IDEAS FOR GESTALT ASSESSMENT IN BRIEF THERAPY

by Gaie Houston

Fore-Contact

What happens before you meet may have a profound effect on your whole work together. I am fond of quoting the strap line from Chaos Theory, that:

***There is sensitive dependence on initial conditions in non-linear systems*.**

Therapeutic encounters are ephemeral, but may turn out to be most potently influential non-linear systems.

In training you have learnt to be sensitive to nuances of what people do in entering, in greeting, in how they chose a seat and sit, and so forth. You have probably also learned not to be over-confident of all these first impressions you form. Intuition scores some bull's eyes, and at least an equal number of wides. The client is working away as sensitively as the therapist, noticing the therapist's behaviours and omissions; the difference is that she may not have learned to let data lie around on the desktop of her mind before filing it. The therapist who is unwittingly showing in her lacklustre eye the signs of last night's party, or who has attempted to stuff a nasty phone call out of awareness before need allows, may, without wanting to, give a prospective client some alarming data. The evidence is that once there is some bond, some shared experience, then a pale face or a mishearing or other error is likely to be far more tolerable to the client. He has good experience to set alongside a moment's bad experience of the therapist.

I have laboured this point, because I see it as massively important in brief therapy, where it may be wasteful of the client's time to spend some of the therapy on *iatrogenic* issues. This medical word means 'originating in the doctor'. It is a word to keep therapists humble.

Certainly there are people who come to brief therapy who have trouble trusting people, and that may show from the start, and may be the primary focus of the work. What I am talking about here is an unhelpful imposition of the therapist's way of being, so that it distracts the client. I am also talking about the nervy nature of the beginning, and the usefulness of respecting and allowing for that.

Even before you meet, many events may prejudice how you perceive each other. When a manager tells an employee he had better go for some counselling, this prescription may sound shaming or punishing rather than an attempt to be of use. When a doctor says to a counsellor that she can do nothing with a certain patient so hopes the counsellor can get somewhere, the counsellor may feel some dread or hopelessness, before ever clapping eyes on the person spoken of.

A robust referral system is intrinsic to the work, and in Primary Care or Workplace Counselling Gestalt therapists are advised to offer seminars where referral criteria, and methodology, including clarity about the extent and limits of confidentiality, can be agreed, with all the people involved. This is an aspect of the holistic view encouraged in this approach. If a Gestalt Therapy Group is available, some people maybe routed there at this early stage. Not only the therapist needs to keep awareness of Paul's [1967] dictum about

what treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances.

There are many many other pre-contact phenomena that will colour the first contact. You do not have months in which to unravel whether an apparent surliness in the client at your first meeting is to do with something profound in her, or something superficial about the circumstances of your meeting.

Careful supervision helps guard against falling into counter-transferential swamps. The supervisee as well as the supervisor needs to be specially careful to examine her own processes as well as consider the larger field.

Contact

There are two major paths to choose from in Gestalt Brief Therapy [GBT]. One path is to rely on your ability as a therapist to make good sense of the absolute present, of what happens between you and the client when you meet. You will have only a limited number of sessions together, typically six if you work in the NHS. This means that you keep in awareness what may be colouring the first contact for both of you. Of your meeting. Using this path, the structure of the contact is the diagnostic tool. The beginning of therapy is likely to be more influential on outcome than later parts of it. What happens in the first seconds of meeting is just as likely to colour the whole episode of therapy.

In a first meeting, the patient may or may not have a sense of his need, of what he wants from the therapy. Not infrequently he will say that the doctor thought it might help, or that his manager sent him. Raising awareness of the nature of a talking therapy is thus an important early step. A willing patient may assume that he is to be a docile passive recipient of a Treatment, albeit one that requires from him a confessional input, as indeed would a visit to the doctor.

Patient in Charge

Learning something of the interactive and co-operative task the therapist has in mind, will encourage some people, and dismay others.

So, even in such a short episode of treatment, I recommend the therapist at the end of the first session to ask the client or patient to think over whether he wants to continue, and to get in touch about this in some specified way at or within an agreed time, but certainly not before having time to sleep on the decision. If you use a pre-meeting questionnaire, it might well include a sentence such as:

Some of what you write here may in itself help you think about your difficulties in a new way. It will also help us both decide if and how we can best work together when we meet. After our first meeting you will have until X to decide if you would like to continue seeing X for the remaining X sessions.

Many people have told me that this small device has helped them to feel committed and in charge of their own therapy. It also gives reflection time to the therapist, and an opportunity for her to refer on at this stage.

This is the exit of the first session. Before it comes, the hope is that the patient has had time to describe what is troubling him, and to say what he wants from the therapy, if he can at this stage, and to form an impression of the therapist and her way of working.

On her side, the therapist does what she can to take on board the patient's way of looking at the world.
The therapist sees if she concurs with him about the task of the therapy, and consults him about her first impressions of what the task is for them and how they might go about it. As I have implied earlier, the contact or emotional process has particular salience in this method.

Indeed, in brief therapy, it is as well for the therapist to bear in mind that this meeting may be not just the first, but the only one she will have with this client.

The tasks of the first or early sessions include

- Forming an impression of the contact boundary created between the two
- Focussing on the therapist's impression of whether she can create enough trust to allow a therapeutic bond to develop
- Finding out as much as she can of what the client has brought as a difficulty
- Filling out the client's impressions of the therapist and her task
- Formulating , in co-operation with the client, a first picture of what seems to make him tick.
- Feasibility – coming to a tentative agreement about what aspect of the client's life or difficulty needs to stay foreground

During assessment, as generally in the work, the primary focus of awareness for the Gestalt therapist is often most usefully on the I-Thou, on the quality of contact with the patient. From this, and from the nature of interruptions to it, a tentative picture can be drawn of the likely work of most of the whole episode of therapy. Communicating this to the patient, and negotiating the future work in the light of his reactions, begins the process of shared responsibility **which in itself constitutes part of the healing process.** It is also of great use to the therapist to be able to describe her insights, guesses and observations in a more I-it language and discipline, to herself, and perhaps in supervision. An aid to this is provided by Paul McHugh of Johns Hopkins University, in his book, *The Perspectives of Psychiatry*. These perspectives are the framework for descriptive formulations, and are used in some of the foremost psychiatric institutions in the world.

They are also so much in the spirit of Gestalt Therapy, in their holism and respect for the idiosyncrasy of each patient, that I offer them here. They are an aid to raising awareness of the field in which the patient perceives himself. The new field of the therapist and patient as a system is attended to in the opening of dialogue, and the attention to the contact boundary I outlined already. Assessment needs also to include an evaluation of whether the therapist is in her and her supervisor's judgement well enough suited to the needs of the particular patient. This may emerge partly from the first formulation, a method for which I suggest at the end of this note. First, here are the foci, mostly on the other, which McHugh outlines. He recommends that proper attention is given to

- *What the patient is.*
  This includes all that is readily measurable, such as age, marital status, position in family and so forth, to include general social history. In other words, these are the facts-about, rather than the value given to them.
- *What the patient has.*
  By this he means the symptoms, signs and difficulties the therapist is told or otherwise becomes aware of. In Gestalt language, these may often be perceived as interruptions to contact, reported, or in the here-and-now.

- *What the patient does.*
  This is the here and now of behaviour, and the phenomenology generated in response in the therapist. It extends to cover patterns of behaviour the patient reports or demonstrates. Here are many clues about counter-transferential response, the way the therapist takes up the dialogue, and how else she might, to be of more use to the patient.
- *What the patient tells.*
  McHugh calls this the rich poem the patient has made of his life, to make sense of it. It is of great importance. But without attention to the other perspectives, it is insufficient background.

He insists that it is never enough to pay attention only to one or two of these areas. Noticing all these perspectives means being as aware as possible of the whole of the person and one's first responses to him.

With awareness in these areas, the therapist can make a tentative formulation about how to work. As a way of learning this method, many students find it useful to write down one-paragraph answers to the following:

- **I notice:**

  Here you write concrete data, both the patient's history in the general sense, and your own phenomenological response.

- **I imagine:**

  This paragraph contains your formulation, or first guesses about what makes the patient tick, what you imagine is needed in the field, and how you suppose you might best focus in the therapeutic dialogue - what you see yourself needing to keep as foreground.

- **I want:**

  Here is a first essay at an outline of what as therapist you need to do, in the light of your suppositions about the other person. With few but important exceptions, this will involve negotiating and modifying your ideas with the patient, so that both of you can work together to raise awareness.

REFERENCES

McHugh Paul and Slavney P. (1986) The Perspectives of Psychiatry. Baltimore: Johns Hopkins University Press.