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Gestalt Therapy Approach to Psychopathology

by Gianni Francesetti, Michela Gecele and Jan Roubal

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1. The Suffering of the Relationship at the Contact Boundary

For Gestalt therapy, a continuum exists, without clear-cut distinctions, between healthy and so-called pathological experience. It is on this conviction that all attempts at diagnostic categorization and nosology have always been treated with caution (Perls, Hefferline and Goodman, 1994). The value given to momentary experience and to the contingency of each and every situation underpins the legitimacy and the value of all lived experiences. It is this value that prevents the crystallization into fixed *Gestalten* of people and their experiences.

This consideration of ours first emerges when reflecting on the question "how can we treat psychopathology in Gestalt therapy?". And how can we do this without falling back onto categories which crystallize experiences and patients?

Etymologically, the word "psychopathology" consists of three roots: 'psycho-', '-patho-', '-logy'.

Psyche, meaning *soul* in Greek, derives from *psychein*: to breathe. *Patho*, from the Greek *pathos*: affection, suffering, derives from *paschein* (indeurop.): to suffer. *Logos*, in Greek: discourse (Cortelazzo and Zolli, 1983). Hence, psychopathology is a discourse on the suffering of the breath, of something elusive, which cannot be confined within a stable object form.

It is the suffering of the animating breath, the suffering of the animate[1] living body (in German: *Leib*), not the object-body (in German: *Körper*)[2]. All living bodies are living precisely because they have intentional contact with their environment (Minkowski, 1999). Psychopathological phenomena concern subjects as they interact with the environment, or more precisely, the *interaction* of subjects with the environment. At this point, we come to a radical bifurcation. We can focus on psychopathology as either the suffering of the individual or, alternatively, as the suffering of the field: this suffering becomes manifest in the individual and can be transformed by the individual: the individual is an organ of choosing of the field (Philippson, 2009). This change of focus opens up two very different universes and two profoundly different ways of approaching psychological suffering.

These two perspectives on the reality of mental suffering can be likened to the two perspectives through which light can be understood in physics: is it a wave or a particle? Reality depends on the way we investigate the world. Psychopathological phenomena are much the same. Psychopathology can be considered a phenomenon belonging to the individual or a phenomenon emerging from the field, belonging to the *Zwischenheit*[3], to quote Buber (Buber, 1993; Salonia, 2001a; Spagnuolo Lobb, 2001a, 2005a; Francesetti, 2008). In more strictly Gestalt theory terms, it is a phenomenon that happens at the contact boundary[4].

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[1] In this text, we shall not use the noun *soul* but rather inflected and adjectival forms of the verb *to animate*, to refer to living beings in their condition of being animate, and hence concerned with vital interaction with their environment.

[2] For the distinction between *Körper* and *Leib* in psychopathology see Galimberti, 1991.

[3] The between (Buber, 1993).

[4] The often-used term "boundary" is somewhat misleading because it implies that there is a Country of The Client and a Country of The Therapist with a dividing line in between the two – the contact boundary. This is a structural and static model. Gestalt therapy's focus on process would be better illuminated by another metaphor. Imagine the therapeutic relationship as a football match (a friendly one hopefully). The ball then represents the contact boundary. It constantly changes its position and is the focus of attention for both parties all the time. This is the point where the contact of the two teams is happening at every

Our epistemology is founded on the consideration that experience does not strictly belong only to the organism, nor only to the environment (Perls, Hefferline and Goodman, 1994; Spagnuolo Lobb, 2001b, p. 86; 2003b; 2005a). Rather, experience emerges as a "middle voice" at the contact boundary. The experiential figure that emerges contextually from the ground (constituting the continuum of experience) is a figure that *belongs* to the individual (for example, in a discussion group, no two people have the same experiential figure). At the same time though, it *does not belong* to the individual (again, in our discussion group, the figure of each person also belongs to the others because it is from the others and through the others that it emerges and takes shape) (Robine, 2011). Returning to psychopathology, if we view such phenomena as emerging at the contact boundary, then strictly speaking it is not the subject that suffers. What suffers is the relationship between the subject and the world: that space which the organism experiences and in which the organism becomes animate. Psychopathology, in this view, is the pathology of the relationship, of the contact boundary, of the *between.*

The subject is the sensible and creative receptor of this suffering: the subject can feel pain.

Suffering may be perceived and creatively expressed by the subject, but it emerges from the contact boundary. The agent of this feeling (of all feeling) is the self, which is a function of contact. For Gestalt therapy, psychology is the study of what happens at the contact boundary (while what happens inside the organism is the realm of biology and physiology, and what happens outside the organism is the realm of sociology and politics) (Perls, Hefferline and Goodman, 1994). As such, psychopathology must necessarily refer to the suffering of that boundary. This approach entails a number of important consequences.

Psychopathology is not simply subjective suffering. Psychopathology is the suffering *of the "between"*. The presence of this suffering can be felt by anybody standing in the relationship: the other or a third party. Suffering is perceived by the organism but it does not belong to it, neither in terms of origin nor cure. Suffering emerges and develops within a relationship (Sichera, 2001, pp. 17-41; Salonia, 1992) or, in more strictly Gestalt theory terms, in the space to which it belongs and in which it is generated: the contact boundary. Hence, psychopathology can be understood as knowledge concerning the suffering of the animating breath, of the *between*, of the contact boundary. The animating breath, the *between*, and the contact boundary are not entities belonging to the individual, but rather living spaces that emerge through contact. Psychopathology is an emergent property of the contact boundary[5] perceived by the individual.

Psychopathology is not simply subjective suffering. Subjective suffering may exist without being psychopathological, that is, without the suffering of the *between* (in this case there is pain, but no harm). On the other hand, subjective indifference (without perceived pain) can be psychopathological if the *between* suffers (in this case, there is harm even though there is no pain). Not all suffering felt by individuals is necessarily unhealthy (for example, grief, which is suffering but not psychopathology), while a pathology is not always perceived by individuals as suffering (for example, with psychopathy that leads to violence). To orient ourselves more clearly through psychopathology, we need to move beyond sole reference to the individual and consider the relationship (Salonia, 1989c; 1999; 2001a; Spagnuolo Lobb, 2003a; 2003b). The question leading us is no longer "is the subject suffering?", but rather, "is the relationship suffering?".

We do not see the individual as the bearer of the psychopathology. We describe patterns of functioning rather then types of people, we talk for example about anxious or borderline processes rather than people. (Greenberg and Goldman, 2007). This enables us to see psychopathology from the field theory perspective, where the psychopathology phenomena are not attributed to either side of the contact but rather they are functions of the field.

Psychopathological suffering comes from and expresses a lack of significant contact[6], and is all the more serious the more precocious and fundamental the relationship is for the development of the self and the growth of the organism. The individual sensation of this suffering is a manifestation of awareness (which is

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

[5] On the concept of emergent properties, see Bocchi and Ceruti, 1985; Waldrop, 1992. «At each level of complexity, entirely new properties appear. [And] at each stage, entirely new laws, concepts, and generalizations are necessary, requiring inspiration and creativity to just as great a degree as in the previous one. Psychology is not applied biology, nor is biology applied chemistry» (Anderson quoted in Waldrop, 1992, p. 123).

[6] In this regard, see the perspective offered by phenomenological psychiatry: Minkowski (1927); Binswanger (1963); Tatossian (2003); Borgna (1989; 1995; 2008b); Galimberti (1991); Callieri (2001a).

always awareness of and at the contact boundary)[7]. As the suffering belongs to the relationship, it may happen that not all the parties involved feel it.

An example can be given by a man whose relationship history has left him with a narcissistic suffering: he cannot feel the pain of the relationship between the couple, which is only felt by the female partner. The fact that she is suffering (from a profound sense of loneliness and sadness, for instance) does not imply that it is she who should be treated to overcome her troubles (perhaps with anti-depressants). Rather, her distress is a *healthy* sign showing that their relationship is in need of support. In this case, therapy should assist him to feel the pain of their relationship, which will probably reveal past relationship wounds that he guards without touching.

Children also very often cannot recognize and express their psychological suffering when the relationships they are a part of suffer. They cannot speak up and say "I am suffering", but instead manifest physical disturbances or learning difficulties at school, hyperactivity or aggressiveness towards their companions. However, if someone who can perceive what is happening at the contact boundary comes into contact with the child (or the family), s/he will feel the suffering that afflicts the relationship. Psychopathology can be felt as subjective pain, for instance when anxiety or melancholy grips us. However, it can also be a suffering that is perceived only by others, where the pathology – the suffering – lies precisely in the fact that the individual is incapable of feeling pain (as in the case of people who act violently). Almost paradoxically, in this case, the purpose of support is to help the person become capable of feeling pain. Becoming aware of the suffering of a relationship is a cure in itself.

The shift towards an essentially relationship-based view of psychopathology sheds new light on pain and the relationship between pain and harm. If relationship pain is given insufficient support, it becomes unaware and hence self-destructive. It becomes harm.

2. The *Third Party* as Constituent of Relationship

In order to understand psychopathological experiences, not only do we need to go beyond references to the individual, but also beyond the dual relationship. A relationship never consists solely of two people; there is always a third party (Spagnuolo Lobb and Salonia, 1986; Fivaz-Deperusinge and Corboz-Warnery, 1999; Irigaray, 2002; Salonia, 2005b; Spagnuolo Lobb, 2008b). Our field theory already implies the presence of a background that gives meaning to the figure: in different situations different figures can emerge from the background that anchor – and give meaning to – the present relationship. We can call these figures, with this function of anchoring the relationship to the larger field, *third party*. For example, in clinical work, the supervisor functions as a crucial third party. In a supervision group, a colleague tells us how difficult her work is with a patient with narcissistic suffering: she often feels impotence and humiliation, she is "never enough for him". What supports her in those moments is to remember the support from the supervisor and the group, from this she can feel herself more grounded and remember that her feelings belong to the field and are not "absolute definitions" of herself. In this way she can breathe and stay present with her patient. The group is working as a third party: it provides ground and meaning to the therapeutic relationship. Another colleague describes his feelings with a patient: he has wanted to speak about this therapy for at least two months, but he feels shame about this relationship. He thinks he's falling in love with her. He is aware of the risks and at the same time he loves these feelings: he wants to help and save her and in some way he thinks that the group cannot really understand her needs. This revelation opens up a lot of important things, about the patient, the therapist and the group, and provides a good and solid ground for going on with this therapy. One of these is the awareness that his love for the patient is a healthy and generous feeling that can support their relationship, he must just keep the group with him in the therapeutic room. This is not something he has to do deliberately, it's enough to have brought his patient into this larger field, to have received support and recognition for his feelings and her needs, and to keep the contact between the therapy and the group. This functions as a third presence that avoids "craziness" in the dual relationship. In case of difficulty, during or after the session, he can ask himself: "What would the supervisor or the group say if they were here in this moment?". It can be a question that supports him in this phase of the therapy. Another example could be helpful: an abusing family is sent to therapy by the public social service because the young daughter suffers from intense anxiety symptoms. Two therapists start working with them. In supervision they report that

[7] On the concept of awareness in Gestalt psychotherapy see Perls, Hefferline and Goodman, 1994; Perls, 1969; Polster and Polster, 1973; Salonia, 1986; Yontef, 2001a, and for a more recent review Spagnuolo Lobb, 2004b.

during the sessions nothing is brought that can be considered "pathological" in classical diagnostic terms, but to stay with this family – to enter into contact as a third party – just to sit with them, gives a feeling of being dirty and involved in a spider's web that is almost unbearable. They are functioning as a third party that can feel the suffering of the relationships in that family. So, psychopathology is not only an issue of the subjective feelings of the implicated parties: we should always ask "what would a third party feel at that contact boundary?". A person present at the contact boundary of a relationship that suffers would feel pain or distress. On a general and social level, a third party is always present (Bruni, 2007; Cavarero 2007; Žižek, 2002): society, the people bordering on the relationship, humanity as a whole: what effect does the relationship have on them? What do they stand to lose? And how and to what extent does what happens contribute to determining a certain "blindness" in society and in people surrounding the relationship? In this sense, torture, indifference to one's pain or to the pain of others, the dominion over others, and the failure to listen, all fall within psychopathology, just as anxiety and depression do. In all these cases, relationships suffer. This triadic perspective is fundamental in reading both distress and the possibility or impossibility of providing support. The presence of the "third party" (Lévinas), of "the other Other" (Derrida), in relationships is also an ethical issue, touching on the very meaning of human life. This was, especially for the twentieth century, and still is, a philosophical issue of great importance[8] which opens up and addresses other disciplines, such as sociology, anthropology, politics and psychology.

Where psychopathological suffering is most serious – concerning issues of fragmentation and the non-boundary between the individual and the world as happens in psychosis – it is crucial that the therapist support the consistence of the third party, by functioning as ground her/himself. For example, a patient tells me about his delirium: he is spied on by a secret agency, that is mysteriously and continuously checking if he is suitable to work for them. The therapist can't talk to him about this unquestionable figure: this would immediately become a challenge between his definition of reality and the therapist's definition and would implicitly confirm his madness and the therapist's mental health. The therapist must function as background where this figure can emerge, waiting and searching for the meaning that is carried by this suffering. He is the ground in the sense that he keeps and holds the basic conditions of the situation that are almost lost in a psychotic field: he continues to breathe, to sit in her/his chair, to feel the time flow, the floor and the space between, to keep hoping for the emergence of a shared meaning. He feels the background and doesn't lose it and in doing so s/he provides the ground for the patient and for the relationship. He has to trust that, even in such a condition, there is a contact intentionality that is striving to emerge. In doing so, he takes on in the relationship the role of a third party, of an environment able to contain the relationship, and provides it with its essential existential space-time coordinates. In this containing environment, archaic and interrupted intentionalities can re-emerge and find a way to reach the therapist in a more healthy contact. Sometimes everything appears so fossilized that even breathing seems an overwhelming challenge. It is important to create an atmosphere that supports the emergence of archaic – mad and incomplete – relationships (which seldom have reached the point of I/you separation). The therapist must be available to feel, bear, give ground and, in some way, to be contaminated by this field without wanting to affirm her/his definition of reality (Benedetti, 1992; Stolorow *et al*., 1999). In this stage the relationship is filled with anguish and projections: the therapist has to dwell in this atmosphere, to be the ground that allows this phenomena without getting lost and trusting that by her/his presence the mist and obscurity will become more and more clear. In this process the patient will define her/himself and put down roots in the therapeutic relationship.

Only at a later stage can the therapy change and the therapeutic relationship present here and now become the figure and focus of the work. At that moment the patient can begin to see the therapist as an *other*. And it is now that the therapist can let the relationship rest on the "external" third party, always present as the ground, horizon and frame of reference. The therapist no longer needs to provide the basic ground to the relationship. Gradually, and with great effort, that ground has become a shared, consistent heritage, both containing and founding. So, an important diagnostic element lies in the overwhelming need for a third presence, as a touchstone of reference to avoid going mad and to find legitimacy in a world perceived as new and without given certainties. In a psychotic field, not only the patient but the therapeutic relationship itself reveals an immense need for support: if there isn't enough support, one of the risks is confluence with the patient against the context, for example. The therapist can blindly feel a duty to save the patient despite and against the limits of the care service, the family, the society. The strong need felt for a third party can be a pointer to the degree of seriousness. It reveals the extent to which contact experience has been uprooted from the world commonly taken for granted, from the ground given by assimilated contacts.

[8]See, for example, the work of Lévinas and Derrida.

We need to consider that this third party is implicated not only in therapy but also in psychopathology. Indeed, for most serious disturbances, treatment may be difficult, not because there is no cure, but because the environment (from the family to society) would need to be broadly changed, and often this is not possible. At times, the patient may progress to establish a healthy relationship, in which s/he does not suffer, with the therapist, but not outside the therapeutic setting. As our founders pointed out, it is not only the patient that "needs" to change, often it is the family and/or the social context that is "ill".

The *Folie à deux* – a situation of confluence where two people share the same delirium and psychotic field – can be understood as a dual relationship where the third party (the relational network, the work group, the context) provides no support. In this case, awareness is lacking of the need for anchorage in a third party. As we said before, even the therapeutic relationship runs the risk of confluent "shared madness". In this sense, a sort of isolated space-time may be created, disconnected from the larger field. This risk may occur due to the relationship history brought by the patient, due to the limits of the therapist, or due to the limits of the context (the third party) that can be too weak. These three components, of course, are not separable; however, prying them apart can be useful, especially to stress the third. Among the limits of the context we have to take into account the way every society defines what is normal and what is not, what symptoms need to be cured and what behaviours need to be modified (see chapter 10).

To summarize our perspective, psychopathology is the suffering of the contact boundary. It may or may not be felt as subjective pain. When the subject does not fully perceive that which happens at the boundary, no subjective pain is felt. However the other, or a third party, may feel it. From a clinical point of view, it is not the pain which is pathological, but rather the impossibility of sustaining it and of being fully aware of it at the individual, family and social levels. In order to reduce subjective pain, it is the *between*, the boundary, which is made to suffer. In this way, the level of pain perceived is lowered, but so is awareness. In developmental terms, this capacity to reduce unsustainable pain is a creative adjustment that protects the individual, the family, and society. But now, that same capacity inhibits the individual from feeling, living, and acting to the full, from fully experiencing the self and the environment with which he is in contact.

Full experience is healthy experience, produced by the co-construction at the contact boundary. It can be recognized by the creation of a bright, harmonious, strong and graceful figure (Perls, Hefferline and Goodman, 1994; Bloom, 2003). For such a figure to be formed, it is essential that the self is fully present at the contact boundary. For the self to be fully present, it needs sufficient support (Perls L., 1992). Unsustainable pain becomes anaesthetization, and thus the incapacity to perceive the self or the environment/other. When sufficient support is provided, the subject is present and can feel pain. When insufficient support is provided, the subject is in some way absent and unaware at the contact boundary, and can act with cruelty or self-destructiveness. One way of preventing and curing harm at the social level is to provide support for pain. This gives us an ethical key and a political perspective to our work as psychotherapists.

3. Healthy, Psychotic, Neurotic Experience

In trying to differentiate these three dimensions of human experience, we want to remind you that we are not defining people, but a way of experiencing in the here and now, in the present situation. This kind of experience – healthy, neurotic, psychotic – is an emergent phenomenon at the contact boundary, so it is always co-created. This means that during the session, the therapist contributes to building one of these kinds of experience. S/he can also contribute to the creation or fixing of a psychotic experience, so it is important to be aware of these different dimensions, to be able to recognize them and to know how to stay with them (see also specific chapters in this book). Another preliminary point: healthy, psychotic, neurotic, are not proposed here as categories, but as dimensions. This means, firstly, that an experience can be more or less psychotic, neurotic or healthy – nevertheless they remains three different types of dimension; secondly, that all of us have the potential for experiencing these dimensions: there is a dynamic threshold that probably depends on the situation, circumstances and personal dispositions.

Now, let us try to focus on what are the characteristics of healthy experiences and how we can evaluate them.

We can identify some elements that have to be present in healthy and ordinary experiences from a Gestalt point of view. Healthy experience is a process of contact with a novelty present as a potentiality in the environment, it implies a co-destructuring that makes the novelty assimilable and also time for the assimilation itself. The result is a growth of the organism (Perls, Hefferline and Goodman, 1994). Each

situation is in some way new: healthy experience is the meeting with the incessant novelty of life. It is by definition unique and nourishing: unique because the encounter with the novelty is unrepeatable (if not, it is not a meeting with something new), nourishing because the result is a growth of the organism (if not, there has not been a nourishment).

In neurotic experiences contact with novelty at the contact boundary is dimmed: there is reduced contact with the potentialities present in the field. This limitation is realized by the so-called contact interruptions. These were healthy protections of the organism when they were established, the best way to be present in past relationships, but then they became unaware habits – fixed *Gestalten* – that limit the possibilities of being present in the relationship. The neurotic experience is not unique, but rather stereotyped, and not nourishing, since there is not a full meeting with novelty to be assimilated.

In order to understand psychotic experiences, we have to consider another element of the healthy ordinary experience. We define as "ordinary" the experience that is built on a common and shared ground of time, space and boundaries. In this case, there is a defined subject that experiences a defined world, and they are part of the same texture of time and space, a common world where subject and objects are separated and connected. This seems obvious because it is our usual way of experiencing. But it is exactly this structure that is disturbed in psychotic experiences[9] where the common ground is lost: the boundaries that *separate* and *connect* the subject and the world are disturbed, causing a loss of differentiation such as "people can read my thoughts", "my intentions can cause a financial disaster", or "I can feel myself far from the others, without any connections or without future". The defined subject/world structure, necessary for ordinary experience, is not a basic state of human life, it is rather how we build our experience moment by moment. In our senses there is not a radical differentiation between subject and object, this separation is a cut that we – pre-cognitively – make in each moment. The reality as we usually know it is an *après coup* that emerges at the contact boundary. The subject that experiences here and now is continuously being created through an *opera* of differentiation at the contact boundary. The self is an emergent phenomenon (Philippson, 2001). Before the emergence of "my" self, there is an undefined self "of the situation" (Perls, Hefferline and Goodman, 1994; Robine, 2011). We can feel our stability as subjects thanks to the personality function, but it is not a primitive data of our life[10]. Psychotic experience is characterized by a lack of this ground, a distortion in space, time and boundaries that brings an unbearable anguish: the world is finishing, at least as the person was used to experiencing it. As a consequence, psychotic phenomena emerge: melancholic depression and schizophrenic sufferings may perhaps be situated on a continuum where at one pole at the contact boundary there is no connection and at the other pole at the contact boundary there is no separation. Melancholic or manic experiences happen when the subject is disconnected from the situation (disembodied from space/time of the situation, disconnected from the between); schizophrenic experiences, when the boundaries are not defined and what is outside can be felt inside and vice versa (Francesetti, 2011). In these situations delirium and hallucination can provide a sense of reality and certitude that is less terrifying than to be completely disoriented and lost in an uncertain nonsense. These fixed protections often make the experience stereotyped. In this condition, the sequence of contact can't flow because, since there is not a process of differentiation, the consequent possibility of encounter is lost: the novelty is not identifiable as object, it is like an overwhelming wave, the unconstituted subject can't destructure it, so the novelty cannot be met and assimilated.

Both neurotic and psychotic experiences are unable to meet the novelty, they are not nourishing, so miss two fundamental conditions of healthy and ordinary experience.

We can consider these two kinds of suffering as qualitatively different from healthy experience and at the same time possible for everybody, under certain circumstances. On the other hand, a person in this kind of

[9] Other non-ordinary experiences, with distortion of the common ground, are, for example, mystical experiences and experiences under the effects of drugs. So, not all non-ordinary experiences are unhealthy, that means they can be unique and nourishing experiences.

[10] We are in the vein of the findings of phenomenological tradition and of psychiatric elaboration of this philosophy. Phenomenologists (see, for example, Husserl, Heidegger, Merleau-Ponty 1945, Maldiney 2007, Kimura) teach that our experience is generated before the separation from subject and object, from self and world: at the very root of our experience there is the common ground where *something* happens. It is the embodied borderland (Callieri, 2001a; Maldiney, 2007) where time, space, boundaries are created moment by moment. It is the realm of the id of the situation, where something undistinguished moves (Robine, 2011). These are the phenomenological transcendentals that make our ordinary experience possible: our normal experience is made of time, space and boundaries. When these fundamentals, that constitute the ground of our ordinary experience, are altered, the experience is done in a psychotic (or for example mystical) way (see also chapter 20 on psychosis).

experience is never reduced to it alone. As Minkowski said, it is as important to know "how much" a patient is schizophrenic as it is to establish how much s/he isn't. Even though we can see a continuum between them in the experience of a specific person, and even rapid passages between them, it is important to keep in mind that neurotic and psychotic are two qualitative different experiences.

We could also say that an experience is as healthy as the person's ability to be present and aware at the contact boundary, and that neurotic and psychotic experiences are two different ways of being absent from the contact boundary. This consideration brings us to the issue of evaluation.

Indeed, one of Gestalt therapy's revolutionary concepts is to have established an intrinsic criterion to evaluate experience. In order to establish whether an experience is pathological or not, we don't need an external criterion with which to compare what is happening in the contact: a healthy experience is an experience of a good *Gestalt* that has grace, strength, harmony, rhythm, fluidity, intensity etc. This criterion is aesthetic[11] because it is an implicit knowledge that comes immediately from our senses: we can directly feel how good is the *Gestaltung* – the process of figure forming. Presence and aesthetics at the contact boundary are the same phenomena: a complete and full experience is aesthetic. Aesthetic evaluation is not a cognitive judgment: it is an implicit knowledge, in the sense that it is pre-verbal and pre-cognitive (D'Angelo, 2011; Desideri, 2011). The distortions of these attributes are the ways through which we can perceive in the here and now the contact interruptions: the suffering of our co-constructed experience, the limitations of our present contact, the degree of our absence. On the aesthetic criterion is based the intrinsic diagnostic process (Bloom, 2003; Francesetti and Gecele, 2009; see also chapter 3 on diagnosis). When we are in a psychotic field, a specific aspect we can feel is the need for a third party – often as fear – as we described above. This is the way the therapist feels the unbearable lack of ground in the field, it is again an intrinsic evaluation, perceived by senses at the contact boundary.

4. The Co-ordinates of Gestalt Psychopathology

From a Gestalt perspective symptoms are products of a creative self and display human uniqueness (Perls, Hefferline and Goodman, 1994). Psychopathology is a co-creative phenomenon of the field, which represents a unique creative adjustment in a difficult situation. When it becomes fixed, it stops serving the needs of the individual and his/her environment, it narrows the individual's spectrum of potentials. The symptoms are viewed not as discrete items but as a narrowed spectrum of functions (Zinker, 1978). The symptoms indicate limited flexibility in the reactions of the client. S/he is then limited in her/his ability to have fluent contact with her/his environment. S/he is not able to act in accordance with his actual need but his behaviour and present experiencing are determined by fixed patterns. He follows a habit, not a deliberated choice (Yontef, 1993).

Psychopathological symptoms are phenomenologically observable manifestations of fixed *Gestalten*. These rigid patterns cause suffering of the contact boundary and of relationships (of course the individual contributes to the organization of her/his relational field). They become a figure also in the therapeutic relationship: both client and therapist are co-creators of the psychopathology which emerges in their relationship. Therapists can step out of the rigid field formation using their awareness. In that way they give support to the relationship and offer to the clients a chance of widening their spectrum of possibilities. The therapist provides a contact experience that was missed by the patient and which s/he was seeking (Salonia, 1989c; 2001a; Spagnuolo Lobb, 1990; 2001a). In this sense symptoms are always a plea for a specific relationship: a kind of contact where the symptoms are not needed anymore (Sichera, 2001). In this sense a panic attack can be a plea for a relationship where there is enough support from the mutual belonging, a kind of contact that provides enough support for stepping forward into the world (see also chapter 24 on panic disorder). Standing at the contact boundary helps the therapist to understand the contact difficulty affecting the relationship, and what to do to provide the relationship itself with support. In Gestalt therapy terms, the clinical understanding of suffering is founded on a range of co-ordinates that trace out an epistemological profile. It is on these bases that we believe a Gestalt perspective of psychopathology can be founded, which we would go so far as to call Gestalt Psychopathology, defined as:

Phenomenological: that is, not interpretative but concerned with understanding lived experience. Lived experience, under this approach, is granted full and unconditional dignity and validity. This position brings

[11] Aesthetic comes from the Greek *aisthesis*, to perceive by senses (Spagnuolo Lobb, 2003b).

us in line with the epistemological approach taken by phenomenological psychiatry (Jaspers, 1913; Merleau-Ponty, 1945; Binswanger, 1963; Minkowski, 1927, 1999; Callieri, 2001a; Borgna, 1989; 2005; 2008b; Kimura, 2000; 2005). Fixed *Gestalten* cause relationships to suffer by inhibiting full contact from being made with present reality. It is for this reason that Gestalt psychopathology treats the categorization of experience with caution, and avoids the categorization of subjects. The experience of psychopathological suffering is anthropologically "normal". It is accessible to all human beings. All human beings may find themselves expressing the more or less serious suffering of a relationship, for which a continuum exists between healthy and psychopathological experience.

Relational: in the sense that:

1. Psychopathology is the suffering of relationships. The subject and object of treatment is not the individual, but the relationship that emerges at the contact boundary. It is the relationship that the psychotherapist treats, by standing at the contact boundary. What suffers is the contact boundary, and it is the contact boundary that is cured through therapy. The origin of distress and its cure lie in the relationship (Salonia, 1992; 2001a; Spagnuolo Lobb, 2001a; 2005a; Sichera, 2001; Yontef, 2001a; Philippson, 2001). Subjective suffering does not coincide with psychopathology: subjective suffering may exist without psychopathology, and psychopathology may exist without subjective suffering. Indeed the latter case is perhaps the most common.
2. Lived experience is co-created within the relationship (Spagnuolo Lobb, 2003b; Stern *et al*., 1998). Even the fundamental experiential co-ordinates of boundaries, space and time, along with energy and vitality, are not functions of the individual but functions of the relationship upon which they also depend (Salonia, 2001a; Francesetti, 2011). In therapy, the patient's suffering has to be understood as an emerging phenomena of the therapeutic field (Robine, 2011; Spagnuolo Lobb, 2001a; Stolorow *et al*., 1999).
3. It focuses on the moment and the way in which the spontaneity of contacting is interrupted, and intentionality is left without support (Spagnuolo Lobb, 2001a). At that moment, the self is not fully present at the contact boundary, and the therapist intervenes to support the relationship. What is interrupted is not, strictly speaking, contact, but the spontaneity of contacting. Contact (the relationship here and now) lacks the necessary support to maintain the intensity and the harmony of the intentionalities in play; it cannot attain the novelty that could emerge from the co-creation of the contact experience in all its field's potentialities. The energy which underpins intentionality is either lost or channeled elsewhere: intentionality is distorted[12] and the arrow does not reach its target[13]. The contact episode goes through all the phases of the contacting pattern, but without the strength and beauty that would otherwise emerge if all the intentionalities in the field were gathered and expressed.
4. Relationships are never dual: as we have seen, there is always a constituent third party, to which they are open and which restricts them.

Temporal: time and space are co-created by the patient and the therapist. The therapist accommodates himself to the space-time of the patient and (by co-building the experience) modifies it. The more fragile the ground of the patient (and hence the greater his suffering), the more the therapist will need to take responsibility for establishing and safeguarding the space-time coordinates of the relationship (Spagnuolo Lobb, 2003a; Francesetti, 2011). Time is a constituent of the third party. It roots and situates the relationship in a history, thus making a narrative which builds bridges with the Other possible. Essentially, a subject can only be such insofar as he is a subject of a history. Time and reality are correlated (Salonia, 1992; Maldiney, 2007; Irigaray, 2008). The relationship gives meaning to time, though time also gives meaning to the relationship. This is why, for example, it is possible to cure a temporal pathology, such as a mood disorder, through the relationship (and not just understand it phenomenologically).

[12] «[…] this is a possible definition of psychopathology for Gestalt therapists: the spontaneity is interrupted (excitation becomes an anxiety to avoid); the intentionality is distorted; the contacting carries anxiety (which is unaware, forgotten) and happens via introjecting, or projecting, or retroflecting (we could add egotism)» (Spagnuolo Lobb, 2001a, p. 62).

[13] «The arrow does not always reach its target. Due to lack of energy or direction, it may drift off the trajectory that leads to the target, interrupting the sequentiality of stochastic processes. […] Even the interaction between organism and environment does not always achieve the full contact towards which it tends. At a certain point, the process, or sequentiality (Polster and Polster, 1973), is interrupted. Lived time breaks away from relationship time, contact is interrupted, and the organism develops a pathology, a dysfunctional behaviour» (Salonia, 1989a, p. 78).

Holistic: suffering is not just mental. The suffering of the relationship is perceived by the subject in its whole and through experience, which is always corporeal. The mind/body dichotomy is a neurotic divide (Perls, Hefferline and Goodman, 1994; Kepner, 1993; Frank, 2001; Salonia, 1986; Spagnuolo Lobb, 2004b). Moreover, suffering is always phenomenologically visible at the contact boundary where lived-bodies emerge: the inter-corporeity is the dimension where suffering reveals itself and it can be met and cured (Merleau-Ponty 1945; Salonia 2008; Frank, 2001).

Oriented towards creativity: the suffering of a relationship is the outcome of creative adjustments made within a difficult field. Original creativity may have been lost and have become a fixed *Gestalt*, though it may still have held positive meaning in the person's life (Perls, Hefferline and Goodman, 1994; Zinker, 1978; Spagnuolo Lobb, 1990, 2003b, 2005a). This can easily be seen in neurotic adjustment, where a creative adjustment made at some stage in a person's history results in her diminished presence at the contact boundary. The case of psychotic experience is different. Psychosis is the expression of a lack of basic ground. Here, the goal is not to restore awareness of interrupted contact, and in so doing assimilate it, with the result that the possibility for new creative adjustments is restored; rather, the task of the therapeutic relationship is to build a ground that has never been created (Spagnuolo Lobb, 2003a; Salonia, 2001a; Conte, 2001)[14].

Situational: suffering is always determined by a given situation, and it is from the context that it emerges. Situation does not just define psychopathology: it is fundamental in generating psychopathology or in protecting a person from it (Robine, 2011; Salonia, 2007b; Gecele and Francesetti, 2007). An exemplary case is given by the well-known Stanford Prison Experiment (Zimbardo, 2008)[15]. Depending on the context, a type of suffering (for example, narcissistic suffering or panic attacks) may be a symptom which is rare and isolated or endemic and normal; it may be valued and rewarded, or it may cause disadvantage for the person expressing it. Salonia observes that all social contexts promote the emergence of a "basic relational model" which is supported and rewarded in the specific historical and cultural moment, becoming the norm for relationships in that context (Salonia, 2007b; 2008b).

Developmental and *next* oriented: all suffering has a history which holds the key to its meaning. The symptom is the trace left by the past on the present relational field crossed and actualized in the here and now. Of these traces, relationship experiences from infancy hold significant weight in the development of the self, and hence for the seriousness of the disturbance (Pine, 1985; Salonia, 1989b; 2001a; Stern, 1985; Wheeler and McConville, 2002; Spagnuolo Lobb, 2003a; Righetti, 2005; Mione and Conte, 2004). There are many understandings that try to relate infant researches with Gestalt therapy (Salonia, 1989b; 2001a; Frank, 2001; Wheeler and McConville, 2002; Spagnuolo Lobb, 2011a), focusing on how the competences to contact are acquired or missed. What is missed emerges in therapy as a need for a specific and new contact experience. This is the relational need that the patient is looking forward to satisfying – or of which to become aware and be recognized – in therapy, it is her/his interrupted contact intentionality, it is at the same time her/his history and her/his next step. All suffering has its relational "next" towards which it is oriented and which illuminates its meaning (Polster and Polster, 1973; Salonia, 1989c; 1992; Spagnuolo Lobb, 2007c; 2008b). In giving support, the fundamental question orienting the therapist is "towards which relational experience is the person headed?" The answer to this question marks and points the direction of therapy. For example, the narcissistic suffering carries on a needy part that has not been possible to express in any past relationship; in the contact this part is hidden and covered by shame; the "next" of the therapeutic relationship is to provide the conditions to let this part emerge as a relational need.

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[14] On creativity in psychotic experience, Margherita Spagnuolo Lobb writes: «Creativity, a human quality exercised freely in situations when spontaneous contacting is possible, is limited: it cannot be relaxed, and what could appear to us as an artistic eccentricity is in effect a hard-won solution, charged with anxiety, which attempts to hold a catastrophe in check. I do not mean that there is no creativity in the experience and behavior of psychotics, but rather that theirs is a creativity that does not resolve a grave existential anxiety, at least until such time as it is recognized within a meaningful relationship» (Spagnuolo Lobb, 2003a, p. 340).

[15] The experiment consisted of creating a prison setting in which one group of students played the role of detainees, and another group the role of prison guards. In less than one week, the experiment had to be interrupted because the level of violence exercised by the "guards" had become dangerously unacceptable. One of the main conclusions drawn from the Stanford Prison Experiment was the demonstration of the pervasive power, however intangible, of situational and contextual variables.

Aesthetic: the criterion that distinguishes what is healthy and what is unhealthy is intrinsic to the relationship (see above). It is an aesthetic criterion: being healthy means being able to create a contact figure which has grace, brightness, rhythm and harmony (Perls, Hefferline and Goodman, 1994; Bloom, 2003; Spagnuolo Lobb, 2007c, 2007a; Robine, 2006b). There is no need to use extrinsic evaluation methods, based on a comparison between what happens and an external norm taken as a benchmark (Perls, Hefferline and Goodman, 1994): it is the aesthetic beauty of contacting that orientates the therapist. The therapist perceives continuously the contact qualities and creatively adjusts her/his presence at the contact boundary: this constitutes the unity of the diagnostic and therapeutic act (Perls, Hefferline and Goodman, 1994; Bloom, 2003). By sensing the drops of intentionality and losses of spontaneity, the therapist re-positions her/his self in the relationship, co-creating and curing it, moment by moment.

Dimensional rather than categorical: the categorical approach defines discrete categories with clear-cut borders which provide an objective identity to pathological situations or individuals. The dimensional approach distinguishes itself from this by situating phenomena of suffering along a continuum, in which it is impossible to establish a clear-cut boundary between health and illness (APA, 1994; Barron, 1998). All experiences and all relationships have more than one dimension. Everybody can have a narcissistic, borderline, depressive, addictive, psychotic or other dimension, depending on moments in life and situations. Hence, pathology is not a clearly defined entity which can be distinguished from a healthy spectrum. People seeking help find themselves confronted with the same existential issues that we all face – love, loneliness, time, death. What makes the difference is the possibility or impossibility of drawing on the support necessary for realizing and living one's art. A dimensional approach can be integrated with a perspective that takes into consideration thresholds for each of the various dimensions (Cancrini, 2006). From this perspective, for example, all individuals can manifest borderline experience depending on the circumstances. What changes from one person to the next is the threshold at which such experience sets in. For some people, their threshold is lower than for others, for which they easily manifest this type of experience. Therefore any given situation or relationship can give rise to borderline, narcissistic, psychotic or other experiences. In certain historical and social circumstances, a certain type of experience becomes the norm. Examples include borderline behavior during the French Revolution (Cancrini, 2006) or the narcissistic trend of the final decades of the last century (Lasch, 1978). This perspective weds perfectly with the concept of the "basic relational model" proposed by Giovanni Salonia (Salonia, 2007a; 2008b).

5. Conclusion

Gestalt Therapy theory provides a very rich ground and precious tools with which to understand human suffering: we think that on this basis it is possible to found a *Gestalt psychopathology*, coherent with our theoretical epistemology and useful for our clinical practice. It is possible to look at human suffering as an emergent figure expressed by the individual, but carried on by the relational field.

Each person receives from life, through relationships, a heritage of pain and joy, limits and resources and it is her/his chance to transform it into beauty and full presence. This can be seen as the artistic *oeuvre* of every life. As therapists, we are daily committed in this transformational work: to support people in their endeavour to transform pain into beauty, to "distill joy from suffering", as a patient told one of the authors. And from this perspective, a wide and deep meaning of our work emerges. But, in order to be able to support it, we have to be sensible and capable to understand which contact and relationship the suffering person is calling for. And we have to be ready to participate in this challenge with our lives.

As Alda Merini, a poet that suffered from psychotic experiences, said: «Pain is nothing but the surprise of not knowing each other».