer when he was 12 years old, his father, a regular soldier, died a year ago. Martin has been advised to enter therapy by his general practitioner and would rather try this than take pills.

Martin speaks quietly with his look mostly pinned to the floor. After each of my questions he always takes time to think for a while, then looks up and answers precisely and with attention to every detail. While he is discreetly fixing the wrinkled carpet with his feet, I notice his shiny polished shoes.

What is my awareness in his presence? At first he arouses my interest and I quickly take up the role of an expert, which he is expecting. I notice that I am concentrating on the problem (as Martin does himself) and that I am not seeing Martin as a person with many dimensions whom I might encounter now. His answers are always so precise and comprehensive that they satisfy me yet also discourage me from further conversation with him. It becomes gradually more and more difficult to maintain concentration and in the meantime, while Martin is thinking about his next answer, I escape into my own thoughts. The conversation runs on the rational, problem-solving level. To questions such as: "How do you feel?", Martin answers: "I think, it is because of…".

From the *Psychopathological Perspective* I create various working **hypotheses** and infer possible interventions from them:

Medical hypotheses: I observe Martin's obviously anxious state, I hear about his panic attacks and chronic backache, I notice the obsessive compulsive personality traits.

Gestalt theoretical hypotheses: After initial contact on the cliche level is

established, the overall interaction becomes gradually more and more disturbed and both of us find ourselves in a state of isolation. The contact cycle of Martin's experience is markedly set back at the stage of energy mobilization; action is delayed and is not aimed at establishing contact (but at the fulfillment of a task). Martin's typical contact style is egotism; the chronic backache implies somatised retroflection. The rational processing of a situation predominates for Martin; when it comes to focusing on emotion, he avoids it.

There are some **guidelines** for therapeutic attitude that arise from the *Psychopathology Perspective* of diagnosis:

- Martin enters psychotherapy to "try it". It is necessary to take into account his cautious attitude and clearly anxious state. That is why it is advisable to accept his perspective to begin with – to focus on the problem, the symptom, to stay within the frame of rational thinking. It might be helpful to offer him a lecture on panic attacks and possibilities of coping (e.g. controlled breathing).

- The therapist might only very carefully and slowly examine the relationship and experiential areas of Martin´s life (emotion, body) as this approach is new and threatening to him.

- It would be good to give him time and space for his inner elaboration (egotism). And gradually also offer him a means of getting out of it through contact facilitated by the authentic interest in his person.

- The therapist can notice the moments when Martin is gathering energy and go to meet him in such situations.

3.2. The Contextual Perspective

The *Psychopathology Perspective* described above arises from the medical model, which encompasses concepts such as objectivity and disorder. From this perspective, the clinician describes the static structure. Thanks to this perspective, the diagnosing psychotherapist obtains information on the gravity and character of the client´s disorder which determines the basic setting of the therapy.

However, the therapist is not stuck in this point of view and can also use other perspectives of diagnosing. Here, I would like to stress the difference between two other perspectives often used by Gestalt therapists: the *Field Theory Perspective* and the *Systemic or Contextual Perspective*. I would like to focus now on the second perspective, which I prefer to call a contextual one, because the word systemic has many different connotations in other psychotherapeutic approaches, e.g. in family and systemic therapy.

There are two ways to extend the therapist's view of his client when moving from the *Psychopathology Perspective* to the *Contextual Perspective* of

diagnosing. Firstly, the therapist does not focus solely on the client as an isolated person, but sees him as a part of a manifold system of relations[11]. Secondly, he does not understand the client's suffering as a dysfunctional disorder but as a means of survival. From an etiopathogenetic attitude leading to the treatment of dysfunctional disorders, the therapist transits to a salutogenetic attitude that reinforces health and the potential for self-healing. From the *Contextual Perspective* the therapist sees the client as a member of a system and observes the roles he takes within the system; he explores the function of the client's phenomenology (seen as symptoms from the *Psychopathology Perspective*) in a wider context.

It might seem redundant to talk about the *Contextual Perspective* when we have a field theory. However, it is important to distinguish between these two to gain benefit from both of them. From the *Contextual Perspective* we look at the therapeutic situation and see individuals that have certain roles within a system. It could be a client's family system or a system constituted by the client-therapist pair. From the individualistic point of view of the *Psychopathology Perspective* we observe the individual personal structure and the causality of functioning of the client – what has caused or contributed to the appearance of symptoms (etiogenesis) and how the symptoms have developed (pathogenesis). Now, from the *Contextual Perspective* we adopt a systemic point of view that deals with circular causality. The symptoms appear within systems of the client's relationships with other people and they also feed back into, and thereby influence these systems.

The *Field Theory Perspective* seems similar but there is a significant difference, which is, however, not easy to describe. When we look from the *Field Theory Perspective* we do not see individuals but rather events happening in "the between"; we do not see causality (even the circular kind) but rather the interconnectedness of all mutual influences (including the diagnosing therapist) and the permanent process of co-creation. From the *Contextual Perspective* a client, a therapist and "symptoms" **play a role in the system** and from the F*ield Theory Perspective* they **are functions of the field**. The contextual (or systemic) point of view defines objects as existing independently outside the field and the context is added to the object later. By contrast, field theory assumes there cannot be anything that is not "of the field" (Yontef, 1993). This difference will be described later in the text. Both the contextual/systemic and field theory approaches provide useful means for not treating complex phenomena in isolation but rather in their context, situations, and environments (Parlett, 1991). The Gestalt therapist can gain useful insights using both of them if he distinguishes between them and adopts them consciously.

The contextual perspective: focus on roles within a system of relations

- The therapist asks: **What is the role of the client's phenomenology** (seen as a "symptom" form the *Psychopathology Perspective*)?
- The therapist inquires about the function symptoms had performed in the client's personal history. How had they served him? What have they protected him from? What needs have they satisfied?
- The therapist also examines the purpose they serve in the client's present relationships (including the therapeutic one). What are the "secondary benefits" and limitations the symptoms bring?
- The therapist applies a systemic *Contextual Perspective* and focuses on the dynamics of the roles and ways of relating within the system to which the client belongs.

The *Contextual Perspective* of diagnosis describes how the client has functioned and is functioning in various systems (the original and present family, job etc.). It maps out the role the client's phenomenology (seen as "symptoms" from the *Psychopathology Perspective*) has played in his relationships. Throughout life a person learns that certain roles he takes within a system of important persons are acceptable or appreciated while others are refused or ignored. A person thus repeats the roles which proved useful and result in the satisfaction of personal needs. These repeating roles are then adopted, creating each person's unique being in the world and the particular way in which each person relates to his surroundings.

These ways of relating have served the client well and played their part in his life. However, as he is now seeking help in therapy we might assume he is stagnating in these roles and ways of relating and is unable to react to changing surroundings, to act alternatively. The original adaptation and functional way of relating has turned into a rigid form that the client automatically applies in situations that require a different approach. This leaves his needs unsatisfied. Diagnoses made from the *Contextual Perspective* are descriptions of such rigid roles and ways of relating.

The therapist does not focus only on where these roles and ways of relating have restrained the client and what they have deprived him of. He also explores how they have served the client and how they have enabled him to survive non-supportive environmental conditions. **The *Contextual Perspective* of diagnosis focuses on the client´s inner and outer sources of support.** The therapist understands the symptoms as the best possible way of coping the

client has had at his disposal so far. The therapist is searching for the role of a particular symptom, inquiring about what maintains it and whether the client has any other possible roles at his disposal.

The therapist and the client co-operate as they co-create the diagnostic description from the *Contextual Perspective* together. The therapist may ask the client: *"How has your suffering, or this particular role or way of relating you described helped you in your life? What is its origin? What is its present contribution? At what price?"*

3.2.1. Contextual Perspective: Diagnostic Case Example

Let's come back to Martin. Taking the *Contextual Perspective*, I broaden my view and think of Martin's phenomenology (described from the Psychopathological Perspective as "symptoms") as a part of the client´s relationship systems and as a kind of survival mechanism.

> *From the Contextual Perspective of diagnosis I form "systemic and relational" working hypotheses: Martin´s contact style (his restriction of the mobilization of energy and his egotistic rational elaboration) probably helped him to sustain himself throughout a childhood without siblings, cope with his mother's early death, and share one household with just his soldier father from then on. It is possible that this way of relating also serves him well in his office job position, where he is quite successful. It seems, though, that this way of relating restricts him and causes him trouble as well. His wife´s experience in their relationship might be close to my own experience in his presence – she is losing interest and escaping. His sons are becoming estranged. His body is responding with backache. From this perspective his panic attacks appear to be an alarming signal urging him to change. It seems that Martin is passing through a crossroads, which might be related to his father's death (a year ago) and Martin´s upcoming 50th birthday.*

There are some **guidelines** for the adoption of the appropriate therapeutic attitude that arise from the *Contextual Perspective* of diagnosis:

- To be on the safe side, it is important to stick with the level of rational elaboration at first as it is natural for Martin. Gradually and slowly I can also offer him a new point of view on his current problems.

- It would be suitable, here, to examine his personal history (primarily the relationship with his father) as well as map the important stages and critical points of his life . This might shed new light on Martin's present anxious troubles and provide them with fresh meaning.

- Another strategy might focus on his communication style. The therapist and Martin together may map how Martin managed periods of solitude, what helped him.

- They may explore how this experience has influenced his present relationships. What are his sources of coping and what is the price he pays for his safe, conservative way of life?

3.3. The Field Theory Perspective

It is not easy to define the *Field Theory Perspective* because the language we must use for the description is meant to fix subjects and structure. But we want to describe "the between" process. So, for example, Martin Buber had to use a strange expression "I-Thou basic word" (Buber, 1996) because we have no words for the ongoing process happening in between the elements of the field (and including the elements). Moreover, there are different understandings of field theory in Gestalt literature (Staemmler, 2006) and the concept of field theory is sometimes mixed up with the systemic point of view; the differences between the concepts of "being of the field" and "being in the field" are often overlooked (Yontef, 1993).

The advantage of the presented *Three Perspectives Diagnostic Model* is that when we explicitly distinguish the *Psychopathology* and *Contextual Perspectives* we can dare to take the very radical position of the *Field Theory Perspective.* We can adopt the field theory outlook, in which concepts like holism, organismic self-regulation and present-centredness are all woven together (Parlett, 1991). A clinical situation can then be seen as a constant flow of mutual interconectedness, where everything that appears is a function of the field. There is no client and no therapist as isolated persons, no clearly bounded system; there is no history or inner and outer world, there is no causality. Every memory of a client, every so called "counter-transferential" experience of a therapist, every diagnosis that comes to a therapist's mind – all these are functions of the field. And so are all the other events, even the bird flying outside the window of the therapy room or the illness of the therapist's daughter that occupies his mind for a moment. **All the events co-create the ongoing flow of the process**. The mental structures and limitations we use are strategies to give the potentially overwhelming world experience some meaning so that we do not become mad.

The *Psychopathology Perspective* and the *Contextual Perspective* as described above are common to several psychotherapeutic approaches. The *Psychopathology Perspective* is very profoundly elaborated, for example, in Cognitive Behavioral Therapy, and the *Contextual Perspective* in systemic

and family therapeutic approaches. We Gestalt therapists can find a great deal of inspiration there. However, the *Field Theory Perspective* is traditionally cultivated within the Gestalt approach and represents something unique which the Gestalt therapy approach can offer as an inspiration to others. Gestalt therapy theory has explored and developed this concept more than most of the other psychotherapeutic approaches (the Process Oriented Psychotherapy of Arnold Mindell is very developed in this sense too).

How can we use this perspective to supplement the other two above-mentioned perspectives in the process of diagnosing? From the *Psychopathology Perspective* the therapist knowingly and on purpose observes the client as a static, "physical" object. Then, he can move from a medical model to a contextual one, from assessment to understanding. Taking the *Contextual Perspective*, the therapist allows the client to "come to life" in the therapist's imagination. He does not observe the client as a fixed lifeless thing (*Psychopathology Perspective*) but is discovering the client's functioning (*Contextual Perspective*), as if transiting from physics to biology. Nevertheless, the therapist continues to be a clear-cut, separate observer while the client continues to be an object.

From the *Field Theory Perspective* the therapist observes the co-creation of the situation here and now. He moves from the psychodynamic model, where he assessed the intrapsychic and interpersonal dynamics, to the field theory model. He realizes he is not an independent observer but a part of the actual co-creation of the field.

What was seen as the client's symptoms from the *Psychopathological Perspective* or roles from the *Contextual Perspective* is now understood as co-created by both the client and the therapist. The therapist observes how he is co-creating the field phenomena together with the client. He transfers his attention from "another time and another place" (Yontef, 1993) to "here and now". He is watching how the client's usual ways of organizing the field meet the therapist's ones. And he explores the way the actual field is organised. The therapist observes how he organises himself in the presence of the client; he traces his own here and now responses to his client.

From the *Field Theory Perspective* every person organises himself here and now on the contact boundary with his environment by the process of creative adjustment. A person is not seen as a thing or subject and his uniqueness is not built from the inside. (Although we may knowingly reduce him to an observable "thing" (the *Psychopathology Perspective*) or a subject taking a role (the *Contextual Perspective*), if such reductions are functional.) A person can be seen as the ever changing process within relationships. The process of organising oneself, the "selfing" (Parlett, 1991), has certain regularities that are

specific for each individual. These regularities of the field organisation create individual uniqueness enacted on the contact boundary with the environment at every present moment as well as continuously throughout life (Roubal, 2007). The client's regularities of field organisation meet the therapist's regularities of field organisation. The actual field organises itself as a kind of dance that arises from the interaction of the two "original choreographies" (Jacobs, 2008) where also some unique "new steps" might appear.

The *Field Theory Perspective* of diagnosis has a direct impact on the therapeutic attitude. Thanks to diagnostic assessment made from this perspective, the therapist is able to step out of a fixed pattern; he is able not to react to the client, but, rather, knowingly to choose a different way (or allow a new one to appear): to open up a space for a change of the stereotypical process of field organisation. The *Field Theory Perspective* of diagnosis also inherently offers the unique healing potential of a therapeutic relationship. The therapist proceeds from a focus on the present relationship to a state of being together within the present relationship. He does not perceive the client as an object (as he did when taking the *Psychopathology Perspective* and *Contextual Perspective*) but takes a part in the meeting of two human beings that define each other by mutual contact. The therapist is not limited to the I-it level as he opens himself up to the potential of an existential encounter with the client on the I-You level.

Taking this *Field Theory Perspective* of diagnosis, the therapist also takes notice of the spiritual extent of the encounter with the client. He wonders what it means to himself to have this particular client entering therapy at this particular time. What does it reveal about the therapist himself? What kind of challenge does it pose?

The field theory perspective: focus on co-creation of creative adjustment here and now

- The therapist asks: *"How do we co-create the present phenomena of the shared field (seen as "symptoms" from the Psychopathology Perspective) together with the client here and now?"*
- The therapist explores his own contribution to the clinical situation in which these phenomena appear here and now in the therapy.
- The therapist also focuses on the kind of potential present in the therapeutic relationship.
- The therapist asks in what way this particular client is unique for him personally. In what way is the therapist himself unique for this particular

client? What meaning does this encounter have in their lives?

The *Field Theory Perspective* of diagnosis maps the patterns of field formation here and now. The therapist concentrates on the existing process in the therapeutic relationship. What kind of contact do the client and therapist have? How does the contact proceed? What are its regularities? What patterns of field organisation appear in the client-therapist relationship? Which patterns from the client's and therapist's personal histories come to life here? How do they interact and what new possible ways of field organisation might appear? The therapist employs the phenomenological method (Yontef, 1993) while putting his presumptions "in brackets" and observing the obvious. His observations are tested through questions posed to the client: *"What do you feel now? What is happening? What are you aware of at the moment?"*. The therapist is aware of his own contribution to the process of organisation of the field here and now. His own awareness is a substantial part of the *Field Theory Perspective* of diagnosing.

3.3.1. Co-created Gestalt

From the *Field Theory Perspective* of diagnosing, the therapist applies a paradigm radically different not only from the medical approach, but also from the systemic approach. The observable phenomena ("symptoms" and their "roles" in the context) are now seen without evaluation as creative adjustment, as functions of the field. Also the therapist's own awareness and interpretations are understood as **functions of the field**; they do not have an "objective" quality, but rather arise from the shared situation and contribute to the ongoing process.

The therapist is diagnosing a relationship. The client's anxiety, borderline behaviour, retroflection, or disturbance of the contact cycle are seen and accepted as phenomena of the field which are co-created here and now together within the therapeutic relationship and to which the client and therapist contribute with their own share. Client and therapist are both part of the process of relating in which these phenomena emerge. Therefore, the therapist includes himself in the phenomenological observation. This is a necessary part of Gestalt diagnosing. The therapist uses himself as a tool, his awareness providing him with information on the way in which the actual field he shares with the client organises itself. **All that the therapist experiences, thinks and does is a function of the field**. He, himself, is a function of the field. The therapist asks: *"How do the client´s phenomena affect me? How do I contribute to them?"*

The therapist is aware that the way he is just now is determined by the relationship. The therapist knows that he rearranges and reorganises himself through the relationship with the other person in order to make sense of the experience here and now. The client also reshapes and reorganises himself in the relationship with the therapist. They define each other. Each of them is the ever changing process that meaningfully organizes itself the moment they come into contact. Each of them is a function of the actual field. The therapist might wonder: *"Who did I become when meeting this client? And what kind of person is he with me?"; "In what kind of story are we taking part together?"; "What metaphor might I choose to describe our relationship? Might we be, for example, like a pair of fairy tale creatures or animals? What are the risks and potentials of such a relationship?"*.

The therapist sees not only the client (as from the *Psychopathology Perspective*) and his pattern of relating (as from the *Contextual Perspective*). He also looks at himself and so he completes the complexity of the therapeutic situation. He is able to perceive the whole "shape" of the usual ways of relational field organisation that the client brings with him into the therapy and which are revived once more in the therapeutic situation with the therapist as an active co-creator. And the therapist is aware of his own usual ways of relational field organisation that emerge when meeting this particular client. When the therapist notices these usual ways and also new creative potentials, he is diagnosing from the *Field Theory Perspective*.

The usual process of relational field organisation that the client is well familiar with and that has actually brought him into therapy is inevitably repeated in the therapeutic situation. The therapist experiences a relationship with him similar to that experienced by people from the client's surroundings. This is not a mistake though. On the contrary, it is crucial that the therapist allows himself to be seduced and pulled into his client's usual process of field organisation so that he can taste this kind of field process from within, in his own skin. **The therapist co-creates the client's diagnosis.**

There is a danger, though, that the therapist slips into one of the extreme positions. He might assess the situation either through projective thinking: *"the client is the diagnosis and none of it is my business"*, or through retroflective thinking: *"I am the diagnosis and the way the therapy is proceeding is my fault"*. There are always both of these poles present: *"When I am labelling the client, I am always talking about myself at the same time. When I am talking about myself, there is always a message present about the client with whom I am co-creating the field"*. It is the therapist's task to observe with curiosity his own awareness within the field he shares with his client. Then he can use himself as a diagnostic tool.

The capacity to take up a metaposition enables the therapist to accept and eventually step out of the usual ways of field organisation, a diagnosis. The therapist realizes his part in the co-creation of the situation, he gains orientation which allows him to creatively reorganise himself in a new way. He can then begin to organise himself differently, which alters the whole field. Thus he also opens up a space in which to change his client's diagnosis. The therapeutic relationship brings to life the usual ways of field organisation – the diagnosis. At the same time the unique encounter of two individual beings embraces the potential of hope for liberation from the diagnosis.

3.3.2. The Non-Expert Approach

When the therapist is diagnosing from the *Field Theory Perspective*, he steps out of the expert position. He is aware of his own habitual and safe ways of field organisation, his fixed gestalts, his diagnosis. He is aware that the diagnosis he imputed to the client from the *Psychopathology Perspective* and *Contextual Perspective* points, to a great extent, back to him. How could he diagnose the particular characteristics of the client if he was not well familiar with them himself? **The diagnosis serves both as glasses and a mirror.** It is necessary that the therapist is aware of his own diagnosis to the greatest extent possible while diagnosing the client. The more the therapist fears the discovery of certain traits in himself (e.g. borderline patterns) the more vehemently he will seek to diagnose them in his clients. It is the same as when a half-deaf person shouts loudly because he automatically presumes the other must also suffer from impaired hearing.

When diagnosing the client, the therapist inevitably diagnoses the relationship with him as well. At the same time, he always diagnoses himself. When I say that my client suffers from a "borderline personality disorder" I am, in reality, saying a great deal about our relationship and myself. The psychotherapist does not give up his ability to phenomenologically observe and orientate himself. He is simply aware that, as the observer, he is a part of the observed and that he finds himself in a recursive loop of the diagnosis (Fuhr et al., 2000). In place of the objectifying diagnostic criteria, he puts the following questions: *"When I observe the traits of a borderline personality disorder in my client, how do I then feel myself? How do I contribute to this phenomenon? What can I learn from all this about my relationship with the client? And what can I learn about my own process?"*

3.3.3. Diagnosing Within A Relationship

Through diagnosing, the therapist creates distance from the therapeutic situation in order to gain orientation, simultaneously stepping back from contact with the client. However, it is impossible for the therapist to step out of the relationship with the client; he must diagnose within the frame of their relationship.

The diagnosis made from the *Psychopathology* and *Contextual Perspectives* does not appear somewhere outside the therapeutic relationship. By choosing and labelling one particular aspect of his relationship with the client, the therapist reduces a substantial amount of meaning and potential that the field of relation bears. **The therapist diagnoses within the frame of a relationship.** When I diagnose the client with "the traits of a borderline personality disorder", even if I do not say it aloud but just to myself, I am thus changing our relationship. **While diagnosing, the therapist always actively transforms the therapeutic relationship.**

Let me use a metaphor to illustrate this. I remember how I was chasing small chickens as a little boy in the country. They used to run away in a tight, yellow and squeaking flock. Once I picked one up and the rest of them scattered in all directions. I could get a thorough look at the one I was holding in my palm. However, I disturbed the coherence of the flock, of the whole. By choosing one part, I inevitably actively influenced the whole. There is much of the same when diagnosing. When the therapist examines one aspect of the client's presence in detail, he simultaneously actively transforms the situation at the risk of frightening away the other possible dimensions of the therapeutic relationship. Diagnosing is already an active formation of the contact with the client.

3.3.4. The Existential And Spiritual Dimension

Stepping out of the expert position enables the client and the therapist to meet as two equal and fully-valued human beings. It facilitates the **dialogic encounter**, which is not aimed at a certain goal but is the "meeting without aiming" (Yontef, 2006). The existential offer of the therapist towards the client is: *"Accept your experience"* (Greenberg, 1996). Such a challenge may be truly answered only if the therapist, through his own attitude, also conveys the other part of the message: *"...just as I do accept my own existence"*.

When we speak of the existential encounter in the therapeutic relationship we often quote the dialogic concept of existence of Martin Buber and his description of the horizontal human encounter on the I-Thou level. Buber also naturally speaks of the "eternal You" where "the prolonged lines of relations intersect" (Buber, 1996).

A person exists only in relationships with other persons and so also in a relationship with the essence of our common existence, where "prolonged lines" of these relationships also "intersect". It is the basic source of existence which transcends us and connects us with other human beings.

The effort to define oneself as a personality (even through attempts to define the personalities of others and their pathology) is just a more or less successful attempt to escape anxiety. The nature of this anxiety is existential and it arises from the idea that we are not a thing but a process on the contact boundary: that we do not exist, but are happening; that we are not the water in the stream, but the flowing of the water.

From the *Field Theory Perspective* of diagnosis the therapist therefore also contemplates the **existential dimension** of a relationship. He embraces the experience stemming from the encounter of I-You and the spiritual extent of a relationship. The relational field presents for him a basis for both his and his client's spiritual growth; both of them may evolve a worldcentric, global and non-dual awareness as a higher level of spiritual development (Williams, 2006). The therapist encountering the client may ask questions such as: *"What does the encounter with this particular person mean for my life? And what does meeting with me mean for him? What is the meaning of the fact that we are meeting at this time and in this place? How does our encounter contribute (due to "the butterfly effect") to changing the world?"*

From the Field Theory Perspective the therapist diagnoses the present processes happening here and now on the contact boundary.[12] The therapist comprehends psychopathology as the pathology of a relationship, as the "suffering of the 'between'"(Francesetti and Gecele, 2009). He describes the usual ways and patterns organising the field of the therapeutic relationship and also the possible new creative way by which the field is pregnant. Also from this perspective, the therapist creates the diagnostic hypothesis **dialogically** in cooperation with the client. He may ask the client: *"Do you recognize the relational issues that trouble you in your life, also here in the therapy, in our relationship? How do you think I contribute to it? What do I do to make it happen again? How do we both together co-create it? And what would you need from me? What would you need to happen in our relationship?"*

3.3.5. Field Theory Perspective: Diagnostic Case Example

From the *Field Theory Perspective* of diagnosis I focus on the process of co-creation of the shared situation. I wonder at how we, Martin and I, cooperate in forming the pattern of relating here and now in our relationship. How do I myself contribute to it? And what is the meaning of our encounter?

I create hypotheses on the process of field organisation here and now in the therapeutic situation. We define each other in a way that can be described like this: "Martin has a minor problem, otherwise he is perfectly fine. I am the expert for his minor trouble. I pose questions and he accurately answers each one after a short moment of reflection. We are thinking, our focus is on "an error that needs to be fixed". We look at the problem and we avoid direct eye contact that might be understanding, sympathetic and full of empathy." This last point is what he has probably been missing in his personal development, what he has been seeking in his relationships. But at the same time he acts in such a way that he does not recognise it. This usual process of field organisation recurs here and now in our present relationship.

There are some **guidelines** for adopting the correct therapeutic attitude that arise from the *Field Theoretical Perspective* of diagnosis:

- I shall notice the moments when I am avoiding contact myself, when I am focused on the problem and do not see Martin as a person I am meeting at the present moment.

- I shall more carefully distinguish when these moments of avoiding intensive contact provide Martin with feelings of safety and support and when such contact is simply comfortable for me (which would signify my own fixed gestalt).

- I shall also focus on capturing moments when Martin arouses my interest as a person, when I am experiencing emotions with him. I might gradually use these moments to establish more personal contact – either through sharing my experience or through authentic interest in his own.

- This is related to another possible path to follow – to see Martin as a person that has now entered my life. I can ask myself: What can I learn from him? In what way do my relationships resemble his? He is ten years older than I and might now be passing through the exact lifetime crisis that yet awaits me in a way. I shall not expose these thoughts to Martin. Nevertheless, they mean a distinct change in my perspective.

- Posing these questions makes Martin a very interesting, inspiring person for me. And through this change in my attitude I transform the stereotyped organisation of the field of relations. When Martin gets to arouse my interest as a unique person I may also relate to him otherwise. I stop focusing solely on the problem he has brought into therapy. Thus, I stop pushing him to change, which might open up a space for change (see the paradoxical theory of change (Beisser, 1970)). He may begin to step out of his cosy prison of fixed gestalts, to leave the "diagnosis" behind, and within our relationship he might also try

to organise himself in other ways.

4. Conclusion

Diagnosing helps the therapist to gain orientation and consciously differentiate between therapeutic styles of working with different clients. It is necessary that Gestalt therapists should not stagnate, solely focusing on observation of the present interactions, but that they should also be capable of forming operational hypotheses, to set both short-term and long-term treatment projects (Mackewn, 1999). It is important to cultivate the capacity of Gestalt therapists to connect practice with theory, to create Gestalt case formulations. The *Three Perspectives Diagnostic Model* introduced here might contribute to this. It might guide the therapist through the complex process of Gestalt diagnosing. It would help him **identify the perspective of diagnosing he is employing at the moment** – seeing either clinical symptoms (*Psychopathological Perspective*) or roles within a relational system (*Contextual Perspective*) or the process of the co-creation of the field organisation here and now (*Field Theory Perspective*). Each perspective has its benefits as well as its limits and they complement each other.

Using this *Three Perspective Model*, the therapist can decide which perspective to choose. When it is useful, the therapist can allow himself to consciously look at the therapeutic situation from the position of the medical model (and he does not need to compete with it). And then, when it is useful, he can allow this particular perspective to step aside in favour of the other perspectives, the contextual or field theory one. It would be a waste of energy if we Gestalt therapists let these models compete with each other (even if only in our heads) and remain caught up in the paradigm of good versus bad. Instead, it is possible to take advantage of the potential provided by their different focuses and let them dynamically complement each other. One becomes prominent at a certain moment and the other perspectives step into the background, then they can change their position according to the process.

Whenever we diagnose we are fixing the particular way the field of the therapeutic situation has organised itself. Doing this, we do not follow the flow of the process of the actual meeting. By diagnosing we gain distance and lose contact. But if we burdened ourselves with the demand that we should flow with the process all the time, we would paradoxically limit our therapeutic flexibility. Full contact in the therapeutic relationship can happen if we allow ourselves also to withdraw, look from a distance, diagnose. An encounter is enabled by distance. We cannot avoid diagnosing. All we can do is to remain aware of the process of diagnosing and bring our awareness back into contact with the client.

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Notes

1. When I write about a therapist and a client I use the male gender just not to make the reading complicated by many she/he or her/his. Every he or his in the text can also mean she or her.
2. In another similar overview publication – the fifth edition of *Case studies in Psychotherapy* (Wedding, Corsini, 2008) – the Gestalt approach is fortunately represented by a carefully written case study (Denham-Vaughan, 2008) accompanied by the elaborated comments of other Gestalt therapists (Blaize, Denis, Latner, Jacobs). The aim of this chapter is neverthless rather to illustrate the concrete clinical thinking of psychotherapists and not its systematic implementation into the Gestalt theory.
3. I distinguish between the content and process of diagnosis. I use the expression "diagnosing" when I want to emphasize the process of making a diagnosis.
4. I write here on diagnostics and diagnosing in a broader meaning of the word as of the naming and conceptualizing that serve the therapist to orientate himself while working with the client. This "perceptive" part of the therapeutic work is then complemented by the "action" part in the form of therapeutic intervention.
5. Except for the psychopathological labels of the medical classification system I also apply the term diagnosis for different namings from the field of psychotherapy, namely Gestalt therapy.
6. In the later Gestalt approach the *Field Theory Perspective* and the dialogical approach are becoming more applied even in describing clinical cases. For instance, the disturbance of contact caused by inappropriate mechanisms is no longer spoken of, but rather the

individually specific way of contacting (Wheeler, 1991; Melnick, Nevis, 1998) which is not evaluated (Mackewn, 2004; Joyce, Sills, 2006).

7. For the sake of remaining comprehensive and illustrative, the introduced model simplifies a great deal the manifold and multidimensional flow of encounter of two people in the positions of the therapist and the client. The whole process of therapeutic relationship including the therapist´s capacity to step back into metaposition is complex and the individual stages mutually merge. The concept of metaposition is also merely an abstract simplification as the therapist is always a part of the field and even the metaposition itself is a function of the actual field.
8. Rather then "objective" (which might have a negative connotation among Gestalt therapists) I like to use "observed from a distance". With the same client a contact is useful sometimes (e.g. an empathic stance to the depressive client) and sometimes a distance is useful (e.g. suicidal risk assesment with depressive client).
9. In this text the term "symptom" is used to describe the individually specific kind of suffering of the client (e.g. obsessively anxious thoughts, psychotic displays, insomnia, emotional lability, isolation in human relationships and so forth). Keeping the principal of "horizontalisation", I do not use the term "symptom" here in the medical sense as a label to the expression of a particular disorder. The term "symptom" remains neutral throughout this text and it does not indicate pathology. A symptom is a piece of work of the creative self and a display of personal uniqueness (Perls et al, 1951), it becomes a "plea"(Sichera, 2001; in Francesetti, Gecele, 2009) marking next direction.
10. It is the so-called composite case study (Gabbard, 2000) which combines the description of several actual clients in one sample case to achieve descriptive illustration of a shared phenomenon.
11. Medical diagnostic systems such as DSM IV or ICD 10 also similarly apply the systemic view while using more diagnostic axes that map the client´s personal history and his relationship and social situation.
12. It is necessary here to specify the often used and somewhat misleading term "boundary". It implies that there is a Country of The Client and a Country of The Therapist with a dividing line in between the two – the contact boundary. This is a structural and static model. Gestalt therapy's focus on process would be better illuminated by another metaphor. Imagine the therapeutic relationship as a football match (a friendly one hopefully). The ball then represents the contact boundary. It would constantly change its position and is all the time in the focused attention of both parties. This is a point where the contact of the two

teams is just happening at every moment. Imagine the camera shots at the football match – what is happening in the nearest surroundings of the ball comes to the foreground and becomes a clear figure, all else steps back into the background for the moment. The contact boundary is as changeable as the ball´s position and as the processes enacted on the contact boundary gets in the camera´s focus, they become a figure. Every comparison is slightly limping, of course. The aim of the therapeutic relationship does not lie in scoring a goal but in the fluid process of contacting and the bigger awareness of the processes enacted on the contact boundary.

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