Skills in GESTALT
Counselling & Psychotherapy

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The very concept of assessment creates a dilemma for many Gestaltists. The idea of deliberately attempting to adopt an objective or 'expert' stance in order to assess or diagnose a client appears to run counter to many of the fundamental principles of Gestalt practice. The objections seem to fall into four categories.

**First**, to give a diagnostic label to a client seems to imply that they are somehow fixed and static and can be reduced to a simple set of words. **Second**, historically and politically, diagnosis has often been used as a means to depersonalize, objectify or oppress. **Third**, it can be used to deny the uniqueness of a client and potentially supports an expert position that claims to have a better understanding than the client has of herself. **Fourth**, it undermines the fundamental Gestalt principle that raising awareness, relational contact and living in the moment are of themselves often sufficient for effective psychotherapy and healing. And if that were not enough, **fifth**, the recognized diagnostic systems are often deeply flawed, unhelpfully reductionist and, arguably, are manipulated by politicians and the pharmaceutical industry (Verhegge, 2004, 2007; Leader, 2006).

However, despite all these justifiable arguments, we believe that there are many compelling advantages to carrying out an initial and ongoing assessment. What is more, we believe it is professionally and ethically necessary to do so.

As we wrote this, we had a discussion about the difference between diagnosis and assessment. It seems to us that diagnosis has to do with 'identifying' an existing or enduring situation – naming it, distinguishing it from others. Assessment is a more evaluative description of the issues or situation and can be more fluid to allow for moment-by-moment change. In our opinion, a formal diagnosis in the psychosomatic world has a couple of limited yet important benefits, which we discuss below. Otherwise, we will be using a looser definition of diagnosis, one that is more akin to assessment and is compatible with Gestalt philosophy and principles.

**ASSESSMENT IS AN INEVITABLE PART OF BEING IN RELATIONSHIP**

We cannot not assess. As we described in Chapter 2, human beings are meaning-making creatures. Our way of making sense of the world can be said to be an ongoing
form of assessment or diagnosis. We observe, encounter and try to understand all the time. For example, in the way we recognize, react to, and form impressions of people. It is almost impossible to miss a person for the first time and not form some opinion, some like or dislike. Often, these processes are barely conscious but are nevertheless a part of an ongoing relational assessment. Without this happening you would not be able to meet an old friend and say, 'I recognize you, feel a warm emotion and sense a wish for closeness.' The same process happens in the consulting room. From the moment of meeting the client, the counsellor is paying attention, in and out of awareness, to a myriad of details and impressions: the age of the person, how he walks, the expression on his face, what clothes he is wearing, his emotional tone and his style of relationship as well as the counsellor's own felt sense of his reactions and responses and how the relationship is being constellated. Surfacing these impressions is the start of gathering important information and an unavoidable part of the counsellor's natural assessment.

Suggestion: Remember the last time you carried out a first assessment with a client (or the first meeting of a new social relationship). What was your first impression, what opinions, judgements and emotions did you have before you knew the person better? You may have described this as 'I had an intuition that ...'. You somehow knew that you could trust him/her; trust him/her ...'; 'I just had a feeling about him,' without any obvious evidence. How accurate did this impression turn out to be in the long run? It is surprising how accurate first impressions can be (and also sometimes how inaccurate). (For an interesting expansion of this see Gladwell, 2006.)

Of course, accepting the reality of this 'out of awareness assessment' presents a tension or paradox that arises in many areas of Gestalt practice. On the one hand, we seek to honour and respect the uniqueness of each client, in his unique situation, in his unique relationship. We also seek to honour his unfolding dynamic process of living in relationship. On the other hand, like it or not, we automatically form impressions and make judgements. It is also true, in our experience, that many clinical phenomena and behaviours do fall into recognizable repeating patterns that have predictable consequences and treatment implications. For example, a client reports that she has had several previous therapies that have ended prematurely. In order to effectively help our clients, we need to be open to see and name the repeating patterns, fixed schemas and habitual styles of contact in order to understand how their way of making contact with the world is contributing to their difficulties. For example, clients with borderline process often need stronger therapeutic boundaries. Narcissistic clients need more attention. Depressed clients are at greater risk of suicide, and sexually abused clients usually have great sensitivity or fragility around their body boundaries. Generalizations like these — if held lightly as possible guides — can sometimes help the counsellor be more effective and safer in her work.

Suggestion: Take a moment to see if there are any fixed or repeating patterns of behaviour in your own life. For example, would you describe yourself as shy or outgoing; are you a 'thinking type' or a 'feeling type'; do you find relationships easy or problematic; do you have any self-critical or self-limiting beliefs? Make a brief sentence of the answers — 'I am ...' (for example, I am someone who doesn't like conflict, I am easily embarrassed). Notice what it feels like to have labelled yourself. Do you find this description of yourself demeaning or is it just a 'description'. What label would you not like to have applied to you and why?

INITIAL ASSESSMENT IS VITAL FOR A COMPETENT PROFESSIONAL RESPONSE

In an 'ideal' therapeutic situation, our client would be a person who knows and embraces Gestalt principles. He would come into counselling with unlimited time and funds and with the sole desire of getting to know himself, engage meaningfully in a therapeutic relationship, become aware of and change some unhelpful patterns, fulfill his potential and see where his creativity leads him! In such a case, an initial diagnosis would not be important and the practitioner would be free to take each moment and each session as they came. From time to time she would review the work with her client, to make sure that he was getting what he wanted. Otherwise, their time would be a genuine journey of mutual exploration.

However, it is rare that clients seek therapy with such an open agenda. Normally, clients want help with some form of psychological distress. Life isn't working for them. Either they are suffering from depression, anxiety or some other inner turmoil, or they are having problems in their daily functioning — difficulties in their relationships, with their job or with some other aspect of the existential challenge of living. They come with a reasonable expectation that the therapist has the expertise to help with the problem in as short a time as possible (and are often only funded for short-term contracts). We believe it would be unprofessional, therefore, if a therapist and client did not address some important issues. Together they need to:

• identify the presenting issue; its current significance and implications, and find out what sort of difference the client wants therapy to make;
• form an understanding of the meaning and implications of the problem;
• identify any risks to self or other that need immediate attention;
• identify any risks or disadvantages that therapy may provoke;
• decide as far as possible whether the therapist is suitable and competent to help with this problem;
• agree an outcome or at least a direction for counselling that is achievable;
• have some way of evaluating whether the ongoing counselling journey is being effective, for example, the client says they are improving and you agree.
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This process will, of course, be provisional and updated frequently as the client changes and moves forward.

FORMAL DIAGNOSIS ALLOWS USEFUL COMMUNICATION WITH OTHER PROFESSIONALS

We believe that if Gestalt is to command respect and credibility in the larger therapeutic field, Gestalt counsellors need to be able to describe their clients in diagnostic terms that allow a dialogue with other psychotherapeutic approaches. This is crucial if referrals to another therapist, GP, social worker or psychiatrist are necessary.

Suggestion: Pick a client you have seen for some time and imagine his GP has asked for a report to enable him to refer him for specialist treatment for his problem (both you and the client agree this is a good idea). How would you describe his problem, the diagnosis, and the focus of your work without using specialized Gestalt terminology?

You will find this much easier if you become familiar with a formal method of diagnosis such as the International Classification of Diseases (ICD) or the Diagnostic and Statistical Manual of Mental Disorders (DSM) (although the validity and accuracy of the DSM-5, even in the psychiatric profession, is increasingly being called into question). These can also be useful in giving access to literature and resources, for example the different types of depression, possible outcomes, suicide risks, relapse rates, associated conditions.

At the simplest level, the use of a label as a descriptor simplifies the process of referral. You might telephone a colleague and ask 'Do you have space in your practice for a person who is suffering from PTSD following a road accident?' and the colleague can immediately have some idea of the nature of the referral and the likely nature, length of time and intensity of the work required.

A FLEXIBLE AND CO-CREATED DIAGNOSIS HELPS TO BUILD THE WORKING ALLIANCE

Quite separate from the formal psychiatric diagnosis is a 'process-focused' Gestalt diagnosis, which is most useful if we can keep it descriptive, phenomenological and flexible, rather than simply defining and naming. Gestalt diagnosis is an attempt to see patterns, themes and repetitions that are unique to the client (a light-hearted example of this can be found at the start of Chapter 2). It is primarily a description of a process, of how the client is behaving in the present moment (in relationship with you and in their current field conditions). It is therefore a description of activity or 'gestalting'. For example, you would describe a 'narcissistic process' rather than a narcissistic person or disorder. Or you would say that the client is 'retroreflecting' not retroflected.

One definition of Gestalt diagnosis is to say that it is a dynamic description of a fixed gestalt (or several fixed gestals) in the life of the client – a process that has become static. The fixed gestalt is a description of a creative adjustment made, at some time, to previous life circumstances, which has become habitual and inappropriate in the present, for example never showing vulnerability based on past experiences with the schoolyard bullies. Therapy is about loosening this fixed gestalt and helping the client to move from this static blissness to a more appropriate response in the present. A perfectly healthy person would live each moment freshly and would therefore have no 'diagnosis'.

We recommend to 'co-diagnose' with the client wherever possible. This should certainly happen at the end of the assessment session, and also at times when you have a strong hypothesis about what is happening. You might share with a client, for example, that you think his current distress may be connected with an unresolved bereavement, or that his bodily tension may be related to a holding back of anger. This also requires the counsellor to translate Gestalt jargon into language accessible to the client. For example, 'You have a lot of held-back feeling' (retroflection). 'You have a strong belief that it is wrong to cry' (an introject or core belief). 'It seems that you never got over the death of your father' (unfinished business). He can then agree, disagree or clarify and help to co-create a more accurate diagnostic understanding. He will then also be actively involved in the understanding of his own problem. It also empowers him to make counselling a shared experience.

ASSESSING SUITABILITY

The basis of professional and effective clinical work is to decide if Gestalt therapy is suitable for the potential client and whether you are the most suitable counsellor (see also Chapter 1). Assessment will allow you to make this a more informed decision in the following areas:

The mark of a competent therapist is to know the limits of their ability and capacity. It is important to have a clear idea of who is out of your range of ability, experience and training or who needs more support than you can offer. A common experience in supervision is to discover that stuckness in the therapy is due to unsuitability. For beginning therapists, this can be the territory of suitability for the modality (see Chapter 1). For more experienced therapists, it is about the question of whether the client is suitable for your particular style – for example, more dialogic, more body-focused, more strategic or more experimental.

Further, clients sometimes present with desperate situations and therapists can feel pressured by urgency rather than a careful consideration of whether Gestalt is the primary modality. This can include a need for help with an immediate crisis, a client who is suicidal, self-harming, or a psychotic illness (current or in relapse), clients who are denying the effects of trauma, or

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with specialized problems such as eating disorders or addiction. (This is one reason for taking some biographical details early in the first session.)

### Suitability Considerations

- Are there any boundary conflicts that might make it difficult for you to be able to work? You should never see a relative, friend, probably even friend of a friend, if you are to avoid a conflict of role or interests (this also includes a relative, good friend or colleague of a current client).

- Are you reluctant to take on the client for personal reasons? The client may scare you, re-activate an unfinished past trauma, or have an issue for which you have a strong negative attitude, e.g., domestic violence. It is probably not necessary to ‘like’ a prospective client but you should at least feel some resonance, interest and compassion. Clients deserve our best efforts, energy and commitment and it is much better to refer on if you cannot be sure of this.

- Do you have a shared ‘theory of the problem’? We make the distinction between a life circumstance (‘I don’t have any friends’, ‘I hate my job’, ‘I can’t find a partner’, etc.) and an issue that they want to understand better, make some change in themselves or accept some responsibility for (e.g., ‘I’m miserable but I think it’s something to do with my belief that am unlikeable’).

- Do you have a compatible ‘theory of change’? You can ask ‘How do you think therapy will help with your problem?’ Some clients just want to lose their symptoms, be told what to do by an expert, gain support, or have a friend because they are lonely. They are not interested in exploring the past they play in it (sometimes called ‘psychological mindedness’). They will expect you to make it different or just want you to be a sympathetic listener. With these clients you need to spend more time talking about a contract where it is clear what the purpose of your meeting will be (and sometimes deciding that they want, or need, such as a treatment modality or intervention other than CBT).

- Is the client sufficiently motivated for what is sometimes a painful and strenuous journey?

- Are you able to make sense of the client’s history and presenting issue? Do you find it almost impossible to get clear information or avoid being triggered into an unhelpful response? Is this a client who, very soon, makes you feel out of your depth? Do they report symptoms or problems that seem unfamiliar to you?

- Is the risk acceptable, in the context of the client’s life circumstances and the setting of the therapy? Might therapy destabilize an important part of the client’s support, for example might exploring a traumatic memory trigger a client into a crisis? (See Chapter 17 for more details of risk assessment).

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### Assessment and Diagnosis

#### Box 5.1

In the initial assessment, we have found that it can be useful to consider these four essential questions:

1. Does the client have a problem that they wish to address? Or have they been ‘sent’ by their GP or their partner who believes that they need help? Are they in the middle of court proceedings and think that a therapist’s report might support their cause?

2. Do they wish to have the sort of therapy you are offering, that is, a focus on awareness and their possible contribution to the presenting issue? Some clients may be looking for a magic solution, or advice about how to behave differently. These clients may expect an instant response and become dissatisfied if there is no fast resolution to the problem.

3. Are they able and willing to work within the boundaries of frequency and duration imposed by the setting of your work (e.g., short-term, weekly contract)?

Part of this assessment will be your ability to make a sufficiently good connection such that you can see the working alliance developing. The client appears to feel understood and you feel engaged and interested in your contact with them. Sometimes you may decide that the nature of their presenting issue means that they need longer-term therapy than you can offer, or referral to a specialist. In this case, you need to resist the urge to offer something just because you want to help, or because the agency expects you to. In these circumstances, we suggest that you might offer a ‘holding contract’ of a few sessions so that the client can feel supported while you investigate what other support might be available.

Even if you cannot offer therapy, you will nevertheless have made a valuable preparation for future therapeutic contact, demonstrating that there are people who are understanding and interested, even if they don’t have a solution to offer. In that sense, you have decided that the client is suitable for a short-term ‘clarifying contract’ but is not suitable for therapy with you or perhaps your agency. In effect, they are suitable for psychotherapy but not with you at this time. The model of four types of contract we offer in Chapter 1 can be useful in helping you decide what you can offer.

Paradoxically though it seems, be careful not to make too good a connection with the client if you are going to refer them on. We cannot stress too strongly how important it is that you don’t make any offer of psychotherapy before you have completed the assessment process, formed a shared diagnosis or understanding of the problem, assessed risk and decided suitability. Many trainees can be seduced by the nature of the vulnerability and are tempted to offer ongoing sessions before completing this process and it is our experience as supervisors that insufficient assessment is a common cause.
of failed therapies. It is why you need to become skilled at referring on or refusing clients, without feeling that you are a failure if you cannot offer therapy to everyone. The considerations should, of course, involve your supervisor who might be more aware than you of your capacities or potential blind spots or whether you are working too hard or close to overwhelm.

In summary

- Is the client suitable for the type of therapy you are trained to offer?
- Does the client want the type of therapy you are offering?
- Are you a suitable therapist in this setting?
- Is the presenting problem and the level of risk acceptable for the length of time you can offer?
- Given your capacity, is the offer of therapy feasible?

METHODS OF ASSESSMENT AND DIAGNOSIS IN GESTALT

Many of the theoretical concepts of Gestalt are themselves frameworks of assessment, for example the zones of awareness, modifications to contact, the degree of support, the style of contact or relationship with the therapist, and so on. It is important for you to develop a way of assessing which is compatible with your own particular style and approach.

The art of diagnosis lies in describing what you see and experience, making sense of this, and understanding how this causes difficulties for the client. You are looking to see how the client functions, what his beliefs are about himself (and the world) and what processes are absent, minimal, appropriate or exaggerated. As you go through a diagnostic overview, several figures will emerge as sharp or interesting. They may or may not be relevant. Part of your skill is to be alert also to what is in the ground, not yet figured for the client but possibly more important. Yontef and Jacobs (2013: 299–338) talk of ‘resistance… to the formation of a figure (a thought, feeling or need) that threatens to emerge in a context judged to be dangerous‘. Some aspects of the client, therefore, are ‘purposely and regularly relegated to the background‘ yet may be quietly influencing what figures emerge. The counsellor will therefore need to be alert (and alert to hunches or intuitions) about what is missing in the client’s presentation, what polarities are absent, what is implied but not spoken about.

Where possible and appropriate, your assessment should be (sensitively) shared with the client who will then tell you whether the particular features, processes or issues you have identified are also important or relevant for him. It can then become a respectful co-diagnosis.

Caveat: Before we identify the traditional list of Gestalt diagnostic criteria we would make the point that they are sometimes viewed as if one could have an objective perspective, ‘the client is reflecting his feelings’, with the implication that this is generally true for the client in his life. We would argue that, in many ways, it is impossible to separate the process of the client from the relational field that is formed at the first point of meeting between counsellor and client. All you see in the assessment room is potentially a response to you the therapist.

The many ways the client makes contact with the world are all responses to different field conditions. Only as you hear the story of the client and hear him describe his historical ways of making contact can you start to identify what is unique to you and him and what is generally true of his creative adjustments in a range of different relational field conditions. This makes it all the more important to check with the client, ‘Is that generally true?’

We have designed a model of assessment that identifies three areas of possible focus:

- The client in process.
- The client’s relational patterns.
- The dynamic field conditions.

Each section contains suggested questions (there are many more) to stimulate your thinking.

THE CLIENT IN PROCESS

Embodied process

This is a description of the activity of the client in the room, his bodily sensations and movement, his energy and his contact functions.

- Movement. For instance, how does your client move – stiffly or in a relaxed way? Does he make a lot of movements or remain still?
- Voice. Is it loud or soft, distant or present, fluid or tentative, emotional or flat? What sort of language does your client use? Is it matter of fact and concrete, or poetic? Does it contain imagery? What kind? Are there pauses in the speech? When? Does the person seem to ‘own’ his experience, as in ‘I can’t make a lasting relationship’, as opposed to ‘relationships never last’.
- Sound. Does he make eye contact? Is his gaze steady or darting? When does he look away, and what at?
- Hearing. Does the client hear what you say easily? Does he hear correctly or appear to mishear or misunderstand?
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- **Feelings.** How does the client experience his inner world of feelings — and how easily can he express them? What emotions does he feel and how intensely? Does he find it difficult to access any feelings at all?
- **Body processes.** How much does he seem 'embodied' or disconnected from his body? Is he in touch with bodily sensations; if so, where? Does he use embodied language, e.g. 'I can feel my stomach turning over as I remember what happened'?

**Support systems**

Rather than refer to internal and external resources as two different elements, we have decided to incorporate them in a single concept of support.

- As he describes his life to you, do you get the sense of a person with enough personal and environmental resources or does he seem to be living always in scarcity or in need of something he doesn't have? Is he using the support that is available or neglecting it?
- Does the client seem to be sitting well-supported in the chair? Is his breathing relaxed and even? Does he appear to be confident and sure of himself or does he appear nervous, restless or rigid with erratic breathing?
- Does he have close friends, strong family connections? Does he feel supported by these people or is he isolated and lonely?
- How does he manage stress? Does he use alcohol or drugs to desensitize, or more healthy forms of relaxation such as exercise, sport, yoga or meditation to unwind and relax?

**Belief systems**

What sense or meaning does the client make of the circumstances relevant to his presenting problem and of his life situation? Does he think life the world is being unfair to him, that if only his circumstances changed all would be well or does he think it is 'all his fault', or all due to bad luck?

- What core beliefs does the client hold about himself, others and the world? What other fixed positions does he take? Core beliefs are central and fundamental to the client's sense of who he is. They often tend to be formed in childhood in response to repeated relational experiences and continue into adulthood, unquestioned, sometimes barely in awareness. Examples of core beliefs are: I am unlovable; other people cannot be trusted; the world is a dangerous place (more healthy people may have more positive beliefs). However, they may also be chosen freely by the client (for instance, a religious or political conviction). They often underlie and justify his creative adjustments and modifications to contact.
- What inner projects are influential? An inner project is an opinion, an attitude or an instruction unquestioningly taken in from the environment as if it were true. They are based on implicit or explicit messages from past influential others (usually parent figures), internalized as injunctions and owned as decisions. Examples of inner projects are 'I can never depend on others', 'I will never succeed'. The person who is under the influence of an inner project feels a strong pressure to conform with the inner project and feels uncomfortable if he tries to go against it.
- Does he have an over-arching positive or negative attitude? How does he see the 'glass' as half full or half empty?

**Unfinished business**

What is still unfinished from the past and presses for closure? Does the client talk about a particular incident as unresolved and the starting point of his problems? (see also Chapter 12).

- Does he describe a relationship, trauma or disturbing event that still troubles him, or he keeps going over in his mind? (see also Chapters 20 and 21).
- Does he describe a reaction to a current event, which you both think is out of proportion to the actual reality, for example an irrational fear of making a small mistake and losing his job? (If so, consider that it might be re-triggering a past trauma.)

**Example**

Every session with Janice seemed to return to the theme that her life had been ruined by her cheating partner, and however much the therapist tried to bring her back to her presenting issue of managing her anxiety, somehow the conversation always circled back to her indignation at his behaviour. Janice seemed unable to resolve this compelling figure.

**The client's relational patterns**

How the client describes his relational experiences with other people and how he makes relational contact with you is a crucial part of the assessment process. You can begin to form a picture of how he constructs his relationships generally, his anxieties and avoidances, his attitudes, his flexibility and his style of contact. You can also identify how he makes or breaks relational contact with you in the assessment process (e.g. his modifications to contact — see Chapter 11).

The client may be present and make good contact, or he may appear not to listen, or interrupt what you say. His way of relating may change suddenly depending on the issue or relationship that he is describing. All this gives you important information about him, and you may form an impression of a particular style of relating you think is significant or problematic. It is important, as we said above, having made some sort
of assessment of your client, to gently explore with him whether this is a common pattern in his life, and whether it is a problem to him:

- Does he know his patterns of relating? (For example that he keeps other people at a distance because he fears becoming dependent, or jumps impulsively into new relationships.)
- Does he describe repeating patterns, e.g. 'everybody leaves me in the end'?
- Does the pattern happen with you in the session, for example, do you feel pushed away? Or strongly invited to agree?
- Does he want to address this relational pattern in the therapy with you?

The last point is another way of including the client in the process of his own assessment. It is not a label imposed upon him from outside, but a shared picture of an individual co-creating a relationship.

**Example**

The counsellor was aware of feeling more and more pleased with himself as he interviewed Beverley for the first time. It seemed that all his observations were 'spot on' for Beverley - she responded as if all his suggestions were inspired. After a while, he decided to check out a hypothesis. In a friendly and humorous way he said, 'You are giving me the impression that everything I say seems to be absolutely right. That's very nice for me of course, but wonder whether you generally have a tendency to support and agree with what other people say?'

Inevitably, Beverley said, 'Yes I do, how clever of you.' There was a pause as they both realized that she had done it again. Then they both laughed and she repeated in a much less adapted tone of voice, 'No really, I know I do that and I think that it may be part of the problem.'

The counsellor's intervention served several purposes. It checked out the validity of his observation and hypothesis, it investigated Beverley's capacity for self-reflection, it tested out whether she could withstand a gentle confrontation and it explored how she responded to humour.

**Suggestion:** Imagine you are sitting next to a stranger on a long-haul flight to Australia. He or she turns out to be (astonishingly) similar in all respects to a particular current client. How do you think you would get on? What sort of relationship would start to form? What would happen next? Try this as an exercise of self-supervision about both the overt and the underlying relational dynamics.

The relationship you have with a particular client will be different from any other relationship you make, and uniquely co-created.

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**Transference and counter-transference**

All the responses you have to your client and his to you are important. They may also reveal transference or counter-transference (see Chapter 13). Is he treating you consistently, are you surprised or puzzled by his relational expectations of you? How would you describe his way of relating to you? Does he listen and respond appropriately or does he appear not to hear you, argue with everything you say or alternatively agree very readily as if keen to please? The way he is modifying contact may be an indicator of how he is perceiving you in the relationship.

What about your reactions to him? Are they typical of your way of responding to new people? Or are you responding to him in a way that is unusual, for example excessively gentle, distant or surprisingly challenging? Might this be an indication of the impact he also makes on other people in his life?

- What feelings and images do you have in response to the client in the first session?
- Who does he remind you of?
- What metaphor would you use to describe him (for example, like an express train, like a frightened animal)?
- What reactions do you have to your client's appearance (e.g. their clothes, hair, face, skin colour)?
- What has most impact on you as you listen to him (his voice tone, the rhythm of his speech)?
- What is your body resonance (for example do you feel tense or relaxed, energized or passive as you sit with him)?
- As the assessment process continues, how does your client respond to you - as a support or as an adversary?

**Field conditions**

The field conditions are the context, the situation and the influences, both local and global, that determine the meaning of everything you are assessing about the client, or more accurately, 'the client in his situation'. Every situation is part of a context, and a figure cannot have meaning without ground.

**What are the dynamic field influences?**

- What general life circumstances are influencing the client at the moment (e.g. illness, economic hardship, relational difficulties)?
- What is the life stage or concerns of the client (young, single, career track, family-maker, mid-life, retirement, etc.)?
Cultural factors

An awareness of the importance of race and culture in the consulting room is, of course, important throughout the counselling process, but at no time is it more important than at the assessment stage. Both counsellor and client bring, as part of their ground structures, a wealth of values and assumptions — most of them not in awareness — ranging from the right way to behave in different situations to the definition of healthy living.

These considerations are true in a sense, for any relationship. Even if client and counsellor come ostensibly from the same cultural group, there will be many different assumptions and beliefs. They may both be influenced by what could be called the multi-cultural dynamic of their lives — their family, their school, friends, associations, travels, jobs, etc., as well as the mini-culture of, say, northeast England, as opposed to south. What is more, there is another level to the inter-cultural element. The therapeutic relationship is one where, however respectful and mutual the counsellor, there is a power imbalance. How could there not be, when one of the two people has come to the relationship feeling distressed and having the experience of not coping well in her life? She puts herself in a vulnerable position and, anyway, is not sharing his own vulnerabilities. Imagine the additional dynamic reaction when in the example in the previous sentences, we chose to describe the client as female and the counsellor as male.

This can be particularly striking where counsellor and client have different racial identities. The counsellor who is involved in any sort of inter-cultural or inter-racial counselling can familiarize herself as far as possible with the more obvious differences. However, she must remember that there will be countless subtle assumptions made — particularly if one of the pair is part of the dominant culture. She must be ready to explore phenomenologically and sensitively, and she must be even slower to define or label (see also Chapter 25).

**BOX 5.2 CHECKLIST**

What are the obvious differences between you and your client in the following areas?

<table>
<thead>
<tr>
<th>Culture</th>
<th>Race</th>
<th>Nationality</th>
<th>Age</th>
<th>Religion</th>
<th>Physical ability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class</td>
<td>Gender</td>
<td>Sexual orientation</td>
<td>Power</td>
<td>Political affiliation</td>
<td>Personality style</td>
</tr>
</tbody>
</table>

What implications might this have for the client, for you, for your relationship? What are the pressures on you in your culture about these differences, for example prejudice (positive or negative) or fear about a particular group? What difficulties might you foresee, and what might you do to address these?

The historical field

- What stressful or significant events have happened in the past year? The last few years?

The presenting issue of the client is often the consequence of a creative adjustment that was made long ago and has now become a fixed gestalt. Much of this may be out of the client's awareness and only understandable with knowledge or remembering of earlier field conditions or difficulties. Some of these influences will emerge naturally in the course of therapy, but some will not. In order to understand fully what the client is bringing, the counsellor may need to investigate not only the current field, but also the historical field. Taking a history is subordinate to the here-and-now situation, but it has many advantages.

**EXAMPLE**

Nerys had come for counselling because of relationship difficulties. The counsellor worked dialogically 'in the present' for many weeks with some success, but was puzzled that the relationship did not seem to become deeper, given Nerys's obvious need for this kind of support. It was only when the counsellor actively investigated her history that the following information emerged. Nerys had been fostered several times as a child, after being abandoned by her parents, and had no experience or expectations of supportive or consistent relationships. She had not thought it relevant to mention this to the counsellor and only gradually started to see how she was not open to forming a stronger working alliance with the counsellor.

Suggestion: Ask the client to take a large piece of paper and draw on it a line all the way across the middle (a 'lifeline'). Ask her to write her major events on this line, such as her first school experience, first girlfriend/boyfriend, first job and other major life events. This may take some time, and the line may have to be re-drawn as she remembers more and more; she may start to draw the line with natural peaks and troughs. Then ask her to step back and look at the whole to see what patterns start to emerge. Is there a theme of disappointment or loss for example? Are there periods of engagement and periods of isolation? What is the most important part of the lifeline for her? This diagrammatic representation of the client's life can be very revealing. You can also ask her to chart her emotional reactions to these life events on the same piece of paper, using a different colour pen. Also ask for a chart of positive events or people as potential remembered resources.
**COLLATING THE ASSESSMENT MATERIAL**

On the next page is a Client Assessment Sheet, to help you collate the information and themes you have gathered in your first meetings with the client. You may wish to use it after the initial session as a way of thinking about your client, and then add to it from time to time as other important information emerges. Be aware of what you notice, but do not try to make sense of it all within the session – you need to be in the present moment too! In fact, it is rare for a busy counsellor to have the time to consider in detail all of the elements in the sheet and, in practice, certain aspects will be more figural and will form your provisional initial diagnosis. This is why we suggest taking up to four sessions to complete the assessment process.

**THE ASSESSMENT OF RISK**

There are many situations where the therapist needs to anticipate potential risk or danger to her client or even to herself. Among these may be when there is risk of suicide, self-harm, violence or mental illness, or when the problems involve addictive behaviour, eating disorders or personality disorders. Other risk situations may be those involving children or criminal behaviour. The elements of risk may be obvious at the initial assessment, but may also emerge during the course of therapy. In either case, before you accept or continue to work with such clients, you need to check whether you have enough specialist knowledge and arrange appropriate supervision. We suggest you read Chapter 17 for a fuller discussion.

**CONCLUSION**

A Gestalt diagnosis is an understanding or assessment of all the ways the client makes meaning and contact with his world. We believe it to be most effective and most respectful when it is co-created with the client (and indeed therapy outcome research described by Duncan and Miller (2000) stresses the importance of a shared view about the nature of the problem, its causes and treatment). The assessment you make of your client will, of course, be a part of 1–I relating rather than 1–Thou. However, if it is sensitively and respectfully carried out, it can be something in which the client can be fully involved. Its completion can provide a feeling of containment, understanding and structure for both the counsellor and for the client. As therapy progresses, the counsellor will move between modifying or updating the assessment and a bracketing of all of this to allow a full engagement and openness to the possibility of 1–Thou relating.

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**CLIENT ASSESSMENT SHEET**

<table>
<thead>
<tr>
<th>The client in process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embodied process</td>
</tr>
<tr>
<td>Support systems</td>
</tr>
<tr>
<td>Belief systems and introjects</td>
</tr>
<tr>
<td>Unfinished business/fixed gestals</td>
</tr>
<tr>
<td>The client's relational patterns</td>
</tr>
<tr>
<td>All the nature of the relational contact with you</td>
</tr>
<tr>
<td>Your reactions and responses</td>
</tr>
<tr>
<td>Field conditions</td>
</tr>
<tr>
<td>Significant current circumstances</td>
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<tr>
<td>Significant historical events</td>
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<tr>
<td>Significant historical relationships</td>
</tr>
<tr>
<td>Cultural factors and issues of difference</td>
</tr>
</tbody>
</table>
### Recommended Reading


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### 6 TREATMENT CONSIDERATIONS

#### IS 'TREATMENT' A USEFUL CONCEPT?

As with assessment and diagnosis, we are aware that we are taking a somewhat controversial position in devoting a chapter to what we are calling treatment considerations, treatment planning or strategic thinking (we use the terms interchangeably). Although many Gestalt authors use the concept of treatment planning (for example, Shub, 1992; Keper, 1995; Yontef and Fuhr, 2005; Delisle, 2011), there is still an understandable reluctance to see the concept as useful to a Gestalt therapist. In some therapeutic models, treatment planning, like diagnosis, can seem like a detached, alienating process where an ‘expert’ categorizes and labels the person in order to apply a standard treatment. This approach can be seen at its most extreme in the treatment of mental illness with psychotropic drugs in some hospitals. The totality of the person in her unique situation is lost and the patient herself is only consulted superficially, if at all, about her treatment.

In addition to these reservations, some Gestaltists see treatment planning as incompatible with the formation of a dialogic relationship and with the natural, spontaneous emergence of new meanings that flows from healthy relational contact. We see the validity of these objections and take them seriously. However, we believe they need to take second place to such issues as the anticipation of possible risk and the particular needs associated with different presenting issues.

We propose then that a good treatment plan will take into account the unique circumstances of the client and be sensitive to the dangers and objections identified above. It will be discussed and agreed with the client wherever possible and will be responsive to changing field conditions as therapy progresses.

A typical treatment plan would initially include the following considerations:

- any risks or dangers (see Chapter 17);
- relevant knowledge from previous clinical experience or clinical literature about the kinds of issues presented;