Gestalt Approach to Diagnosis

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This chapter was published in a book "Gestalt Therapy in Clinical Practice. From Psychopathology to the Aesthetics of Contact" (Francesetti, Gecele, Roubal, 2013)

1. Introduction

Is diagnosis necessarily an objectifying act? Does diagnosis impede contact or support therapeutic process? These questions challenged us to write this chapter. We, the authors, are three psychiatrists. Our competence and way of thinking are in our background. We cannot and do not want to forget them, rather we try to make them explicit and use them in order to give a more specific contribution and build possible bridges between psychiatric practice and Gestalt therapy[1].

Diagnosis can be understood as a mark that gives meaning to the clinical situation. The Gestalt therapist is grounded in the here and now encounter with the patient, s/he understands the situation in a certain way, orientates her/himself in it and accordingly directs her/his interventions. A metaphor of travelling seems useful here. In psychotherapy, the patient and the therapist together set out on a journey of discovery. The therapist has a specific role and responsibility, sometimes s/he leads, sometimes s/he lets her/himself be led. They together discover the interesting, useful and risky features of the territory. They can travel with or without a clear goal.

They can get lost. The therapist needs to stop then and look at maps to get orientation. If this is the case in the clinical situation, the therapist needs to withdraw temporarily and let her/himself take time so the therapeutic situation can give a meaning to her/him[2]. Then s/he can give a name to this

[1] Substantial part of the text of this chapter is based on the article "Gestalt Therapy Perspective on Psychopathology and Diagnosis" (Francesetti and Gecele, 2009). We recommend the article to readers interested in more fully elaborated concepts mentioned in this chapter.

[2] We use the contact-withdrawal dynamic model of the interaction between the patient and the therapist. When withdrawing the therapist still remains in the relationship with the patient and the diagnostic considerations s/he is making are influenced by the relationship and, in a circular way, the diagnostic process influences the relationship.

meaning, which is a diagnosis. The therapist temporarily and consciously changes a focus. For the moment s/he does not focus on the patient and the relationship, rather s/he focuses on the description of the meaning of the situation which represents a "third" party there. By changing focus the therapist does not escape from the contact with the patient. Indeed, by temporarily changing focus the therapist supports the contact with the patient, as though pointing out a position on the map and getting directions for a journey. For example, interventions would be heading in different directions when therapist and patient are part of a borderline field or when they are part of a psychotic field. Diagnosis serves as a map in a clinical situation. To be useful the map has to simplify. Therefore we should not blame diagnosis for not covering the suffering of a person in its whole complexity.

There are two kinds of diagnosis when orientating towards a therapeutic relationship (Francesetti and Gecele, 2009). The first one which was briefly described above may be called *extrinsic* or *map diagnosis.* It results from a comparison between a model of the phenomenon and the phenomenon itself and is created when the therapist consciously focuses on the description of the meaning of the situation. However, when facing the patient, the therapist cannot always stop for a moment and consider how s/he understands the situation. In practice, s/he can only do this from time to time and maybe mostly after the session. In the live dialogue the therapist responds immediately. S/he reacts by a word, gesture or tone of voice in the blink of an eye. Also here s/he has guidelines that help her/him to direct her/his response. These are guidelines not reached by changing a focus (a temporary switch of a focus from the territory to the map) but on the contrary by being fully involved in the flow of the relationship. The therapist feels completely involved in the contact process and s/he acts supporting the relationship as a whole.

The second kind of diagnosis can be called *intrinsic* or *aesthetic diagnosis*, which is the specific diagnosis of Gestalt therapy. It arises from the aesthetic criterion (Joe Lay, in Bloom, 2003) and it is the perception of the fluidity and grace of what happens, or what fails to happen, that orients the therapist in adjusting his manner of being-with the patient. We can compare the *extrinsic* diagnosis to a map of the territory of the therapeutic situation. The *intrinsic* diagnosis we can then see as a sense of direction that a therapist feels during his journey through the territory. Both kinds of diagnosis serve the therapist for better orientation, but each does so differently. A *map* provides overview and understanding, a *sense of direction* is important for immediate decisions and movement in a blind terrain.

2. Intrinsic or Aesthetic Diagnosis

«There are two kinds of evaluation, the intrinsic and the comparative. Intrinsic evaluation is present in every ongoing act; it is the end directedness of process, the unfinished situation moving towards the finished, the tension to the orgasm, etc. The standard of evaluation emerges in the act itself, and is, finally, the act itself as a whole» (Perls, Hefferline and Goodman, 1994, pp. 65-66). Instant after instant, interactions between the therapist and the patient take place unpredictably and chaotically, bringing into play thousands of elements every fraction of a second. Interaction is incredibly complex: it is visual, aural, tactile, muscular, glandular, neurological, gustatory and olfactive, reactivating layers of memory which fluctuate in waiting, ready to participate in forming a figure. Moreover, it involves expectations and comparisons with thousands of contacts and faces. What orients us in this complexity?

One possible option is to observe the situation, describe it and create a map that can serve as a tool for orientation. How this map, an *extrinsic diagnosis*, is created and used will be described further in this chapter.

Another option is to remain within this relational chaos, to navigate or float on the waves of this sea "which never stands still". The orientation is then enabled by a kind of diagnosis traditionally cultivated in Gestalt therapy. It is based on a sensed aesthetic evaluation and emerges from moment to moment from the contact boundary. It is also a diagnosis because it offers orientation for the therapist and because it is knowledge (*gnosis*) of the here and now of the relationship through (*dia*) the senses. This act of diagnosis is not a comparison between a model and a phenomenon. We shall call this second kind of diagnosis "*intrinsic or aesthetic diagnosis*", because it is intrinsic to the process and because is based on the perception throughout the senses (*aisthesis*, in Greek, means to perceive throughout the senses).

This kind of orientation is based on the intuitive evaluation of a contact situation: it is a specific kind of knowledge that emerges at the contact boundary in a moment when the organism and environment are not yet differentiated. For this reason, the aesthetic knowledge is implicit (pre-verbal) and already attuned to the intersubjective dimension (D'Angelo, 2011; Desideri, 2011; Francesetti, 2012). Guidelines for the next intervention are immediately evaluated according to aesthetic criteria. Only later can the therapist name (mostly quite vaguely) the process of making her/his decisions: "It seemed the right thing to do in that moment"; "I

would not dare to say it in that situation", etc. Time is not spent on cognitive processes, because this kind of evaluation is pre-cognitive and pre-verbal and implies not only a passive act but also an activity, leading the therapist straight to intervening action. Working with intrinsic diagnosis we use intuition[3] as a source of support for a therapist. Most immediate interventions are not made from a conscious cognitive deliberateness, but the therapist's awareness orients her/him throughout the aesthetic criteria. Often, only after the session can the therapist find a way of describing verbally and understanding cognitively what s/he did and what were the reasons for the interventions.

It does not mean that the therapist works chaotically. Her/his understanding of the clinical situation and her/his interventions are lead intuitively. Her/his intuition is cultivated by experience and training. Cultivated intuition enables the therapist to perceive more sensitively slight shades of the therapeutic situation and intervene immediately in an appropriate way even without a cognitive processing. Intuition can lead her/him in the space "in between" through a soft web of minute signals, for which words and thoughts are too rough instruments.

What does it really mean making an intrinsic kind of diagnosis? To be aware, awake, with senses active, and at the same time relaxed, allowing yourself to be touched by what happens (Spagnuolo Lobb, 2004; Francesetti, 2012). To remain confident that a chaos does indeed make "sense" and that with sufficient support a meaning will emerge. The therapist is not disoriented, but present. He is not idle, but ready to join the dance that unfolds at the boundary where the patient and therapist make contact. The therapist is ready to gather intentionality and to support the unfolding of breath. It is the intentionality towards contact that brings order to intersubjective chaos. When the arrow of intentionality loses energy and falls, it is recovered by the therapist, who gives it new momentum. When the arrow falls and is recovered and re-launched, the emotive intensity of the moment is heightened. Moments of fullness of contact are always unpredictable: we do not know when they will occur, in which minute or second of contacting. They do not occur by chance though: it is the

[3] «Intuition represents a way of direct knowing that seeps into conscious awareness without the conscious mediation of logic and the rational process». (Boucouvalas, 1997, p. 7) The concept of intuition is not explicitly developed in Gestalt therapy theory although it is implicitly often used, e.g. in describing the creativity of a therapist. When aware, the therapist acts intuitively in an aesthetic way. *Intuition* comes from the Latin word *intendere*, used for musical instruments, and means *to tense the instruments cords* in a way that they are *accorded*, i.e. they are perfectly resonant with the heart's cords (in Latin, *heart* is *cor, cordis).*

therapist who helps deliver those moments by supporting the intentionality of the patient as it unfolds second by second and encounters the therapist's own intentionality (Bloom, 2010; 2011).

Intentionality orients the therapeutic process. A loss of momentum, a drop or interruption in intentionality will prompt the therapist to intervene: intervention may also be silence, immobility, or almost imperceptible movement. The intervention is directed towards the completion of a Gestalt, supports the potential that is ready to appear. How does the therapist notice the movement or interruption of intentionality? The answer lies in being present at the contact boundary, with senses alert and an awareness of one's bodily, emotive and cognitive resonances. These resonances emerge indistinctly, not by cognitive process, but rather by giving time to unfold, and only through later reflection can they be distinguished.

A rigorous criterion is what guides this awareness: the aesthetic criterion (Joe Lay, in Bloom, 2003) that leads therapist and patient to co-create a good Gestalt of contact.

Again, in this diagnostic approach, no comparison is made between a model of the phenomenon and the phenomenon itself, as happens with diagnostic maps. Here we have the perception of the fluidity and grace of what happens, or what fails to happen, which is what orients the therapist in adjusting his manner of being-with the patient. It is a note out of key, a brushstroke out of place, a touch too much or a touch too little, a little too soon or a little too late. It is not an *a priori* model that guides us, but the unique, special aesthetic qualities of a human relationship in that specific situation. Just as we know how to recognize a note out of key, we can sense that something is out of place or out of time, or so indefinably strange or fatigued in ongoing reciprocal responses.

The cardinal points of this "second by second" diagnostic approach are in the here (the experience of space) and now (experience of time) of lived experience, as it manifests itself at the contact boundary. The therapist is the sensitive needle to changes in these seismographs which record (via individual resonances) the aesthetic values of the relationship here and now, and not individual parameters. The therapist gauges these variations and continuously positions herself in relation to them, with sensorial-physical unity. In this way, the therapist does not only bring about the intrinsic diagnostic act, but also the therapeutic act itself: this constitutes the unity of the diagnostic-therapeutic act (Perls, Hefferline and Goodman, 1951, 1994; Bloom, 2003). Sensing the interruption of intentionality, the therapist re-positions herself in the relationship, guiding and curing it, moment by moment.

3. Extrinsic or Map Diagnosis[4]

3.1. Do We Need to Diagnose?

> The therapist needs his conception in order to keep his bearings, to know in what direction to look. It is the acquired habit that is the background for this art as in any other art. But the problem is the same as in any art: how to use this abstraction (and therefore fixation) so as not to lose the present actuality and especially the ongoingness of the actuality? And how – a special problem that therapy shares with pedagogy and politics – not to impose a standard rather than help develop the potentialities of the other? (Perls, Hefferline and Goodman, 1994, pp. 228-9)

In its theoretical foundations and historical and clinical evolution, Gestalt therapy sees the therapeutic relationship as a space for contact. Through contact, subjects give rise to an authentic, unique and co-created relationship, which in turn shapes and constitutes them. The aim of the therapeutic relationship, in this model, is to support the contact intentionality[5] in order to co-build a new, nutritious experience, able to help the patient grow. S/he is in no way objectified. Objectification would lead to the irreparable loss of the presence of the other, and would be diametrically opposed to the direction in which Gestalt therapy moves. In this relational horizon, diagnosis becomes a problematic issue.

The mistrust of Gestalt therapists towards diagnostics warns us of the risk of becoming experts for the lives of our patients, the risk of treating our image of the patient and not meeting the patient. However, it is important to realize, that we cannot avoid making some kind of diagnosis. Every experience is random, changeable, amorphous and chaotic in the moment of its birth (Melnick, 1998). A basic human tendency is to organize each experience into a meaningful structure. We organize our experience of the presence of other people, we give name to our experience, we give it a

[4] The term "diagnosis" is generally used in the sense of an extrinsic or map diagnosis. It is so also in this chapter: when we use the word "diagnosis" without an adjective, we mean an extrinsic or map diagnosis.

[5] Intentionality as a philosophical concept "signals the aboutness of experience" (Brownell, 2010, p. 83). Man in his being alive is always directed toward an object, something or someone that exceeds himself. From Gestalt therapy point of view the intentional process is meaningful and directed to the next step of contact (Crocker, 2009; Bloom, 2010).

structure[6]. We label our surroundings all the time. However, in the position of a therapist we must do it with the patient's benefit in mind and constantly reflect on the process of formulating a diagnosis.

When a therapist meets a patient, s/he encounters an enormous amount of complex information. It comes from various sources: through the therapist's senses; from her/his own emotional and bodily experiences; from immediate thoughts and intuitive insights and 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. To process all this information a therapist needs filters and concepts that help her/him organize it in a meaningful way. This is necessary for good enough therapy, for contact which is healing and not re-traumatizing, for identifying realistic treatment aims and procedures, and also as a foundation for a responsible creativity on the part of the therapist.

Gestalt therapists working in a clinical setting (psychiatric department of a hospital, mental asylum, outpatients psychiatric services) must inevitably learn to use at least two perspectives in their approach to the suffering of their patients. On the one hand, for Gestalt therapists, it is natural to use the relational, dialogical, field perspective. But if they stick only to that, they can hardly find a common language with their colleagues educated in a medical system. They also might not succeed in developing a working alliance with their patients who come with expectations influenced by the medical paradigm. Gestalt therapists in clinical practice must therefore be familiar also with the perspective of current psychiatric diagnostic systems and psychopathology theories. The medical and Gestalt perspectives represent polarities of the daily work of Gestalt therapists in clinical practice who must stay with the tension between them. One of the perspectives can arise as a figure, the other moves to the background and then they switch according to the situation, so they can enrich each other.

Diagnosing helps the therapist to gain orientation and consciously differentiate between therapeutic styles of working with different patients. 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).

3.2. History and Context of Psychiatric Diagnosis

[6] As our experience of the "between" is very changeable and difficult to grasp, we are prone to project the understanding of our experience onto the people around us. But what seems to be a label of the other is rather a name we give to our experience with the other. The diagnosis serves both as glasses and a mirror for he who is making it.

Diagnosis comes from the Greek *dia-gnosi*, meaning *to know through* (Cortelazzo and Zolli, 1983). This in itself stresses the impossibility of not using diagnosis, in broad terms at least. In the last century, the philosophy of science and hermeneutics taught us that knowledge free of all filters and foreknowledge cannot exist. If we can only know *through*, and there is no *gnosis* without *dia*, the question transforms into which *dia* (which prejudices, which presuppositions) should we use (Salonia, 1992). For diagnostics, the most influential *dia* in our society has been the medical model.

Modern psychiatry was borne from the attempt to give a name and classification to psychopathological phenomena. Kraepelin achieved a great step forward for the psychiatry of his time (second half of the nineteenth century) through his clinical distinction between *Dementia Praecox* and *Manic-Depressive Psychosis* (Kraepelin, 1903). He believed he had identified "natural disease entities", such as pneumonia or infarction. In doing so, he disentangled mental suffering from the spires of moral guilt, placing it squarely in the field of medicine. In this way, a map was created to help clinical practitioners orient their way through the chaotic world of madness[7].

Psychiatric diagnostic systems that appeared subsequently followed the example of somatic medicine. They tried to demarcate mental disease as a diagnostic unit which has some recognizable cause and foreseeable progress and prognosis. Psychiatric diagnostics used an *inferential* approach that goes beyond the observable phenomena and inferred from them possible causes and processes (e.g. distinguishing between "endogenic" and "reactive" depression). However such an approach was based more on wishful thinking and proved to be an illusion. We do not know the etiopathology (causes and mechanisms leading to an emergence of a disease) of the absolute majority of mental disorders (Smolik, 2002).

From the sixties of the twentieth century psychiatric diagnostics applied a more *empirical* approach based just on observable phenomena (e.g. diagnosing simply depressive symptoms without speculating about their causes). Moreover, diagnostic systems started to describe not only the

[7] The problematic nature of using medical diagnosis in the field of psychopathology soon also began to be appreciated, as were the risks associated with it (Jaspers, 1913; Minkowski, 1927, 1999): the risk of objectifying that which cannot be objectified; the risk of crystallizing that which is constantly changing; the risk of losing the subjective experience of the patient, which is precisely what the therapist seeks to grasp and define. In short, the risk of making the epistemological error of treating subjective experience as an object of nature. The diagnostic act traces out demarcation lines that always respond to very precise epistemological structures. Diagnosis reflects the world view of the person performing the diagnostic act. Hence, diagnosis is in some sense arbitrary.

psychopathological symptoms. Other diagnostic axes were included to cover also the personality, life style, degree of disability and the environment of a patient. Today we have two predominant psychiatric diagnostic systems (DSM IV, ICD 10). They present careful though arbitrary outlines whose purpose is to simplify the distress-territory so as to communicate through the use of a map shared by everybody working in clinical practice.

3.3. Diagnosis in Psychotherapy

Psychotherapists admit that maps are the unavoidable reality of psychotherapeutic work in our cultural context. However the relationship between psychotherapy and diagnosis is a complex one (Bartuska *et al.*, 2008). The issue has attracted, and still attracts, very different positions in the field of psychotherapy. There is a distinct effort in the various psychotherapeutic approaches to elaborate methods which would enable the assessment of an individual patient that would facilitate the clinical psychotherapeutic treatment he receives. The effort to create *psychotherapeutic diagnostics* (see e.g. Bartuska *et al.*, 2008) is based on the following principal questions (Pritz, 2008): How can we describe diagnostic processes in psychotherapy and is it possible to describe different methods of diagnostics used by varied psychotherapeutic systems and thus set the stage for a conjoint diagnostic practice[8]?

There are several different kinds of psychotherapeutic diagnostic systems. The Gestalt approach as a part of humanistic and experiential traditions considers psychotherapeutic diagnostics not as a fixed system of boxes into which patients are meant to be put, rather it is a system of clues helping the therapist to continuously orientate her/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 patient, the therapist watches the ongoing change of a unique therapeutic process and consequently adjusts his description of a situation in cooperation with his patient.

[8] Psychotherapeutic diagnostics is related to another term frequently used today, which is the *case formulation* (see e.g. Eells, 2007). Case formulation is a method of organizing complex information about the patient, to extrapolate the individual treatment, to observe the changes and to transform the theory and research into clinical practice.

3.4. Gestalt Approach and Diagnosis

Pondered, critiqued and assimilated use of current nosologies can provide a contribution to therapy. It is up to the Gestalt psychotherapist to skillfully include this world and tradition in the relationship, and not just to borrow objectifying grids foreign to the field. Here we find ourselves faced with the paradox of the hermeneutic circle. A circle in which knowledge of diagnostics and psychopathology is at one and the same time a necessary condition and insurmountable obstacle to understanding suffering (Gadamer, 1960, p. 312; Spagnuolo Lobb, 2001b). It is the awareness of this circularity that enables the diagnostic process to become relational.

From a Gestalt therapy point of view diagnosis is a process of naming the emerging meaning of the complex and changeful clinical situation. 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 him/herself in a clinical situation and to consider accurate therapeutic paths. Diagnosis is most useful when kept descriptive, phenomenological and flexible (Joyce and Sills, 2006). The Gestalt therapist co-creates and continuously corrects the diagnosis through dialogue with the patient. 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 patient are important objects of the therapist's explorative interest.

Throughout history, Gestalt therapists either shunned diagnosis[9] or they strived to create its specific Gestalt version (Brownell, 2010). The Gestalt approach has traditionally stood against the objectifying, pathologizing and depersonalised labelling of people (Perls, Hefferline and Goodman, 1951, 1994), 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[10].

[9] There are different kinds of labels, not only the psychopathological labels of the medical classification system. Terms from the field of psychotherapy, including Gestalt therapy, are applied as labels too.

[10] However, in describing clinical cases, the Gestalt approach was still not able to emancipate itself completely form the medical point of view. When we read, for example, descriptions of "introjectors" or "retroflectors" (Perls, Hefferline and Goodman, 1951, 1994; Polster and Polster, 1974), or of people who interrupt the contact cycle in a certain way (Zinker, 1978), it is a similarly objectifying and pathologising perspective, only using different diagnostic labels. (But unlike medical diagnostics, the diagnostic description here is not static but reflects the process and thus signifies the possibility of change). In the later Gestalt approach the field theory perspective and the dialogical approach is now more in

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, Hefferline and Goodman, 1951, 1994). Diagnosis cannot be avoided and so the choice, here, is either to do it inadvertently and negligently, or thoughtfully and with full awareness (Yontef, 1993). Gestalt therapists are aware of the risk that they would treat the diagnosis instead of the patient and their approach would become depersonalized and anti-therapeutic. They are also aware that rejecting diagnostics and differences among people can bring about similar effects (Delisle, 1991).

Although shared clinical and diagnostic models grounded in Gestalt theory have yet to be developed, there have been many attempts to constitute a diagnostic system (e.g. Tobin, 1982; Delisle, 1991; Swanson and Lichtenberg, 1998; Melnick and Nevis, 1998; Baalen, 1999; Fuhr, Sreckovic and Gremmler-Fuhr, 2000; Francesetti and Gecele, 2009; Dreitzel, 2010). These authors invest much effort in the use of terms from both general psychopathology and the theory of Gestalt therapy. It is not an easy task since psychopathological and Gestalt terminology each originate in different paradigms. Authors have often turned their attention to the connection, briefly addressed in the final part of Perls, Hefferline, Goodman (1951, 1994), between suffering and the manner in which contact is interrupted. This kind of analysis offers guidance for the therapeutic process and different interpretative keys (Salonia, 1989a, 1989b; Müller *et al.*, 1989; Spagnuolo Lobb, 2003b).

The Gestalt diagnosis focuses on the way of relating between the patient and her/his environment and describes the processes occurring at the contact boundary[11]. In healthy contact there is a smooth sequence of forming a contact and withdrawing from it. If these processes are blocked, the contact is considered unhealthy (Korb, Gorrel and Van de Riet, 1989). The contact sequence can present drops in intentionality and losses of spontaneity originally described as contact interruptions (Perls, Hefferline and Goodman, 1951, 1994) and nowadays often called modifications or flections of contact (see Robin's chapter on anxiety). Gestalt Therapy studies how and when they can occur. It teaches us to sense these modifications of contact when they are applied rigidly and to offer a wider range of possible ways of contacting so as to support the relationship

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evidence when describing clinical cases. It can be illustrated for example by the development of the concept of "defence mechanisms".

[11] For the elaboration of the term "contact boundary" see a note in the chapter about Psychopathology.

(Perls, Hefferline and Goodman, 1951, 1994; Salonia, 1989a; Spagnuolo Lobb, 1990; Robine, 2006).

A Gestalt reading of relationship suffering has various theoretical instruments at hand:

1. figure/ground dynamics;
2. the self and its functions: ego, id and personality functions;
3. intentionality and the interruption of contact (contact styles and contact sequence);
4. stages in the life cycle;
5. existential and spiritual issues;
6. the relationship ground and history (family, couple, society);
7. the *next step* in the contact and relationship: which relational experience is the subject striving towards?

However, caution is needed here. When partial models from Gestalt therapy theory are used for diagnostics (e.g. the contact sequence and the styles of contact) there is a risk, that the attempt to grasp the clinical situation might betray the theoretical basis of Gestalt therapy. There is hardly any difference in, for example, labelling the patient as "depressive" or as an "introjector". Both cases put the label "there" on the patient and eliminate the vital contribution of the Gestalt approach, which is openness towards encounter and reliance upon the process. Brownell (2010, p. 190) poses a question: «How do we speak *about* the patient without doing damage *to* the patient?».

It is the phenomenological reality of the here and now of the therapeutic relationship, of the contact between the therapist and patient, which lies at the basis of a Gestalt diagnostic methodology. This reality is the framework of reference which the Gestalt therapist should draw from in considering diagnosis. Models need to be built upon this reality to belong strictly to the Gestalt approach and not to a hybrid of other theories which, however valid they may be, are based on different epistemological principles (Spagnuolo Lobb, 2001a, p. 90). In Gestalt therapy, diagnosis is an attempt to read relationship suffering without considering it an attribute of the isolated individual.

Gestalt conceptual tools enable experience to be punctuated, named and communicated. In this way, the patient's experience is translated – though it is also inevitably betrayed. This paradox, however, is useful: the truth of our words – and diagnoses – comes from the fact that they are co-constructed through the contact experience. That is stressed in Gestalt therapy. The resulting diagnosis is not of or about the person; it concerns the relational phenomena that have been co-created, representing the expression and evaluation of the relationship, not the individual. Although

it may be difficult to remain within a relational paradigm, this is the horizon towards which we should most radically be moving.

3.5. How an Extrinsic Diagnosis is Formed

The therapist has the skill to change his/her focus during the therapeutic process. S/he is focused on the relationship with the patient and heading towards a full contact at one moment. Then s/he can switch the focus to the "third", which in this case is a description of the meaning of the situation, and s/he is heading towards orientation and understanding. The therapist cannot be outside the relationship with her/his patient even if s/he diagnoses. But when s/he is making an extrinsic diagnose, her/his intention for the actual moment is to withdraw temporarily in order to orientate her/himself[12]. The therapist temporarily and deliberately gives her/himself time so her/his awareness can organize itself and s/he can name the meaning of it[13]. In this way s/he creates an extrinsic diagnosis, a map of the territory of the clinical situation[14].

The patient and the therapist are not wandering alone through the complex territory of a clinical situation. There is also a third element, the map, which is available when needed for orientation and which helps the therapist and patient not to go in circles. The map is created on the way. The therapist marks many different signs and symbols on the map. They come from two sources: from the observation of the patient and her/his context and from the awareness of the therapist.

Phenomenological observation provides information about the patient: how s/he looks, what her/his bodily structure is, what expression s/he is putting on, what s/he is wearing, how s/he talks etc. Further information is obtained from anamnestic data, either given directly by the patient himself or drawn from other sources (medical reports from the patient's general

[12] We can also say that the therapist temporarily and deliberately relates in the "I-It mode". The therapist's intention is understanding for the moment, which is different from the intention to encounter in the "I-Thou mode". However, we realize the Martin Buber (1923, 1996) concept of "I-Thou" and "I-It" and its integration into Gestalt therapy theory is much more complex, therefore we only offer it here to readers for further elaboration.

[13] This diagnosing activity of the therapist naturally also plays a part in the dynamics of relational processes. The more the suffering of the patient (e.g. psychotic or deeply depressive), the less time the therapist can stand being with him/her. There is a need to diminish the length of contact sequence and the process of making diagnoses allows the therapist to withdraw.

[14] A metaphoric expression of a "metaposition" from which the therapist observes the landscape can be used here.

practitioner, his psychiatrist, or his relatives). The therapist learns about the patient's family, the history of similar difficulties among his relatives, the quality of relationships within his family, the patient's previous and present social situation, the character of her/his existing relationships, the duration and development of her/his suffering, the kind of treatment s/he has already been subjected to, etc. All the data are observed and become one of the sources of a diagnosis as a working hypothesis. Gestalt therapists should have enough clinical experience to evaluate the phenomenological observation and recognize signs of serious suffering of the patients (depressive, psychotic, dependent, etc.).

The therapist and the patient exchange more than just information. They react to each other and, to a great extent, replay their usual patterns of relating. It is a necessary stage of the therapeutic process, for which the therapist does not have to criticise her/himself. On the contrary, s/he personally experiences how the patient's relational field tends to be organized and re-actualised in her/his presence. All that the therapist experiences and what he does is a function of the field and might be used as diagnostic information. The therapist observes with curiosity what is happening to her/himself in contact with the patient and uses her/his awareness (own feelings, thoughts, physical perceptions and impulses in the patient's presence) as a source of information.

The therapist is relating to her/his patient all the time, but the focus of her/his work changes. S/he is either focused on being within the relationship and the intrinsic diagnostic process is leading her/him (see later in this chapter). Or s/he is focused on the "third", an extrinsic diagnosis, a supervisor, etc. (see also the chapter about psychopathology)[15]. When focused on the "third", the therapist uses all the information gained from observation of the patient and his context and from the therapist's own awareness. S/he lets the information organize into a meaningful whole and gives a name to it. This way s/he creates an extrinsic diagnosis which helps the therapist step out of the repeating fixed pattern of field organisation and helps find ways to support a healthy contact. Diagnosis handled this way becomes a therapeutic possibility (Baalen, 1999).

Paul is a fifty year old man with a long history of psychiatric and psychotherapeutic treatment. He is in a long term individual psychotherapy and also uses antidepressant and anxiolytic medication. He comes to a

[15] Both these processes are mutualy interconnected. The separation of the two different focuses is made here for didactic purposes, but in fact both the processes are simultaneously present in the process of psychotherapy. What changes is the figure/ground formation. At one moment the focus on the relationship becomes figure and the focus on the "third" becomes a ground. And at the next moment they change their positions.

session now and reports that his state has become much worse, he is feeling very bad. He has a feeling that nothing has any meaning for him, he experiences only emptiness, thoughts about suicide appear too. With him the therapist experiences heaviness, helplessness and a kind of irritation, a feeling like "Oh no, it's here again!". When the therapist becomes aware of his experience, he realizes it brings him valuable information. Yes, he has already experienced this with his patient several times. The last time was approximately a year ago. At this moment the therapist collects the information coming from his actual awareness, from his long time experience with the patient and from the observation of the patient now. A psychiatric category of a recurrent seasonal depression comes to his mind, he is considering his knowledge about it, its relevance for the situation with the patient now. He recalls what was helpful for him in a similar situation in the past: to reduce demands and expectations of himself and of the patient to a minimum level; to discuss the situation with a colleague psychiatrist; and most of all simply to hold on, keep on coming into contact with the patient. A depressive phase does not last for ever!

An extrinsic diagnosis has served here as an anchor for him, as a "third party" in his relationship with the patient. It helped the therapist to calm down, stay grounded and centered. He can once again be fully present and available for good contact with the patient.

3.6. There are Different Maps

As repeatedly stressed here, the process of ongoing creation of diagnosis is heading towards the horizon of the relational paradigm, where it concerns co-created phenomena, not the individual person. This orientation is essential for a Gestalt approach. However, in their daily practice Gestalt therapists also use diagnostic tools rooted in other paradigms. How to handle this dilemma?

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 the place again and look at the sculpture from some other perspective. One perspective is not enough to meet the sculpture. This metaphor is used here for a clinical situation and diagnosis. There is an epistemological disagreement between medical and Gestalt approaches. However, it does not have to lead to an unproductive conflict: "The sculpture must be seen from this perspective!". Instead, the observer can be more aware of the place from which s/he is observing and what perspective

another place can offer. What we see depends upon our point of observation. With different perspectives we create different maps, different types of diagnosis of the same clinical situation[16].

When meeting a patient, a therapist has a complex experience. S/he can form a multidimensional diagnosis by using different points of view, flexibly changing perspectives from which s/he observes the therapeutic situation. It is important that these perspectives are not treated as hierarchical, as one higher or better then the other. The perspectives do not compete with each other but rather supplement each other to form a multidimensional diagnosis together. Diagnosis must be multidimensional to guide reliably through the complex territory which a therapist enters when meeting a patient. 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 patient with regard to the different dimensions of his life (developmental, current relational, spiritual, psychosomatic etc.), it supports good contact.

The content of diagnosis depends on the perspective from which the practitioner observes the clinical situation. It is most important that the therapist recognizes the perspective s/he is applying at a given moment. If s/he were to confuse the different perspectives, it would make it impossible for her/him to benefit from any of them.

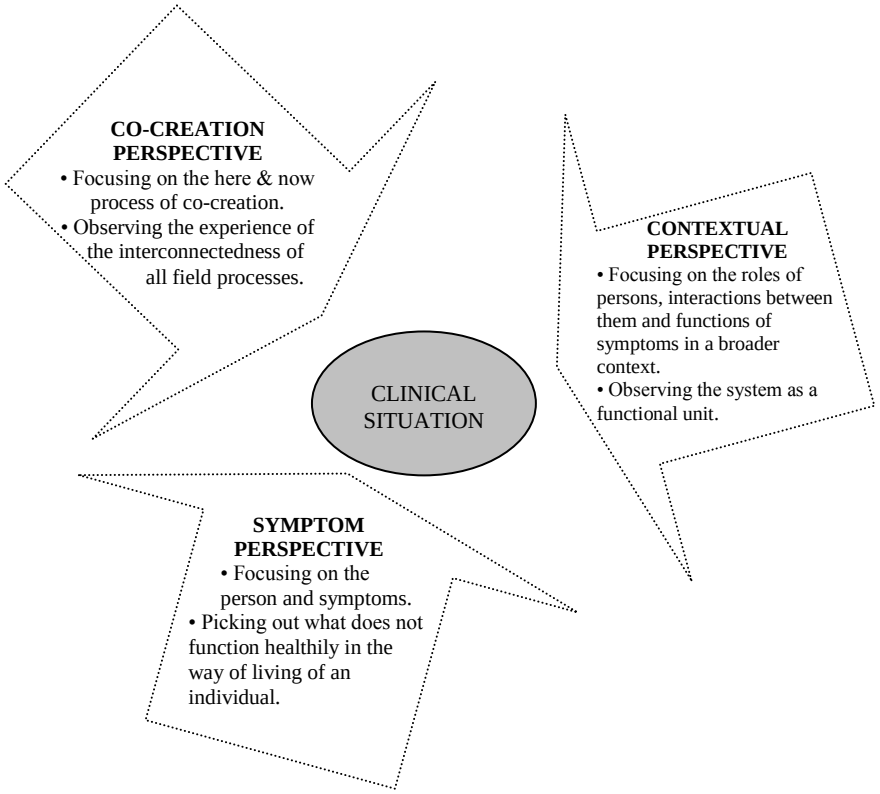
There are three perspectives that can be used by Gestalt therapists when forming a diagnosis. These three perspectives are frequently used in Gestalt literature and they are also very often used by Gestalt practitioners when referring to their clinical work. However, they are often not well differentiated from each other, which causes a theoretical confusion and limits their use for a daily psychotherapeutic practice. We want to offer a tool here for the recognition and use of the three ways of conceptualizing a situation: "co-creation perspective", "context perspective" and "symptom perspective".

With the first perspective, which is a specific contribution of Gestalt therapy to the psychotherapic field, the therapist observes a process of the co-creation of the field organization here and now. With the second perspective s/he observes interactions and roles within a relational system and its story. And with the third perspective s/he observes clinical

[16] We are aware of limits of this metaphor. Changing perspective does not imply to step out of the contact with the patient or going around the patient. All the observation happens within a therapeutic relationship and the observation and relationship are mutually influencing each other. We can also use a different metaphor: to observe and give meaning to our observation we need a *filter* (a specific concept and related words). Observing the clinical situation we can use different filters to get a multidimensional map.

symptoms. Adopting these perspectives deliberately and separately helps the therapist become aware of their individual benefits as well as their limits. With each perspective we create a different kind of map. They can then complement each other and form a multidimensional diagnosis. Each map describes different features of the territory and is useful for different situations.

FIGURE 1: Three Diagnostic Perspectives



The picture shows three possible diagnostic perspectives of Gestalt practitioners. During the process of formulating a diagnosis a therapist is aware of the specific focus s/he is applying when looking at the therapeutic situation. The focus will emerge from the process of contact.

3.6.1. Symptom Perspective: Focus on What is not Working Healthily

It can be difficult for Gestalt therapists to look deliberately from this perspective, because we claim not to be pathologizing and objectivizing. However, it is more useful not to compete with the medical paradigm but rather make use of its value. We need to function within a system that is very much influenced by a medical paradigm. We need to know medical diagnoses for the simple reason that they exist, they are in any case part of the field we live and work in. They are used not only in the field of psychotherapy but also in psychiatry, research, forensics and, last but not least, in popular language. To ignore this aspect would mean shutting ourselves off from our context. As a consequence, we would reduce the possibility of supporting the people entrusted to our care and protecting them from being categorized. Therapists need to know the medical diagnoses to be able to look behind them. Foreknowledge is both a limit and a resource. It does not constitute *a priori* knowledge through which to categorize the subject; rather, it is knowledge to contribute to the field. There is a two-way flow between clinical knowledge and the relationship being created.

Patients often come to therapy with a previous way of thinking and an expectancy gained in a medical context: the problem needs to be identified and an appropriate treatment needs to be found. Therapists need to respect this initial setting of patients to be able to establish a working alliance.

We agree with Wollants (2008, p. 25) that «despite their emphasis on the unitive interactional field, most Gestalt therapists still consider that illness is a category of psychological disturbance that applies to the individual person». What we suggest is to use this individualistic perspective deliberately when useful for the patient, enabling us to distinguish and use fully the perspective of suffering of the "between" (Francesetti and Gecele, 2009) or the suffering of the situation (Wollants, 2008). For a moment, the Gestalt therapist can give her/himself the freedom not to worry whether s/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. These concepts of Gestalt therapy theory are the most valuable guidelines for Gestalt therapists. However, if we apply them obligatorily and rigidly, they also become assimilated introjects. We can bracket them for the moment to use the benefits of a *symptom perspective*.

The therapist can deliberately adopt a *symptom perspective* to focus on the disorders and dysfunctional ways of functioning of the patient. The advantage of such an approach is that the therapist obtains a clear and

distinct image of the risky and limiting features of the patient's suffering (e.g. suicidal tendencies, dependant behavior, traumatizing history). We can say, metaphorically, that using this perspective the therapist obtains a basic image of the territory where s/he is going to travel with his patient. It is a map that describes the dangerous steep chasms and swamps and other traps. The style of travelling and the necessary equipment depends on the territory. Therefore this perspective is of great advantage at the intake-assessment (see e.g. Brownell, 2010; Joyce and Sills, 2006), while mapping a critical situation (e.g. trauma or alcohol dependency) or monitoring the risk (see also the chapter *Assessing Suicidal Risk*).

The therapist consciously focuses on the observation of symptoms[17]. From the individualistic point of view of the *symptom perspective* the therapist observes the individual personal structure and the causality of functioning of the patient: what has caused or contributed to the appearance of symptoms (etiogenesis) and how the symptoms have developed (pathogenesis). The therapist diagnoses the symptoms in the most accurate way possible, critically and comprehensively looking for what is not working in a healthy way for the patient. S/he is applying her/his knowledge of general medical psychopathology and theoretical models of the Gestalt approach (and possibly of other psychotherapeutic systems) to discriminate and name the patient's difficulties, forming working hypotheses on how they appeared and how they are being maintained.

The risk is that the therapist might think s/he has attained the only and definitive image of the patient's suffering. S/he must be aware of the subjectivity and limitations of her/his "symptom" diagnosis. The therapist also has to validate his thoughts through the dialogue with the patient. Questions underlying a therapist's interventions towards the patient might be: "What troubles you the most?", "What diagnosis, 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?".

Alice came to a therapy worrying if she was not dependent on alcohol. During the dialogue with the therapist it became obvious that Alice drinks

[17] In this text the term "symptom" is used to describe the individually specific kind of suffering of the patient (e.g. obsessive anxious thoughts, psychotic state, insomnia, emotional lability, isolation in human relationships and so forth). Keeping the principle of "horizontalisation", the term "symptom" is not used here in the medical sense as a label of the expression of a particular disorder. The term "symptom" describes here the specific kind of suffering as a piece of work of the creative self which displays a personal uniqueness (Perls, Hefferline and Goodman, 1951, 1994). It can even be seen as a "plea" (Sichera, 2001) marking next steps in the direction of finding the needed kind of contact and relationship.

alcohol when she feels great tension and fear. When the tension is not as great, she can manage several weeks without alcohol. Alice has felt greater and greater tension for the last half year. She is afraid something serious is happening to her mental health. There are moments when she experiences a terrible fear that she is going mad. She fears the beginning of a psychotic illness.

The therapist accepts the point of view from which the patient looks at her suffering to establish a working alliance with her. He voluntarily starts to look at the situation from the *symptom perspective* (aware that it is just one of many possible perspectives) because it is the perspective the patient adopts at the moment. Through the reading of suffering the therapist also gets the orientation needed to identify the support which the patient specifically needs.

The therapist and Alice together map her current difficulties. Anxiety, tension and fear appear to be the most urgent for her. The therapist informs Alice that during a period of extreme anxiety the fear of going mad often appears, but it does not lead to a psychotic disease. They find out together that drinking alcohol reduces the tension and makes it survivable for her. Alice obviously calms down, she is able to put aside her fears of psychotic disease. Together with the therapist they focus more on her experience of tension and fear. They explore when the tension appears, when it rises into a panic. And on the other hand, under what circumstances it reduces, and what helps Alice to feel less tension.

3.6.2. Contextual Perspective: Focus on Roles and Interactions

During the dialogue with the therapist Alice realizes that her tension is associated with the great responsibility she is taking over things she cannot influence. For example, she is sitting in a bus and gets very tense while observing a rider catching the green light on a crossing. She immediately imagines all the complications that possibly might happen on the crossing. Similarly she is taking responsibility for the members of her family (if her husband gets into work in time, what mark would her daughter get at school...). Alice is convinced that this responsibility is part of her role as mother. She is taking care of her husband and daughter and they do not help her with any of the housework. When she then stays alone at home, the tension gets bigger, it escalates into a panic. On the other hand, on the rare occasions when she goes out to a wine bar with friends, the tension reduces (alcohol helps here too). When with her friends she frees herself for a while from her image of how a mother should behave.

Diagnosis becomes a pathway along which the therapist accompanies the patient towards recognizing, naming and sharing her/his experience of suffering, towards placing the experience and giving it meaning. From a definition which may be more or less external and extraneous, i.e. "panic attack", the therapist and patient move towards a co-constructed narrative through which the meaning and relationality of the suffering experienced emerges. In our example the therapist voluntarily, consciously changed a focus when observing the clinical situation. He helped the patient discover the context in which her difficulties appear. The therapist has left the symptom perspective and looked at the patient and her situation from the *contextual perspective*[18]. With this perspective the therapist adopts a systemic point of view that deals with circular causality. The symptoms appear within systems of the patient's relationships with other people and they also feed back into and influence these systems. The contextual perspective of diagnosis describes how the patient has been functioning and is functioning in various systems (the original and present family, job etc.). It maps out the roles the patient's phenomenology has played in her/his relationships.

It might seem redundant for Gestalt therapists to talk about the contextual perspective when there is a field theory. However, it is important to distinguish between these two to gain benefit from both of them[19]. There is a difference between a description of an "interaction between person and world" and " the interactional person-world whole" (Wollants, 2008). From the contextual perspective a patient, a therapist and "symptoms" *play a role* in the system but from the field theory perspective they *are functions* of the field. When we describe: "The patient is projecting his fear on me", we describe the situation from a *context perspective,* we are focusing on separated elements interacting in a system. Such a description can be useful because it gives meaning to the therapist's experience of the situation. However, s/he must keep in mind there is also a *field theory perspective* from which the projected fear is a function of a field which is co-created here and now; the symptom, the patient and the therapist are parts of a process of mutually defining each other.

From the contextual perspective the therapist asks: What is the role of the patient's phenomenology? He inquires about the function symptoms

[18] We might call this perspective a systemic one, but we prefer the term contextual, because the word systemic has many different connotations in other psychotherapeutic approaches, e.g. in family and systemic therapy.

[19] 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).

have performed in the patient's personal history. How have they served her? What have they protected her from? What needs have they satisfied? The therapist also examines the purpose they serve in the patient's present relationships. In what way does the symptom present a creative solution to a difficult situation and what limitations the symptom brings? The therapist focuses on the dynamics of the *roles* and *interactions* between the subjects of the systems to which the patient belongs[20].

The contextual perspective of diagnosis focuses on the patient's inner and outer sources of support. The therapist understands the symptoms as the best possible way of coping the patient 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 patient has any other possible roles at her/his disposal. The co-operation between the diagnosing therapist and the patient is dialogical as they co-create the diagnostic description from the contextual perspective together. Questions underlying therapist's interventions might be: "How has your suffering, or this particular way of relating you described helped you in your life? What is its origin? What is its present contribution? At what price?".

3.6.3. The Co-creation Perspective: Focus on Regularities of Field Organisation

From the co-creation perspective the therapist diagnoses the present processes happening at the contact boundary. S/he does not see an individual but rather events happening in "the between". S/he does not see causality (even the circular kind) but rather the interconnectedness of all mutual influences (including the diagnosing therapist). The therapist does not classify the patient or her/himself by any kind of labels. S/he is focused on the permanent process of co-creation, s/he is making a diagnosis of the situation (Wollants, 2008).

A person is seen as the everchanging process within relationships. The process of organizing oneself through contact with the environment, the "selfing" (Parlett, 1991), has certain regularities that are specific for each individual. These regularities of the field organization create individual uniqueness enacted on the contact boundary with the environment at every present moment as well as continuously throughout life. The patient's regularities of field organization meet the therapist's regularities of field

[20] The contextual perspective also includes a transcultural way of thinking (see the chapter *Living Multicultural Contexts*).

organization. The actual field organizes itself as a kind of dance that arises from the interaction of the two original choreographies where also some unique new steps might appear (Jacobs, 2008).

Diagnosis is a process when the therapist's experience enables her/him to discriminate by recognizing patterns (Yontef, 1993). The therapist uses her/his exploration of the therapeutic relationship for drawing a map of the patterns of field formation of the patient's relationships. The therapist explores and maps what kind of contact do patient and therapist co-create, how does the contact proceed and what are its regularities. What patterns of field organization appear in the patient-therapist relationship, which patterns from the patient's and therapist's other relationships come to life there, how they interact and what new possible ways of field organization might appear. The therapist asks: "How do this patient and I co-create the present phenomena of the shared field here and now?".

The phenomena that were seen as "symptoms" from the *symptom perspective* or as a kind of communication from the *context perspective* are now described in a radically different way. For example, instead of labelling the patient as being "depressive" or seeing "depression" as a call to the patient's family, the therapist asks now: "How are we, I and the patient, depressing together here and now"? The therapist explores his own contribution to the situation in which the "symptoms" appear. S/he is also curious what kind of potentiality is present in the therapeutic relationship asking her/himself a question: "What kind of development is trying to come about in this situation at this moment?" (Wollants, 2008, p. 63).

The therapist creates the diagnostic hypothesis dialogically in cooperation with the patient. Questions underlying the therapist's interventions towards her/his patient might be: "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?".

During the next sessions Alice always watches the time very carefully and takes care that the sessions end on time. Later Alice and the therapist explore together how she is taking responsibility for the shared space here in the therapeutic situation. The therapist shares his awareness – he realizes it was partly quite convenient for him when Alice was taking care of the time. And at the same time he experienced a slight irritation that Alice was taking over some of his therapeutic competencies. When they started to talk about their experiences the mutual sharing of new awareness lead to a precious moment of encounter. Later in therapy Alice started to

be aware how her usual way of relating contributes not only to her tension and fear, but also to her loneliness and general lack of meaning in her life.

The therapist co-creates the patient's diagnosis. All that the therapist experiences, thinks and does is a function of the field. While diagnosing, the therapist always also actively transforms the therapeutic relationship. Thanks to a diagnostic assessment made from the co-creation perspective, the therapist is able to step out of a fixed pattern. S/he is able not to re-act to the patient within a repeating fixed pattern of field organization, but rather knowingly to choose a different way or allow a new one to appear. It opens up a space for a change in the stereotypical process of field organization. Indeed, one of the risks of the symptom and contextual perspective is to define the patient and his/her story and environment without being aware that at the same time the therapist is contributing to a co-creation of the suffering in the here and now of the situation.

3.6.4. Different Maps, One Basic Attitude

Gestalt therapists can use several different maps. They can decide which perspective to choose without losing either their Gestaltic competence or any other competence. When it is useful, the therapist can allow her/himself to deliberately focus on the aspects of the therapeutic situation that are well observable using the filter of psychiatric diagnostics. S/he can make use of the medical model and s/he does not need to compete with it.

However, we use the medical model without assuming the medical paradigm as a whole. A Gestalt therapist uses diagnostic systems in a hermeneutical way, which is different from the medical approach (see below). A Gestalt therapist is not labelling her/his patients as if labelling something belonging exclusively to the patient, something fixed and existing also if abstracted from the situation. This would be a medical model position. A Gestalt approach uses all the information coming from that realm as part of a ground in the process of creating a figure of contact: this background, like many others, is unavoidable and what we can do is just be aware of it and use it for what it is: a foreknowledge.

Then, when it is useful, the therapist can allow this particular *symptom perspective* to step back into a background in favour of the other perspectives, the *contextual* or *co-creation* one. It would be a waste of energy if we – as 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 complement each other dynamically. The therapist uses them to give name to a meaning of the therapeutic situation and in this way s/he is supporting the co-creation of the contact figure. When making a diagnosis, s/he is always present at the contact boundary. The therapist might look at different maps to get orientation, but s/he still remains on the journey with the patient and is available for a common wandering.

3.7. Using Diagnosis to Support the Therapeutic Process

The diagnostic description of the therapeutic situation is useful for reflective processes, e.g. when the therapist writes notes after the session or when s/he comes to supervision. It is also useful as a tool for orientation directly during the course of the therapeutic session. And it can also become a therapeutic tool, when the therapist sensitively and safely brings in his diagnostic reflections during the conversation with the patient and they thus can enlarge the awareness of the present situation together. Any extrinsic diagnosis system can be used by the Gestalt psychotherapist, if it is used hermeneutically, that is, in a manner functional to contact.

Considerable caution is needed when using diagnosis as an extrinsic map[21]. As an act which inevitably objectifies, it presents the risk of "inflicting violence" and losing the subjectivity of the person. No map can say all there is to say on the subjectivity of the other: it will always remain a mystery (Jaspers, 1963). How can we bring this type of diagnosis into the relationship without «imposing a standard on the other instead of helping him to develop his own potentials?» (Perls, Hefferline and Goodman, 1994, p. 229)

Two different horizons exist in which to situate diagnosis in therapy: the first is the naturalistic model, the second the hermeneutic model. The naturalistic model implies an objectifying relationship that is not oriented towards intersubjective contact. It is the medical model whereby the clinic maps symptoms and then uses this map for treatment, without concerning itself with the subjectivity of the patient. In the hermeneutic model, on the other hand, the diagnostic process is co-constructed, pooling together the knowledge (and foreknowledge) of the therapist and patient (Gadamer, 1960; Salonia, 1992; Sichera, 2001).

[21] Therapists must be aware of both the general limits and psychopathological limits of maps. For details see Francesetti and Gecele (2009).

The "metaposition" or 'other space' that is gradually co-created with the patient constitutes a 'third' party in which to anchor the therapeutic relationship. It is a space that emerges from the therapist's need to orient her/himself, to read the experience co-created with the patient, and to avoid confluence with that experience. It is a space that emerges from the patient's need to believe that there is a starting point and, therefore, an arrival point.

The objectifying use of naturalistic diagnoses creates a gulf between the patient and her relational context, which may lead to isolation. It can become pathogenic, contributing to creating the suffering perceived and expressed by further wounding the patient's relationships. We need to avoid the latent risk of confusing behaviors with lived experiences, freezing the Other into a category. Alternatively, diagnosis can be a relational process which is co-created through contact and through the truth released through contact.

The map influences the territory in a circular way: the diagnosis made has significant consequences (pathogenic or supportive) at the individual, family and social levels. When part of the relational process in psychotherapy, the intention of diagnosis is to provide support to the therapeutic relationship. Two support functions can be identified: the first lies in giving the therapeutic relationship developmental direction. Diagnosis needs to be able to gauge and communicate the suffering of relationships. What the therapist seeks to bring out is the way that a relationship suffers, and which intentionality needs to be supported during contact. The second support function lies in anchoring the therapeutic relationship in a third party. Diagnosis itself can be a third party, anchoring therapy in an extended corpus of knowledge and experience, in a sedimentary and shared history, in the professional community.

In the therapeutic relationship, extrinsic diagnosis can help support contacting where the patient feels the need to express his experience in words and compare them to the words and background knowledge of the therapist. In this case, diagnosis is part of a much broader process of definition and the construction of personal acknowledgement. Finding the words to describe one's suffering together with the therapist can prove a profoundly meaningful and transforming experience, as it is the result of co-creation within a hermeneutic framework[22]. How diagnosis is brought

[22] Psychopathology is a field strongly exposed to pressures exerted by the political world-view of the time and by the designer of the map: deciding who is mad and who is not in a given context also responds to the logic of power and political utility. Defining power, however, may not only be exercised within a certain social context. It may also be used to define other contexts and cultural sedimentations as a whole, along with the people who

into the therapeutic relationship is clearly much more important than the kind of extrinsic diagnosis used.

Let us come back to the case of Paul, who came to a therapeutic session desperate and could not see a way out. As described above, the therapist has found a description of the therapeutic situation (an extrinsic diagnosis) which gave a meaning to his actual experience with the patient. It has helped to free him from the immobilizing feelings of frustration, helplessness and inner pressure to take too much responsibility. The therapist was ready again to meet the patient. Now, there was a question, how to bring an extrinsic diagnosis into the dialogue with the patient? It was important to choose words and concepts that are already familiar to the patient.

The therapist used a metaphor of "up and down mood waves" that had already been discussed earlier in the therapy and on which they had both agreed as a suitable description of the patient's emotional fluctuation. The therapist offered a description of a current state as a "depressive wave down" now and he showed the curve by hand. He asked the patient, where he would place himself on the curve now. Paul pointed a place at the bottom of the curve and said that he cannot stand it, that it lasts too long and that he does not have the power to handle it. He was desperate, did not see any hope, no jumping-off points.

The therapist assured him he really believed his experience, how hard it was. And he introduced to Paul his image that a person who is deep down on the "depressive wave" cannot see the resources that might be visible from the "wave up", that the experience of hopelessness belongs to the state of being down on the wave. Paul looked up with some interest for a moment, then nodded with agreement.

Together they were recalling, when has Paul experienced a similar kind of state in the past and how long the "depressive wave" lasted then. They discussed their memories and discovered that a similar "wave" had already appeared several times, the last time had been almost a year ago. Paul remembered that each "wave down" lasted about 2 months and the most desperate states lasted each about two or three weeks. The therapist also suggested they explore what has been helpful and what made the situation worse in the past. But this last topic appeared to be too

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belong to or come from such contexts. Deciding to whom the problem belongs also determines who should be brought into play in 'recovery processes': if an individual is depressed, is the problem only his? Or does the problem also belong to the couple? To the family? To the social context in which he lives?

demanding for Paul's actual capacity and they agreed to come back to it at the next session.

The patient and the therapist became aware of a broader context of his current state. The patient's experience has not changed during the session, he still felt hopeless and desperate, but he has received a tool to understand his situation and this has helped him to tolerate his current state. And, most important, he has experienced a contact with his therapist, who wanted to bear this hard time with him.

An extrinsic diagnosis is used to support a being-with-the-patient. It can do this in different cases:

- There is a phenomenon (thought, fear, question, desire...) that appears in the contact and the therapist needs to give meaning to it and choose what to do with it. The diagnostic process is co-constructed by both the therapist and the patient.
- There is a demand from outside (i.e. the health service). The therapist has to bring this into the session and use this given in the process of contact. This is in part a hermeneutical use (to put our knowledge on the table) and in part one of the possible givens in the process of contact.
- After and before the session (i.e. during supervision or in the moment of taking notes) an extrinsic diagnosis is a way of giving names to the experience. It supports the process of assimilation of what happened and also the process of becoming grounded in preparation for meeting the patient.

An *intrinsic diagnosis* is a continuous process during the therapeutic session. An *extrinsic diagnosis* can appear at different moments – before, during, after the session – and has to be used for supporting the process of contact and also for supporting an intrinsic diagnosis.

4. Conclusion

As Gestalt psychotherapists we need both the map (an extrinsic diagnosis) and the sense of direction (an intrinsic diagnosis). The *extrinsic diagnosis* is ground for the work of a psychotherapist. Whenever we create an extrinsic diagnosis we are fixing the particular way the field of the therapeutic situation has organized itself. We focus on the description of the meaning of the present therapeutic situation and we do not focus on being with the patient for the moment. However, if we burdened ourselves with the demand that we should focus on the flow of the therapeutic relationship all the time, we would paradoxically limit our therapeutic

flexibility. A fluent and nourishing flow of contact can develop if we also allow ourselves time to find orientation and meaning, to anchor in a third party, to diagnose.

We can have several kinds of maps, each describing the clinical situation from a different perspective. As Einstein once said: "The theory decides what we can observe". So we can have a map based on observation of the process of co-creation here and now, another one based on observation of roles and interactions within a system and another one based on phenomenological observation of the symptoms. During the process of psychotherapy we naturally develop maps to give meaning to our experience. We cannot avoid making some kind of a diagnosis. All we can do is to remain aware of the process of diagnosing and bring our awareness back into contact with the patient. And we must keep in mind that *a diagnosis is not a description of the person in front of us, it is merely a tool that enables us to organize meaningfully our experience with this person and so helps us to be grounded and present for an encounter.*

The extrinsic diagnosis becomes progressively less important as the therapist gains greater expertise. All travellers need maps to orient themselves, but it is also true that the more experienced a traveller you are, the more you can rely on your sense of direction. Sense of direction is something developed moment by moment during your journey, without the use of too many maps. The *intrinsic or aesthetic diagnosis* is essential in orienting ourselves moment by moment through interaction. It is fundamental in providing specific support in Gestalt therapy. No map will ever be detailed enough to warn us of the potholes in the road and the bends along the track. No map is ever updated to the point of what is happening here and now. This kind of orientation is sufficient when, after having travelled widely and studied countless maps, the traveller is confident of how to move across unknown territories.

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