To Isadore From

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Preface

A Gestalt therapy handbook on Psychopathology, and to boot a relational approach to this complex topic! This book is ground breaking and revolutionary. Breaking new ground is always controversial, as I am sure this book will be, both among Gestalt therapists and among more traditional medical model psychopathologically oriented psychiatrists and psychologists. First generation Gestalt therapists would probably respond with shock and surprise to see Gestalt being applied to severe disorders and to the use of labels such as borderline and narcissistic. On the other hand medical model practitioners will find it hard to assimilate concepts such as that psychopathology emerges at the contact boundary and ideas of process oriented, aesthetic diagnoses. But as revolutionary ideas they hopefully will have an impact on received views of treatment and psychopathology and help give Gestalt therapy a voice in mainstream dialogue on more severe disorders.

Gestalt therapy initially was occupied with supporting the growth of the self and greater autonomy in neurotic personalities. As part of the Third Force of Humanistic Psychotherapies it was part of a new cultural movement. Gestalt therapy promoted supporting the autonomy and creativity of those individuals, who felt the need to free themselves from suffocating societal "shoulds" and family introjects. Self-expression, growth and excitement in the personality was the aim of therapy.

The Gestalt approach began and developed without paying much attention to more severe forms of suffering and psychopathology. Gestalt psychotherapy was not developed to treat more severe disorders such as psychosis, self-harm or severe trauma or personality disorders such as borderline and narcissistic disturbances. Perls promoted Gestalt therapy as the therapy of choice for "neurotic" individuals but he was clearly aware that he could not use Gestalt techniques with seriously disturbed individuals.

In addition Gestalt therapy was identified by many with techniques without the theoretical understanding that guided their practice. It proliferated through workshops and self-experience. Research and theory development were viewed

with scepticism and academic work on Gestalt therapy suffered. Gestalt came to be seen as a growth therapy and not applicable to serious disorders.

The view of Gestalt therapy offered in this book is refreshingly quite different. This book is revolutionary in its effort to tackle the topic of psychopathology from a Gestalt relational perspective and it offers a specifically formulated Gestalt therapy view of understanding psychopathology. It views psychopathology as a co-created phenomenon of the field, that emerges at the contact boundary and as being able to be transformed in the process of contact. This is a laudable attempt to expand the core concepts of a Gestalt theory of human functioning to understanding seriously disturbed clients and psychotic functioning.

There has until recently been a lack of development of theory and research in Gestalt therapy that has greatly hampered the recognition of what Gestalt therapy has to offer. Being an experiential therapy, training was based strongly on promoting personal experience as a way of learning. This led to the denigration of intellectual and scientific pursuits, to the elevation of learning by doing, and to only valuing "knowledge of acquaintance". You had to experience it to know it. This was in line with Gestalt phenomenological theory of practice, but this approach had its problems in promoting theory and research. This approach exposed Gestalt to the danger of becoming an esoteric practice and of losing any recognition as a serious academic, professional and scientifically valid approach. The theoretical and clinical writing that appears in this book is an antidote to this trend.

With the advent of the worldwide call for evidence based practice Gestalt has begun to shift its focus and has begun to develop and encourage more theoretical and research efforts. A sophisticated treatment of psychopathology as offered in these chapters fits into, and points the way, along this new path. In my view it can be thought of as helping to set a new frame for a third generation of Gestalt therapists, one that is more holistic, integrating theory research and practice in a phenomenological, relational and empirical framework.

Chapters in the book focus on many classical diagnostic categories: mood, psychotic, personality, eating and psychosomatic disorders, sexual difficulties, violent behaviours, and dementia. These chapters, although adopting classical diagnostic categories, attempt to keep the meeting with the client as central and preserve the importance of the uniqueness of each person and each encounter.

In addition, I think this approach will help promote one of the key views I have promoted, that of the importance of what I have called process diagnosis which the editors capture in their concept of intrinsic or aesthetic diagnosis. In this view diagnosis involves the moment by moment observation and sensing of where the client is, a functional diagnosis that guides the therapist's next moment. This is a co-constructive form of engagement that is at the heart of a

form of diagnosis that leads to differential intervention. Thus following the process, a central Gestalt principle, is not some mystical or esoteric process, wild and creative, beyond description or understanding, but rather a disciplined form of recognising the obvious, a form of perceptual differentiation akin to radiologists reading of scans to detect phenomena indicating that certain processes are occurring internally. We have suggested that therapy benefits from the identification of certain markers as indicators of internal states that offer opportunities for particular types of actions by therapists that best fit these states. Viewing diagnosis and intervention in this light helps bring the art and science of psychotherapy together in the performance of skilled practice.

I congratulate the editors on producing a volume that adds to the development of Gestalt therapy theory and captures the complexity of the Gestalt approach applied to clinical practice with complex problems.

Leslie Greenberg
Toronto, December 2012

Introduction

This book was conceived as a project in Athens in 2007, during the 9th EAGT Conference when we shared the dream of creating such a volume. We have all been interested in psychopathology for many years and expecially in the specific Gestalt therapy perspective on this issue (see i.e. Francesetti, 2007; Roubal, 2007; Francesetti and Gecele 2009). We are Gestalt therapists and psychiatrists, and each of us has undergone a process of integrating these backgrounds. Gestalt therapy has deeply influenced our way of being as clinicians: to understand human suffering, to dwell on the therapeutic relationship, to support our clients, to take care of ourselves as therapists. Additonally our clinical experience has made us more sensitive to specific aspects of the Gestalt approach. We were enthusiastic to share with our colleagues the support that Gestalt therapy has provided us as clinicians and to start a dialogue on clinical applications of our modality.

Commento [AG2]: Si possono eliminare questi spazi bianchi tra un capoverso e l’altro in tutto il volume?!

Three elements have been – at the same time – backgrounds and aims in our work: first of all, there was (and still is) a gap between the rich clinical experience of many Gestalt therapists and the literature available; to have literature on Gestalt therapy clinical work is a fundamental tool for students in training programs and also a support for the ongoing dialogue on psychopathology and its changes over time. It is also relevant for the reputation of Gestalt therapy with colleagues from other modalities and a means to dialogue with them: too often our approach has been identified only with techniques without the knowledge of how rich and illuminating the theoretical understanding is that leads our practice. So this book is an attempt to make explicit what Gestalt therapists are doing in their clinical practice and our specific way of understanding psychopathology.

A second element that pushed us to start this project was the caution that Gestalt therapists have often held towards psychopathology. It has not been an easy relationship for epistemological, historical and political reasons. Nevertheless Gestalt therapy has a specific psychopathological understanding: each

psychotherapeutic model has one, explicit or implicit. We think that the lesson of humanistic movements – the uniqueness of each person and experience – remains always precious: Gestalt psychopathology is an understanding of human suffering through our theory, not a way of labelling our clients. This process is a valuable support in our clinical practice. Actually, we think that our seminal book by Perls, Hefferline and Goodman has described healthy and neurotic experience well, but that its core concepts can be further expanded: i.e., the theory of human experience can be the basis for understanding seriously disturbed clients and psychotic functioning.

The third drive was our passion to understand human suffering as a field phenomenon: we are daily involved and challenged by suffering, both when working and in our daily lives. We believe, and have experienced, that Gestalt therapy can offer an original key to understanding, staying with and supporting people who suffer. Moreover, to see human suffering as a field phenomena opens up the possibility of understanding better both the individual and the social field. Then, by understanding these connections, all of us as professionals play a role in supporting the social field.

These were our motivations that – along with partial blindness to the amount of work – led us to start this book.

Since our understanding of psychopathology is addressed in many chapters, here we just want to focus on the subtitle: *from psychopathology to the aesthetics of contact.* In this line you can find the core of our vision: in the contact process human suffering can be reached and modified and this transformation is aesthetic. Two ideas are present here: first of all, psychopathology is a co-creative phenomenon of the field, it is emerging at the contact boundary and can be transformed in the process of contact. Secondly, this transformation is aesthetic: that means, it is perceived by our senses, it is evaluated by aesthetic intrinsic criteria and can even create beauty[1].

Through this means we can bring psychopathology to the heart of Gestalt therapy theory.

We want to make clear to the reader that clinical practice is only one of the fields where Gestalt therapy is applied. Gestalt therapy theory and practice can be a model for work in organisations, in arts, in education, in a social and political dimension. Gestalt therapy can be seen as the way to support the *Gestaltung*, the process of creating the Gestalten, the unified whole of human experience. So, psychopathology and clinical practice are only one of the fields where our theory can be fruitfully applied.

[1] See also G. Francesetti (2012), "Pain and Beauty. From Psychopathology to the Aesthetics of Contact", *The British Gestalt Journal*, 21, 2: 4-18.

The book has four sections.

The first part focuses on fundamental principles related to Gestalt therapy in clinical practice. Here you can find some basic issues that have to be addressed before or along with the clinical work: core and updated Gestalt concepts, Gestalt perspective on psychopathology, diagnosis and development, ethics, research and the relationship between psychotherapy and drugs.

The second part addresses specific contexts and focuses: this section supports the field perspective of the individual's suffering and helps the reader to consider it in the frame of social, political and multicultural dimensions. You can also find two specific focuses particularly relevant to clinical practice: developmental theories and shame.

In the third section some specific life situations and moment of risks are addressed: childhood, adolescence, old age, loss and grief, trauma and suicidal risk.

The fourth part examines different clinical sufferings from a Gestalt therapy point of view. This section offers an overview of clinical experiences and research on the main psychopathological issues. We have addressed many classical categories: dementia, dependent behaviours, psychotic, depressive, bipolar experiences, anxiety, panic attacks, phobic, obsessive, compulsive styles, anorexic, bulimic, hyperphagic experiences, psychosomatic disorders, sexual difficulties, personality disturbances (borderline, narcissistic, hysteric), violent behaviours. We have chosen to use these categories because they belong to the current psychopathological and diagnostic vocabulary. We hope that by going through the book the reader can find her/his own way to keep these categories as a point of reference and at the same time to deconstruct them when the meeting with the client happens and reveals the uniqueness of each encounter. We have tried to support this journey in all parts of this volume.

At the end of our work we have realised that the structure of this book has changed from the initial project: we planned to focus one volume on specific clinical sufferings and now this is the last part of four. We think that this evolution witnesses an important issue: to speak about psychopathology is always at risk of reductionism and labelling. So, according to our Gestalt perspective, we have felt the need to nourish and enlighten the ground of clinical suffering and work. In this way, the book has – in some way spontaneously – taken its final shape: quite a long and complex journey into the background before being able to enter into specific individual suffering. In the end, this form mirrors a theoretical cornerstone of this book: individual suffering creatively emerges from a relational ground and this provides meaning and direction to therapy.

Each chapter is followed by a comment written by another author: the aim

is to offer a second point of view on each topic in order to put it in a wider and critical frame, a kind of binocular perspective that allows three-dimensional vision. The reader is exposed to these different perspectives: a complex horizon that witnesses the complexity of the field in this moment. The wide final bibliography can be a precious orientation that covers most parts of the available literature on Gestalt therapy applied to clinical practice. We have received some very critical comments to some chapters: we think this is both a sign of vitality and of a developing field where different points of view are still struggling with each other and deserve further discussion.

The perspectives you can find in the book come from the available literature and the specific clinical experience of each author. We think that this provides a valuable clinical treasure and we hope that it may encourage the cultivation of research on these topics. Indeed, to have hypothetical clinical constructs is a good ground for both qualitative and quantitative research.

As editors, during this work, starting from our common grounds, we have discovered our differences and tried to deal with them. And we discovered many differences too between us and the authors and amongst them. We have more than fifty contributors involved in this book: this is another reason for complexity. Even though we have done our best to orient them towards a common horizon, different ways of looking at psychopathology emerge from all the chapters and comments. The book offers a picture of the complexity of the Gestalt approach applied to clinical practice. The reader can taste the variety of approaches related to the geographic origin of the authors (they come from about 20 countries) and to the development of Gestalt therapy theory. Again, a rich ground and a witness to a growing field.

In conclusion we hope the book has reached a good form: a polyphonic chorus where each voice has its own specificity and contributes to a holistic whole. Anyway, it is the form we can foster in these times, representing both our own and the field's resources and strengths. We also hope that this volume will be a starting point for future developments: a stimulus to clinicians and researchers to go further with the richness of Gestalt therapy.

If we look now at our motivations described above, we can say that we are satisfied: we think this book provides significant literature in a wide field and can be a fundamental tool for the clinical practitioner.

We want to dedicate this book to Isadore From: to his effort in making Gestalt therapy a coherent clinical approach to addressing psychopathology.

We address this book to our Gestalt colleagues committed in clinical practice, to trainers and trainees in their teaching/learning endeavour. But also to clinicians from other modalities: they can find an original way of approaching psy-

chopathology, and in a time of dialogue and integration we hope this volume can be a bridge to meeting different perspectives.

Gianni Francesetti
Michela Gecele
Jan Roubal

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Thanks to the European Association for Gestalt Therapy, this book witnesses how valuable it can be to support the relationships in our community. This organisation has not only given financial support to the publication, but has especially fostered the net of contacts without which it would have been impossible to even imagine such a volume. Among other EAGT colleagues, a special thanks to Peter Schulthess: he was the President when this project was supported by the EAGT and we have always felt encouraged by his willingness to support research and scientific dialogue.

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And finally, thanks to you, the reader: your interest and curiosity make our efforts worthwhile. We hope these pages can be an inspiration to your creativity and care towards suffering people.

Part I

Basic Principles of Gestalt Therapy in Clinical Practice

Fundamentals and Development of Gestalt Therapy in the Contemporary Context[1]

by Margherita Spagnuolo Lobb

If we look at the various descriptions of the basic principles of Gestalt therapy from its foundation to the present day, we can see how the core values of our approach have been described in different ways[2]. Every time we try to describe our theory, we need to in-scribe this description in the historical moment in which we live and in the current needs of present society. In this way it may seem that the original principles are completely changed in modern descriptions, but they are in fact the result of a natural and obvious evolution of the relationship between society and psychotherapy – as well as of society and anthropology, society and economics, society and technology, etc. In order to support and be in line with the necessary development that our approach, like any other, needs, without losing our roots, a hermeneutic method is needed (Spagnuolo Lobb, 2001c): it allows the original principles of our approach to be located in a certain socio-cultural context, and considers their development in parallel with the development of the needs of society and culture. To accomplish this aim, it is important to define the epistemological principles of Gestalt therapy, which need to be respected, since they constitute the boundaries within which any development has to take place. For example, the technique of the empty chair, a basic and brilliant one which incarnates a core spirit of our approach, needs to be used considering the changed social feeling. The empty chair was created in order for the client to focus on her/his bodily experience, and therefore give support to her/his self-regulation, which emerges first of all from physiological (as opposed to mental) experience, as it is harmonized with the systems of previous contacts (the definition of who I am) and with the capacity to deliberate. That basic tech-

[1] This chapter is a synthesis of the first two chapters of Spagnuolo Lobb M. (2011c), *The Now-for-next in Psychotherapy. Gestalt Therapy Recounted in Post-modern Society*, FrancoAngeli, Milano.

[2] See a recent study on development of Gestalt therapy values in issue 2012-1 of the French Journal *Cahiers de Gestalt-Thérapie*, in particular Spagnuolo Lobb and Cascio (2012).

nique was invented at a time when to trust one's own potentialities was the necessary ingredient to become independent of the other. Without going into details of this particular technique which I will discuss later, what I would like to underline for the moment is the fact that when we use the empty chair today, we must take into account that the main need of our present society is not to get rid of bonds and become autonomous, but to create bonds where we can have the experience of being recognized and restrained by the other. So the technique remains one of our best, but we need to use it with a different aim (and with a different accent on what to support).

This hermeneutic maneuver is basic for our model to survive and develop[3], and saves us from applying concepts and techniques in a naive way. It is particularly important if we want to treat serious disturbances and orient ourselves in the realm of psychopathology, which today has taken ground in everyday life. The survival of our model depends on our skills in addressing psychopathology (Francesetti, 2005).

We all know that Gestalt psychotherapy was not born to cure psychosis or serious disturbances. At that time, however, psychotherapy in general did not address the treatment of serious disturbances. The bi-univocal link between psychotherapy and society has always put in the foreground the lack of consistency in the relationship between the individual and society emerging at a particular time. At the birth of Gestalt psychotherapy this missing consistency was seen in questions like "who owns the truth? The healer or the helped? Does human relational suffering include a dignity and a potential autonomy, or is it simply a matter of a lack of social adjustment? Do social minorities and "different" feelings and ways of being need to be controlled and brought to "normality", or do they rather need to be supported as an important resource for the self-regulation of society? Psychopathology was not among the main interests of psychotherapy at that time: serious disturbances were in fact considered a fairly separate event from daily life; crazy people lived in mental hospitals and social problems were of a different sort.

When, over the years, the whole of society had to cope with psychopathological suffering, it became impossible for psychotherapy to avoid an interest in it. Since the 80s, any psychotherapy model that has had an interest in surviving has had to deal with the reality of the ever increasing spread of serious disorders, looking for new thoughts and techniques to prevent and treat them. What is usually meant by the term "serious disorder" is the experience in human relations of uncontrollable anxiety, the feeling of losing oneself, the perceived inability to continue to live one's own daily life.

[3] This has been the theme of the 6th European Conference of Gestalt Therapy "Hermeneutics and Clinical" (Palermo, Italy, October 1-4, 1998) that I have organized as President of the European Association for Gestalt Therapy (EAGT).

In this chapter I will first make an excursus on the development of social feeling and psychotherapy in the last 60 years (since Gestalt psychotherapy was founded). Then, in the light of present society, I will describe the basic principles of our approach, its fundamental values. I will subsequently describe the Gestalt concept of psychopathology as creative adjustment, locating it in contemporary society, and will motivate the necessary change for Gestalt therapy to deal with the term "psychopathology", which was till the 80s banned from our language.

I will try to assess all the theoretical statements with clinical or relational examples, in order to be consistent with the pragmatic soul of Gestalt psychotherapy.

1. Development of Social Feeling and Psychotherapy

Almost all the psychotherapeutic approaches were founded around the 1950s, and then spread in the following twenty years. Since then, our patients have changed greatly, and so we are challenged to modify both the formulations and the method, on the one hand keeping faith with the epistemology of our approach and on the other creating new instruments to solve today's problems. Let us reflect on the clinical development of these 60 years.

- *1950s-1970s* – These were the years when the majority of the psychotherapeutic methods were spread to the greatest degree. In this period, defined by sociologists as "narcissistic society" (Lasch, 1978), all the new psychotherapeutic approaches were aiming at the resolution of a relational and social problem: how to give more dignity to the capabilities of real life, which had been in the shade in last formulations of Freud, who had attributed more power to the strength of the unconscious. Freud's own more or less dissident "offspring" – Otto Rank, with the concept of will and counter-will (Rank, 1941), Adler (1924) with the concept of will for power, Reich (1945) with his absolutely trusting perspective on sexuality (see Spagnuolo Lobb, 1996, p. 72 ff.) – had expressed, at the beginning of the century, a change of psycho-social perspective on human relationships: the children's (and the patient's) "no" is healthy, the emotions of power are "normal", bodily energy and sexuality can be fully experienced without falling into orgiastic disorder. The philosophical equivalent of this change is found in the thinking of Nietzsche[4], while at artistic level new forms, which ranged from jazz to surrealism (we may think of the deconstructed figures of Miró), reflected the desire to affirm new subjective perspectives. At the political level the emergence of the rights of

[4] See comparative studies by Polster (2007), Crocker (2009).

minorities as a development of dictatorial regimes testified to the desire to give dignity to any and all human forms of existence. All the psychotherapeutic currents that arose in the twenty years from 1950 to 1970 (as well as some "revisions" of psychoanalysis) had in common the desire to give greater dignity and trust to individual experience, considered of fundamental importance for society. The ego was re-evaluated, attributing to it a creative, independent power: the child had to be liberated from the father's oppression and patients from the social norms. Even madness was no longer seen as an irrecoverable lack of the sense of reality, as domination by a destructive unconscious, but as an opportunity to understand an otherwise unreachable part, which though deviant was also a source of creativity: the schizophrenic's word salad, like a picture that expresses emotions without structure, has a value in itself which, though it is quite other than rationality, supports the creative, independent power of the human being. The emerging need was to rediscover oneself as important though deviant, or not dominant.

Gestalt therapy, in this context, declined this need, founding a theory of the self[5] capable of grasping the experience during a process of contact of the organism with the environment (as opposed to intrapsychic), revealing the creativity of the ego in this process, which is at one and the same time creator and created. The middle mode which is incarnated in the esthetics of Greek culture (in the West, it is only in the Greek language that certain verbs have a "middle mode"[6]) also characterizes the description of the self, which "is made" at the boundary between organism and environment, by means of an esthetic process, awareness, presence to the senses, as an intrinsic quality of a good contact. Another original concept with which Gestalt therapy made its contribution to the emerging needs of society in the 1950s refers to the positive nature of conflict in human relationships: the suppressed conflict leads either to boredom or to war (Perls, 1969, p. 7). Going through the conflict is a guarantee of vitality and of true growth.

But what were the sentences, the typical language of patients in the 1950s? The heart of the request for psychotherapy in those years could be: "I want to be free"; "Bonds are suffocating: they stop me fulfilling myself with my potentialities"; "I'm asking for help to free myself from the bonds that oppress me". "I'd like to leave home, but I can't do it", "I can't stand it when my father orders me to do things". The clinical evidence of the 1950s-1970s emerged

[5] Gestalt psychotherapists choose to write the words "self", "ego", "id" with a lowercase initial letter to signify a procedural, holistic definition of these terms, as opposed to the tendency to objectify them, considering them as applications.

[6] The "middle mode", or *diathesis*, is exclusive to the Greek language and indicates a special participation of the self in the action. It often indicates the subject's great interest in the action in which s/he is involved; it corresponds to the reflexive in Italian and in English.

around these experiences. There was a need to expand the ego, to give it greater dignity, a need for independence. The experiential ground from which this need emerged was more solid than it is in our days: intimate relationships were more lasting (although often leveled out by normative factors), and the primary family relationships were certainly more stable.

The therapist's answers were: "You have the right to be free, to fulfill yourself, to develop your potentialities"; "I am I and you are you …". In short, what was supported was self-regulation and separation from bonds, at the cost of caring for what happens at the contact boundary with the other.

- *1970s-1990s* – These years were characterized by what Galimberti (1999) calls the "technological society", precisely because they put the machine on a pedestal, and alongside it they put the illusion of controlling the human emotions, especially pain, and considered the relationships of the *oikòs*[7] to be a "blunder", a hindrance to productivity, which in contrast was seen as the only reliable value. Love and pain, two emotions which in reality are inseparable, were in this period considered irreconcilable. If considered as the product of the "narcissistic society", the "technological society" could be defined as "borderline". This generation had on the one hand the strong pressure of successful parents, who wanted their children to be "gods" like them; on the other the lack of support for their own wishes and for their attempts to be someone in the world. The child of a god doesn't make mistakes! This generation, which on the one hand grew up with the illusion of being exceptional, and on the other had to conceal the sense that they were bluffing, developed a borderline relational modality: ambivalent, dissatisfied, incapable of separating themselves in order to affirm their own values. The flight of the young into "artificial paradises", their anger at their parents as bearers of values remote from their humanity, facilitated the spread of drugs, but also of important group experiences. It was no accident that in psychotherapy these twenty years saw a special interest in groups: the group was perceived as one (sometimes the only possible) source of healing.

Patients' phrases in the 1970s and'80s might for example be: "I've fallen in love with a colleague, I'm having an affair with her, my wife doesn't know, and I don't know whether to tell her or not", "My parents are always nagging me, when I'm in a group I feel freer, smoking a joint is a liberation from the daily oppression", "Drugs (or my job or my lover), that's my main bond, the bond with my partner is an optional extra". There was a search for the self outside the intimate bonds, an attempt to solve the difficulty of being-with via the illegal substance or via work. In the '90s, only ten years later, the search for the self was transformed into a need to feel oneself in solitude: "I'd like to feel

[7] In Greek "house".

myself, find myself. At times I'm forced to fast so as to feel myself through hunger. Everybody wants something from me and I don't know how to find out who I am", or "I have a relationship with a man that lives 600 miles away. I don't know much about him. At first it was nice to be together when we met. But now it's a bore. We just don't know what to do. Do you think that's normal?"

The therapist's answers were: "Trust yourself – go back to the origins of your being (in phenomenological terms) – find out who you are by concentrating". Or else: "Let's see what's happening between the two of us". In practice, all the methods were addressed at that time to what in Gestalt therapy we call the "contact boundary": a new way of looking at transference and countertransference. "Trust in self-regulation, both of your emotions and of the space between the two of us". In other words, the Perlsian slogan "lose your mind and come to your senses" was revised as "follow your incarnate empathy", "I recognize myself in your glance".

- *From the 1990s to 2010.* In social feeling the interest in technology (a resource that by now is taken for granted) and the ambivalence towards one's own value gave way to a sense of liquidity, as Bauman (2000) puts it so well. The children of the "borderline society" are experiencing the absence of intimate, constitutive relationships: parents have been absent, in part because they were busy at work (the value diffused by society was the value of technology), and worried about the imminent social crisis, in part because they were incompetent on the relational level (borderline ambiguity is poured out on the offspring with an emotional detachment). The generation of these twenty years also grew up in a period of great migratory movements, in which many people were unable to rely on the intergenerational tradition for support and a sense of rootedness (Spagnuolo Lobb, 2011b). Traditions are often lost and the village squares have been replaced by the virtual "squares" of the social networks. The social experience of young people today is "liquid": incapable of containing the excitement of the encounter with the other and extremely open to the possibilities of exchange offered by the globalization of the communicative flows. The child doing homework, for instance, at the moment when s/he has difficulty needs a restraint and an encouragement, in order to solve it by using the energy that animates her/him. But there is no one home to tell, no restraining wall that can make her/him understand what s/he feels and what s/he wants. So s/he goes on the Internet, where a research engine provides the answer; her/his excitement is scattered and strewn round the world and s/he finds every possible answer, but does not find a relational container, a human body, but just a cold computer incapable of embracing the child. The unrestrained excitement becomes anxiety. This is disturbing and in order to avoid feeling it the body must

be desensitized. This is why today we have many anxiety disorders (like panic attacks[8], PTSD, etc.), difficulty in forming bonds, pathologies of the virtual world, body desensitization. Our patients, especially the youngest ones (as anyone who has to do with adolescents or young couples knows), say things to us like: "I made love with a boy for the first time, but I didn't feel anything", "In a chat online I feel free, but with my girlfriend I don't know what to talk about", "Nobody really interests me", or " On our honeymoon my husband told me he's had another woman for a long time". Forms of malaise emerge linked to a body insensibility that appears in the relationship. It is even difficult to perceive the other: the field is full of anxiety and worries.

The therapist responds by supporting the physiological process of the contact (the *id* of the situation, as Robine, 2006a says): "Breathe and feel what happens at the boundary". Further, s/he supports the ground of the experience: s/he identifies how (with what modality of contact) the patient maintains the figure (or the problem). In other words, the therapist focuses on the *support of the process of contact*, where once s/he had to direct attention to the support of an egoic individuality, to favor its emergence among other individualities. In other words, if previously being healthy implied finding the reasons for winning, for emerging in the battle of life, today it means experiencing the warmth in intimate relationships, and the emotional and bodily reaction to the other. In groups, the therapist supports the harmonious self-regulation that comes about when one lives a horizontal (equal) context in which it is possible to breathe and give mutual support.

2. Development of Basic Values: the Importance of the Hermeneutic Method

From what I have said thus far, Gestalt therapy reached its maximum diffusion at a cultural moment that has been defined as the "post-modern condition" (Lyotard, 1979). Criticism of a priori values, dictated by criteria outside the individual's experience, and the consequent need to free oneself from the traditional points of reference (the "fall of the gods") envisioned by post-war culture determined this condition of evaluation of the egoic creativity, at the expense of "letting oneself go to the environment", or if you like to emotional bonds. This was clearly a necessary stage in order to reach personal autonomy in the face of a social axis polarized between authoritarianism and dependence.

In the '80s there was widespread interest in relationship. In these years some philosophers put forward "weak thought" (Vattimo and Rovatti, 1983), ac-

[8] See Francesetti (2005).

cording to which freedom from paradigms determined a priori is an opportunity to build new, genuinely independent certainties, not polluted by values that have been handed down and hence are not one's own. It was a matter of faith in the uncertain, of the affirmation of the value of the "pure" relationship, able to create new solutions precisely from the uncertainty of the fleeting moment. Weak thought gave excellent expression to the Gestalt faith in the now and in the creative power of the self-in-contact. How could one fail to be fascinated by the prospect of letting the new solution emerge for the patient from "nothing" from the nakedness of the relationship? All the expectations of the Gestalt therapist of creating through her/his very presence, and together with the patient, a solution that does not need the support of the analysis of the past were welcomed. Many writers on Gestalt, myself included, stressed the positive value of uncertainty as against the false security given by schematic systems; Staemmler (1997b, p. 45) for instance, states that cultivating uncertainty ought to be the fundamental value of the Gestalt therapist, and Miller (1990) affirms the value of the psychology of the unknown. I personally create the concept of improvised co-creation (Spagnuolo Lobb, 2003b; 2010b), as a Gestalt countermelody to the concept of implicit relational knowledge of Stern *et al.* (1998; 2003). In other therapeutic approaches too stress was laid on the importance of not allowing oneself to be tempted by the power given by diagnostic certainties in psychotherapy (see for example Amundson, Stewart and Valentine, 1993).

But this optimistic view of post-modern uncertainty, shared in the Gestalt ambit as far as letting oneself go to the here and now of the therapeutic contact, clashes with an experience of emergency that, in the absence of a secure relational ground – to which I referred above and which has been much discussed in Gestalt circles (see for example Cavaleri, 2007; Francesetti, 2008; Spagnuolo Lobb, 2009c) – is readily transformed into traumatic experience. Clinical evidence today is characterized by widespread anxiety (panic attacks, post-traumatic stress disorder, attention deficit and hyperactivity in children), relational disorientation (disorders of sexual identity, conflicting relational choices, difficulty in maintaining couple or intimate bonds), bodily desensitization (lack of sexual desire, self-harm with the aim of feeling oneself, anhedonia or lack of feelings).

What value can Gestalt therapy bring today to the panorama of psychotherapies?

Our hermeneutic gaze tells us that the basic intention of the founders of Gestalt therapy, when they wrote the founding text, was to dissolve the chief neurotic dichotomies (Body and Mind; Self and External World; Emotional and Real; Infantile and Mature; Biological and Cultural; Poetry and Prose; Spontaneous and Deliberate; Personal and Social; Love and Aggression; Unconscious and Conscious).

Every time we want to develop our theory, we need to keep faith with this aim: how can we be psychotherapists who help people (with their relational suffering) to overcome dichotomies?

The art of the Gestalt therapist, therefore, is a difficult one: it is difficult both to apply it and to transmit it, because it implies remaining wholly adherent to a spirit, to principles, without abandoning the creativity that our passion allows us.

Until twenty years ago it was difficult to remain in the relationship; today it is difficult to feel oneself in the relationship, sometimes even sexually: the clinical evidence ranges from ambiguity in the choice of partner (Spagnuolo Lobb, 2005d; Iaculo, 2002) to the inability to feel sexual desire in the body. The Gestalt reading of "liquid fear" (Bauman, 2008) corresponds to a feeling in which the excitement that should lead to the contact becomes undefined energy: mutual mirroring and relational containment, the sense of the presence of the other, the "wall" that allows us to feel who we are – these are lacking.

I believe that today psychotherapy has a twofold task: to *resensitize the body* (overcoming the dichotomy of virtual/real), and to give tools of *horizontal relational support*, that can make people feel recognized by the glance of the equal other (overcoming the dichotomy of vertical/horizontal in healing contacts).

3. Basic Principles of Gestalt Therapy in Clinical Practice

Certain epistemological principles of Gestalt therapy seem to me to currently define the specificity of the approach as compared to others. This is what I would answer today if someone asked me what is specific to Gestalt therapy.

3.1. From the Intrapsychic Paradigm to the Paradigm of the Co-Created Betweenness

In the current cultural trend centered on the relationship, Gestalt therapy redefines in terms of co-creation the original intuition of the founders, which considers experience as a happening at the contact boundary, in the "between", which is to say between the I and the you (Spagnuolo Lobb, 2003b).

In the field of clinical psychological practice, Gestalt therapy, thanks above all to the contribution of Isadore From, passed from the viewpoint of the organism/environment *interaction*, aimed at the resolution of the individual needs (see Wheeler, 2000a), to the viewpoint of the *organism/environment field,* a

unitary phenomenal event, from which modalities of contact emerge, that the psychotherapist welcomes in order to favor the clear perception and hence the spontaneity of the self of the patient.

One clinical example of this is the case of the patient who says to the therapist: "I was in a terrible state last night and I didn't sleep". According to contemporary Gestalt therapy, he is expressing not only an experience that belongs to himself ("I'd like to understand better my terrible state"), but also something that belongs to the present contact with the therapist (the *remembered* "terrible state" is a way to speak of the *actual* one, it is a matter of figure/ground dynamic, of picking certain parts from the ground of experience of contact with the therapist, instead of others, in the very moment of the present session with the therapist). Perhaps he wants to communicate to her an anxiety concerning the previous session, or the session that is about to begin; for instance, he might want to say: "At the last session something happened that made me anxious. I hope that today you'll realize the effect it had on me and be able to protect me from the negative effects". This relational reading (it would be more correct to call it "situational") allows the therapist to come out of the traditional intrapsychic view, namely to work on the "terrible state" and see what emerges, and sees the treatment as a process related to the patient's being aware of the satisfaction (or sublimation) of needs, to enter fully into the post-modern perspective, which collocates the treatment in the space co-created by the patient and the therapist, in which new patterns of contact are built up, which free the spontaneity of the self.

Moving from the intrapsychic paradigm to that of the "between" implies that the therapist sees her/himself and the patient not as separate entities but as a dialogic totality – the patient in dialog with the therapist/the therapist in dialog with the patient (Yontef, 2005). Every communication on the part of the patient is inscribed and receives meaning from the *Gestalt* of the mutual perceptions, in which the relational intentionality is expressed.

An example may clarify this. A patient says: "I feel a tension in my stomach, I don't know… it's as if I were angry". The therapist who uses an "intrapsychic" approach will direct her/himself to try to understand from what past experiences this anger comes, what or who the patient is angry with, etc. Her/his questions will be of the type: "Concentrate on your body and see what this sensation reminds you of". If, instead, s/he uses the paradigm of the "between", s/he will direct her/his attention to what in the "between" has caused the figure of tension in the stomach and of anger to emerge. S/he will ask questions such as "How does being-with-me make the tension in your stomach and the anger emerge? What are you angry with me about? And what are you holding back towards me that provokes tension in your stomach? " After a certain disorientation, in which the therapist invites him to take his time and breathe,

the patient replies: "When I think that you made me wait fifteen minutes before seeing me, I get furious". At this point an opening appears which allows the recovery of a previously interrupted relational pattern. The patient can be spontaneous with the therapist, and can dissolve the retroflection that was creating the tension in the stomach, as the habitual relational pattern.

This type of therapeutic dialog opens to the patient the possibility of overcoming the relational anxiety that he was attempting to avoid with interruption of contact (and which he then forgot). Once the relational intentionality has been brought back to the contact boundary, the therapist can use a variety of Gestalt interventions capable of supporting the energy of contact, by this time conscious.

3.2. The Therapeutic Relationship as a Real "Fact": the Sovereignty of the Experience

Broadly speaking, psychotherapeutic approaches consider the therapeutic relationship a virtual tool to improve the real relationships of the patient's life[9]. Gestalt therapy, in contrast, attributes to the therapeutic relationship the character of a *real experience*, which is born and has its own history in the space that lies "between" patient and therapist.

The therapeutic relationship is in fact considered not as the result of projections of relational patterns belonging to the patient's past, nor only as a laboratory in which "tests" are carried out on relational patterns that are more effective for the outside world, for real life. Between patient and therapist there comes into being a unique, unrepeatable relationship, in which the reciprocal perceptions are modified, in which the patterns of the past are developed with a view to improving *this* relationship, not that of the past. It is what happens between this specific therapist and this specific patient that constitutes the treatment, one of the many possible experiences of treatment. This implies that the Gestalt therapist immerse her/himself fully in the relationship, that s/he use her/his own self. The treatment is in fact based on two real people, who although they may also be revealed by means of techniques, stake themselves spontaneously, through their human limitations, in a relationship clearly defined by their complementary roles: one who gives the treatment and one who receives it. Recalling an example that Isadore From used to relate, a patient had recounted a dream to him, beginning with the words: "I had a little dream last night". Isadore was rather short. Fully conscious of this limitation, which stimulated in his patients reactions that were often not displayed out of "good

[9] By way of illustration, see Spagnuolo Lobb (2009d).

manners", he immediately replied: "Yes! Little like me". The patient was struck by this little joke, stopped for a moment feeling ill-mannered and then burst into freeing laughter. His breathing became fuller and he was able to enter into contact with feelings of tenderness and trust towards the therapist, feelings he had previously blocked. That very encounter between therapist and patient, in the humanity of their limitations, had given the patient the possibility to open up in the relationship with the most hidden feelings, and with a sense of trust in the other which it was difficult for him to experience. This example shows how – for Gestalt therapy – it is the real encounter between two people that produces the treatment, an encounter in which there occurs a novelty capable of reconstructing the patient's ability for contact.

A similar perspective has to be found in Stern (2004; Stern *et al*., 2003) who considers an important factor for psychotherapeutic change the "signature" that the therapist puts in his/her intervention (a particular smile, a particular way of speaking or looking, etc.), which gives the patient the sense that *that* is the way s/he (the therapist) cares about a significant other.

3.3. The Role of Aggression in the Social Context and the Concept of Psychopathology as Unsupported **Ad-gredere**[10]

Fritz Perls' intuition on childhood development, which gives value to the deconstructing implicit in the development of the teeth (*dental aggression*, Perls, 1942), is based on a conception of human nature as capable of self-regulation, certainly positive as compared with the mechanistic conception in force at the turn of the 19th-20th century (with which Freudian theory was imbued). The child's ability to bite supports and accompanies her/his ability to deconstruct reality. This spontaneous, positive, aggressive strength has a function of survival, but also of social interconnection, and allows the individual to actively reach what in the environment can satisfy her/his needs, deconstructing it according to her/his curiosity.

The physiological experience of *ad-gredere*[11], which supports the more general organismic experience of going towards the other, requires oxygen, in other words has to be balanced and supported by exhalation, a moment of trust towards the environment in which the organism relaxes its tension and control, to go on to take another breath (and oxygen) in a spontaneous, self-regulated manner. The pause in control, letting oneself go to the other or to the environment, is the fundamental cue for the control/trust rhythm to be able to occur sp-

[10] See Spagnuolo Lobb (2011c, p. 130 ff.) for a wider description of the concept of aggression today and the methodological consequences for clinical practice.

[11] In Latin "ad-gredere" means "going-towards".

ontaneously, so to reach the other balancing active and restraining presence, creativity and adjustment, assimilating the constitutive novelty of contacting the other.

When this support of oxygen is lacking, excitement becomes anxiety. The definition we give of "anxiety" in Gestalt psychotherapy is in fact "excitement without the support of oxygen". The physiological support to reach the other is lacking. The contact comes about in any case (it could not fail to come about as long as there is the self, or as long as there is life), but the experience is characterized by anxiety (Spagnuolo Lobb, 2005d). This implies a certain desensitization of the contact boundary: in order to avoid perceiving anxiety, it is necessary to put to sleep part of the sensitivity in the here and now of contacting the environment; the self cannot be fully concentrated, awareness decreases, the act of contact loses the quality of awareness and of spontaneity[12].

For this reason, the Gestalt therapist looks at the bodily process of the patient-in-contact, and suggests breathing out in the event that s/he sees that, concentrating on a significant experience, s/he is not exhaling fully. The therapist knows that in this case the patient's physiological experience is of an excitement without the support of oxygen, s/he knows that the patient is distracted at that moment from the therapeutic contact and cannot assimilate any novelty contained in it. In other words, the therapeutic contact cannot come about without the support of oxygen, in that the change for Gestalt therapy concerns all the psycho-corporeal and relational processes. It is necessary to suggest to the patient that s/he breathe out in order to have the support of oxygen to accept the novelty brought by the therapeutic contact.

Gestalt therapy thus wonderfully puts together the "animal" soul and the "social" soul, for centuries considered mutually antagonistic in western philosophical culture: if the contact is a super-ordinate motivational system, there is no separation between instinctive motivation to survival and social gregarious motivation.[13]

The stress Gestalt therapy puts on relationality thus has an anthropological valence in considering self-regulation (between deconstruction and reconstruction) of the organism/environment interchange and a socio-political valence in considering creativity a "normal" outcome of the individual/society relationship. *Creative adjustment* is in fact the result of this spontaneous strength of survival that allows the individual to be differentiated from the social context, but also to be fully and importantly part of it. Every human behavior, even pathological behavior, is considered a creative adjustment.

[12] These concepts are the basis of the theory of Gestalt therapy.

[13] Daniel Stern's theory of intersubjective knowledge as superordinate motivational system in humankind confirms the intuition of the Gestalt theory of contact, brought to light a good 50 years earlier (see Spagnuolo Lobb *et al.*, 2009).

The concept of *ad-gredere* finds its Gestalt specificity in the formation of the contact boundary.

3.4. The Unitary Nature of the Organism/Environment Field, Tension to Contact and the Formation of the Contact Boundary

According to the Gestalt perspective, individual and social group, organism and environment are not separate entities, but parts of a single unit in mutual interaction, and consequently the tension that there may be between them is not to be regarded as the expression of an irresolvable conflict, but as the necessary movement within a field that tends to integration and to growth.

Our phenomenological soul reminds us of the impossibility of getting out of a field (or situation) in which we find ourselves, and gives us tools to operate with, while remaining within the limit imposed by the "situationed" experience. The founders of Gestalt therapy from the very first proposed the "contextual" method (Perls, Hefferline and Goodman, 1994, pp. 20-21), which, many years before Gadamer, proposed a hermeneutic circularity between the reader and the book: «Thus the reader is apparently confronted with an impossible task: to understand the book he must have the "Gestaltist" mentality, and to acquire it he must understand the book» (Perls, Hefferline and Goodman, 1994, p. XXIV).

Gestalt psychotherapy borrows the concept of "intentionality" (Husserl, 1965) from phenomenology. Consciousness exists only in its "relating to", in its "in-tending towards" an object, in its transcending itself. It is in the act of "transcendment" that subjectivity is formed (Spagnuolo Lobb and Cavaleri, forthcoming). «If the person is formed essentially in being formed, in being intentioned, in entering into contact with what surrounds her/him, this implies the need for psychopathology and psychotherapy to address the analysis of this continual transcending, being intentioned, entering into contact. It is in this relationship with the world, in this in-tending towards it, that the origin of mental suffering and at the same time the space of the treatment must be identified» (*ibidem*).

In Gestalt therapy we speak of "intentionality of contact" and, in so doing, we consider both the physiological "aggressive" strength (as explained in the preceding section) that accompanies going towards the other (from the Latin *ad-gredere*), and the evidence of being-there-with, the constitutively relational physiology of the human being.

Here we have a way of describing the process of contact focusing on the totality/differentiation rhythm that characterizes the movements of being-there-with in a given situation, according to a typically Gestalt epistemology (see, among others, Philippson, 2001).

From an initial undifferentiated unitary state, in the field energies and hence differentiations emerge, which lead to the emergence of differentiated perceptions constituting the contact boundary, the place where the intentionalities of contact are fulfilled in the concreteness of the here and now of the contact. The process of the making of the self-in-contact is precisely this going through an initial lack of differentiation, which gives way to a growth of excitement, accompanied by the perception of a novelty in the phenomenological field. It is precisely the excitement of the senses that allows differentiation (I realize that my movement is different from others', so I identify myself, I define myself precisely because I am different from them). The contact boundary is defined by meeting one another in diversity, which is then developed in deciding the movement towards the other, undertaken as from the solidity of one's own diversity (from the ground of self-awareness).

Going back to the examples of the preceding sections, communicating to the therapist one's nocturnal agitation or describing the dream as "little" are the contact-boundaries co-created in a field.

3.5. A Psychotherapy Based on Aesthetic values

The word "aesthetic" derives from the Greek word αισθετικός, which means "related to senses". In Gestalt therapy the term *contact* not only implies that we are interconnected beings, but also expresses a consideration of the physiology of the experience. Interest in the mentalization of the experience is decidedly replaced by interest in the experience generated by the concrete nature of the senses. We use the term *excitement* to refer to the energy perceived in the physiology of the experience of contact (Frank, 2001; Kepner, 1993). The concept of excitement is for us the physiological equivalent of the phenomenological concept of intentionality (Cavaleri, 2003).

The concept of *awareness*, quite different from that of consciousness, expresses being present to the senses in the process of contacting the environment, identifying oneself in a spontaneous and harmonious manner with the intentionality of contact. Awareness is a quality of contact and represents its "normality" (Spagnuolo Lobb, 2005c). Neurosis, in contrast, is the maintenance of isolation (in the organism-environment field) through an exacerbation of the function of *consciousness*.

This concept provides the therapist with a mentality with which to be present at the contact boundary with the patient and allows her/him to avoid facile diagnostic readings of the other. Only faith in the intrinsic ability of the human being to do the best thing possible at a given moment and in a given situation can direct the Gestalt therapist towards being in the therapeutic contact and re-

lationship, not depending on diagnostic patterns outside it. It is this awareness that allows her/him to find a new therapeutic solution every time.

3.6. The Figure/Ground Dynamic

As a clinical consequence of these hermeneutic aspects of the therapeutic contact, the therapist feels that s/he is part of the situation, supports the *adgredere* implicit in differentiation (which should be the patient's and one's own), collocates her/himself in the role of treatment, finalizing to that end her/his behavior, remains at the contact boundary with the senses, rather than with mental categories. Additionally, taking the view of the unitary nature of organism and environment, the therapist asks her/himself: "How do I contribute to the patient's experience at this moment?". The question is not posed in terms of action/reaction, nor in terms of taking on responsibility, but is rather: "From what ground of the experience of the therapeutic contact does the figure that the patient is creating emerge?" It is not a matter of a moral attribution of responsibility, but of being curious about the perception that the patient has now, in this specific given situation. It is a "lively" taking care of the patient's perception, of which the therapist is profoundly part, with her/his emotions and sensations, which certainly participate in the co-created phenomenological field. It is the definition of the therapeutic situation itself (the therapist provides treatment to the patient who requests it) who "sets" the phenomenological field in which both therapist and patient are immersed.

For example: the patient tells the therapist that he dreamed of an insurmountable wall the night before the session. The therapist wonders: "How was I an insurmountable wall for this patient during the previous session?".

It is a matter of referring not to the transferal logic of projection, but to the figure/ground dynamic. The therapist asks her/himself: "Why, of the many possible stimuli that my current presence can provide, does the patient extrapolate some and not others?". The hypothesis is that this particular stimulus hooks to a relational need that the patient is motivated to solve. The patient's "projection" (it would be better to call it perception) always has a hook in the therapist, whose personal characteristics are considered necessary aspects for the co-creation of the relationship.

In the clinical example, the patient, at the beginning of the session, says: "Last night I dreamed about a wall. It was in front of me, insurmountable. I could see neither the beginning nor the end of it. I woke up with the feeling of not being able to go ahead, I didn't know where else to go". From what experiential ground does the figure of the wall emerge? And further, still more importantly, what intentionality of contact determines the formation of this fig-

ure? If the background of the experience belongs to the phenomenological field co-created by the presence of the patient and the therapist, the formation of the figure must have to do with this contact. The therapist asks: “How was I an insurmountable wall for you at the previous session?” The patient, a little upset, says: “You... the wall...?” Therapist: “Concentrate on the experience of the wall in your dream and think about our last session. Do you think there’s some similarity?” The patient concentrates, then: “It was when I got upset in front of you. At that moment I’d have liked to embrace you. You were impassive. I felt the way I did in front of my father when I was little. I was never able to tell him if I had a problem or if I was happy. All my attempts to reach him were aborted by his severity. His grave look was like a bolt of lightning that nailed me down. I felt off balance with you: I didn’t know where to go at that moment. Maybe it’s no use hoping to be spontaneous”. The therapist: “So I was a wall for you when I didn’t accept your emotion. Thank you for giving me the opportunity not to be that way now. Try to tell me what you didn’t tell me about your emotion at the last session. I’m listening”. Patient: “I’m a bit ashamed”. Therapist: “You’re so used to having insurmountable walls in front of you that you’re embarrassed when you don’t have them”. Patient: “Sure, it’s something new for me”. Therapist: “Take a breath, look at me and, when you’re ready, tell me – as you breathe out – about your emotion. I’m listening”. The patient takes a deep breath, looks at the therapist and manages to say: “You’re important for me. I like your patience, the warmth I intuitively feel in you when I look at you. Thank you for being here with me”. Therapist: “How’s it going now?” Patient: “Fine, I feel I’ve done what I wanted. I feel light and I know where I want to go. It was important for me to tell you that”.

Defining the figure brought by the patient (the insurmountable wall) as an emerging property of the figure/ground dynamic that animates the therapeutic contact made it possible for the therapist to retrace the patient’s intentionality of contact and to support it so that it might be developed in the contact between them. It might be asked how important it would have been in this case to favor the “transition to the act” with a real embrace. In my view, the support in this case had to be directed to revealing the wish for the embrace, to defining himself as someone who wants an embrace, rather than putting into effect the bodily movement: A support to the *personality-function* rather than the *id-function* of the self (see Chapter 2). It is this support to the contact with the other according to the definition of the self that will then make the concrete embrace possible. It is important that the Gestalt therapist should not consider the transition to the act as a cure-all for the patient, but rather develop the sensitivity to discriminate what is actually useful to the patient; the risk is retroflection, on the part of both the therapist her/himself and the patient, of unspoken emotions. This condition would create dependence and desensitization at the contact

boundary between them. Before the seduction of an embrace from the therapist, then, the patient says nothing, but remains with a confused aftertaste (that was not really what s/he wanted), which might be made explicit outside the session, in the form of criticisms of the psychotherapist or of psychotherapy. Tracing what intentionality of contact animates the formation of the figure from a specific ground of the patient's relational experience is a fundamental ability for the Gestalt therapist, in order not to remain naively bound to obsolete, generalising humanistic patterns.

3.7. The Self as Process, Function and Event of Contact

What led the group of founders to create a new theory of the self was a weakness in the psychoanalytic theory of the ego: «In the literature of psychoanalysis, notoriously the weakest chapter is the theory of the self or the ego. In this book, proceeding by not nullifying but by affirming the powerful work of creative adjustment, we essay a new theory of the self and the ego» (Perls, Hefferline and Goodman, 1994, p. 24).

The self, the hinge on which all psychotherapeutic approaches are based, is conceived in *Gestalt Therapy* as the ability of the organism to make contact with its environment spontaneously, deliberately and creatively. The function of the self is to contact the environment (in our terminology, the "how" of human nature).

To think of the "self as function" still represents a unique perspective among personality and psychotherapeutic theories. The theory of Gestalt therapy studies the self as a function of the organism-environment field in contact, not as a structure or an instance. This approach is based not so much on a rejection of contents and structures, but simply from the conviction that the task of anyone who studies human nature is to observe the criteria that produce spontaneity, not the criteria that allow human behavior to be schematized.

What does it mean to say that the self, as function, expresses a capacity or a process? Let's take as an example the newborn baby sucking milk: s/he *knows how* to suck. The child's ability to suck (and later to bite, chew, sit up, stand, walk, etc.) brings the child into contact with the world and supports her/his spontaneity. If the child is forbidden to suck (bite, chew, stand, walk, etc.), s/he must compensate by doing something else to make contact, thereby seeking a creative adjustment to the situation. For example, if a child is given bad milk or punished for trying to crawl, stand, or walk, s/he is significantly influenced by this experience. However, Gestalt therapy is not interested in judging the quality of the milk or the parents' behavior; rather, it is focused on how the child reacts. This allows us to look at how the organism can be supported in order to

re-acquire its spontaneous functioning, which for us is the aim and the means by which it lives: contact brought about through various abilities. What helps patients rediscover their spontaneity is not only knowing what was not good but also experiencing new possibilities of making contact or rediscovering their ability to spontaneously make a new creative adjustment – a new organization of the experience of the organism-environment field.

3.7.1. The Three Functions of the Self

Having defined the self as the complex system of contacts necessary for adjustment in a difficult field, the authors of *Gestalt Therapy* identified certain "special structures" which the self creates "for special purposes" (Perls, Hefferline and Goodman, 1994, pp. 156-157). These structures are clusters of experiences around which specific aspects of the self are organized. Although *Gestalt Therapy* uses psychoanalytic terms (especially the id, the ego), borrowed, as the authors themselves say, from the psychological language then in force, they are described in experiential and phenomenological terms, as capabilities of integrated functioning in the holistic context of the experience that constitutes the self. This epistemological inconsistency generates confusion. In any case, rather than replacing these terms with others that are more experiential, the recent theoretical development of Gestalt therapy is directed to putting in the background those partial structures of the experience of the self, in order to shift the focus to other processes, such as the co-creation of the contact-boundary. Id, ego and personality are just three of the many possible experiential structures: they are understood as examples of the person's capacity to relate to the world: the id as the sensory-motor background of the experience, perceived as if "inside the skin"; the personality as assimilation of previous contacts; and the ego as the motor which moves on the basis of the other two functions and chooses what to identify with and what is alien to it. Now, we will examine these three partial functions of the self.

The Id-Function of the Self

The id-function is defined as the organism's capacity to make contact with the environment by means of: a) the sensory-motor background of assimilated contacts; b) physiological needs; and c) bodily experiences and those sensations that are perceived "as if inside the skin" (including past open situations). (Perls, Hefferline and Goodman, 1994, pp. 156-157).

a) The ground of the sensory-motor experience of assimilated contacts. In the various chapters of *Gestalt Therapy* there are different definitions of "contact" that at times seem to conflict. For example, contact is a constant activity of the self (the self being in continuous contact), while also being described as a significant experience capable of changing the previous adjustment of the self. What, then, is contact? Is it sitting on a chair (physical contact between parts of the body and the chair) or something like making love for the first time with all the fullness of our being with the person with whom we are deeply in love? *Gestalt Therapy* makes reference to two kinds of contact: assimilated contact and the contact which brings novelty, which leads to growth.

In general we do not need to check every time, when we are seated, whether the chair is strong enough to hold us or whether we have to reconstruct the whole series of proprioceptive and motor coordinations that permit us to remain seated. Only a deconstructing event, such as the chair wobbling or breaking, would reactivate the self at the contact boundary between our body and the chair. Sitting on the chair includes the experience of the ground (which we need not recall as a figure) acquired in previous contacts, and becomes "taken for granted".

At the beginning of life, the individual has to learn everything, and everything is a novelty to be experienced, deconstructed and assimilated. The newborn child experiences a connection between crying and mother's arrival (or failure to arrive) and learns to regulate her/his inner sense of time. When mother does not respond, s/he may experience the anguish of abandonment. The sensory-motor ground of assimilated contacts, then, pertains to those specific acquisitions relating to the complexity of psychophysical development (Piaget, 1950) and of bodily experience (Kepner, 1993).

b) Physiological needs. In the context of Gestalt therapy theory, where the self is a function of the field, physiological needs constitute the excitement of the self that comes from the organism. The self can be activated by an internal excitement (generated by the emergence of a physiological need or event) or by an external influence (received from an environmental event). This distinction, however, exists only in our minds, since the self is a function of the field, an integrated process in which an environmental element may stimulate a physiological need in the same way as a physiological need may stimulate the perception of a part of the field not previously perceived. For example, seeing a fountain as we walk along under a blazing sun may remind us of thirst, just as thirst activates us to the search for water in the environment. These perceptive, relational dynamics were originally identified by the Gestalt psychology theorists (Köhler, 1940; 1947; Koffka, 1935).

c) Bodily experience and what is experienced "as if inside the skin". This third aspect of the id function synthesizes the preceding two, giving the sense of integration in an experience of basic trust (or lack of trust) in making contact with the environment. It reflects the delicate relationship between self-support and environmental support, between the sense of internal fullness and the sense that the environment can be trusted. The two experiences are linked; the more one experiences the sense of being able to trust the environment, the more one experiences an internal fullness as a relaxation of anguish or of physiological desires. Vice versa, the more secure one feels internally, the more it is possible and functional to entrust oneself to the world. Laura Perls was particularly attentive to this interconnection in her clinical work. Her attention to the patient's posture and gait enabled her to modulate her intervention, privileging the sense of self-support arising from the relationship with environmental support (L. Perls, 1990). Isadore From, on the other hand, connected psychotic experience to a powerful anxiety that characterizes contact-making through this experience of the self. For psychotics, the experience of what is perceived as "inside the skin" proves to be highly anxious-making and (what is still more important) is perceived as undifferentiated from or confused with what is "outside the skin". In other words, in the psychotic disorder we see the lack of perception of the boundary between the inside and the outside (see Spagnuolo Lobb, 2003a).

The Personality-Function

The personality function expresses the ability of the self to make contact with the environment on the basis of what one has become. «The Personality is the system of attitudes assumed in interpersonal relations […] is essentially a verbal replica of the self» (Perls, Hefferline and Goodman, 1994, p. 160). Thus, the personality function is expressed by the subject's answer to the question "Who am I?". It is the frame of reference for the basic attitudes of the individual (Bloom, 1997).

Contrary to what might be inferred from a parallelism with psychodynamic theories, the *personality-function* is not a normative aspect of the psychic structure. The *personality-function* expresses the ability to make contact with the environment on the basis of a given definition of self. For example, if I think of myself as shy and inhibited, I set up a completely different kind of contact with my environment than someone else whose definition of her/himself is as daring and extroverted. This concept recalls the empirical "me" of G. H. Mead (1934), whose theory influenced Paul Goodman (see Kitzler, 2007). The *personality-function*, in fact, pertains to how we create our social roles (e.g., becoming a

student, a parent, etc.), how we assimilate previous contacts, and creatively adjust to changes imposed by growth.

Thus, one of the basic aspects a therapist must look at is the functioning of the self at the level of *personality-function*. For example, an eight-year-old boy spontaneously uses language appropriate to his age. If he expresses himself in adult language, this may be viewed (as it is a modality of contacting the environment) as expressing a disorder of the personality function. The same may be said of a woman of forty who talks like a sixteen-year-old, or of a mother who behaves like a friend or a sister towards her children, or of a student who behaves like a professor, and obviously of a patient who defines her/himself as a person who has no need of help.

The Ego-Function

The *ego-function* expresses a different capacity of the self-in-contact: the ability to identify oneself with or alienate oneself from parts of the field (this *is* me, this *is not* me). It is the power to want and to decide that characterizes the uniqueness of individual choices. It is the will as a power, in the sense of Otto Rank's thinking (1941, p. 50), which is organized autonomously, and is neither a biological impulse nor a social drive, but rather constitutes the creative expression of the whole person (Müller, 1991, p. 45).

Thus, the *ego-function* intervenes in the process of creative adjustment by making choices, identifying with some parts of the field, and alienating itself from others. The ego is that function of the self that gives an individual the sense of being active and deliberate. This intentionality is spontaneously exercised by the self, which develops it with strength, awareness, excitement and ability to create new figures. «It is deliberate, active in mode, sensorially alert and motorially aggressive, and conscious of itself as isolated from the situation» (Perls, Hefferline and Goodman, 1994, p. 157). According to *Gestalt Therapy*, these are precisely the characteristics of the ego function that lead us to think of the ego as agent of experience. And once we have created this abstraction, we no longer think of the environment as a pole of experience, but rather as a distant external world, thus unfortunately seeing ego and environment not as parts of a single event.

The *ego-function* works on the basis of the information coming from all the other structures of the self. The ability to spontaneously deliberate is exercised in a harmony with the ability to contact the environment through what is perceived as if "inside the skin" (*id-function*) and through the definition given to the question "who am I?" (*personality-function*). It is the capacity to introject, project, retroflect and to fully establish contact.

A didactic example may be useful here. An emotion, normally experienced as a unitary phenomenon, can be described according to different functions of the self. According to the *id-function* when experiencing emotion, the muscles are perceived as relaxed or rigid and breathing is experienced as free and open or constricted. The *personality-function* defines the emotion as part of the self ("I'm the sort of person who feels these emotions"). The *ego-function* allows the development of excitement connected with the emotion, e.g., by introjecting (defining the experience as "I'm moved, it's okay with me"); by projecting (noticing the excitement in the environment too, for instance saying something like "I can see that other people are moved too"), or by retroflecting (avoiding full contact with the environment, pulling back or turning the energy on to the self, e.g., "I want to handle this experience alone").

The founders describe these *ego-functions* both as ability to make contact and as resistances to it (loss of *ego-functions*). This double use of the above terms reflects a fundamental consistency with the epistemological principles of Gestalt therapy, which does not separate healthy from pathological processes. However, the use of the same terms to describe normality and psychopathology may give rise to confusion, if the epistemological principles of process and phenomenology of the Gestalt theory of the self are not thoroughly learned.

3.8. The Experience of Contact - Withdrawal from Contact

Attention to the process in Gestalt therapy leads us to see the experience of contact as it develops, thus considering the time dimension. In fact, in an ordinary healthy experience,

> one is relaxed, there are many possible concerns, all accepted and all fairly vague – the self is a "weak *Gestalt*". Then an interest assumes dominance and the forces spontaneously mobilize themselves, certain images brighten and motor responses are initiated. At this point, most often, there are also required certain deliberate exclusions and choices. […] That is, deliberate limitations are imposed in the total functioning of the self, and the identification and alienation proceed according to these limits. […] And finally, at the climax of excitement, the deliberateness is relaxed and the satisfaction is again spontaneous. (Perls, Hefferline and Goodman, 1997, pp. 185-186).

The self is defines as the *process* of contact and withdrawal from contact. It is the process by which the self is expanded until it reaches the contact boundary with the environment and, after the fullness of the encounter, withdraws. The experience of contact is described in *Gestalt Therapy* as the evolving of four phases (*fore-contact, contact, final contact, post-contact*), each with a different stress on the figure/background dynamic.

The activation of the self is called *fore-contact*, the moment at which excitements emerge which initiate the figure/ground process. As an example of the development of the self, let us take the need of hunger. In *fore-contact* the body is perceived as ground, while the excitement (need of hunger) is the figure. In the following phase, that of *contact*, the self expands towards the contact boundary with the environment, following the excitement which in a *sub-phase of orientation* leads it to explore the environment in search of an object or a series of possibilities (food, various types of food). The desired object now becomes the figure, while the initial need or desire withdraws into the ground. In a second *sub-phase of manipulation*, the self "manipulates" the environment, choosing certain possibilities and rejecting others (it chooses, for example, a savory, hot, soft food rich in protein), choosing certain parts of the environment and overcoming obstacles (it actively looks for a place, a restaurant, a bakery, a diner where the chosen food can be found).

In the third phase, the *final contact*, the final objective, the contact, becomes the figure, while the environment and the body are the ground. The whole self is occupied in the spontaneous act of contacting the environment, awareness is high, the self is fully present at the contact boundary with the environment (the food is chewed, tasted, savored) and the ability to choose is relaxed because there is nothing to choose at that moment. It is in this phase that the nourishing exchange with the environment, with the novelty, takes place. This, once assimilated, will contribute to the growth of the organism.

In the last phase, *post-contact*, the self diminishes, to allow the organism the possibility of digesting the acquired novelty, and to integrate it, quite unaware, in the pre-existing structure. The process of assimilation is always unconscious and involuntary (like digestion). It may become conscious to the degree that there is a disorder. The self, therefore, ordinarily diminishes in this phase, withdrawing from the contact boundary.

It is clear that this example cannot do justice to the complexity of the system of contacts of the self, which are constantly in action, at various levels, and which constitute the current experience of the individual. One may read a book (mental contact) lying in a hammock (taken-for-granted contact, unless the hammock overturns), listening to the birds singing (acoustic contact), smelling the scent of the flowers (olfactory contact) and relishing the warmth of the sun (kinesthetic contact). In this complex system of contacts, however, the organism is prevalently centered on one – the one it chooses and identifies with in order to grow. It may be reading the book if the emerging need is linked to mental growth, or listening to the birds singing if this acoustic contact evokes emotions and thoughts that are important at that moment, or something else.

At this point it must be admitted that an important limit of the theory of the

experience of contact developed in the founding volume (Perls, Hefferline and Goodman, 1951) is the lack of differentiation between human and non- human environment (see Robine, 2006a). The most important originality of this theory consists in looking at the contact from the perspective of the "between", of the contact boundary. An absolutely necessary development is the specification of the difference between the contribution of a (non human) environment, which does not react, and that of a (human) environment which reacts to the creativity of the individual equally creatively. As Wheeler (2000a) stresses, this homologation leads to a perspective centered on the individual rather than on the act of co-constructing the contact. This is the *growing edge*, the boundary in development, and the challenge of the theory of the experience of contact today.

3.9. The Disorders of the Functioning of the Self. Psychopathology and Gestalt Diagnosis

«A strong error is already a creative act and must be solving an important problem for the one who holds it» (Perls, Hefferline and Goodman, 1994, pp. 20-21). The first question we ask regarding the issue of psychopathology is: "How can we speak of psychopathology in Gestalt therapy?" (Robine, 1989). The basic understanding of resistances as creative adjustments leads us think of psychopathology in a remarkable way. We believe that any symptom or behavior that is usually defined as pathological is a creative adjustment of the person in a difficult situation. The so-called losses of *ego-function* are creative choices to avoid the development of excitement during the various phases of the experience of contact with the environment. This excitement, as it is not supported, would lead to an experience of anxiety, as I've said before.

Habitual interruptions of contact lead to the accumulation of uncompleted situations (interrupted spontaneity leads to open *Gestalten* and unfinished situations), which consequently continue to interrupt other processes of meaningful contact.

The *anxiety* accompanying the primary interruption of contact (which, as the situations are repeated, becomes habitual) is the consequence of excitement not being adequately supported by oxygen (adequate breathing) at the physiological level and by environmental response at the social level (Spagnuolo Lobb, 2001c, 2001b). This type of excitement cannot lead the organism to the spontaneous development of the self at the contact boundary. Retroflection is the interruption most often seen by the therapist in the patient. You must "peel the onion", as Perls put it, in order to arrive at the primary interruption.

Many of us, especially within the *New York Institute for Gestalt Therapy*, wondered what is blocked, in the case of the interruptions described by Perls,

Hefferline and Goodman (1994, pp. 228-239). Is the contact blocked? And how can the contact be blocked if there is always contact? What else, then, is blocked? My answer is that the spontaneity with which contact is made is blocked, not the contact as such (Spagnuolo Lobb, 2001a). The contact in fact comes about in any case, it is the quality with which it happens that changes, making it less spontaneous and hence a source of anxiety.

Spontaneity is the quality that accompanies being fully present at the contact boundary, with full awareness of oneself and with full use of our senses. This is the condition to see the other clearly. A dancer moving spontaneously dances with grace, but without knowing which foot moves first. When *spontaneity* is interrupted (the dancer might be afraid of not moving his feet at the right moment), excitement becomes anxiety to be avoided (dancing becomes heavy); the *intentionality* is developed along complex, distorted lines (the self-who-dances becomes for instance the self-who-watches-the-person-who-dances); and the *contacting* comes about with anxiety (of which one is unaware) and happens via introjecting, projecting, retroflecting, egotism or confluence.

To take another example, if a young girl spontaneously feels the desire to hug her father, and she encounters the father's coldness, she interrupts her spontaneous movement towards him, but she does not block her intentionality to contact him. The excitement of "I want to hug him" is blocked in an inhaling movement (she holds her breath), and, unsupported by oxygen, becomes anxiety. In order to avoid this anxiety, she learns to do other things, and forgets it. What she does is to establish a contact by means of styles of interruption or resistance to spontaneity such as:

- *Introjecting*: the development of excitement is interrupted using a rule or a premature definition, (e.g. "you shouldn't be expansive", or "fathers should not be hugged");
- *Projecting*: the development of excitement is interrupted by disowning it and attributing it to the environment (e.g., "my father is rejecting me", or "my expansiveness must be wrong for him");
- *Retroflecting*: the development of excitement is interrupted by turning it back on herself instead of letting it lead to fully contacting the environment (e.g., "I do not need – it is not good for me – to hug him");
- *Egotism*: contact with the environment happens, but it is over too soon, before the novelty brought by the environment is contacted and assimilated (e.g., the girl hugs her father but does not experience the novelty of this event, and says to herself: "I knew that hugging him wouldn't be anything new for me");
- *Confluence*: the girl's excitement is not developed, since the process of differentiation of organism from environment does not even start (e.g., she takes her father's coldness as her own attitude and does not even think of the possibility of hugging him).

Besides the above-mentioned “losses of the *ego-function*”, we need to ask which function, the *personality-function* or the *id-function*, is mainly disturbed. When there is a disorder of the *personality-function*, a rigidity or anxiety towards a novelty in the field regarding social relationships disturbs the contact and the ego loses certain abilities. One example might be that of becoming a mother, which requires not only a biological change but also a change in social relationships (being mother of a child). What seems new is defined as “not for me” by the *ego-function* (in that the support of the *personality-function* is lacking), which cannot adapt to the changes in the social relationships or in the cultural values or the language presented by the current situation. In conjunction with the *id-function*, through which what is felt is organized, disorders of the *personality-function* contribute to the loss of functioning of the ego and are at the root of neurotic disorders.

In contrast, in the case of psychoses, there is a serious disorder of the *id-function*: the ground of securities arising from assimilated contacts is missing and the ego cannot exercise its ability to deliberate on this ground. Thus contacting is dominated by the sensations that invade a self which, so to speak, “has no skin”. All that happens on the outside is potentially experienced as if it were also happening on the inside: the self moves without the clear perception of the boundaries with the environment (confluence), in a state in which everything is anxiety-inducing novelty (one cannot be sure that there will not be an earthquake in a few seconds) and nothing can be assimilable (because nothing can really be recognized as different, as new). This disordered experience of the *id-function* can be read in the breathing and posture, in the way the patient looks at others and in her/his manner of relating in general, as well as in her/his language. The body and the language are, indeed, for this reason the most important tools of phenomenological reading for the therapist. For example, a patient might define her/his experience by saying: “Your voice has entered my brain”, or “That glass of water has destroyed my stomach”, or “It wasn’t the hero of the film who was bleeding, it was me, but you could see it on the screen”, or again “When you smile I breathe easier”. These examples remind us of the strict connection between external and internal in the case of psychotic experiential structures, and the need to consider them in the therapeutic intervention (Spagnuolo Lobb, 2002a, 2003a).

I shall go more deeply into Gestalt diagnosis in Chapter 4, which is devoted to this subject. The aim of this section is simply to define the epistemology of psychopathology and of Gestalt diagnosis[14].

[14] See also Francesetti and Gecele (2010).

3.10. Psychopathology as Creative Adjustment

What has been said thus far implies a number of fundamental points. First of all, to consider human development and psychopathology as *creative adjustment* (see Spagnuolo Lobb and Amendt-Lyon, 2003). There are not some behaviors that are mature and right and other behaviors that are mistaken or immature. The terms "healthy", "mature", or "pathological", "immature" all make reference to a norm external to the experience of the person, set by someone who is not immersed in the situation (and who for precisely this reason can claim to be "objective"). The phenomenological perspective, though in the dilemma between subjectivity and objectivity that is a central question in the thought of many philosophers (from Husserl to Heidegger to Merleau-Ponty and in some respects also Kierkegaard and Adorno), considers experience to be that which gives *the* knowledge, and which can in no way be replaced by conceptual analysis (Watson, 2007, p. 529). Hence it is important to consider the intentionality of a behavior, in other words the contact that animates and motivates it. A knowledge which is incarnated, intentioned-to-contact and esthetic, rooted in the unitary nature of organism/environment, is what does most justice to our approach. As Merleau-Ponty (1965 or. ed; 1979) reminds us, phenomenological knowledge every time implies a "re-learning to look": in the world of phenomenology knowledge does not exclude intuition, in that it emerges from perception (Merleau-Ponty, 1965) and – since perception is based on the senses – it is strictly linked to esthetic judgment. Defense, which in a psychodynamic perspective has traditionally been seen in its impedimental aspect to the therapeutic process, in the Gestalt approach is seen, in contrast, as a relational ability based on a *process* of creative adjustment to be supported. This permits psychotherapy to move from an extrinsic model of health to an esthetic model, based on the current perception of the encounter between therapist and patient, so on factors intrinsic to the relationship (see Spagnuolo Lobb, 2011c, p. 117; Francesetti and Gecele, 2011). Gestalt diagnosis focuses on the modality of contact with which the person avoids the anxiety of the excitement of contact, and makes it possible to identify the type of contact on which the therapeutic relationship will be staked.

Hence the clinical problem that is posed to the Gestalt therapist is in line with phenomenological research, which, starting from the natural evidence, arrives at a transcendental knowledge, setting aside any judgment and letting ourselves be guided by intuition. It is also in line with pragmatism, which roots the experience in the sensation (James, 1983) and considers it to be an esthetic process of the organism and the environment in co-creative equilibrium, gifted with grace, harmony and rhythm (Dewey, 1934)[15]. The Gestalt therapist does

[15] See Bloom (2007, p. 100).

not intend to bring the patient to a "healthy" or "mature" standard of experience or behavior, but to lead her/him to (re)appropriate spontaneity in making contact, to (re)acquire the fullness of her/his being-there in the contact. The therapeutic task consists in helping the person to recognize the creative experience of her/his adjustment, re-appropriating it in incarnated manner, without anxiety, in other words with spontaneity.

In the current scientific fervor for the relationship, neuroscientific research, which with ever-increasing emphasis confirms the relational nature of the brain[16], and the most recent reflections of Daniel Stern (2010), who sees in the perception of forms in movement the basic unit of consciousness, confirm the intuition of the founders of Gestalt therapy, according to whom the primary reality is the co-created presence at the contact boundary, the *Gestalt* emerging from the encounter of the intentionalities of contact.

Comment

by Gordon Wheeler

Belonging and differentiation, identity and evolution, conservation and change: these are the essential elemental dynamics we recognize as definitional of relationship *(differentiated connection), complexity (a field viewed in terms of relational dynamics), and for that matter* life itself *(any bounded sub-field marked by capacity to act in its own behalf). Since its beginnings a century ago in the psych labs of the early Gestalt psychologists, our Gestalt model has stood firmly for respecting the complexity of these relational processes as actually lived and experienced by living subjects in real situations, moving to potentiate their own creative adaptations to those changing conditions. Thus the focus of Gestalt study quickly became* understanding the processes and structures by which human subjects organize and interpret their perceived worlds, rendering event into coherent experience through interpretation, evaluation, and action. *Action research, the integrative tool and perspective pioneered by Gestaltist Kurt Lewin, is the hallmark Gestalt method and stance: we treat everything as an experiment, experience/evaluate the outcome, infer the process patterns which seem to be functional/flexible or uncreative/stuck – and add support for new test of the usefulness of those inferences, deconstructing those patterns where they are no longer adaptive, and so on. Everything we do in*

[16] Gallese's most recent studies (2007) specify that the ability to intuit the other (attributed to the mirror neurons) is linked to the perception of intentional movements: the mirror neurons are activated in front of an intentional movement made by the other, not in front of a repetitive movement.

Gestalt can be looked at as an application/variation of this action-research frame of mind; and everything potentially becomes material for a new ongoing experiment, which is life itself.

Building on the path-blazing work of Lewin and others who had taken this revolutionary approach to understanding human process out of the psych lab and into "real life" situations, Goodman and Perls and their early collaborators then set out at mid-Century to render this legacy into an articulated method for application to individual and group-setting psychotherapy, and by extension, to ordinary life as well. As Spagnuolo Lobb rightly insists here, they did this necessarily in the context of their own times and their own personal histories. In that immediate post-War era, still at the highwater mark of all the mass fascisms of the 20th Century, it made sense that a Sartrean individualism and "autonomous criterion of value" might seem to them the most reliable place to ground a restoration of the health, creativity, and free movement of the human spirit (even though that approach did contradict some of the field/relational implications of the inherited Gestalt legacy). Today, in the age of the soft fascism of consumerism, mass media, and profound isolation, our situation and our felt needs are differently weighted; and our method must evolve creatively, to remain true to its own roots and identity and its own theoretical and practical potential.

This kind of contextual perspective is basic to hermeneutic inquiry*, which Spagnuolo Lobb has long and fruitfully championed in our field: the demand that we understand each articulation of core principles, each identity text "from the inside", in terms of the perspectival values and choice points it promotes* in the context of its own situation – as we interpret those values and choices now*, conditioned as we are by our own current situations. This then takes us into the open-ended "hermeneutic circle" of endlessly recursive creative interpretation, since a dialogue of interpretations, including reflexive interpretations of our own perspective here and now, is the very essence and nature of our human contact process. We make meanings, cocreatively, and move on; and we know those meanings are never finished, never final.*

But what is that identity? What are the "core principles" we shall steer by, as we conduct and live out this hermeneutic process, dialoguing with (our interpretation of) the identity core of our legacy, in dialectic with (our interpretation of) the context of those core principals' original exposition, and (again, our interpretation of) our situation today? This process may then feel like an invigorating adventure into an ever-new world – or more like a destabilizing series of funhouse mirrors, shadowboxing with shadows with no sure grounding underfoot. The difference between these two possible responses to the challenge of the hermeneutic perspective, as Gestalt insists, will be in the quality and amount of support *offered and used out of the field, in the face of this chal-*

lenge. Most fundamental to that support, of course, is the quality of presence and contact offered by the clinician/facilitator/practitioner herself, in the process of intervention.

Spagnuolo Lobb's approach here is to offer us the support of a highly useful and creatively updated review of the core topoi *or main thematic attractors of our inherited theory, as presented in our inherited 1951 text. In her treatment, each of the key thematics of the original presentation is woven quite seamlessly into the increasiong relational emphasis which has characterized the next sixty years of Gestalt (an evolution in which Spagnuolo Lobb herself has played a significant role). The result is both highly coherent and immediately applicable, especially in the classic setting of one-to-one therapy, dyadically or in a group setting. Using this evolved thematic catalog to make the move from this modality to others including larger social formats may still be something of a stretch, in much the same way it was a stretch to apply Goodman and Perls' (or for that matter Freud's) original formulations of these topics to larger groups and other settings.*

Another approach to this question could be step back to the original exploration of the constituent processes of experience-formation itself, which characterized the first four decades of Gestalt research and practice leading up to Goodman and Perls' work, and is summed up in a useful way in Lewin's action research perspective referenced above. Today's Gestalt landscape across the world is one in which individual therapy is only a small part of the rich application of contemporary Gestalt theory and methods. That application ranges through counseling, group work, couple and family therapy, executive and life coaching, organizational consulting, management, intensive group treatment modalities, education, and political work and organization at both mass and high levels. Along with Spagnuolo Lobb's lively reformulation here, we may need other perspectives as well on the this rich hermeneutic dialogue, to accommodate all the fruitful applications of the Gestalt legacy today.

Gestalt Therapy Approach to Psychopathology

by Gianni Francesetti, Michela Gecele and Jan Roubal

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 sub-

[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).

jects 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].

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

[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 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.

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

[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).

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 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

[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).

[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).

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 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 defini-

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

tion 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 con-

tact experience has been uprooted from the world commonly taken for granted, from the ground given by assimilated contacts.

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

[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, 1931; Heidegger, 1953; Merleau-Ponty, 1945; Maldiney, 2007; Kimura, 2000; 2005) 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

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 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, fluidi-

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).

ty, 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 possi-

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

bilities. 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 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

[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).

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).

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 ex-

[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).

emplary 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.

Aesthetic: the criterion that distinguishes what is healthy and what is unhealthy is intrinsic to the relationship (see above). It is an aesthetic criterion:

[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.

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».

Comment

by Peter Philippson

I want to congratulate the authors for taking on a much-needed subject: the meaning of psychopathology within a relational framework. There is a need to avoid the trap of seeing what the client brings as a given, which the therapist or psychiatrist merely observes and diagnoses or treats. As a general Gestalt theme, a person does not adjust him/herself to a situation which s/he enters, and therapy is not merely about helping them adjust better. The way the person enters *the situation (with confidence, fear, aggression, eroticism) affects not just how s/he experiences the situation but the actuality of what s/he finds. Of course, the same applies to the other people who make up the situation. In therapy, this entering into the "occasion of the other" (Robine, 2012) is what is explored.*

Yet there is a way in which I think it is wrong to speak of "the suffering of the field (or relationship or contact boundary)", as this chapter does. "Suffering" is a value-judgement put onto raw experience, and it is at the level of the person, not the field or the relationship, that such values are applied. It is per-

fectly possible for one person to find a relationship satisfying and to become startled to find that the other person does not. And it is also possible that the person will not allow of a relationship that functions in a mutually happy way. To give an analogy, factory emissions produce "acid rain" that adversely affects trees, so from one perspective is ecologically wounding. On the other hand, acid rain pulls greenhouse gases from the atmosphere more than normal rain, so has some protective function against planetary warming. What may hurt one part of a system can enhance another part: this is inherent in evolution. To say that the situation where someone suffers involves the whole field does not imply that the suffering *belongs to the whole field. The background does* not *"give meaning to the figure": meaning emerges in the interaction between figure and background, as the figure and background are energised/cathected by the person. Neither figure nor background are meaningful independently from how they are perceived by the person.*

Furthermore, there is an assumption that relationship is a given. Yet some people work to improve the relationship and others leave. A person may complain to friends about their partner, and they say "leave them and you'll be happy", and in some cases that would be true. In the situations that come to therapists, the underlying problem is that they will eventually be back in similar relationships. The other person is involved in this process, but is that what we are working with? From a Gestalt perspective, we would be looking at how the relationship between therapist and client becomes difficult, and what happens if we do not follow the usual track as the client's relationships. But I would not see that as a suffering relationship between therapist and client, but a complication that is revelatory of the fixed processes the client invites and participates in, which cause suffering for the client. Indeed, it would be problematic if the client tried to "behave well" with the therapist and only brought the relational difficulties as reports.

This leads to a further problem in seeing suffering as belonging to relationships. Therapists usually do not work with both parties to the relationship, and the other person is only present as reported by the client. The most significant dynamic in the therapy situation is the relationship with the therapist, and the reporting belongs to that relationship more than to the relationship with the partner. The client may be trying to show that they are blameless, or that they are totally to blame. I tell supervisees to imagine the client goes to his/her partner and describes their therapist (the supervisee): would they expect to recognise themselves? If not, why would they expect that the partner would recognise his/her description as given to the therapist? Those of us who do couples work know that the same relationship is described in very different ways by the two people.

So how does one conceptualise a field-relational approach to psycho-

pathology? Fortunately I believe that Gestalt Therapy theory provides an answer. The pathology is truly a pathology of the psyche *or self, in terms of fixed, unaware patterns in neurosis, or absence of a functional self/other boundary in psychosis. However, as self forms in contacting and assimilates from achieved contacts, even though these are patterns inherent in the individual's self-process, change will emerge from new contacting and relational possibilities within the therapy, coupled with a refusal of the therapist to follow the habitual pattern. Even the concept of "support" needs to be seen as a relational event rather than something one person gives to another. Support involves what is received as well as what is given, and it is perfectly possible for someone to make themselves "unsupportable". Conversely the client can only maintain fixed behaviour if the therapist acts in ways they can view as supporting that behaviour: for example, if they can see the therapist as confirming that they are wrong and bad, or as replaying parental demands to fit in that they are perfectly capable of resisting.*

Gestalt Therapy Approach to Diagnosis

by Jan Roubal, Michela Gecele and Gianni Francesetti

1. Introduction

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

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

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

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

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

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

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

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

2. Intrinsic or Aesthetic Diagnosis

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

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

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

This kind of orientation is based on the intuitive evaluation of a contact situation: it is a specific kind of knowledge that emerges at the contact boundary in a moment when the organism and environment are not yet differentiated. For this reason, the aesthetic knowledge is implicit (pre-verbal) and already attuned to the intersubjective dimension (D'Angelo, 2011; Desideri, 2011; Francesetti, 2012). Guidelines for the next intervention are immediately evaluated according to aesthetic criteria. Only later can the therapist name (mostly quite vaguely) the process of making her/his decisions: "It seemed the right thing to do in that moment"; "I would not dare to say it in that situation", etc. Time is not spent on cognitive processes, because this kind of evaluation is pre-cognitive and pre-verbal and implies not only a passive act but also an activity, leading the therapist straight to intervening action. Working with intrinsic diagnosis we

use intuition[3] as a source of support for a therapist. Most immediate interventions are not made from a conscious cognitive deliberateness, but the therapist's awareness orients her/him throughout the aesthetic criteria. Often, only after the session can the therapist find a way of describing verbally and understanding cognitively what s/he did and what were the reasons for the interventions.

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

What does it really mean making an intrinsic kind of diagnosis? To be aware, awake, with senses active, and at the same time relaxed, allowing yourself to be touched by what happens (Spagnuolo Lobb, 2004b; Francesetti, 2012). To remain confident that a chaos does indeed make "sense" and that with sufficient support a meaning will emerge. The therapist is not disoriented, but present. He is not idle, but ready to join the dance that unfolds at the boundary where the patient and therapist make contact. The therapist is ready to gather intentionality and to support the unfolding of breath. It is the intentionality towards contact that brings order to intersubjective chaos. When the arrow of intentionality loses energy and falls, it is recovered by the therapist, who gives it new momentum. When the arrow falls and is recovered and relaunched, the emotive intensity of the moment is heightened. Moments of fullness of contact are always unpredictable: we do not know when they will occur, in which minute or second of contacting. They do not occur by chance though: it is the therapist who helps deliver those moments by supporting the intentionality of the patient as it unfolds second by second and encounters the therapist's own intentionality (Bloom, 2009; 2011a).

Intentionality orients the therapeutic process. A loss of momentum, a drop or interruption in intentionality will prompt the therapist to intervene: intervention may also be silence, immobility, or almost imperceptible movement. The

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

intervention is directed towards the completion of a *Gestalt*, supports the potential that is ready to appear. How does the therapist notice the movement or interruption of intentionality? The answer lies in being present at the contact boundary, with senses alert and an awareness of one's bodily, emotive and cognitive resonances. These resonances emerge indistinctly, not by cognitive process, but rather by giving time to unfold, and only through later reflection can they be distinguished.

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

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

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

3. Extrinsic or Map Diagnosis[4]

3.1. Do We Need to Diagnose?

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

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

The mistrust of Gestalt therapists towards diagnostics warns us of the risk of becoming experts for the lives of our patients, the risk of treating our image of the patient and not meeting the patient. However, it is important to realize, that we cannot avoid making some kind of diagnosis. Every experience is random, changeable, amorphous and chaotic in the moment of its birth (Melnick and Nevis, 1998). A basic human tendency is to organize each experience into a meaningful structure. We organize our experience of the presence of other people, we give name to our experience, we give it a structure[6]. We label our surroundings all the time. However, in the position of a therapist we must do it

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

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

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

with the patient's benefit in mind and constantly reflect on the process of formulating a diagnosis.

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

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

Diagnosing helps the therapist to gain orientation and consciously differentiate between therapeutic styles of working with different patients. It is necessary that Gestalt therapists should not stagnate solely focusing on observation of the present interactions, but that they should also be capable of forming operational hypotheses, to set both short-term and long-term treatment projects (Mackewn, 1999).

3.2. History and Context of Psychiatric Diagnosis

Diagnosis comes from the Greek *dia-gnosi*, meaning "to know through" (Cortelazzo and Zolli, 1983). This in itself stresses the impossibility of not using diagnosis, in broad terms at least. In the last century, the philosophy of science and hermeneutics taught us that knowledge free of all filters and fore-

knowledge cannot exist. If we can only know *through*, and there is no *gnosis* without *dia*, the question transforms into which *dia* (which prejudices, which presuppositions) should we use (Salonia, 1992). For diagnostics, the most influential *dia* in our society has been the medical model.

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

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

From the sixties of the twentieth century psychiatric diagnostics applied a more *empirical* approach based just on observable phenomena (e.g. diagnosing simply depressive symptoms without speculating about their causes). Moreover, diagnostic systems started to describe not only the psychopathological symptoms. Other diagnostic axes were included to cover also the personality, life style, degree of disability and the environment of a patient. Today we have two predominant psychiatric diagnostic systems (DSM IV, ICD 10). They present careful though arbitrary outlines whose purpose is to simplify the distress-territory so as to communicate through the use of a map shared by everybody working in clinical practice.

[7] The problematic nature of using medical diagnosis in the field of psychopathology soon also began to be appreciated, as were the risks associated with it (Jaspers, 1963; Minkowski, 1927; 1999): the risk of objectifying that which cannot be objectified; the risk of crystallizing that which is constantly changing; the risk of losing the subjective experience of the patient, which is precisely what the therapist seeks to grasp and define. In short, the risk of making the epistemological error of treating subjective experience as an object of nature. The diagnostic act traces out demarcation lines that always respond to very precise epistemological structures. Diagnosis reflects the world view of the person performing the diagnostic act. Hence, diagnosis is in some sense arbitrary.

3.3. Diagnosis in Psychotherapy

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

There are several different kinds of psychotherapeutic diagnostic systems. The Gestalt approach as a part of humanistic and experiential traditions considers psychotherapeutic diagnostics not as a fixed system of boxes into which patients are meant to be put, rather it is a system of clues helping the therapist to continuously orientate her/himself in the ongoing therapeutic process and to create a useful map of a therapeutic situation. The therapist creates this map aware of the fact that it is merely a simplification of reality and that he himself is a part of this landscape under examination. While remaining in a relationship with his patient, the therapist watches the ongoing change of a unique therapeutic process and consequently adjusts his description of a situation in cooperation with his patient.

3.4. Gestalt Approach and Diagnosis

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

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

From a Gestalt therapy point of view diagnosis is a process of naming the emerging meaning of the complex and changeful clinical situation. Gestalt diagnosis is not pointed at fixed conclusions (Brownell, 2010a) but serves as a flexible and momentary working hypothesis (Höll, 2008), which enables the therapist to orientate him/herself in a clinical situation and to consider accurate therapeutic paths. Diagnosis is most useful when kept descriptive, phenomenological and flexible (Joyce and Sills, 2006). The Gestalt therapist co-creates and continuously corrects the diagnosis through dialogue with the patient. The therapist who is formulating a diagnosis represents an inseparable part of the actual web of relations and, thus, the phenomena of the interaction between the therapist and the patient are important objects of the therapist's explorative interest.

Throughout history, Gestalt therapists either shunned diagnosis[9] or they strived to create its specific Gestalt version (Brownell, 2010a). The Gestalt approach has traditionally stood against the objectifying, pathologizing and depersonalised labelling of people (Perls, Hefferline and Goodman, 1951, 1994), widely used in medicine and early psychoanalysis. Different theoretical conclusions were emphasized, based on the interconnection of the field phenomena and the uniqueness of the life story of each person[10].

On the other hand, there has always been a need present in the Gestalt approach to deal with typology for the sake of the therapist's orientation and choice of intervention (Perls, Hefferline and Goodman, 1951, 1994). Diagnosis cannot be avoided and so the choice, here, is either to do it inadvertently and negligently, or thoughtfully and with full awareness (Yontef, 1993). Gestalt therapists are aware of the risk that they would treat the diagnosis instead of the patient and their approach would become depersonalized and anti-therapeutic. They are also aware that rejecting diagnostics and differences among people can bring about similar effects (Delisle, 1991).

Although shared clinical and diagnostic models grounded in Gestalt theory have yet to be developed, there have been many attempts to constitute a diag-

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

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

nostic system (e.g. Tobin, 1982; Delisle, 1991; Swanson and Lichtenberg, 1998; Melnick and Nevis, 1998; Baalen, 1999; Fuhr, Sreckovic and Gremmler-Fuhr, 2000; Francesetti and Gecele, 2009; Dreitzel, 2010; Roubal, 2012). These authors invest much effort in the use of terms from both general psychopathology and the theory of Gestalt therapy. It is not an easy task since psychopathological and Gestalt terminology each originate in different paradigms. Authors have often turned their attention to the connection, briefly addressed in the final part of Perls, Hefferline, Goodman (1951, 1994), between suffering and the manner in which contact is interrupted. This kind of analysis offers guidance for the therapeutic process and different interpretative keys (Salonia, 1989b; 1989c; Müller *et al.*, 1989; Spagnuolo Lobb, 2003a).

The Gestalt diagnosis focuses on the way of relating between the patient and her/his environment and describes the processes occurring at the contact boundary[11]. In healthy contact there is a smooth sequence of forming a contact and withdrawing from it. If these processes are blocked, the contact is considered unhealthy (Korb, Gorrel and Van de Riet, 1989). The contact sequence can present drops in intentionality and losses of spontaneity originally described as contact interruptions (Perls, Hefferline and Goodman, 1951, 1994) and nowadays often called modifications or flections of contact (see chapter 23 on anxiety). Gestalt Therapy studies how and when they can occur. It teaches us to sense these modifications of contact when they are applied rigidly and to offer a wider range of possible ways of contacting so as to support the relationship (Perls, Hefferline and Goodman, 1951, 1994; Salonia, 1989c; Spagnuolo Lobb, 1990; Robine, 2006a).

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

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

However, caution is needed here. When partial models from Gestalt therapy theory are used for diagnostics (e.g. the contact sequence and the styles of contact) there is a risk, that the attempt to grasp the clinical situation might betray the theoretical basis of Gestalt therapy. There is hardly any difference in, for

[11] For the elaboration of the term "contact boundary" see note 21 in chapter 2 (*Gestalt Therapy Approach to Psychopathology*).

example, labelling the patient as "depressive" or as an "introjector". Both cases put the label "there" on the patient and eliminate the vital contribution of the Gestalt approach, which is openness towards encounter and reliance upon the process. Brownell (2010a, p. 190) poses a question: «How do we speak *about* the patient without doing damage *to* the patient?».

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

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

3.5. How an Extrinsic Diagnosis is Formed

The therapist has the skill to change his/her focus during the therapeutic process. S/he is focused on the relationship with the patient and heading towards a full contact at one moment. Then s/he can switch the focus to the "third", which in this case is a description of the meaning of the situation, and s/he is heading towards orientation and understanding. The therapist cannot be outside the relationship with her/his patient even if s/he diagnoses. But when s/he is making an extrinsic diagnose, her/his intention for the actual moment is to withdraw temporarily in order to orientate her/himself[12]. The therapist tem-

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

porarily and deliberately gives her/himself time so her/his awareness can organize itself and s/he can name the meaning of it[13]. In this way s/he creates an extrinsic diagnosis, a map of the territory of the clinical situation[14].

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

Phenomenological observation provides information about the patient: how s/he looks, what her/his bodily structure is, what expression s/he is putting on, what s/he is wearing, how s/he talks etc. Further information is obtained from anamnestic data, either given directly by the patient himself or drawn from other sources (medical reports from the patient's general practitioner, his psychiatrist, or his relatives). The therapist learns about the patient's family, the history of similar difficulties among his relatives, the quality of relationships within his family, the patient's previous and present social situation, the character of her/his existing relationships, the duration and development of her/his suffering, the kind of treatment s/he has already been subjected to, etc. All the data are observed and become one of the sources of a diagnosis as a working hypothesis. Gestalt therapists should have enough clinical experience to evaluate the phenomenological observation and recognize signs of serious suffering of the patients (depressive, psychotic, dependent, etc.).

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

The therapist is relating to her/his patient all the time, but the focus of

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

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

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

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

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

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

3.6. There are Different Maps

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

Imagine you are walking in a park and you notice a sculpture. You look at it, sense and explore it. Then you go around it and look at it from a different place. It is the same sculpture and yet you perceive it differently now. Then you change the place again and look at the sculpture from some other perspective. One perspective is not enough to meet the sculpture. This metaphor is used here for a clinical situation and diagnosis. There is an epistemological disagreement between medical and Gestalt approaches. However, it does not have to lead to an unproductive conflict: "The sculpture must be seen from this perspective!". Instead, the observer can be more aware of the place from which s/he is observing and what perspective another place can offer. What we see depends upon our point of observation. With different perspectives we create different maps, different types of diagnosis of the same clinical situation[16].

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

The content of diagnosis depends on the perspective from which the practitioner observes the clinical situation. It is most important that the therapist recognizes the perspective s/he is applying at a given moment. If s/he were to con-

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

fuse the different perspectives, it would make it impossible for her/him to benefit from any of them.

There are three perspectives that can be used by Gestalt therapists when forming a diagnosis (see Fig. 1). These three perspectives are frequently used in Gestalt literature and they are also very often used by Gestalt practitioners when referring to their clinical work. However, they are often not well differentiated from each other, which causes a theoretical confusion and limits their use for a daily psychotherapeutic practice. We want to offer a tool here for the recognition and use of the three ways of conceptualizing a situation: "co-creation perspective", "context perspective" and "symptom perspective".

With the first perspective, which is a specific contribution of Gestalt therapy to the psychotherapic field, the therapist observes a process of the co-creation of the field organization here and now. With the second perspective s/he observes interactions and roles within a relational system and its story. And with the third perspective s/he observes clinical symptoms. Adopting these perspectives deliberately and separately helps the therapist become aware of their individual benefits as well as their limits. With each perspective we create a different kind of map. They can then complement each other and form a multidimensional diagnosis. Each map describes different features of the territory and is useful for different situations.

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

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

Patients often come to therapy with a previous way of thinking and an expectancy gained in a medical context: the problem needs to be identified and an

appropriate treatment needs to be found. Therapists need to respect this initial setting of patients to be able to establish a working alliance.

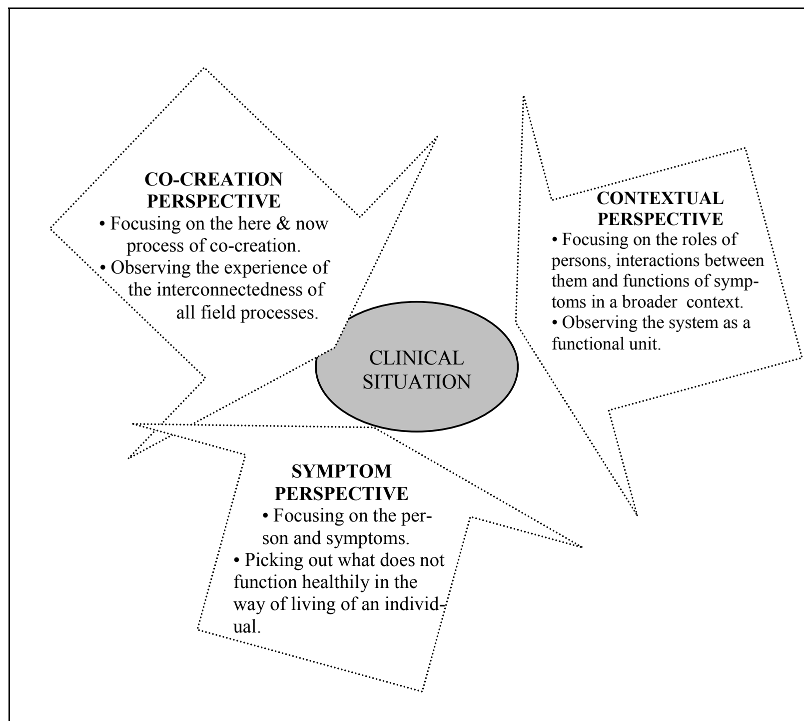


Figure 1. The picture shows three possible diagnostic perspectives of Gestalt practitioners. During the process of formulating a diagnosis a therapist is aware of the specific focus s/he is applying when looking at the therapeutic situation. The focus will emerge from the process of contact.

We agree with Wollants (2008, p. 25) that «despite their emphasis on the unitive interactional field, most Gestalt therapists still consider that illness is a category of psychological disturbance that applies to the individual person». What we suggest is to use this individualistic perspective deliberately when useful for the patient, enabling us to distinguish and use fully the perspective of suffering of the "between" (Francesetti and Gecele, 2009) or the suffering of the situation (Wollants, 2008). For a moment, the Gestalt therapist can give

her/himself the freedom not to worry whether s/he "should" be focused on the relationship, the process of creative adjustment, the field theory perspective or the co-creation of symptoms at the present moment. These concepts of Gestalt therapy theory are the most valuable guidelines for Gestalt therapists. However, if we apply them obligatorily and rigidly, they also become assimilated introjects. We can bracket them for the moment to use the benefits of a *symptom perspective*.

The therapist can deliberately adopt a *symptom perspective* to focus on the disorders and dysfunctional ways of functioning of the patient. The advantage of such an approach is that the therapist obtains a clear and distinct image of the risky and limiting features of the patient's suffering (e.g. suicidal tendencies, dependant behavior, traumatizing history). We can say, metaphorically, that using this perspective the therapist obtains a basic image of the territory where s/he is going to travel with his patient. It is a map that describes the dangerous steep chasms and swamps and other traps. The style of travelling and the necessary equipment depends on the territory. Therefore this perspective is of great advantage at the intake-assessment (see e.g. Brownell, 2010a; Joyce and Sills, 2006), while mapping a critical situation (e.g. trauma or alcohol dependency) or monitoring the risk (see also chapter 17, *Assessing Suicidal Risk*).

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

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

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

therapist's interventions towards the patient might be: "What troubles you the most?", "What diagnosis, labels did you get in the past and what is your opinion of them?", "What do you think – why are you having these troubles? How do you understand the situation?".

Alice came to a therapy worrying if she was not dependent on alcohol. During the dialogue with the therapist it became obvious that Alice drinks alcohol when she feels great tension and fear. When the tension is not as great, she can manage several weeks without alcohol. Alice has felt greater and greater tension for the last half year. She is afraid something serious is happening to her mental health. There are moments when she experiences a terrible fear that she is going mad. She fears the beginning of a psychotic illness.

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

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

3.6.2. Contextual Perspective: Focus on Roles and Interactions

During the dialogue with the therapist Alice realizes that her tension is associated with the great responsibility she is taking over things she cannot influence. For example, she is sitting in a bus and gets very tense while observing a rider catching the green light on a crossing. She immediately imagines all the complications that possibly might happen on the crossing. Similarly she is taking responsibility for the members of her family (if her husband gets into work in time, what mark would her daughter get at school...). Alice is convinced that this responsibility is part of her role as mother. She is taking care of her husband and daughter and they do not help her with any of the house-

work. When she then stays alone at home, the tension gets bigger, it escalates into a panic. On the other hand, on the rare occasions when she goes out to a wine bar with friends, the tension reduces (alcohol helps here too). When with her friends she frees herself for a while from her image of how a mother should behave.

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

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

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

[19] The concept of field theory is sometimes mixed up with the systemic point of view; the differences between the concepts of "being of the field" and "being in the field" are often overlooked (Yontef, 1993).

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

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

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

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

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

[20] The contextual perspective also includes a transcultural way of thinking (see chapter 10, *Living Multicultural Contexts*).

original choreographies where also some unique new steps might appear (Jacobs, 2008).

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

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

The therapist creates the diagnostic hypothesis dialogically in cooperation with the patient. Questions underlying the therapist's interventions towards her/his patient might be: "Do you recognize the relational issues that trouble you in your life, also here in the therapy, in our relationship? How do you think I contribute to it? What do I do to make it happen again? How do we both together co-create it? And what would you need from me? What would you need to happen in our relationship?".

During the next sessions Alice always watches the time very carefully and takes care that the sessions end on time. Later Alice and the therapist explore together how she is taking responsibility for the shared space here in the therapeutic situation. The therapist shares his awareness – he realizes it was partly quite convenient for him when Alice was taking care of the time. And at the same time he experienced a slight irritation that Alice was taking over some of his therapeutic competencies. When they started to talk about their experiences the mutual sharing of new awareness lead to a precious moment of encounter. Later in therapy Alice started to be aware how her usual way of relating contributes not only to her tension and fear, but also to her loneliness and general lack of meaning in her life.

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

3.6.4. Different Maps, One Basic Attitude

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

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

Then, when it is useful, the therapist can allow this particular *symptom perspective* to step back into a background in favour of the other perspectives, the *contextual* or *co-creation* one. It would be a waste of energy if we – as Gestalt therapists – let these models compete with each other (even if only in our heads) and remain caught up in the paradigm of good versus bad. Instead, it is possible to take advantage of the potential provided by their different focuses and let them complement each other dynamically. The therapist uses them to give name to a meaning of the therapeutic situation and in this way s/he is supporting the co-creation of the contact figure. When making a diagnosis, s/he is always present at the contact boundary. The therapist might look at different

maps to get orientation, but s/he still remains on the journey with the patient and is available for a common wandering.

3.7. Using Diagnosis to Support the Therapeutic Process

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

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

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

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

The objectifying use of naturalistic diagnoses creates a gulf between the patient and her relational context, which may lead to isolation. It can become

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

pathogenic, contributing to creating the suffering perceived and expressed by further wounding the patient's relationships. We need to avoid the latent risk of confusing behaviors with lived experiences, freezing the Other into a category. Alternatively, diagnosis can be a relational process which is co-created through contact and through the truth released through contact.

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

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

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

[22] Psychopathology is a field strongly exposed to pressures exerted by the political world-view of the time and by the designer of the map: deciding who is mad and who is not in a given context also responds to the logic of power and political utility. Defining power, however, may not only be exercised within a certain social context. It may also be used to define other contexts and cultural sedimentations as a whole, along with the people who belong to or come from such contexts. Deciding to whom the problem belongs also determines who should be brought into play in 'recovery processes': if an individual is depressed, is the problem only his? Or does the problem also belong to the couple? To the family? To the social context in which he lives?

dialogue with the patient? It was important to choose words and concepts that are already familiar to the patient.

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

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

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

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

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

- there is a phenomenon (thought, fear, question, desire...) that appears in the contact and the therapist needs to give meaning to it and choose what to do with it. The diagnostic process is co-constructed by both the therapist and the patient.
- there is a demand from outside (i.e. the health service). The therapist has to bring this into the session and use this given in the process of contact. This

is in part a hermeneutical use (to put our knowledge on the table) and in part one of the possible givens in the process of contact.

- after and before the session (i.e. during supervision or in the moment of taking notes) an extrinsic diagnosis is a way of giving names to the experience. It supports the process of assimilation of what happened and also the process of becoming grounded in preparation for meeting the patient.

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

4. Conclusion

As Gestalt psychotherapists we need both the map (an extrinsic diagnosis) and the sense of direction (an intrinsic diagnosis). The *extrinsic diagnosis* is ground for the work of a psychotherapist. Whenever we create an extrinsic diagnosis we are fixing the particular way the field of the therapeutic situation has organized itself. We focus on the description of the meaning of the present therapeutic situation and we do not focus on being with the patient for the moment. However, if we burdened ourselves with the demand that we should focus on the flow of the therapeutic relationship all the time, we would paradoxically limit our therapeutic flexibility. A fluent and nourishing flow of contact can develop if we also allow ourselves time to find orientation and meaning, to anchor in a third party, to diagnose.

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

The extrinsic diagnosis becomes progressively less important as the therapist gains greater expertise. All travellers need maps to orient themselves, but it is also true that the more experienced a traveller you are, the more you can rely on your sense of direction. Sense of direction is something developed moment

by moment during your journey, without the use of too many maps. The *intrinsic or aesthetic diagnosis* is essential in orienting ourselves moment by moment through interaction. It is fundamental in providing specific support in Gestalt therapy. No map will ever be detailed enough to warn us of the potholes in the road and the bends along the track. No map is ever updated to the point of what is happening here and now. This kind of orientation is sufficient when, after having travelled widely and studied countless maps, the traveller is confident of how to move across unknown territories.

Comment

by Antonio Sichera

The essay by Roubal, Gecele and Francesetti tackles a very tricky topic with clarity, accuracy and expertise, demonstrating lengthy consideration and solid experience in the field. It is an important contribution to Gestalt psychotherapy as it systematizes data and searches for innovative solutions with seriousness and an awareness of the problems. You cannot but agree with some cornerstone points of the text; the need for a thorough knowledge by Gestaltists of the most commonly used models and languages in the diagnostic area – against a widespread and risky lack of theoretical ground; an invitation to the critical use of such schemes, and an insistance on the importance to gestaltic hermeneutic of the instruments, not renouncing one's own individual inclination of the approach. Ultimately, it is about the need for a well thought-out and aware approach towards problems – in a strong, gestaltic sense – that does not concede to approximation, but builds an authentically Gestalt psychopathology based on the most important contributions.

In order to avoid re-examining the essay's judiciousness and seriousness, and given its favourable developments, I believe it is nevertheless fair to highlight some critical points. In fact, Heidegger taught us that thinking always is a radical exercise, which ideally moves towards an origin, in the sense of intentional avoidance of compromises and shortcuts. I would say that in this hermeneutic perspective, there are some "simplifications" and some answers in the essay which don't entirely come to terms with its basic vocation; that is to build a "communicable", sharable, and yet typically Gestalt diagnostic perspective. I shall just underline two key points in the space I have at my disposal.

The first one is philological. The text stems from an exegesis of Perls-Goodman, which identifies the intrinsic diagnosis with what the therapist intuitively works in progress *within the setting, without any explicit support from the* tertium, *or of his theoretic reference model, according to the famous saying that "diagnosis and therapy are the same process"; and reads the passage of*

Gestalt Therapy related to the "extrinsic interpretation" like a possible theoretical excuse in using diagnostic instruments "out" of the setting, like maps that help the therapist to move and orient himself in view of his following appointments: the need for a "fixation" and standardization of characters and types of unease that would be absent in the "intrinsic" moment of diagnosis would come in right here. We are faced with a solution to a very sharp gestaltic aporia, but for sure not respectful of the words of Gestalt Therapy. *What Perls and Goodman mean in that passage is not a "division of the work" between intrinsic and extrinsic, so that the perceptual therapeutic action would happen within the setting on a first level and* subsequent *reflection and orientation on a second level. It may be favourable for us, and we are indeed free to interpret the text in different directions, but you first need to acknowledge that it is not like that from a philological point of view. Perls and Goodman clearly say that Gestalt Therapy is intimately and expressly far from any extrinsic use of interpretation and diagnosis, harmful and useless for the founders, whilst enactment of an interpretation, an intrinsic diagnosis is typically gestaltic; that is the intervention the therapist makes in the setting not without the tertium of theory, but having such a flexible, malleable diagnostic theory at his disposal that it can be moulded and used "within" the setting rather than outside it.*

Like saying that Gestalt Therapy's refrain is: we cannot do without a diagnostic model, because the tertium *is fundamental to avoid falling into symbiotic madness; however, this theoretic reference model rescuing us has to be so contiguous to experience, so able to "think of it", that it can be "used" and "engaged in" by the therapist within the setting itself, within the session.*

And here we come to the second critical point, of hermeneutic background. Even if the essay's layout is excellent, an adequate consideration of a specific and essential aspect of the gestaltic vision of therapeutic process is missing. If we are called to "think" experience, to remain contiguous to it, then we first of all have to admit that the substance experience is made from is time. Having a malleable model at one's disposal means having a diagnostic instrument which helps the therapist to read volatility and blockings of experience within a temporal flow; therefore, he can place himself creatively and consciously within the different moments of a therapeutic itinerary. If the essay's relational and contextual perspective is indispensable in order to achieve gestaltic diagnosis, we also have to say that there is no gestaltic diagnosis without an appropriate temporalization theory (and, I would say, without a proper reading of context in terms of figures/background).

I believe these are the two frontiers theoretical research on diagnosis in Gestalt Therapy has to be oriented towards; and the essay constitutes an essential contribution. In short, unfinished business. *It could not be otherwise…*

Developmental Perspective in Gestalt Therapy. The Polyphonic Development of Domains

by Margherita Spagnuolo Lobb

Our goal is that of recollecting all experiences in their whole – whether they are phisical, mental, sensitive, emotional or verbal – since it is from the unitary work of "body", "mind" and "environment" (which are just abstractions in themselves) that emerges the lively process of figure/ground.
(Perls, Hefferline and Goodman, 1951, p. 331)

1. The Question of the Developmental Theory of Gestalt Therapy

The here-and-now experienced at bodily level by the patient is a creative *Gestalt* that summarizes the bodily and socially relational schemas assimilated in the preceding contacts (the being-with through the body and through the social definition of the self) and the intentionalities that support the present contact that the patient makes with the therapist. It thus becomes fundamental to make reference to a developmental perspective, in order to read the development of the modalities of contact with the significant other and with the environment in general.

Until the 1980s, however, the international Gestalt community considered it pointless to make reference to a developmental theory, since the psychotherapeutic work is carried out in the here-and-now. The use of theoretical schemas (both diagnostic and developmental) was seen as an absurdity, as a de-focalization (on the part of the therapist) from the experience in the present of the contact, in favour of a reading of the blocks of the past. According to the Gestalt mentality of those times, it would have been a matter of going back to the necessity of the interpretation (to ready-made readings) to understand the patient, and this would clearly have implied the impossibility of being in the freshness of the present contact which the patient establishes with the therapist and with her/his environment.

In the 1980s, however, the social change imposed an evolution of these

humanistic constructs: the increase in serious disturbances made a developmental perspective necessary, and also the use of diagnostic keys. And it was realized that the freshness of the contact between the therapist and the patient can be improved, not impoverished, if it is looked at through the lens of a theoretical reference that is consistent with the method.

From that time a Gestalt thinking on human development has been emerging. The challenge for this approach remains, however, even today, that of using theoretical references that start from the experience of the patient and of the therapist in the here-and-now of the therapeutic situation. Concomitantly, the theories of development have also undergone a profound change.

From the "developmental psychology", which studied the passage from childhood (immature and changing) to adulthood (mature and balanced, but not changing), there was a move in the 1980s to the concept of "psychology of the life cycle", which considers all the phases of the person's life as being characterized by a change. Factors both within the person (maturative) and outside her/him (environmental) create conditions of destructuralization of previous equilibriums and of transition to new syntheses, capable of performing other tasks of development (as in Erikson's concept of epigenetic stage, 1982). The concepts of the life cycle and of the epigenetic map are linked to the idea that life, or any developmental path, is constructed by means of phases, characterized by needs, skills, specific existential themes and maturative tasks. The phases, characterized in this way, are linked by a sequential and cumulative process, which finally leads to relational maturity, in other words the ability to set up functional contacts that are nourishing for oneself and for the group (or for the environment in general). This perspective of development has been profoundly deconstructed in the studies of Daniel Stern (1985); following Stern's concept of development, I call the Gestalt perspective the "polyphonic development of domains", which overcomes the idea of phasal structure. While the phases are cumulative, so that each presupposes the competences of the preceding one, the concept of domain is linked to clearly differentiated competences, which have their own development in the whole course of life, and which mutually interact giving rise to the harmony (we might say to the *Gestalt*) of the person's present competence (see Figure 1).

Given these premises, it is obvious that when we look at the patient's relational process and at its development, if we are to be consistent with Gestalt therapy epistemology, we will not think about what developmental tasks linked to specific stages have been fulfilled. Setting developmental goals in advance runs the risk of an external evaluation of the subject's experience. If we think in terms of developmental goals, we are forced to compare our patients with those goals. We must avoid the possibility of the modalities of contact on which our theory is based (introjecting, projecting, etc.) becoming stages to be

reached in sequence in order to achieve relational maturity. They may rather be seen as domains. The domain is a relational capability which is present in the background of the experience, and which becomes figure at a certain point in the development of the human being, interacting with the other capabilities, or domains (see next section).

2. Diachronic and Synchronic Levels in Psychopathology

I believe that a relational, procedural and phenomenological approach such as that of Gestalt therapy must consider the "given" situation – and hence the background of the patient's developmental experience (diachronic level) – and the figure of the present malaise and of the intentionality of contact which s/he seeks to bring to completion (synchronic level). Let's take the case of a patient who, for instance, used to throw up as a child when he had to go to school in the morning. He couldn't stand the tension that he felt in the family in that moment of the day, and couldn't feel supported to go out of home, to school, to have new and stressing experiences. Now the adult that has developed from that child comes into therapy to overcome the difficulties he has in his present family, the figure is his leaving the house when he feels a tension that he thinks he cannot bear, and the desire to succeed in "not throwing up" in the current family in order to support, as a husband and father should, the possibilities of relaxing the tension. The background of the patient's experience is the development of the contacts of that child in the present-day patient: how in the course of the years has he exercised the ability to introject, project, retroflect in intimate relationships (see below, description of the domains), how did throwing up represent a collapsed or resilient modality of contact and what physiological supports (breathing, control of the diaphragm, etc.) does he still experience in the awareness of his body?

The Gestalt therapist needs tools to manage the co-creation of the therapeutic contact boundary and further needs a map which will permit her/him to find direction in the patient's development as presented to the clinical evidence, hence in the treatment setting.

Both the actual evidence in contact and the developmental process respond to the Gestalt principle of *creative adjustment*. Hence, we need to describe *how* the patients' creative adjustment has developed in time within significant relationships. What is helpful to us is not seeing *whether* the patients have reached certain goals, but *how* they have fulfilled the intentionality of contact adjusting creatively to difficult situations. We are interested in the bodily process which they bring into being in order to fulfill the intentionalities of contact and its developmental contextualization or – we might even say – the "music" deriving

from the creative choices made against an experiential background (which may be read with a developmental map)[1].

For Gestalt therapy, the intentionality of contact and its fulfilment through creative adjustment are the guide to work with the bodily process. *Mutual synchronization*, already pointed out by the models of precocious interactive regulation, from Winnicott (1974) to Odgen (1989), to Fogel (1992; 1993) and Beebe *et al.* (1992), is an important criterion of observation for us, both when we are occupied with the background and when we concentrate our attention on the figure of the therapeutic contact. We re-cognize ourselves in the contact with the other, the self is a process of contact (see Spagnuolo Lobb, 2005a) which is formed at the boundary: one rediscovers oneself in contact with the other. And vice versa, the block of development coincides with a block of the bodily process, which always implies a reduction (or loss) of sensitivity (of being fully present to one's own senses), and hence the reduced ability to tune in to the other.

The development of the domains is always a process of self-regulation of the organism/environment contact: the ability to introject, for example, is developed with greater or lesser anxiety on the basis of the support received in the contact with the environment. Each domain can be experienced along a continuum of experience, which goes from full contacting to desensitization.

In a public conversation with Elisabeth Fivaz[2] (with whom my group is engaged in a fruitful dialog regarding the "Gestalt" dimensions of Lausanne Trilogue Play), we examined the case of an 18-month-old child, the protagonist of a demonstration video, who had "resolved" an obvious tension between his parents by leading them to sing: he had become an orchestral conductor, harmonizing the energies of the field which had been in conflict. Though playing a role which was not his (looking after his parents) this child has brought onto the scene a delightful harmony in which they were all in tune with one another. In terms of developmental theories, this behavior on the part of the child is "atypical" and not appropriate to his growth: it cannot be regarded as "healthy" or "typical" that a child act as therapist for his parents. For Gestalt therapy this behavior is appropriate and creative, in that it allows the child not only to fulfil his intentionality of contact towards his parents (he reaches them, he is successful with them), but also to find a solution in which everyone feels better (his parents are happy and moved, they see the beauty of their son's gesture).

[1] I'm referring to the aesthetic criterion of contact – grace, fluidity, rhythmic clarity – according to Bloom (2003).

[2] During the Specialist Seminar in Psychology organized by the Istituto di Gestalt HCC Italy, with the title *Lo sviluppo: co-creazione o evoluzione di dinamiche intrapsichiche?* ["Development: co-creation or evolution of intrapsychic dynamics?"], and held on 5 November 2009, at the University of Catania, Monastery of the Benedictines.

Obviously the solution adopted by the child does not solve the problems between the parents, nor will it remain the sole, rigid response to situations of tension, but it solves the problem that arose at that moment in the phenomenological field, and this gives the child an important confirmation for his growth. To the degree to which the people involved (parents and also other witnesses) are sensitive and succeed in seeing the child's attempt to creatively solve a problem, the child will feel recognized, will be able to close the *Gestalt* (will not develop unfinished business in this respect) and will be free in future to make different decisions. But if the behavior should become repetitive, it would be a sign of desensitization: the child would carry it out without the freshness of the spontaneous contact, and it is this that would create the problem, not the behavior in itself.

The criterion of the suitability of the solution adopted by the child is aesthetic, intrinsic to the – above all – bodily experience: it is the luminous body of the child and the bodies of the parents activated by a pleasant surprise, that constitute our diagnostic criterion, not pre-established criteria external to the bodily experience. It does not help us – to carry out our profession as psychotherapists – to think of pre-established stages or norms with which to confront the child's bodily evidence, but rather it helps us to assess *how* the child organizes what is given in the situation, with a view to appreciating his creative adjustment and supporting it.

The most significant studies on the developmental theory in Gestalt therapy are those by Wheeler (2000b), McConville (1995) and Wheeler and McConville (2002), by Oaklander (1988), while the texts by Smith (1985b), Kepner (1993) and Frank (2001) consider the role of bodily processes within the therapy session. Each of these approaches, in my opinion, complements the other. Ruella Frank, for instance, theorizing what she learned from the clinical work of Laura Perls and from other movement-oriented approaches, provides a model of the development of implicit relational knowledge, of the being-there-in-contact of the child as body on movement (we might also say a model of the development of the *id-function* of the self). Wheeler and McConville recall the need for a developmental model that takes into consideration the unitary, relational nature of development, which therefore takes into account both the child and the environment – in a word, the field[3].

What the Gestalt therapist needs is a "somatic and developmental aesthetic

[3] In Italy there are studies on the developmental perspective of Gestalt therapy. Righetti and Mione (2000) and Righetti (2005), in their application of the theory of the self to prenatal development, consider the interactive aspect between mother/environment and child/fetus. Salonia (1989b) considers modalities of contact as developmental phases. Other texts: Fabbrini and Melucci (2000), Mione and Conte (2004); Spagnuolo Lobb (2000a), provide keys to the reading of intentionality of contact of children and adolescents.

mind", rather than an epigenetic map or a phasal pattern of development. In order to orientate our diagnosis and our intervention, we need to retrace, in the patient's body and words, the evolution of the processes of contact, in order to understand what freshness and vitality they still contain, we need not refer to maturative phases. Therapeutic language must start from the "reasons of the body" of the patient, to use Nietzsche's words, as they reverberate in the body of the therapist.

3. The Gestalt Therapy Map of Polyphonic Development of Domains

I believe that in the developmental perspective of Gestalt therapy two acquisitions of the modern theories of development must be integrated: the principle of the "Representations of Generalized Interactions" (RGI) and the idea of polyphonic development. RGIs (Stern, 1985; Kuhn, 1962; Fogel, 1992; Beebe and Lachmann, 2002, p. 110 ff. it. trans. 2003) consider how the child learns "ways of being-with" rather than single behaviors whose aim is the resolution of her/his needs. Stern *et al.* (1998a; 1998b) and Beebe and Lachmann (2002) speak of the representational symbolic (explicit) level and of the perception-action (implicit) level as fundamental domains that develop along the course of the individual's life. The Gestalt modalities of contact (introjecting, being confluent, projecting, etc.) constitute our hermeneutic category of being-with, our domains, the competences of the self-in-contact with the environment. In Gestalt epistemology it would not make sense to talk about a domain of explicit or implicit relational knowledge, in that the self is a unitary process of contact (see Spagnuolo Lobb, 2005a), with the id, personality and ego functions, by which is acquired a holistic modality of contacting the environment, not a knowledge.

The concept of *polyphonic development of domains*, in contrast, is my way of defining what I learned from Daniel Stern. As pointed out in the preceding section, Stern speaks of the development of domains rather than phases (Stern, 1985; 1990): development does not imply the evolution of increasingly complex phases that presuppose learning in the previous phases, but comes about like the composition of a melody which, acquiring new themes (in Gestalt language we might call them "acquired modalities of contact") and instruments (in other words, abilities to be-with transferred to various relational modalities, just as when the same music is played by new instruments coming into the orchestra), is transformed into a new, ever more articulated and complex harmony (Stern, 1985; Tronick *et al.*, 1978). This new concept does justice to the complexity of the developmental processes and at the same time responds to the Gestalt aesthetic criterion: development does not imply measurements of

comparison as in the concept of phases (according to which the child is presumed to achieve specific developmental tasks or results), but is seen as a melody to be appreciated and supported.

A Gestalt developmental theory that hypothesizes a development of the modalities of contact in terms of maturation (as though the modalities of contact in sequence, from confluence to retroflection, were developmental tasks, for the person, up to the ability to make a "full" contact) superimposes the synchronic level of the description of the experience of contact (as in Perls, Hefferline and Goodman, 1951) on the diachronic developmental level. The description in sequence of the modalities of contact (being confluent, introjecting, projecting, retroflecting, etc.) in fact might belong to the epistemological context of the experience of contact between organism and environment in the here-and-now. This context cannot be transferred to the child's developmental phases, but may be recalled in the patient's competences of contact, in terms of domains. The domain becomes, for us, the experiential realm relative to a certain capability of contact. In other words, the being confluent, introjecting, projecting, etc. cannot be phases of development, but are *modalities of contact* of which the child is capable and which continue to be developed throughout life. The therapist asks, not to what phase of development the patient's block refers, but how the patient's present capabilities of projecting, retroflecting etc. (developed through time) are combined in a *Gestalt* represented now by the patient's being-in-therapy.

The domains are competences of an intersubjective experience, of modalities of contact that become more evident at a certain point of the child's development and which are developed throughout the course of life, as autonomous-in-mutual-interaction capabilities.

In other words, development may be understood as a journey towards the complexity of contacts, rather than as a progression from less mature to more mature stages. Development is like a melody that is at first played by one or two instruments, to which other instruments are gradually added, which increases the complexity of the contacts that the person can implement. The clinical task is to judge, not the maturity of development of a person, but *how* that person deals with the complexity of her/his perceptions.

In contemporary psychopathology[4] behavior is seen as located in a continuum which goes from normality to severity. Applying this dimensional perspective to experience of contact, we might say that every domain can range from spontaneity to blocked/fixed excitement. I prefer to speak of "risk" which is implied in every domain when the contact boundary is desensitized. This gives us the possibility to focus on the spontaneity that is *always* present in contact

[4] See the criticism of DSM categorical diagnosis and the need for a dimensional perspective (Francesetti and Gecele, 2009; 2010).

making and in the polyphonic presence of domains (and this is also what we aim to recognize and support in our role as psychotherapists).

Each domain includes the capacity of being fully present at the contact boundary, perceiving the self and the other in a differentiated, sensitive manner*, with the courage of staying with the uncertainty of the situation of contact*. The person is at the boundary with the ability to adjust creatively to the other's move and to one's own move, hence containing the uncertainty (one never knows what the other person's next move will be, nor what his/her own will be) and continually finding a creative solution that carries forward both one's own being and the other's. The example cited in the preceding section of the child who becomes an orchestral conductor explains clearly this concept: the child's ability to be a "little therapist" is a spontaneous, natural quality which occurs among human beings every time they find a creative solution in being-with when there are differences.

The aim of the description that follows is the possibility of observing the child's behavior without confining it within developmental phases, but considering it as the momentary *Gestalt* of a tangle of relational competences which have their own development.

The developmental perspective of Gestalt therapy is met perfectly not only in this concept, but also in the idea of broadening the observation from the child to the phenomenological field in which s/he is inserted. In other words, the melody that the child learns to play is in its turn part of a greater music, which is the melody created in the phenomenological field. As Frank writes (2001, p. 21): «[…] infants [organize] a *developmental*, *relational body-language*. Both partners influence and shape the other's experience»; moreover: «[…] movement patterns […] are not *of* the infant, nor *of* the environment, but *of the relational field*»[5] (*ivi*, p. 19). It is not a matter of organismic self-regulation (according to the traditional humanistic anthropology that remains in an individualistic perspective), but of the self-regulation of a *situational field of contacts*. Child and caregivers together create their encounter, in a border area which Gestalt therapy rightly defines as "contact boundary", in an experiential, procedural and phenomenological perspective. This is why development – including bodily development – happens in a phenomenological or situational field and the acquisitions deriving from it are like experiential codes that each person inserts in her/his way of being-with in the here-and-now.

The advantage of the developmental perspective on the domains as compared with the phasal perspective is that it reads the complexity of situations considering the momentary tangle of factors which, though they are mutually influential, each have an independent development, rather than reducing this complexity to the pattern of a phase. The complexity of individual development may be better

[5] Italics in the original text.

respected if we consider the present moment as a transversal plane of the development of the various domains (see Fig. 1), which interweave differently at each moment, giving rise to the Gestalt of the contact in the here-and-now.

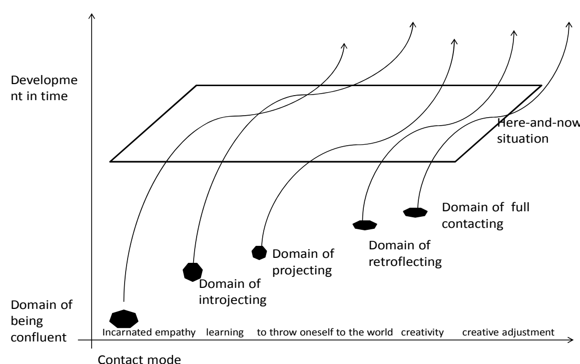


Figure 1. Gestalt map of the polyphonic development of the domains.

Commento [MRC3]: È possibile avere una figura migliore?

3.1. The Domain of Being Confluent. The Ability of Being-with with no Perception of Boundaries

At the time of birth[6] contact comes about in confluent manner: mother and child mutually intuit each other. The child perceives the environment as part of her/himself (Stern, 1990) and the mother is fully aware of being in love with her child. Confluence, in being a modality of contact, is the ability to perceive the environment as though there were no boundaries, no differentiation between it and the organism. This ability constitutes the basis for empathy, and is a natural quality, which today in neurosciences is called *embodied empathy* (see Gallese *et al.*, 2006). The ability to be confluent derives from our being radically part of the environment (Philippson, 2001). Stern *et al.* (2000) have made quite clear the child's competence of intuiting the adult's intentions and bringing them to a completion; his observations, which arise in the context of his criticism of Mahler's theory of primary autism (1968), demonstrate the child's ability (the opposite of autism indeed) to intuit intersubjectively the

[6] It would be correct to see human development as starting from life in the womb, in that the fetus is capable of perceiving the environment and of acting intentionally in it (Righetti and Mione, 2000; Righetti, 2005).

significant other. They also confirm, in parallel and not intentionally, the esthetic perspective of Gestalt therapy: the natural full presence of the child, with her/his senses at the contact boundary, guarantees for her/him an intuition on the other, even if there is a lack of perception of differentiation at the boundary. The Gestalt concept of confluence explains well the intuition existing between mother and child (and possibly remaining in adults) as sensitivity to what there is in the environment, or, to use a phenomenological term, a sensitivity to a "natural evidence" (see Blankenburg, 1998). This domain remains and may be developed throughout life.

The risk linked to a desensitized experience of this domain is madness: a perception without clarity and – I would go so far as to say – without breath (based on anxiety).

3.2. The Domain of Introjecting. The Ability of Being-with Taking the Environment Inside

The child is sensitive to environmental stimuli as opportunities for learning (s/he repeats vocalizations and then words, acquires the syntax of both language and the primary relationships, throws objects on the floor, repeats adults' gestures, etc.). These experiences belong to the domain of introjecting, a modality of contact characterized by the assimilation of environmental stimuli, first and foremost language and the whole cultural apparatus within which s/he is inserted (the customs and rules of a given society), the family's relational patterns (what makes mommy smile when she is tired; what makes daddy decide to give the child permission to go and play and what, in contrast, makes him angry, etc.). The child's energy is focused on "giving names" to things and to the relational patterns. This causes her/him to acquire a sense of power: saying "din-dins" when s/he is hungry allows the child not to scream to make her/himself understood by those around her/him, just as preventing daddy from getting angry with a winning smile lets the child win the "match" with him. His whole self is devoted to learning from the world by taking it in. The child draws energy and sense of self from having the world forge her/him. Her/his creativity is expressed in curiosity towards "what the world tastes like when I eat it". Developing this domain, the child also gives a name to her/himself and to what s/he does ("Luke is hungry", "Luke is a good boy" etc.). This modality of contact is developed throughout life and is the basis for the ability to *learn*.

The risk falling within this domain generally derives from the desensitization that anesthetizes the contact boundary, so that the world enters the organism without receiving energy in exchange, and the organism is depressed, as it is unable to give a name to what it does not feel is its own.

3.3. The Domain of Projecting. The Ability of Being-with by Casting Oneself into the World

Another domain concerns the modality of contact of projecting, through which the child is able to "plunge into the world", entrusting her/his energy to the other and to the environment. The child is curious about everything and uses her/his energy to get to know the world, s/he opens drawers and anything that is closed, projecting the self where it is not and where it might be. The ability to plunge into the world and into the environment is for instance apparent in the projective game with which the child is occupied at the time when the pronoun "you" is used very frequently, with gusto and enjoyment: "You… you… you…". Whatever is said to her/him is returned to the other. *Imagination*, the *courage of discovery*, the use of the body as promoter of change in the contact with the environment, dancing as expressive movement in the world – these are the abilities that the organism develops, throughout life, by means of this domain, which expresses the modality of entrusting the self to the other. Just as in introjecting there is the capability and pleasure of acquiring the world within the self, here there is the capability and pleasure of casting oneself into the world.

The risk, in conditions of desensitization of the contact boundary, is that projecting may come about as an attempt to resolve an anxiety without perceiving the other, generating paranoiac experiences (the other into whom I "cast" myself is incapable or bad).

3.4. The Domain of Retroflecting. The Ability of Being-with Containing One's Own Energy

Another domain concerns the modality of retroflecting, of feeling the fullness of one's energy securely confined/contained within the body and the self. The child now acquires the ability to be alone, to reflect, to produce creative thoughts, to make up a story, as affirmed by Stern (1985), Stern *et al.* (2000) and Polster (1987). What enchants the child when this domain begins is telling stories/telling someone about her/himself, making up stories, pure creativity: s/he tells stories and her/his whole self is engaged in the act of creating. This prompts wonderment in the adults, which reinforces the child's ability to come into contact with the others and with the environment, proposing her/himself as a created and creative figure: in fact, in the child's modality of contact the adult rediscovers her/himself (or the world) in a surprising version, both unexpected and harmonious (well formed). This modality of contact is at the basis of *creativity*, of the ability to feel safe with and trust oneself, to reflect and to offer

oneself to the world with her/his own individuality, and is developed throughout life.

The risk, in conditions of desensitization of the contact boundary, is that retroflecting may lead to solitude, and the subject's creativity may not be revealed to the other, or revealed as grandiosity.

3.5. The Domain of Egotism. The Ability of Being-with the Other in Deliberate Control

Finally, the domain concerning the modality of egotism, refers to the capacity to be proud of being oneself, it's the art of deliberate control (Perls, Hefferline and Goodman, 1994, p. 236). The child who takes the spoonful of food that the mother tries to give him, and wants to do it by himself[7], gets energy from creating a defined figure of himself, in spite of the environment («an attempted annihilation of the uncontrollable and surprising», *ibidem*). This modality of contact-making is at the basis of *autonomy*, of the ability to find a strategy in a difficult situation (*ibidem*) and to offer oneself to the world with her/his own individuality. It is developed throughout life.

The risk of a desensitized contact boundary is that the person «finds his problems absorbing beyond anything else» (*ibidem*), and the perception of oneself faced with the environment incurs a feeling of boredom and void (the figure is a compulsive repetition), so that the need to control oneself takes over the natural spontaneity of being. Table 1 shows how excitements, life abilities and risks characterize each domain.

Gestalt therapy, from its very beginnings, has warned against the dangers of egotism (see Perls, Hefferline and Goodman, 1994, or. ed. 1951; Spagnuolo Lobb, 2005a), considering it as an obstacle to spontaneity and interest in life, which are indeed experiential possibilities of each one of the above mentioned modalities. The ability to be spontaneous, as a matter of fact, is linked to the esthetic presence, to full feeling, to the availability of the senses which, in itself, constitutes the condition for a harmonic synthesis among bodily feeling, definition of the self, intentions of contact, in a word creative adjustment to the situation. Spontaneity and interest are implicit in full feeling, in the spontaneity of the self, and hence in relational ability expressed in each of the domains already considered. For this reason, resilience should be part of the modality with which every domain is experienced[8].

[7] I thank Carmen Vázquez Bandín, Director at Madrid Institute of Gestalt Therapy, who provided me with this example.

[8] The world of psychotherapy is not alone in always having wondered about the provenance of the ability of some individuals to remain positive even in the face of disastrous sit-

Table 1. Excitements, life abilities and risks of each domain

Domain	Excitement	Life ability	Risk
Being confluent	Being part of the environment	Embodied empathy	Confusion Madness
Introjecting	Giving names	Learning	Depression
Projecting	Plunge into the world	Imagination, discovery, courage	Paranoiac experience
Retroflecting	To be well confined in oneself	Safety Well-informed	Solitude Grandiosity
Egotism	The pleasure and pride in being oneself	Autonomy Finding a strategy in a difficult situation	Control, Boredom, Void

4. Gestalt Therapy Developmental Perspective as Clinical Evidence

The developmental model described here helps us to grasp the clinical evidence of the past in the here-and-now of the contact. We might speak of "clinical evidence of the processes of development", which allows us to remain in the here-and-now of the experience of the therapeutic contact.

It's a model that explains the depth of the surface (Cavaleri, 2003), that surface that touches our senses and which we perceive. Our clinical frame of reference is not in fact the dynamic development of the inner experiences (of emotional topics), but rather the development of the processes of contact that the child learns with the caregivers and which later constitutes the ground of her/his habitual patterns of contact as an adult, observable in therapy. As Beebe and Lachmann (2002, p. 20) state, «The foundamental processes which regulate interactions, which are originally at a non verbal level, remain the same for the whole life long». The Gestalt therapist not only observes these patterns, but also tries to grasp the *now-for-next* (Spagnuolo Lobb, 2012), the intentionality con-

uations, and, in direct opposition, the persistence of others in seeing negativity even in situations of normal or favorable life. Some have hypothesized that unhappiness is necessary to be happy (Andreoli, 2008), and some maintain that the great figures of history were great precisely because of their capability of resilience (Short and Casula, 2004).

cealed in the patient's habitual, desensitized pattern of contact. Since the Gestalt model regards all this because of how it happens at the contact-boundary between therapist and patient, it implies the view of the phenomenological field. It is from the phenomenological field created by the patient's modality of contact and by the therapist's response that the possibility emerges of supporting the spontaneous development of the patient's intentionality of contact.

The experience of contact with the environment (and significant others), a key concept for Gestalt therapy in order to understand human nature (we are born, and grow, for and in contact), is the hermeneutic cipher of development and movement, as well as of relational processes. As I wrote in the preface of the Italian edition of Frank's book (Spagnuolo Lobb, 2005d), the *body of awareness* is the body that experiences the limit of the other from the time of kicking, and which builds up relational supports from the concrete experience of the body-in-con-tact (i.e. in touch with).

In other words, the developmental perspective finds its clinical evidence in the patient's words, and above all in her/his bodily experience and in the implicit mutual attunement of the therapist/patient contact. Taking as an example the phenomenological description that Daniel Stern (2004, p. XII) gives of the implicit mutual knowledge in a session in the preface to the book *The present moment*, we can hypothesize the questions that the *somatic developmental mind* of the therapist might pose, starting from this masterly therapeutic tale, absolutely above any theoretical patterns. This is what Stern says:

> She enters my office and sits down in the chair. She drops into it from high up. The chair cushion deflates rapidly, then takes another five seconds to stop accommodating itself. She clearly waits for that, but just before the cushion lets out its last sigh, she crosses her legs and shifts to the other haunch. The cushion deflates again and reequilibrates. We wait for it to get done. Rather, she does, she is listening to it, feeling it. I've been ready since she came in, but now I'm waiting, too. It's hard to know when the cushion has given up all its air. But everything waits. Does she sense she is waiting, or holding time? Everything waits for her readiness. I feel restrained from moving until it's done. Almost as if I should hold my breath to hasten it along, to better judge when the still point is reached and the session can "start". When I finally think that her body and the cushion have reached her readiness, that the sound and feel of settling has stopped, I begin to shift in my chair, in anticipation, breathing more freely. But she is still hearing the sound recede and is not quite ready. My shift is arrested in midflow by her still waiting. I feel like I have been caught in a game of "statue". It's ridiculous. And I can sense an annoyance building in me to have my rhythms so disrupted and controlled. Should I let it go on? Should I bring it up? She wouldn't dream that we have already played out the main themes of the session, and an important theme in her life.

From the surface contact that is set up in the here-and-now with the patient, the therapist grasps developmental patterns which s/he will confirm during the session. The patient is accustomed to adopting this pattern of "waiting" contact as an original creative adjustment in difficult situations. In the therapist's question: "Should I let it go on? or should I bring it up?" we can imagine a spontaneous co-participation in the waiting. The therapist finds himself indulging (though irked in the end) this wait, co-creating the contact boundary of their session. The patient feels that she is in a context of uncertainty (reflected in the feeling of the therapist, who is also uncertain what to do) and probably resolves this dyadic uncertainty with the wait[9].

It will be interesting to discover what domain is mainly revealed in the therapeutic contact (will the patient introject what the therapist says? or project her/his energy onto the therapist? or remain silent, retroflecting…). It will be the therapist who, entering the same domain, provides the specific support so that the patient may arrive at a new perception of their contact boundary (a new Gestalt of domains). S/He (the therapist) will at the same time be whatever is attributed to him/her and also a new "partner" who supports the interrupted intentionalities. As a Gestalt therapist, I recognize myself in the concept expressed by Lichtenberg *et al.* (2000, p. 104) when they say that the therapist must «wear those attributions which are addressed to him/her". In Gestalt language, this can be translated with what we call "co-creation of the contact boundary»: the therapist finds her/himself taking part in the modality of contact used by the patient (for instance, s/he finds her/himself giving introjects to a person who uses the modality of introjection, see the clinical example in next paragraph), but also – and her/his art lies precisely in this – supports what has not normally been supported by the patient, namely the fulfillment of the intentionality of contact.

5. A Clinical Example. Death Reified

A 57-year-old patient sits rigidly in the armchair, facing me, the therapist (*domain of retroflecting*). The patient smiles politely and hangs onto her purse: she holds it tightly, as if she could not relax for any reason (*domain of projecting*). I notice that her breathing is shallow, to the point that her posture seems not to be modified by the inspiration-expiration rhythm. All my attempts to put her at her ease are noticed by the patient, but not welcomed with the reaction of a person who is beginning to feel safe (*domain of introjecting*). My perception

[9] See Mahoney, Spagnuolo Lobb *et al.* (2007) for a detailed clinical example in which the bodily feeling of both patient and therapists represents the co-creation of the therapeutic contact boundary.

at the contact boundary is of astonishment in the face of this patient's extreme closure, I feel incapable of accepting and codifying her reaction as fear. I find that there is a feeling of coldness at the boundary, inability to accept. The relational patterns of movement, both mine and the patient's, are forced, aimed at controlling possible surprises rather than at our expansion towards each other (*domain of egotism*). Observing this, I listen to the patient's story, which seems to be centered on a strange preoccupation about the tomb of her husband's family. Since she has felt obliged to allow her own original family to bury her stepmother in her husband's family tomb, a stepmother with whom she did not have a good relationship, she feels unhappy, distressed. She retired two years ago and cannot get used to the change in her life. She cannot sleep at night. She feels very tense and thinks she is going mad. She has already been in therapy with a psychotherapist who gave her great encouragement about the positive things she has done in her lifetime. At first she felt better, but that basic thought, that idea of a tomb violated by an outsider (it is the tomb in which she and her husband will be buried) never leaves her (*domain of being confluent*). The malaise felt in her physiology has remained, despite the encouragement of the earlier therapist who supported her *personality-function*, her social role.

The clinical evidence of the *id-function* of the self (a rigid, controlling body, and unexpansive breathing) and of the *personality-function* (the sensation of going mad, of losing control of herself), the choice (*ego-function*) of a verbal language that expresses a concern experienced at bodily level that she cannot control so intimate a thing as the family tomb, my sensation at the contact boundary of impossibility of sharing emotions with the patient, are all aspects of the phenomenological field that speak for a diagnosis of "schizoid personality disorder". Without this kind of "deep" observation of the "surface", I would have been induced to make a diagnosis of "depressive-type adaptation disorder", perhaps linked to the patient's recent retirement, which would have led to an intervention centered – like that of the previous therapist – on the support of the *personality-function*, the social definition of the self. Concentrating rather on the processes of co-creation of the contact, and keeping in mind the physiological supports with which the patient makes contact, it is possible to diagnose an *id-function* disorder, which requires a completely different kind of support. With a combination of spontaneity and thought, I decide to modulate the therapeutic intervention on the one hand on my real feeling (what internal or environmental certainty would make me relax at the contact boundary with the patient to the point of allowing me to feel emotions for her?), on the other on a language that starts from the experience of the patient's body, from the violated sense of intimacy, certainly not from reassurances that do not express an empathy embodied in the situation.

In the specific case, I am struck by a symptom mentioned by the patient:

she cannot listen to the word "death". If she reads it in a book she has to close the book and never take it up again, if she hears it on the television newscast she has to go into another room or turn off the television. The power of this word for the patient – beyond my own concern for her obsessive experience, which is a sign of a powerful anxiety which could result in a psychotic collapse – informs me of the domain of confluence and reminds me of Piaget's developmental theory (1937) and the concept of the "reification" of words and objects that may be part of the animistic thinking of children. For the child going through the stage of animistic thought, the moon has a soul and a will, and words (or other objects) may be endowed with a life of their own.

The emergence of this powerful sensation and the memory of Piaget's theory constitute the *epoché* (recalling a phenomenological concept introduced by Husserl) in which the therapeutic intervention is constructed. I decide to intervene on language and say to the patient: "The word 'death' is just a word, it has no power in itself. You have power over the word, not over death as such, but over the word you do. You can cancel it out, not listen to it, replace it. You have power over the word 'death'".

In doing this, I do not disqualify her ability to be confluent with the experience evoked by the word "death", and at the same time I give her a good introject, I teach her that the word is different from the death in itself. My feeling with no emotions in front of her informs me that the kind of relation she is used to "needs" a cold partner, who is not able to contain her anxiety. My giving her a clear introject and her accepting it allows both of us to be in contact with less anxiety.

This linguistic redefinition is followed in the patient by a relaxation of breathing, an opening of the whole bodily posture, which even allows her to put her purse down elsewhere. In the subsequent session I can even ask her to write a couple of sentences containing the word "death", and to feel how she has power over that word. After a couple of weeks the patient has solved the problem of her anguish and ends the therapy. She tells me she has arranged, in agreement with her original family, to transfer the body of her stepmother elsewhere and that she feels much better and more in command of herself.

6. Conclusion

When Gestalt therapists face psychopathological suffering, they need to refer what they see, listen and feel with the client to a map which allows them to understand how the client has developed her/his experience in the actual phenomenon. We need a theory to understand the development of the previous contacts in the here-and-now. In order to accomplish this, we need

to get rid from the idea of developmental phases and consider the development of domains, contact abilities which develop in autonomous ways all the life long and reveal themselves in the therapeutic situation, a momentary *Gestalt*. I have presented here a map of *polyphonic development of domains*, which allow Gestalt therapists to orient themselves in recognizing how the various domains interweave in the here-and-now of therapeutic contact, in order to better support the intentionality of contact that animates the request for help of the client.

In the bodily approach of Gestalt therapy, the concept of relational patterns of movement (Frank, 2005) in a sense replaces what the concept of the unconscious has been for psychoanalysis. The search for the unconscious impulse which conditions the life of social relations is replaced by the phenomenological observation of the ways in which the patient constructs his own patterns of approach to or separation from the other. And in this way, the anatomical knowledge is incorporated in the awareness of an experience *in fieri*: in short, it is a matter of a *phenomenological realism*, not of a translation into bodily experience of the conflict between the demands of adult civilization and the "tribal" spontaneity of the child.

> In the usual character analysis, resistances are attacked and dissolved. But if we consider awareness as creative, then resistances and defences are seen as active expressions of vitality (Perls, Hefferline and Goodman, 1994, p. 248).

This is the key to working with the depth of the surface, on bodily processes which in the here-and-now condition the therapeutic contact: the patient's bodily sensation has a reason to exist in the relationship. And it is in feeling that he is supported in this well-intentioned process that the patient, in the contact with the therapist, can release the bodily tension and allow the emergence of the awareness, of the immediacy of the senses, of the spontaneous emotions. The old concepts of transfer and counter-transfer can be redefined as a "being-there at the boundary", on the part of the therapist too: it is a matter of completely overcoming the dichotomous mentality according to which the therapist must maintain a "neutrality" with regard to the patient's experience. The therapist/patient dyad is self-regulated in the setting, and the therapist is trained to feel her/his emotions as belonging to *that* field, and to use them for therapeutic ends, rather than considering them as disturbances to the treatment.

The use of this viewpoint in psychotherapy makes it possible to face even the most serious psychological disorders, increasingly widespread today, in which the primary psycho-bodily relationship with the environment plays a fundamental role.

Comment

by Ruella Frank

In her chapter, Margherita Spagnuolo Lobb opens an important area of discussion of what had been more or less forbidden ground before the mid-1980s for Gestalt therapists. Times and Gestalt Therapy have changed and Spagnuolo Lobb is one of the explorers of this newly opened territory. The theorizing that she presents here shows some of her findings. Let me briefly summarize her major points in the chapter and, as a fellow explorer acknowledged by her in this chapter, make some comments that I hope will further and relevantly contribute to this topic.

The centerpiece of Spagnuolo Lobb's theory is her concept of polyphonic development of domains*. «The concept of domain is linked to clearly differentiated competences, which have their own development in the whole course of life, and which mutually interact giving rise to the harmony (we might say to the* Gestalt*) of the person's present competence». I agree that the infant or child's "ways of being" are not principally to get needs met (which would be an individual perspective) but rather to make meaning with the other (a relational perspective). I likewise concur that development is not a matter of sequentially phasic experiences, but more a phenomena of capacities developing greater complexity over time and not independently, but as whole experience. As relational capacities, each domain remains background until called out in different ways and in different capacities and all in interaction with the other. Observing them in clinical treatment is not to place them at a particular time period of development, which would not be in keeping with our present-centered, phenomenological theory, but rather to understand how «…the patient's present capabilities of projecting, retroflecting, etc., (developed through time) are combined in a* Gestalt *represented now by the patient's being-in-therapy».*

Spagnuolo Lobb seamlessly integrates her ideas of developing domains within our Gestalt theoretical frame clearly demonstrating how the aftermath of prior contacting experiences – the historic and embodied relational themes – exist in the present and can be explored clinically at the contact boundary. However, I am left wanting to know more precisely how *these domains, as emergent novel capacities of the organism-environment field, take shape within that field. What particular elements of organism-environment interact at a certain time in development for these domains to fluidly emerge or be derailed? And when they emerge, how does the earlier provide support for the later to emerge (feed-forward) and how does the later emerging domain feed-back into the earlier as counter-support? Knowing this would help me to better understand how we move towards autonomy or relational maturity within a spiral of*

development that expands and folds in on itself repeatedly in the process of growth.

In addition, throughout the chapter, Spagnuolo Lobb does an excellent job of repeatedly confirming the inextricable link between mental processes and bodily life. I would like to see greater detailed description as to how *this is embedded within the relational field where domains are co-created. To flesh out the phenomenological description of domains in the first three years of their emergence would clarify the concepts presented here, as well as reveal even more crucial data applicable to aspects of clinical relatedness. For example:* the domain of being confluent; the ability of being with no perception of boundaries; the ability of the child: the child's ability to intuit intersubjectively the significant other.

Let me offer a brief vignette that might further delineate this domain.

The mother opens the door to the baby's room. Baby hears his mother approach. He lengthens his spine, widens his chest and smiles in anticipation. Mother moves closer to the baby's crib, softly gazes down at him, and with a light and mellifluous tone says: "Oh, you look so handsome this morning". The baby sees her face, hears her voice and immediately reaches out with both hands. Mother smiles and reaches back.

*From this, we might infer that the baby is «…intuiting the adults intentions and bringing them to a completion». In other words, we might infer that the baby heard a part of himself in his mother's approaching footsteps and in her voice, and saw a part of himself in his mother's face that he did not know was there until this very moment. Not until the baby experiences the mother as responding to his expression does he know "*It is mine*". Perhaps we could say that what he senses as* mine *is also* part/hers*. We could also infer that something similar may be happening for the mother. Daniel Stern calls this an "implicit relational knowing". At these particular times of creative adjusting, there is not only reciprocity, but also mutuality whereby intentionality is shared. "I see you see me", "I feel you feel me".*

A more full phenomenological account of each domain, I believe, could flesh out the bi-directionality of developmental processes in the longer time-line of the first three years of life and in the moment-to-moment of contacting. We psychotherapists could then ask ourselves: "From my patient's seeing/-sensing himself in me, and my seeing/sensing myself in my patient, what do we both know about the situation we are now living? How does my patient see himself in how I am sitting in the chair, how I move toward or away from him, how I gesture and how I breathe?". Exploring at the contact boundary, as we are rightly and persuasively urged to do throughout this chapter, the achievements of contacting – the capacities gained throughout development – are alive and present to be worked with and through.

Margherita Spagnuolo Lobb presents another crucial idea for our understanding and that is the psychotherapist reverberating *to his/her client. One cannot say enough about this. It is, after all, a primary way we diagnose the relational field – through what we see, hear and sense. From my perspective, what we hear and see emerges from how we are sensing-moving. I believe it's crucial to keep returning to how we psychotherapists experience the weight of our bodies on the chair before shaping an intervention or coming to an idea prematurely, one that might be disembodied. As I suggest to my supervisees, "*Don't make an intervention until you sense yourself in your chair*". My experience of body weight is a shared experience, meaning that in feeling my body I am sensing the "id of situation" (Robine, 2010) or what is happening between us registered through my bodily experience.*

If we cannot sense ourselves clearly – know that *we are here and* how *we are here how will we know how we experience the other, and what is happening* between *the two of us – we can only guess. But when we sharply attend to our bodily attuning that Spagnuolo Lobb says will "unify" the experience of psychotherapist and patient, we are attendant to the ongoing, nonverbal dialogue within the relational field. To this I would add that in paying attention to our bodily experience, we know not only how we respond to the client, but how we also signal to them. This enables us to more clearly conceptualize what happens in the situation of therapy and to make note of when* our *own actions either inhibit or facilitate the ongoing nonverbal dialogue within session. It is crucial to have a sensed basis for our knowing how and what* we *do to influence the phenomenal givens of the situation. In other words, just as clients signal to us through bodily expression, we are also signaling to them. And we need to ask ourselves: What is my part in this person's "symptom" as it reveals itself in this present moment? How do I participate to invite this particular expression to emerge? From here the psychotherapist can «remain close to his or her own and the patient's immediate experience within the co-constructed kinetic dialogue» (Frank and La Barre, 2010).*

This concept of bi-directionality needs to be emphasized in the chapter and reiterated in the case study so it can more clearly show how we work at the contract-boundary, that is, as we work within a two-person embodied relational model rather than within a one- person individualistic model. In her case study, Death reified, *Spagnuolo Lobb stays close to what she sees and feels in order to diagnose the structure of the field from the perspective of domains of experience. The case is well written, the therapy well conceived and makes its point. At the same time, I am left wondering how the psychotherapist might have been part of the emerging* domain of projecting. *In other words, how the psychotherapist might be contributing to the patient's rigid posture and hanging on to her purse. Questions such as: What does she, the patient, see in the*

psychotherapist that influenced her to grasp so tightly? How is it that patient is so determined to grasp onto herself at this moment rather than reach out for and grasp onto the psychotherapist? Again, how are the psychotherapist's words and body also reverberating in the patient, shaping the relational field moment-to-moment? When we are diagnosing through these domains of experience, we need to be clear on how that phenomenal field is a reflection of the co-creation of experience at every moment – and emergent co-created experience affects the phenomenal field from which further co-created experience emerges. The therapist cannot extricate him/herself from the process of diagnosis as it continually unfolds within the co-creating of experience.

In conclusion, I applaud Margherita Spagnuolo Lobb's significant contribution to our field shown in this chapter. The emerging of domains of experience – modalities of contact – is an important concept and useful for us Gestaltists to further understand then-and-there *experiences that live* here-and-now. *The kind of somatic and developmental lens she describes gives us firmer ground on which to stand. She helps welcome us all into the once forbidden ground of human developmental theory, which will continue to make Gestalt therapy a relevant and significant psychotherapy modality.*

Situated Ethics and the Ethical World of Gestalt Therapy

by Dan Bloom

Situated ethics as the underlying ethical architecture of psychotherapy's experiential world is the organizing concept of this chapter. This ethics accounts for our being concerned with ethics at all. I will describe situated ethics and more broadly show how the ethics of our clinical practice is within its framework. In so doing, I will introduce *intrinsic*, *extrinsic*, and *fundamental ethics* as important practical ethical categories to guide us in our daily work as psychotherapists.

The following example illustrates the ethical balance achieved in a contactful moment of a Gestalt psychotherapy session.

A person leans forward, eyes down, and says,

"You know, I didn't want to come here today. Therapy isn't working. Nothing has and nothing will. I feel like a lump of lead".

The therapist now finds himself leaning forward. "Jim, I am drawn to you as you speak. You are here and seem to be coming toward me. Would you lift your head?"

He lifts his head. His eyes meet the therapist's. He smiles.

The therapist smiles… they hear themselves exhale as if with one breath.

The above seems so simple; yet we Gestalt therapists know it is not easy. How can we describe what happened in those moments? It is the nature of contacting to evade verbal description. Notice the gentle back-and-forth of the patient and the therapist, the openness and availability of the therapist as a co-emergent presence with the patient at the contact-boundary. The therapist-patient's perhaps modest risk-taking is supported by the therapist's secure ground as part of the common ground of the session. The therapist's ground includes clinical experiences, skill, professional training, understanding of standards of professional practice and assimilated codes of ethics. These are

unaware background support for the work. Of course, if necessary the therapist will consciously or even deliberately rely upon this support. I will refer to this background support for the therapy as the *fundamental* and *intrinsic ethics* of psychotherapy.

Yet there is something else here. The graceful rhythm of the patient and therapist's co-experiencing at the contact-boundary is shaped by something more basic. It is shaped by the human quality to see one another "ethically" – that is, as humans who recognize one another as fellow humans and look to one another with a certain expectation, with a certain *ethical* sensitivity. This isn't something learned. This is basic to the structure of being human. I will call this "something else" *situated ethics*, the ethics of the human situation, a structure of the phenomenal lifeworld in which all of us can be human *beings.*

This chapter has the following organization: Part One defines situated ethics in Gestalt therapy; Part Two describes Gestalt therapy's potential confusion between extrinsic and intrinsic ethics, and the practical impact of this confusion on the phenomenological method of our psychotherapy practice. I will address how easy it is, especially for Gestalt therapists, to confuse these ethics. In doing so, I will discuss practical clinical concerns this confusion presents in our clinical practices. And I will try to help clinicians through the difficult ethical dilemmas presented in our work.

In short, this is a phenomenologically grounded practical guide for an ethics of Gestalt therapy.

1. Part One: Situated Ethics

How ought we to be toward one another? There have been countless answers to this question and never any generally agreed upon answers for all times and all places. For the purposes of this chapter, the answers, as significant as they always are, are less important than the fact that we are always driven to ask these questions. The universal asking of such questions is the watermark of situated ethics upon human beings. Being open to ethics is at the heart of our humanness and therefore is implicit in the practice of psychotherapy. Asking and answering these questions especially sharpened Gestalt therapy's orientation toward the world.

Gestalt therapists have always emphasized the call for us to be community organizers, social critics, and political activists committed to reforming society according to our view of human nature and society (Perls, Hefferline and Goodman, 1951). A the same time as this reformist appeal, we are also called to be psychotherapists motivated by Gestalt therapy's own humanistic, egalitarian, and non-authoritarian clinical values. Contemporary Gestalt therapists

have been explicitly addressing Gestalt therapy ethics (Joyce and Sills, 2006; Wheeler, 1992; Lee, 2004b.). They have been bringing a welcome focus to the ethics of the psychotherapy. They have been calling for a shift from a modernist "ethics of individualism" to a post-modern "relational", "field", "community", or "environmental" ethics (Wheeler, 2000a; Lee, 2004b; Staemmler, 2009) and to an intersubjective "ethics of care" (Jacobs, 2011). They have been calling for a focus on the therapy relationship. They have been asking us to pay special attention to the Gestalt therapist's impact on the patient since the therapist and patient are co-participants in therapy itself (Hycner and Jacobs, 1995).

But these are not the ethics I am mostly concerned with here. I am concerned with the ethics that sustains the therapy process itself, indeed, is a condition for it – and is also implicit to our existing as human "beings with one another" (Heidegger, 1962). This ethics is an ethics of our common phenomenal ground, the *lifeworld*. It orients our awareness that there are ethical matters in the therapy relationship at all times – for example, in how we handle fees and conduct ourselves towards our colleagues and supervisors. It also *stands behind* our codes of ethics and our standard of practice – and in moments of professional isolation, it anchors our faith that we are never alone in our work. This is not an ethics that tells us what to do, what is right or wrong, but an ethics that opens us to the ideas that there might be a right, a wrong, or a controversy about there being a right or wrong at all. This is "situated ethics" – an ethics of a different order.

My usage of "ethics" in "situated ethics" is influenced by Continental philosophy. In Emmanuel Lévinas's complex philosophy, among other things, "ethics" or the "ethical" is our fundamental practical concrete relation to one another (Critchley, 2002). Ethics is a way of "being in relation with the other as an act or a practice" that Lévinas describes as "ethical" (Lévinas, 1969, p. 12). The "ethical" is an "irreducible inter-personal" structure upon which all other structures "rest". Levinas's ethics provides none of the rules of usual ethics; it is the "condition of my existence" and "defines the very domain I inhabit" (Davis, 1996).

«Ethics is an *optics*» (Lévinas, 1969). Just as the structure of our eyes enables us to see and choose colors, situated ethics sensitizes and opens us to the ethical situation within which we are able to have an ethics of content and choice.

Situated ethics can be imported into Gestalt therapy's paradigm of the organism/environment field, which is being supplemented with various understandings of the "situation", as I discuss below. I also refer to this ethics as situated in order to emphasize that it is an embodied and social aspect of the organism/environment field. Contacting and the contact-boundary, the core of Gestalt therapy, are situated in an ethically organized world. The clinical im-

plication of situated ethics as a platform for the practice of Gestalt therapy is an ongoing theme of this chapter.

My discussion includes a phenomenological dimension. I discuss situated ethics as a structure of the *lifeworld* rather than only of the organism/environment field so as to stress the experiential or phenomenal characteristics of this ethics. There are different meanings of lifeworld in phenomenology as the philosophy developed over its history. However, there is general agreement that the lifeworld is the experiential world. The following aspect of the lifeworld is from the later writings of Edmund Husserl: «the lifeworld is *always already there*, *being for us in advance, "ground" for everyone... The world is pregiven to us*» (in Steinbock, 1995, p. 103). The lifeworld *precedes* experience. And expanding this with Martin Heidegger's similar concept of "world" (Heidegger, 1962), it includes the historical, cultural, social world into which we are "thrown" as its architecture that is then the foundation of our world of experience. The architecture of the lifeworld, I propose, includes our essential ethical perspective. Situated ethics is part of this architecture within the structure of the world.

1.1. The Situation and Gestalt Therapy

Contemporary Gestalt therapists have been bringing "the situation" into Gestalt therapy, although with different emphases (Staemmler, 2006a; Robine, 2011; Staemmler, 2011; Wollants, 2012). It is an idea whose time has come. From my perspective, the situation emphasizes the concrete existential dimension of Gestalt therapy.

As Jean-Marie Robine observes, the term "situation" occurs many more times in (Perls, Hefferline and Goodman, 1951) than "field". The contact-boundary occurs in phenomenal wholes of the "situation", as the ground or figure/ground and self emergence (Robine, 2011). The situation is "chunks in time" as an experiential whole (Staemmler, 2011) and the sequence of contact at the heart of our method is a temporal process. The "situation" specifically locates contacting as a temporal process *within* the broader notion of field.

Phenomenologically and *existentially*, the situation is «where human existence primarily finds itself. […] Whatever is to be encountered is encountered in a situation. Whatever is to be done is done out of a situation and with regard to further situations. Human existence is its situation» (Rombach, 1987, p. 138). Thus, the situation has the quality of human existentiality; it is a marker of human existence. The situation is an experiential and existential subset of the field. Situated ethics, then, is the ethics of Gestalt therapy's situation – an experiential and existential phenomenon. This situation is both emergent of

contacting and the basis for contacting. It is part of the pre-given structure of the lifeworld that is always already there for us – a structure present for us, available to us when we practice Gestalt therapy. «I am made by the situation and take part in the creation of the situation as well. Even before any construction of a *Gestalt*» writes Robine, «a situation has already started to be built and will be ground for the forthcoming figures» (Robine, 2011, p. 110). For Robine it is «the id of the situation» (*ivi*, p. 103); for me, it is also the situation as the lifeworld.

1.2. Situated Ethics and Ethics of Content

Situated ethics is not an "ethics of content". Ethics of content includes moral, personal, or societal values that allow us to choose this or that, "right" or "wrong". Rather, situated ethics is our inescapable ethical orientation *towards* an ethics of content. It is an aspect of the pre-given lifeworld structure that makes possible an ethics of content to occur to us. We are ethical beings *concerned* with an ethics of content because ethical sensitivity is embedded in the structure of our situation as situated ethics.

2. Part Two: Intrinsic, Extrinsic, and Fundamental Ethics

Every theory of psychotherapy
is based on some conception of
the chief dynamic factor in life and society.
(Perls, Hefferline and Goodman, 1951, p. 279)

A clinical example.

A session begins.
The psychotherapy office door opens.
A person enters. The therapist and person shake hands and both sit down.
"What brings you here?" asks the therapist.
The person says "I am depressed, sad, worried…"
Then weeps.

The psychotherapist will next ask about this person's circumstance – and this is necessary for any psychotherapy to proceed. What if there is an emergency in this person's life, for example? What next? What will be the focus of

the "work" – the person's social field, home life, relationship(s), family, drug use, and so on? The "environmental field"? The "relational field"? The "spiritual field"? Global or political matters? Or the contact-boundary of *this* psychotherapist and *this* person where *this* person's suffering can be directly experienced? How can psychotherapists practice phenomenologically when personal beliefs or concerns in the "outside world" are figural?

All psychotherapists have their own beliefs: personal, clinical, ethical, cultural, and so on. Therapists cannot leave their personalities at the office door. It is neither good practice nor possible. What do we do with our strongly held personal beliefs? Devout Roman Catholic psychotherapists hear patients plan abortions. Socially conservative psychotherapists listen to couples discuss multiple sexual partners. Sometimes therapist and patient personal beliefs match – sometimes clash. Our personal beliefs guide our personal lives. These are ethics of content.

Of course some of a therapists' personal beliefs are necessary for psychotherapy to be practiced. These include therapists' knowledge gained from clinical training and personal clinical experience. Therapists remain persons within their clinical role and practice within their personal styles shaped by their life experiences (Perls L., 1992). In this light how can psychotherapists deal with potential conflicts of the personal with the clinical when the question "what brings you here?" is asked and answered?

Distinctions between *extrinsic* and *intrinsic* ethics and the *fundamental* ethics of psychotherapy might help answer this question. When the psychotherapist allows his or her own personal ethical beliefs to be figural within the session, an extrinsic ethics intrudes on the psychotherapy. Perls, Hefferline and Goodman (1951) declaratively say that Gestalt therapy involves «…analyzing the internal structure of the actual experience… *The achievement of a strong Gestalt is itself the cure, for the figure of contact is not a sign of, but itself the creative integration of experience*» (*ivi*, p. 232). And this figure of contact emergent of the contact-boundary must therefore be free of *irrelevant* personal concerns of the psychotherapist. It is the patient who is the patient. Or more precisely, the contact-boundary of therapist/patient is the locus of the psychotherapy in which the *patient's experience is figural* against the active *background* presence of the *therapist* who is oriented by situated ethics.

A hypothetical clinical example.

A person flops down into the chair and looks down at the floor.
"I had a miscarriage". She is breathless. Agitated.
The therapist leans forward toward her.
"Mary, can you look up at me? I had one too a few years ago. Sure you feel

bad today. This will pass. All this means is that you have to try to get pregnant again as soon as you can".

The therapist's personal views are *extrinsic ethics of content* and will shape the course of the work. At least an opportunity to explore the emergent structure of the patient's sense of loss was missed. This is an extreme example. Impossible? Perhaps not.

Of course everything present for patient, even if seemingly extrinsic to the matters at hand, is basic to our work as Gestalt therapists. There is no abstract "here-and-now" (Staemmler, 2011). It is phenomenologically impossible (Zahavi, 2003). The patient's ethics of content is part of the "structure of the actual situation", attention to which is our clinical mandate. We are always interested in what any experience means to a person.

I return to Mary and a different clinical approach.

"I had a miscarriage". She is breathless, agitated.

"Mary, when I hear your words I find myself sinking into this chair in a sense of loss. As I sit with this I wonder how much of this is yours. Would you tell me more about what you are experiencing?"

"I feel heavy, John, and floating at the same time. Odd".

"Would you put your feet on the floor and see what happens?"

Mary does so, breathes, and is silent.

Once again, the therapist and the patient begin to pay attention to what is co-emerging of the contact-boundary. They are supported by a common unexpressed embodied sense, a "seeing", a "knowing" that there is a human relationship sustaining the developing sequence of contact. Mary can be silent now, "held" by the fundamental support of the therapy relationship, unspoken about yet experienceable. Perhaps a new experience of Mary's miscarriage will emerge, or Mary will reach a new understanding, and familiar figure/grounds will reconfigure into new and surprising forms within the continuing process. The architecture of support for this process is the situated ethics of the life-world.

Situated ethics establishes and maintains the conditions for psychotherapy and provides the orientation for the *fundamental ethics* of psychotherapy, which is an ethics of content. Fundamental ethics is the ethical condition that makes psychotherapy possible. For example, fundamental ethics includes the therapist's clinical know-how, experience, knowledge, and even relevant codes of professional ethics. It includes concern for the well being of the patient, potential for harm to or from others, the patient's suitability for therapy and the therapist's suitability for this particular patient. As constituents of the profes-

sional expertise of the psychotherapist, these concerns are fundamental and *intrinsic* to the relationship itself: necessary conditions for the therapy and guidelines for the ongoing work. They are "within" the therapy itself and not brought in from the extrinsic, "outside", irrelevant interests of the psychotherapist. This might sound simpler than it is. But it may be especially more difficult for Gestalt therapists because of our history.

2.1. Gestalt Therapy: A World View With the Best Intentions: Gestalt Therapists are Vulnerable to Confusing Intrinsic and Extrinsic Ethics

Everyone will readily agree that
it is of the highest importance to know
whether we are not duped by morality
(Lévinas, 1969)

Gestalt Therapy (Perls, Hefferline and Goodman, 1951) is the book that launched a thousand Gestalt therapists – psychotherapists, community activists, and social reformers committed to create a more just world. All had an ethics of best intentions. The introduction to *Gestalt Therapy*'s theoretical section ends with these passages, which motivate Gestalt therapy's psychotherapeutic theory and a social reformist philosophy: «we exist in a chronic emergency and... that most of our forces of love and wit, anger and indignation, are repressed and dulled… *Unless we consider life as filled with "creative possibilities" it is frankly intolerable* [italics added] [...] Our standard of happiness is too low». The aware, sensitive, and courageous among us «mainly waste themselves and are in pain, for it is impossible for anyone to be extremely happy until we are happy more generally» (Perls, Hefferline and Goodman, 1951, p. 251).

At the same time, *Gestalt Therapy* calls upon us to be psychotherapists who address the actuality of this person's "interruptions of contacting" and "losses of ego function". We also must pay attention to the patient's context – that we are living in a «society […] opposed to life and change (and love)» (Perls, Hefferline and Goodman, 1951, p. 252). We attend to the process of this person's contacting-making in this session. *Gestalt Therapy* also asks us to be social activists. After all, a *Gestalt* is a whole of its parts; no person is an island split off from the world. The lifeworld is, indeed, a world, as I described above, albeit a phenomenal world. To be sure, Gestalt therapy was not alone with such a clinical-social worldview; it shared a commitment to social activism with radical psychoanalysis, for example (Lichtenberg, 1969).

Our patients, then, are not just suffering individuals; they are parts of the larger social field whose institutions are turned against the good and true animal impulses of them as organisms (Perls, Hefferline and Goodman, p. 275). These impulses possess the «wisdom of the organism» – a "wisdom" that is an «immediate» but fallible «ethics» (*ivi*, p. 275). Gestalt therapy would liberate this "wisdom" not only in a psychotherapy that undoes damage to the individual caused by this society, but by political action to bring about social changes (Perls F., 1992; Stoehr, 1994; Perls and Stevens, 1969; Aylward, 2006; Bocian, 2010). Herein lies Gestalt therapy's vulnerability to confuse intrinsic and extrinsic ethics. Can Gestalt therapy be a clinical practice and an instrument for social change simultaneously in a psychotherapy session?

When Gestalt therapists write about Gestalt therapy they sometimes write about its clinical practice. Sometimes they write about social, political, or religio-spiritual agendas in which clinical practice seems to be subsumed (Levin, 2010). «We are as much a political as a therapeutic art» (Aylward, 2006), writes one contemporary Gestalt therapist. It is unclear if he means these are practiced at the same time.

And going even further another Gestalt therapist writes,

> Gestalt therapy offers more than a mere cure. It is concerned with healing… *A healer for our times is required to care for the environment and the community by addressing a range of socio-economic issues such as globalization, as well as the transpersonal and spiritual interiority of people's souls* (Levin, 2010, p. 147, emphasis added).

How different would a clerical calling be?

Whatever personal creeds are drawn from the humanistic spiritual-socio-political ideals of Gestalt therapy, they are an extrinsic ethics of content, which may be salutary for the world-at-large yet these creeds are extrinsic to the *clinical* practice of psychotherapy – and potentially intrusive on it. The psychotherapist's personal ethical agenda carried into the therapy session can become the norm against which emerging figures are evaluated. Perls, Hefferline and Goodman (1951) caution «the patient will largely truly create himself according to the therapist's conception of human nature» and further, «It is desirable to have a therapy that establishes a norm as little as possible, and tries to get as much as possible from the structure of the actual situation, here and now» (p. 282). Yet the patient and the therapist *are* of the larger social field. Can the therapy be isolated from this? Is there a middle course?

In Gestalt therapy, psychopathology is understood as disturbances at the contact-boundary (Spagnuolo Lobb, 2007d; Francesetti and Gecele, 2009). These disturbance are directly experienced by the patient and therapist as aesthetic (sensed) aspects of contacting (Bloom, 2003). Our phenomenological

method itself requires the setting aside (bracketing) of extrinsic irrelevant presuppositions so that we can attend to what emerges in the session (Bloom, 2009; Crocker, 2009; Philippson, 2009; Yontef, 2009).

Of course the psychotherapist's clinical know-how, clinical wisdom, and standards, are not bracketed. They remain available background since they are part of the fundamental ethics of psychotherapy. How can there be therapy without them? Knowledge of the outside world also remains as background. After all, a session cannot be hermetically sealed. The "bracketer" is "un-bracketable" (Stolorow and Jacobs, 2006).

Does bracketing of extrinsic ethics of content welcome an irresponsible ethical free-for-all supposedly characteristic of the paradigm of individualism (Wheeler, 2000a)? Critics of Gestalt therapists practicing within that paradigm point to therapists as encouraging patients to resist all authority and to be courageously autonomous in disregard of their impact on others (Yontef, 2002). It was true that Fritz Perls cheered on the anti-establishment counter-culture (Perls F., 1992), but it is absurd to say he was responsible for the extreme ethos of the counter-culture.

> We are entering the phase of the quacks and the con-men, who think if you get some breakthroughs, you are indeed cured…disregarding any growth requirements. I am *very* concerned with what is going on right now (Perls, 1992, p. 1).

The ethical values of do-your-own-thing autonomy were followed by some therapists who sometimes behaved recklessly with patients under their assumption of creative freedom. Some Gestalt therapists thought this was sanctioned by *The Gestalt Prayer* (Perls F., 1992). These excesses were not limited to Gestalt therapists, of course. Gestalt psychotherapy within the early individualistic paradigm has been criticized as often shaming patients. Confrontational therapists cajoled patients to "break through" their "resistances" (Yontef, 2002). Therapists are claimed to have sometimes behaved outside what many now consider proper standards of practice. Gestalt therapy apparently got a bad reputation from practice under this paradigm. But does Gestalt therapy need to do penance for alleged past transgressions?

While considering the question of a "Gestalt therapy code of ethics", in *Gestalt Counselling and Psychotherapy*, Phil Joyce and Charlotte Sills reflect that «Gestalt therapy was developed in the 1950s and promoted an anarchic attitude that saw moral codes as outmoded fixed *gestalts* that needed to be challenged. Ethics and codes of conduct were to be individually decided or negotiated».

They continue: «There was little interest in the potential for therapeutic harm or any discussion of morality or community values. We believe that this has led to many examples of abusive therapeutic relationships and continues to

pose a significant problem for a *Gestalt code of ethics and conduct*» (Joyce and Sills, 2006, emphasis added).

Yet weren't those Gestalt therapists committed to "community values and morality" specific to their time and place? Can anyone seriously question Fritz Perls's clinical bona fides, notwithstanding his showmanship in non-clinical settings? The first-generation Gestalt therapists had standards of practice. They were concerned with the welfare of their patients. Of course, not all of them always were. Not all of us are now. There were, are, and will be ethical problems in all professions. All professions need ethical codes just as all societies need laws. Surely Gestalt therapists are not the only "ethical delinquents" in the profession.

Furthermore, it is a core aspect of Gestalt therapy's clinical theory/practice to challenge fixed moral codes when unaware introjecting becomes aware and figural. Some moral codes are indeed outmoded and emerge within sessions as restrictions to contacting at the contact-boundary. This is familiar to all Gestalt therapists. Standards of contemporary practice no longer urge us to provoke our patients but to be concretely present with them at the contact boundary and with them to be sensitive to whatever is emerging.

Robert Lee made a significant contribution to Gestalt therapy ethics. In his essay *Ethics: A Gestalt of Values/The Values of Gestalt. A Next Step* (Lee, 2004a), he wrote of our "implicit relational strivings". These strivings and much of his dialogical intersubjective theory (p. 26) seem similar to the situated ethics described here. Situated ethics, however, refers to the more fundamental architecture of the pre-given lifeworld from which implicit relational strivings are possible. He describes a relational ethic where ethical implications and decisions emerge from a "compassionate ground" valuing connections and relationships. Situated ethics, however, is our ethical perspective from which we can see and then know the value of connections and relationships. Situated ethics can be the basis for compassion. Lee's relational ethic becomes an ethics of content when he extends it beyond Gestalt therapy's psychotherapy of the contact-boundary into a social criticism of the "wider larger field".

«Individual health is dependent on health of the larger field» (p. 27). Gestalt therapy, then, «*places a strong value not only on support for the individual but also on support for the environment field*» (p. 25). He continues, «we must find whole solutions that support both self and environment» (p. 26). This is legitimate as an instruction for socio-political reformers. But how wide is the field of our *immediate* clinical concern for *this* suffering patient in this momen*t* in *this* office?

Attention to a person's social field informs our work since self is inclusive of its widest ground – the social field, phenomenal field, or organism/environment field. But extending this attention to a vague value of "field respon-

sibility" or to a personal opinion about the "health" of the larger field takes this into an uncertain ethics of content with implications for our experiential method. Opinions about the environmental field are honorable ethics of content for social or political reform, but their specific clinical relevance to the fundamental ethics supporting psychotherapy is questionable. Different political parties have different political agendas each with its own ethics of content. It is arrogant to assume any particular sub-group of well-meaning psychotherapists has a lock on truth.

Community values, morality, opinions about the "field", the environment, relational responsibility, even spirituality change over time. But the structure of the actual situation and our work at the contact-boundary remain constant. They are the pole star of our practice while the nature of our patients' suffering and our clinical knowledge base change over time.

Our post-modern world's decentered subject struggles to find an ethical course. Post-modern ethics is hardly a simple matter. In his book, *Postmodern Ethics*, Zygmunt Bauman wrote, «If I do not act on my interpretation of the Other's welfare, am I not guilty of sinful indifference? And if I do, how much of her autonomy may I take away? …There is but a thin line between care and oppression…» (Bauman, 1993, pp. 91-92).

The razor's edge of Bauman's thin line cannot be ignored. We must never forget that at one time the well-intentioned standard of practice was to cure homosexuals and to turn aggressive women into passive housewives. We are wiser now. But what will be said about our wisdom in a hundred years?

2.2. A Practical Matter: Situated Ethics and an Ethical Compass

A colleague asked me to see a woman for one session in order to help her restore her trust in therapists, if possible. She would be seeing other therapists after me. This was her choice. She didn't feel it was safe to see someone more than once. She asked for male therapists.

She keeps her eyes down. When she speaks, it is almost a whisper.

"I loved him. He was a wonderful therapist. He was my therapist, teacher and supervisor. He said it would be okay. It felt right for both of us. We trusted what our bodies told us. Sex was part of the therapy. We made love. In the office. I needed to feel safe in a loving, erotic, relationship. I had breakthroughs in therapy. It was the first time I had orgasms.

Then I found out he was having sex with all of them".

Her eyes filled with tears.

I am troubled to hear this and feel an urge to defend therapists to her. (She must have seduced him, I think, look at how she looks…) I check myself and notice I am feeling myself pulling away, I relax my muscles, and then I feel sad, touched by her hurt. And say,

"Alice, I feel sad when I see your eyes fill with tears".

Looking up, slowly, "Why?..", and then... suddenly... "I'm afraid you'll want to touch me".

"No" I say. I notice I had leaned toward her unawares. I take a breath, noticing now that my chair feels solid under me, more solid than I would have thought, I feel myself settle into the chair.

"No", I say, without thinking, and gently, "No, I won't".

"I believe you". Our eyes meet.

"I want to hear more about what it was like for you with him".

Her shoulders shake as she weeps. She looks up and speaks…

The rhythm in which Alice and I moved back and forth in the session – with our bodies, with our voices – emerges from our seeing one another through the lens of situated ethics. Our "ethical eyes" were open to a sense that "something was wrong" – a sense of a disturbed ethical ground that was for me more fundamental than a simple question of moral "right" or "wrong", or of professional transgression. It was a "wrong" I saw in her eyes, felt in her comportment, and experienced in myself. I experienced something more than empathy, more than my feelingful sense of the other. More complex than compassion. And this is my point.

I was troubled by Alice's story not only because I was empathic to her. I was troubled because I could also identify with her therapist's impulse, and was moved by what I imagined the tensions such an impulse would place on the standards of practice and the code of ethics that I know are fundamental for psychotherapy. I had a felt sense of tensions in an "ethical field".

My empathy with this patient *and* her therapist was also a conflict to which I was open because I could "see" that there were *ethical* choices to be made. For a moment I was in the "space" where I could "see" ethical sensitivities, vulnerabilities, possibilities and the necessity to make choices. Her therapist and Alice had choices – and so did I as I listened to her. I repeat the theme of this chapter: situated ethics is the structure of the lifeworld that is the optics (in Lévinas's sense), of our being able to be concerned with ethics at all. It opens us to one another's vulnerabilities to ethical choosing and to the consequences of our choices. It opens us to compassion.

While situated ethics is our "seeing" of an ethical dilemma, it doesn't in-

struct "proper" choice. It isn't an extrinsic ethics of content within which we can make a choice. All psychotherapists are regularly faced with ethical dilemmas that require ethical choices that impact therapy. For example, a patient's criminal conduct or possible abuse at home requires us to decide a course of action. What do we do when we know about a colleague's breach of professional ethics or are tempted ourselves to violate ethical codes and standards of practice? Add another session to a bill to the insurance company? Or code a different diagnosis to get more sessions authorized? Of course we have codes of ethics, but are they all authoritarian rules we have to swallow? We have standards of practice, but can we make them our own and use as we see fit? Is there a difference between authoritarian rules and just rules?

Emmanuel Lévinas's thoughts on ethics and justice might be helpful. His ethics is within the sphere of the intersubjective and is not about mutuality or equality (Lévinas, 1969). Lévinas refers to matters of justice, morality, and equality as "political" questions within the sphere of the third party that «opens up broader perspectives and instigates a concern for social justice» (Davis, 1996, p. 82). This "third party", writes Bauman in his discussion of Lévinas, «can be encountered […] in the realm of Social Order ruled by justice… [T]he relationship between me and the other must …leave room for the third, a sovereign judge who decides between two equals» (Bauman, 1993). There is no ethics of the same and the other without this third party administering justice, even though in Lévinas's philosophy the third party «puts distance between me and the other» (Davis, 1996, p. 82). It follows that no more can Lévinas's ethics be maintained in a world without the third party than can psychotherapy be responsibly practiced if the psychotherapist is oblivious to the third party for its standards of practice, ethical codes, professional experience, and clinical wisdom.

The situated ethics as our ethical vision encourages us to look to this third party for an ethics of content. Codes of professional ethics, professional expertise, and clinical judgment are included within this ethics of content as a fundamental condition for therapy itself. Codes, professional expertise, learning, judgment, and so on, are included to the extent the therapist has assimilated them and are in what the therapist brings to the contact-boundary of the work.

If the psychotherapist's ethical choosing isn't "seen" through the optics of situated ethics, the therapist will not know there is an actual ethical choice to be made, but will only be formulaically following prescribed rules of conduct or practice. It is by situated ethics that we see there is an ethical concern at issue – and therefore there is a need for an ethics of content, an ethical code as third party – be it an actual code of practice, a community of colleagues, supervision, or any other basis for an ethics of content that would be an intrinsic and fundamental support for the therapy.

Now we can be open to standards of practice and codes of professional conduct as the *relevant* extrinsic third party contextualized *within* the fundamental ethics of psychotherapy and not applied as an irrelevant extrinsic ethics intrusive on clinical practice. As such, the third party furthers the therapy as support for both therapist and patient. This third is not merely an abstract or even concrete written code but can be a living community of colleagues, professional associations, institutes, and supervisors.

Isolated therapists who are disconnected from such actual third party might be lost in ethical confusion when faced by an ethical dilemma. Proper professional training, while no guarantee, provides guidance since there would the ethical third party within the assimilated background of professional learning. And since none of us has been trained in isolation, all of us integrated our social experiences of training as background social support. Our professional community is present in the structure of the lifeworld in which situated ethics is a significant structure. But are these assimilated experiences enough to assure a way out of ethical confusion? This is another way of asking if a therapist can practice without professional supervision. It is difficult to imagine any code of ethics that does not require it.

Situated ethics gives us therapists our ability for ethical *sight*. It orients us to ethical choice. We can *see* and with our best judgment possible, make ethical choices grounded on our experience, professional expertise, training, knowledge of standards of practice and professional ethics – within our community of colleagues. All of these are elements of the fundamental ethics upon which psychotherapy depends. Situated ethics is part of the structure of the widest social field, the lifeworld within which even the isolated therapist dwells.

3. Conclusion

Gestalt therapy deserves to be proud of its ethics. We Gestalt therapists should encourage one another to export our ethics of best intentions for social reform and activism as far and wide as our vision can take us. At the same time, we should be mindful of our commitment to our clinical work as phenomenological psychotherapists who address immediate experience emergent of the contact-boundary. This is the power of our clinical method. Our unique clinical vision is compromised when an extrinsic ethics of content intrudes on the intrinsic ethics of Gestalt therapy fundamental to our work. To some degree, our ethics of best intentions that moves us to be social reformers and humanistic psychotherapists makes us vulnerable to this intrusion. Further, we cannot rely on the felt "truth" of our work at the contact-boundary to know the justice of our behavior towards our patients – only its clinical rightness.

We are at home in this lifeworld and see one another through the optics of the situated ethics, our ethical sensitivity. Situated ethics opens us to "right" and "wrong". Within this home each of us is able to formulate an ethics of content and mold the shape of personal worlds according to always-changing norms of human nature.

«The good is what it is human to strive for» (Perls, Hefferline and Goodman, 1951, p. 334). Situated ethics is the sight with which each of us can see a good towards which each of us cannot but strive, differently.

Comment

by Richard E. Lompa

This chapter in the book considering ethical issues in the practice of Gestalt therapy is a very important and interesting contribution to the complete essence of this publication which offers a wide spectrum of the practical applications of this therapy. Ethical considerations have often received only minimal attention in Gestalt theoretical literature in the past. Training programs for Gestalt therapists have only in the past ten years or so included these issues in a meaningful way in their educational programs. Any attempt to bring this issue into full focus in the practice of Gestalt therapy and to offer guidelines that help the Gestalt therapist with the complex situations he is confronted with are certainly welcome. I and many of my colleagues often struggle with the emergence of ethical issues and/or dilemmas that take place in the relational field that is such a necessary concept in our practice. Reading this chapter has heightened my awareness of my personal position in my contribution to the relational field that emerges at the contact boundary.

Dan Bloom deserves respect and appreciation for his energetic and thorough examination of much of the recent literature that has contributed to more careful consideration of the effect that ethical concepts have on our being as therapists and that of the people who consult Gestalt therapists for help. The concept of situated ethics as being an ethics of the phenomenal ground, the lifeworld, is a concept that resonates to the very core of our humanness in interacting with our fellow beings. This concept reflects the more recent considerations of the field emphasizing Gestalt therapy as a psychotherapy of the situation.

In agreement with the Gestalt theorists, Goodman (Perls, Hefferline and Goodman, 1994, pp. 13-14) states that in order to understand one's behavior one has to determine for every kind of thought, emotion and action in the momentary whole situation, i.e. the structure of the current situation of a person and his phenomenal environment, which implies that behavior is a function of

the psychological situation. The importance of the field perspective becomes increasingly relevant.

Agreeing with this approach, Wollants (2007, p. 43) stresses that «a supportive situation is a situation in which a human being can be self-supportive while being dependant on the support of others. Self-support is impossible without environmental support». This is consistent with the present movement from the practice of Gestalt therapy more as a monopersonal approach to a therapy that recognizes the developing relationship in the therapeutic field of the therapist and the client. This relationship emphasis contributes to evolvement into a multipersonal approach, a different focus.

My experience in the therapeutic field supports me in the conclusion that as more focus is directed onto the relational field of the therapist and the client, the intimacy and the resulting vulnerabilities of the two parties emerge to the foreground. Exactly these vulnerabilities make the ethical behavior of both parties so crucial. It becomes very important for the Gestalt therapist to become aware of these vulnerabilities and develop strategies to address these issues in their practice of psychotherapy with clients.

While appreciating this chapter, I also need to express a critical note. Dan Bloom introduces clinical examples of meetings between the therapist and the client to demonstrate his point of view. However, I am often left with a feeling of confusion as to the message that is being presented and its connection with the ethical considerations that are being stressed, especially in the beginning of the chapter. As a reader I am confronted with the idea that I need to consult my own Gestalt therapy practice for examples of the importance of ethical considerations. I can do this by myself but I do miss the support from the author. Beginning Gestalt therapists reading this chapter might be even more confused since they have less experience in the relationships that emerge in the therapeutic field.

Dan Bloom's introduction of the concepts of intrinsic and extrinsic ethics and their distinctive differences is an offering to the Gestalt therapist in the unraveling of the confusion often experienced in their clinical practice. Here the two clinical examples were more demonstrative of the subtle intrusion of these two ethical concepts on the contact boundary and the impact that this confusion has on the phenomenological methodology of psychotherapy practices.

One of the examples given is with the client that feels much shamed by her former therapist and requests a session to re-establish her trust in a therapist in his therapeutic role. This is a painful example of the result of the behavior of the therapist. I contend that any time shame arises in the therapeutic relationship there is a call to take ethical issues into consideration. I am not referring to the possible shameful experience of the client having to ask for help but that which takes place in the therapeutic field. Shame is a feeling that blocks the

process of self-realization of the person. Lee (1996, preface, p. xii) states that if psychotherapy is relational and if shame is relational, then the dimension of shame in the therapeutic field must be addressed and new theoretical tools must be developed with which to address it.

Our work as psychotherapists is to support and encourage the process of further self- realization which will enable the person to creatively adjust to their life's present and future situation. All experiences that take place at the contact boundary in the therapeutic field need to be assimilated and given a meaning that supports this adjustment. This is a creative process and any obstruction that develops through the relationship of the therapist and the client to this process needs to be evaluated as a possible exploitation of one or both of the parties. Therefore to me any obstruction implies that this is an unethical practice of Gestalt therapy. My opinion is that the shame that is experienced in the relational field of the therapy can therefore become an indicator of an unethical practice. The possibility of this relational connection needs additional investigation and continued reflection.

In conclusion, excitement and gratitude come to the foreground upon reading Dan Bloom's careful and thorough consideration of ethical considerations in the practice of Gestalt therapy. Many ideas and reflections are presented that will contribute to further discussion and exchange of experiences and ideas in an area which is highly relevant to therapeutic practice that will keep this aspect of the psychotherapy practice relevant, meaningful and accentuated in the totality of psychotherapeutic practice.

Research and Gestalt Therapy

by Ken Evans

There has been little attention given to research in the Gestalt community until fairly recently. Thus it seems reasonable to suggest that, in this context, the rubric "lose your mind and come to your senses" has been taken far too literally. Notable exceptions include the work of Professor Leslie Greenberg, for many years an eminent figure in the publication and application of psychotherapy research. Greenberg's work embodies the values and practice of Gestalt psychotherapy. His book, *Facilitating Emotional Change* (Greenberg, Rice and Elliott, 1993), was the main inspiration behind my decision to introduce a research driven Masters degree in Gestalt psychotherapy in a UK university in 1994/5 and a doctoral level degree in 2000.

Other more recent Gestalt researchers of note are Paul Barber (*Becoming a Practitioner Researcher: A Gestalt Approach to Holistic Inquiry*, 2006) and Philip Brownell (*Handbook for Gestalt Theory Research and Practice*, 2008).

Having myself only recently emerged from two years co-writing a book on research for psychotherapists (Finlay and Evans, *Relational Centred Research for Psychotherapists: Exploring Meanings and Purpose*, 2009), I found determining a focus for a single chapter quite a challenge. In the end a simple but ambitious goal for this chapter is to motivate Gestalt trainees and experienced Gestalt clinicians to engage in research. It is for the reader to judge the degree of success of this endeavour.

Both psychotherapy and research involve a journey of evolving self-other understanding and growth. A key assumption Linda and I make in our aforementioned book is that many of the familiar skills, values and interests of Gestalt therapists are, in fact, directly transferable to the research domain. Interviewing skills, reflexive intuitive interpretation, inferential thinking and a capacity for warmth, openness and empathy are all qualities needed in both practice and in research. Indeed we believe a competent, relationally oriented Gestalt therapist, equipped with an appropriate introduction to qualitative research methods, can be a competent researcher. Research will be enriched considerably by the professional competencies and emotional literacy expected of a rela-

tional centred Gestalt therapist. In turn, research can provide clinicians with vicarious therapeutic experiences (Polkinghorne, 1999), broadening our understandings of clients' worlds as well as challenging our assumptions and beliefs about therapy (Cooper, 2004). Good research, writes Du Plock (2004), «should leap off the page to revitalize some aspect of our way of being as therapists» (p. 32).

1. The Political Context. The Desire for Gestalt to Survive in the Highly Competitive Profession of Psychotherapy

As Gestalt psychotherapists we often appear naive, imagining we can continue to practise freely regardless of the social and political contexts in which we work. However a cold wind is blowing across Europe, a cold wind bringing evidence-based practice, statutory regulation, occupational standards, and manualised treatments. These developments are already impacting clinical practice. Can we continue to practise as liberally as we have over the previous 50 years? As I write yet another nation, France, has seen the title *psychotherapist* restricted to psychologists and medical doctors. This has happened despite the ambitious and principled vision of the European Association for Psychotherapy, which has sought the creation of an independent profession of psychotherapy (EAP, The Strasbourg Declaration), since its formation in 1991. Eva Gold and Stephen Zahm wisely urge Gestalt therapists to "creatively adjust" to the current *Zeitgeist* if it is to survive and flourish (Gold and Zahm, in Brownell, 2008).

In the first section of this chapter I explore and critique the "politics of research" to provide a necessary understanding of the issues at stake and better equip Gestalt therapists to challenge the "new" status quo in the way that our founders did the "old" status quo 60 years ago.

Increasingly, psychotherapists are being exhorted to carry out research. We are being pushed to provide evidence of the effectiveness of our work and to draw on evidence-based practice to improve the quality of our services (Rowland and Goss, 2000). But what kind of evidence might best show the value of the work we do? What type of evidence should clients and funders of health care rely on?

Much depends on how "evidence" is defined. The prevailing view of the evidence-based practice movement is that evidence should be "scientific" utilising measurement and quantification. I encounter some Gestalt therapists who are anxious that qualitative methods are somehow lacking in scientific credibility and appear to have lost faith in the efficacy of doing research *with people* rather than *on people.* But how relevant are quantitative approaches when it

comes to psychotherapy? How can a psychotherapist's understanding of the ambivalence of human experience be quantified? Is it possible to measure the complex, ever-evolving, multi-layered nature of therapeutic relationships and the work we do?

While it is crucial to use evidence to back up practice it is also necessary to challenge existing assumptions about what constitutes "best" evidence and to challenge the over-emphasis on quantitative evidence where the use of randomised controlled trials (RCTs) is held up as the "gold standard".

2. Debating the Nature of "Evidence"

In its guidelines on managing depression in the United Kingdom for example, the National Institute for Health and Clinical Excellence (NICE) recommended the application of guided self-help programmes based on cognitive-behaviour therapy (CBT) for patients with mild depression and the use of a combination of CBT and anti-depressants for those presenting initially with severe depression (NICE, 2004/7)[1].

NICE worked with a hierarchy which classifies and rates evidence in terms of its supposed value. At the top of the hierarchy, Grade A evidence is that obtained from controlled experiments, particularly randomized controlled trials (RCTs)[2]. Grade B evidence is derived from well-designed quantitative studies such as surveys and non-randomised experiments[3]. Lower down still, Grade C evidence includes expert opinion based on case reports and clinical examples.

There are major omissions in this version of a hierarchy of evidence. The opinions of service users and carers, as well as the views of psychotherapists themselves are missing. There is no reference to "practice-based evidence". Qualitative research – arguably the main evidence employed in relational oriented psychotherapies – is left completely out of the frame. Issues to do with therapy "process" are shunned in favour of "outcome". All this points to the

[1] The guidelines were initially published in 2004 and amended in 2007.

[2] In RCT experiments, outcomes of treatment with patients/clients who have the same disorder are systematically measured and compared with the outcomes of patients/clients who receive no treatment. The "independent variable" (the treatment) is applied to the "dependent variable" (the client's condition) and the effects are measured. The *random* allocation of patients/clients to treatment groups means that any subsequent difference in outcome can only be attributed to the impact of the treatment.

[3] These experimental designs use methods other than randomisation. For example, a "matched pairs" experimental strategy could be used which sorts participants into pairs similar to each other on particular criteria such as age, duration of disorder and so on. These kinds of controlled experiments are generally considered to produce a slightly lower quality of evidence but a well-controlled experiment is also seen as potentially offering better evidence than a poorly conducted RCT.

politicisation of research. For example, on the basis of the recommendations made by NICE, additional government funding was made available to address the shortage of CBT practitioners; no such extra funding was given to other modalities.

3. RCTs Under the Spotlight

If you were going to study the effectiveness of a drug, you'd want RCT research to be used. After all, it is relatively straightforward to measure and evaluate the impact of a drug which has clear physical consequences, and to compare this with situations where the drug has not been administered. The question is can Gestalt psychotherapy, with its layers of emotional and relational complexity, be equated to a drug treatment?

While RCTs are effective at measuring changes in physical health and behaviour they are less able to measure changes in feelings and in one's sense of being. Furthermore, RCTs do not address real life practice, given they are designed to measure condition-specific efficacy in tightly controlled conditions for carefully screened patients/clients. Long-term treatments are rarely studied in RCTs studies despite the fact that research indicates therapies conducted over longer periods tend to have more successful outcomes.

Critics of the over-reliance on RCTs have highlighted a number of potential weaknesses in the way that experimental research has been applied as the sole measure of therapy effectiveness. They argue that the use of experimental designs (including RCTs) assumes that people's problems can be clearly demarcated and compared, and that techniques can be isolated and applied in the required "dose".

Mottram (2000) explains that the conditions created in psychotherapy RCTs represent a «substantial deviation from usual psychotherapy clinical practice» (p. 1). The tests are wont to focus on disorders that rarely, if ever, exist in pure form in practice. RCTs also tend to focus on single problems, ignoring the fact that most clients have more than one clear primary problem for which they seek psychotherapy. As Westen, Novotny and Thompson-Brenner (2004) point out, much RCT research rests on the DSM diagnostic system – despite the fact that only a very small percentage of those who seek therapy do so because they have a particular DSM diagnosis. In most cases patients/clients are seeking help for the business of living. Dumping people together into groups of disorders erases the specificity of individual personalities and conceals the subtle adaptations therapists make in response to personality differences. Ramsay (cited in Bovasso, Williams and Haroutune, 1999) suggests that we need more research focused on "free range humans" – the people clinicians actually meet

in their consulting rooms. «RCTs typically cast clients as passive recipients of standardized treatments rather than active collaborators and self-healers – assumptions at odds with our values as relational oriented therapists» (Elliot, 2001, p. 316).

One of the potentially erroneous developments stemming from the evidence-based practice movement has been the push to compare the effectiveness of different psychotherapy treatments. In the psychotherapy world, the move to find evidence to value one modality over another has proved divisive and unhelpful. Substantial and compelling research produced over a number of years reveals that relational dimensions which operate across *all* modalities are more important than specific techniques.

In 1975, Luborsky, Singer and Luborsky completed a meta-analytic study of more than a hundred research projects conducted between 1949 and 1974. They found that the type of therapy a client had received had made no significant impact on the outcome. Clients undergoing *any* of the different therapies researched seemed to improve as a result of their experience. They concluded, «we can reach a "dodo bird verdict". It is usually true that everybody has won and all must have prizes» (*ivi*, p. 1003). A subsequent meta-analytic study by Smith and Glass (1977) confirmed the "dodo bird verdict". Wampold *et al.* (1997) reviewed research carried out between 1970-1995 and also found little or no difference between the effectiveness of different modalities. The APA's Division of Psychotherapy published an edited volume titled *Psychotherapy Relationships That Work*, and concluded that general processes which transcend theoretical orientation (such as the establishment of the therapeutic alliance) were found to have the greatest bearing on successful outcomes (Norcross, 2002).

A range of research specifically demonstrates that the best predictor of successful outcomes is a high quality therapeutic relationship. This finding applies across various therapies and a range of client problems (Margison *et al*., 2000; Gershefski *et al*., 1996; Everall and Paulson, 2002; Bryan *et al.*, 2004; Hubble, Duncan and Miller, 1999). Summarizing the findings of a body of research into the relationship between therapy and change in patients/clients, Lambert (1992) found that only 15% of therapeutic change was attributable to factors specific to a particular therapy.

At a time when the growth of qualitative methodologies is placing greater emphasis on the therapy relationship and clients' contribution to it, why is psychotherapy research still committed to efficacy studies across modalities? The pervasive culture of the market place, with its emphasis on accountability, competition and choice, offers a clue (Evans and Gilbert, 2005).

4. Celebrating a "Practice-Based Approach" to Evidence

In recent years there has been a growing call for *practice-based evidence*, rather than evidence-based practice. This promotes relatively small-scale research in natural, everyday clinical settings and places service users' experiences of therapy at the core of the research (Macran *et al*, 1999; Foskett, 2001; Mellor-Clark and Barkham, 2003). In practice-based research, clinicians are often the main researchers and the research is integrated into the therapy programme. In such research, practitioners might offer detailed descriptions of some aspect of their clinical case work, perhaps including descriptions of the context and the patients/clients and an account of the work carried out supported by evidence of its effectiveness, as measured by standardized measures, practitioner observation and client self-reports.

Ryan and Morgan (2004) argue that practice-based evidence not only gives service users and therapists a voice but also recognizes their firsthand knowledge: for example, of what works, and what needs to change. While there is no one model of how to do practice-based research, we would argue practitioners are well placed to conduct research of interest and relevance. The following two examples show something of the range of this broad category of what constitutes practice-based evidence.

4.1. Research Example 1 (Strickland-Clark, Campbell and Dallos, 2000)

Five children/adolescents were interviewed immediately following their family therapy sessions. They were asked about their experiences of helpful and unhelpful events during the therapy sessions. The children/adolescents were helped to identify these significant moments through the use of video-tape cues. Feeling heard; the importance of being included; coping with the challenges of therapy; how therapy brought back painful memories; difficulties of saying what you feel and think; and needing support. The interviews and the significant events were analysed using grounded theory and "comprehensive process analysis". Key themes which emerged included the importance of children being felt empowered by the research and expressing their pleasure in being asked to take part.

4.2. Research example 2 (Gilbert, 2006)

This research involved a phenomenological exploration of the effects of a traumatic event (the death of a child) on six Social Services personnel. The re-

searcher, a Gestalt psychotherapist, had previously been involved in offering Social Services staff support and was interested in how the staff perceived the support they received and what meaning they constructed from the death. Findings included: recognition by the six co-researchers of the scale and uniqueness of the impact; expressions of anger, self-doubt and anxiety; the development of physical symptoms; and a developing awareness of personal qualities and strengths. Participants valued support from friends, family and (most of all) colleagues. Self-support strategies were important along with the use of humour.

Further examples might include Qualls (1998) and also Elliot, Loewenthal and Greenwood (2007).

5. Gestalt and Relational Centred Research

We have an ethical obligation to demonstrate the effectiveness of Gestalt therapy, and I believe this is best done by broadening the process by which our practice is evaluated. The epistemological bases of Gestalt therapy include phenomenology, field theory, holism and dialogue. Gestalt theory and values are located within a post-modern paradigm such that Gestalt therapy simply does not fit comfortably within the positivist paradigm that underpins most quantitative research (Evans, 2007). All too often quantitative research is unable to touch core issues or shed light on processes which resonate with lived experience. Effectiveness studies need to tap the rich vein of clients' and therapists' perspectives drawing on approaches primarily from qualitative research.

It is important for us as practising Gestalt therapists to recognise that aspects of our everyday clinical work can be regarded as respectable "research activity", making a difference to our profession and our clients. There are, of course, major differences between psychotherapy and research. In research we aim to understand individuals and their social world with an eye to producing knowledge. Our contact with those we research may well be short-lived, involving perhaps a couple of hours of conversation. In psychotherapy, we aim to understand and enable another, over a longer period of time. What links Gestalt psychotherapy and research are the elements of mutual discovery and the sense of being in a "process", a process which calls for deep engagement and exploration.

Most qualitative research books describe and evaluate different methods. While celebrating the messiness and multiplicity of the range of qualitative research approaches available, research should not simply be a free-for-all where "anything goes". While the array of research methods at our disposal testifies to the richness and dynamism of the field, it also presents challenges for con-

ducting research. When it comes to choosing from the wealth of qualitative methods available to us it is crucial that very careful consideration be given to the question "which method(s) shall I choose to support the specific research project I have in mind?". Novice researchers can be confused about how to start. The temptation is to engage simplistically with "methods", such as interview or qualitative thematic analysis, instead of "methodology", which includes methods but also encompasses certain philosophical and theoretical commitments. Barber and Brownell in their chapter on qualitative research provide a concise and helpful guide to qualitative methodologies, and the philosophy which informs them (Brownell, 2008). Research is a voyage of discovery and methodology helps us understand the type of trip we are embarking on, and offers maps and guides. Simply engaging methods in the absence of a methodological context is a bit like packing before we know where we are going! Space does not allow a comprehensive exploration of this crucial issue. Therefore in addition to Barber and Brownell you might also see Finlay and Evans (2009), which seeks to guide the reader through the maze to an informed choice of methodology.

6. Defining Features of Relational Centred Research

The major tributaries of our relational centred approach are dialogical Gestalt therapy informed, supported and challenged by existential phenomenology, intersubjectivity and relational psychoanalysis. These tributaries underpin the four defining features of our relational centred approach to research. The first two of these, presence and inclusion will be immediately recognizable to most Gestalt practitioners: They are in turn supported by intersubjectivity and reflexivity.

Presence is the capacity to be open and both emotionally and bodily present. *Inclusion* is the capacity to put oneself into the experience of the other thereby confirming the other's existence and potential. Gestalt therapists will be familiar with the application of these concepts in clinical practice. They can equally be applied to the research endeavour.

Presence and inclusion are, in fact, twin processes each requiring the other in relational centred research. The challenge is being inside the research, practising inclusion and simultaneously sufficiently outside, maintaining a grounded presence, without losing oneself in the other (Yontef, 2002). This capacity of holding both grows and develops with experience.

Although researcher and co-researchers are separate, the concept of *intersubjectivity* highlights their intertwining. Any relational encounter between two people potentially involves multiple entangled subjectivities, conscious and

unconscious. Past and current aspects of the self of one person can be elicited and interact with those of the other in the present. Given the complexity of this intersubjective space, a relational oriented researcher needs to engage in *reflexivity*, a self-aware thoughtfulness about the research dynamics and process and here we strongly advise having a supervisor to support and challenge the researcher in critical reflection.

There is no easy rule book of techniques laid down to conduct a particular research project or to explore a particular client issue. That said these four features of relational research will be present to greater or lesser degree in all relational research projects though with varying emphases[4]. The researcher's presence and way of being is critical to engaging the all-important research relationship and requires bodily and emotional engagement, receptivity and transparency.

Dahlberg, Dahlberg and Nystrom (2008) develop the idea of receptiveness in their version of Reflective Lifeworld Research. They call for the researcher to adopt an «open discovering way of being» and develop a «capacity to be surprised and sensitive to the unpredicted and unexpected» (p. 98). Wertz (2005) applies these ideas to the process of bracketing (*epoché*) in phenomenological research where he suggests the researcher needs to attempt to enter fully into the participants' situations and «savours the situations described in a slow, meditative way and attends to, even magnifies, all the details» (p. 172).

It is our «intersubjective horizon of experience that allows access to the experiences of others» (*ivi*, p. 168). In this intersubjective context there is a «reciprocal insertion and intertwining» of others in ourselves and of us in them (Merleau-Ponty, 1968, p. 138). This intertwining occurs in both visible and hidden ways, as aspects of ourselves interact with and merge with parts of the other. One way of understanding these complicated entanglements where we find ourselves responding to another at many levels, is to recognise the multiple, interacting subjectivities present. De Young describes these relational entanglements as "thickly populated" encounters (De Young, 2003).

So, each of us brings to the research encounter our unique ways of being in the world[5] stemming from personal history including age, gender, ethnicity and personality (Evans and Gilbert, 2005). These shape perceptions of events and influence the relational encounter (Stolorow and Atwood, 1992). The issue at

[4] To give some examples, phenomenological research approaches especially highlight the need for researchers to maintain an open presence as part of the bracketing process. Integrative and Dialogical Gestalt psychotherapy researchers will foreground inclusion and the nature of intersubjective intertwining of conscious and unconscious aspects. Feminist versions of relational research are likely to highlight, reflexively, gender and power issues.

[5] This "way of being in the world" is for example, variously known as a person's "organising principles", "creative adjustment" or "life script", in psychoanalysis, Gestalt psychotherapy and transactional analysis respectively.

stake is the importance of critical reflection on how the researcher *and* the research relationship may impact on both the research process and findings (Finlay and Gough, 2003). Researchers' subjectivity and intersubjectivity, when fore-grounded through reflexivity begin the process of separating out what belongs to the researcher rather than the researched.

As a Gestalt psychotherapist reading this chapter you will undoubtedly appreciate the value and significance of being reflexive and you will also recognise how valuable supervision can be to untangle some of the complicated subjective and intersubjective issues which could impact significantly on therapy. The same applies to the research process. We would suggest that relational centred research ideally requires both academic supervision and supervision of the research process (Evans, 2007).

7. Conclusion

At the centre of dialogical Gestalt psychotherapy and relational centred research is a focus on the co-creation of the relationship as an interactional event, a constantly evolving co-constructed relational process to which client and therapist, participant and researcher contribute alike and impact on each other in an ongoing way.

Whether engaging in research or psychotherapy, a sensitive, "relationally-tuned" attitude needs to be adopted which means letting go of control and committing to whatever arises between researcher and participant. It means not predicting, shaping or molding the course or direction of the research engagement by, for example, rigidly sticking to the "six" questions that have been devised for the semi-structured interview or by getting so overly enmeshed and anxious about outcomes that we are not fully present. Committing to relational centred research requires the practitioner-researcher to surrender to whatever emerges into moment by moment awareness[6]. Herein lies both challenge and possibility in the research endeavour. What does it mean for us as researchers when we are extolled to be "fully present" in the research encounter? How do we recognise and deal with a failure of inclusion? What may be the potential impact on our capacity to commit to the "between" of powerful unconscious processes and how can we bring this meaningfully into a thoughtful research approach? These are questions worthy of continuing reflection and, if I have succeeded in stimulating your interest in research further, then I urge you to read some or all of the texts referred to in this chapter.

[6] This practice is akin to the notion of "creative indifference" in Gestalt psychotherapy and the practice of "mindfulness" in Buddhism.

Comment

by Leslie Greenberg

I was pleased to read that my research efforts have had a significant impact on Evans and I agree with his view on the politics of research – that due to culture wars "practice-based evidence" and "process research" are shunned in favour of "outcome". I agree that the current focus on randomized clinical trials as the sole arbiter of evidence-based treatment has been too simplistic and that in fact existing research shows that the best predictor of successful outcomes is the quality of the therapeutic relationship.

In spite of these agreements I find myself not fully in support of his proposals of adopting relational centered research as the best solution to how to do meaningful research. This approach is characterized by the adoption of a similarly sensitive, "relationally-tuned" attitude to research as one does to therapy which involves «letting go of control and committing to whatever arises between researcher and participant» (Evans). I think that research does differ from therapy and that jettisoning research criteria such as repeatable regularities *and* consensual reliability *can result in the loss of concepts which are necessary for rigorous research.*

The aim of scientific research, as I see it, is best described as involving sequential steps of observation/description, measurement, explanation/understanding and prediction. The problem with the existing emphasis on evidence based research is that it operates only in the domain of prediction and treats this type of research as the pinnacle of scientific method. The use of experimental designs, randomization and hypothesis testing in psychotherapy research is a case of trying to walk before one can crawl. Psychotherapy research is not yet at the stage of being able to engage in taking its first steps by adequately describing, specifying and measuring its phenomena and variables of interest. While Evans's critiques of RCT's and evidence based treatment are cogent I think it is a mistake to follow this critique with too rapid a rush to qualitative research as the savior. Although the qualitative/quantitative distinction has been broadly espoused and promoted as an alternative to quantitative research I think this is a misguided dichotomy that oversimplifies the issue. It is not an issue of numbers vs meaning that is the key problem. Rather it is an issue of seeing clearly that description and measurement are needed before we can proceed to explanation and prediction. Investigators need to clarify their research aims, adopt a pluralistic approach and use both qualitative and quantitative means. They need to avoid methodolatry *– idolizing one form of method – and use whatever methods best suit their questions, pursuing description and meaning as well as measurement, and hypothesis testing when ready. It is important to note that participants' meanings/experience gained by qualitative*

methods although important are not always the open sesame to what is occurring. As Perls noted description of the obvious is the stuff of genius. So observation which is crucial to the Gestalt approach is as important as people's experience.

As I have written elsewhere process research based on observation of what people actually do in therapy is necessary to explicate, test, and revise the theoretical premises and ingredients of specific treatments, as well as to enable researchers to identify the active change ingredients. For psychotherapy research to become a true applied science, it needs to specify the processes of change that produce therapeutic effects.

For example, intensive observational analyses of the client's change process in the empty-chair dialogue led to the development of the essential components of resolution of unfinished business with a significant other (Greenberg, Rice and Elliott, 1993; Greenberg and Foerster, 1996). In the process of resolution, the person was observed to move through expressing secondary blame, complaint, and hurt, to the arousal and expression of the primary unresolved emotion, to the mobilization of a previously unmet interpersonal need. Sufficient emotional processing and emergence of a new emotion leads to a shift in view of the other. Resolution is marked by the person adopting a more self-affirming stance and understanding and possibly forgiving the imagined other, or by holding the other accountable. Greenberg and Malcolm (2002) demonstrated that those in therapy who engaged fully in these change processes be-nefited both more than those who did not, and more than those who experienced the more general effects of a good alliance.

Combination of Gestalt Therapy and Psychiatric Medication

by Jan Roubal and Elena Křivková

1. Introduction

The psychiatric drug treatment has been a part of treating psychic difficulties for 60 years. In their practise, Gestalt therapists relatively frequently encounter patients who take psychiatric drugs. The topic of psychopharmacotherapy and its combination with psychotherapy is nevertheless omitted in the Gestalt literature or mentioned only briefly in connection with another aspect of Gestalt therapeutic work (e.g. Stratford and Brallier, 1979; Harris, 1992a; 1992b; Aviram and Levine Bar-Yoseph, 1995; Resnikoff, 1995; Philippson, 1999; Sabar, 2000; Miller, 2001; Brownell, 2011a and others). It is not an easy task to describe the combined use of Gestalt therapy and psychopharmacotherapy as each of the approaches is founded in a different paradigm and derives from a different understanding of health and illness. We nonetheless assume that some basic knowledge of psychiatric drugs also belongs to the responsible practise of a Gestalt therapist, as well as the effort to find one's own understanding of the use of medication, which is congruent with the Gestalt therapy approach.

In this chapter we utilize our practice as psychiatrists who work as Gestalt therapists and also have experience of pharmacological treatment. We are trying to offer a way of thinking about psychiatric drugs and at the same time not losing the focus on the individuality of each patient and the dialogical essence of the psychotherapeutic encounter. We are introducing our effort to find ways of overcoming the dichotomic thinking of "psychotherapy versus medication".

When a patient takes medication, the therapist could be tempted into the I-it approach (Buber, 1996), as if the patient was an object of treatment. However, the therapist encounters a person with a unique story, a unique way of contacting, a unique way of creative adjustment. Medication belongs to the story, to the way of contacting and to the creative adjustment. A therapist opens up to a humane meeting of I-you right now and here with this patient and the whole

context of his/her life, including the medication. The patient enters the therapeutic situation affected by a number of influences: s/he may have had a sleepless night or a delicious lunch or s/he may have taken Prozac in the morning. The therapist also enters the therapeutic situation affected by external influences: s/he has just had a cup of a strong coffee or had a fight with the spouse the previous night or has just finished a demanding therapeutic session. Two people are meeting and the psychiatric drugs are one piece in the mosaic of the whole complex situation of their meeting.

When writing this chapter, we had on our minds the non-reduceable complexity of the therapeutic situation and the essential importance of human encounter. However, we intentionally narrow our focus on taking medication later in the text, in order to increase the awareness connected to this partial aspect of the field.

2. Medication as a Part of the Therapeutic Situation

If a patient takes psychiatric medication it affects the whole therapeutic situation. The medication modifies the course of the therapy, interferes in the therapeutic relationship and affects the therapy results. It presents a considerable external influence, which is usually independent of the psychotherapy or the therapist. It may be a difficult situation for a therapist, but not an exceptional one. There are many independent influences in psychotherapy[1] and medication is just one of them.

The medication could bring about a significant shift in the patients' experiencing themselves and their environment, as well as in their behaviour. This will be present in the way they are in a therapeutic situation. For instance, an antidepressant can help a patient to mobilize energy, which can significantly affect the course of the psychotherapeutic sessions. We can imagine medication in this case may have a similar impact on the patient as being in love. This also gives the patient energy and bypasses their awareness and control. The influence without a direct link to the psychotherapy (being in love) will have a significant impact on the course of psychotherapy. All of a sudden, the patient has possibilities which used not to be accessible in psychotherapy; s/he feels an influx of energy, believes in her/his abilities and plans changes in her/his live. These possibilities arose without a direct connection to the process of psychotherapy. Being in love opens the way to undreamed-of personal potential, but when it disappears, the effect may fade away. The effect of some medication

[1] The external independent influences are thought to be responsible for 40 per cent of the effect in psychotherapy, compared to the specific intervention (e.g. Gestalt) which is only responsible for 15 per cent (Lambert, 1992).

may be similar even if it does not take such a dramatic form. Other drugs may have different effects, for example they may help regulate emotions and integrate experiences. It is important for the therapist to thoroughly explore and to become aware of their attitude to such influences on the therapeutic situation coming from an independent external factor.

However, as Gestalt therapists we do not consider any factor to be independent, we see the situation in a holistic way. We can look at the medication as the best possible way of allowing the patient to cope with a difficult situation at the moment. Taking the medication is connected to the patient's current need, which arises within the whole field of present and former relations to their outside world as well as to themselves. The medication interacts with other elements of the field in various ways: often it serves the function of support, but it may also emphasize limitations and stigmatize, it may be used to manipulate the outside world and it may have other tasks, some of which will be described in the text that follows. It is essential to bring to awareness in a phenomenological way how the medication enters and influences a psychotherapeutic situation.

3. Combination of Psychotherapy and Pharmacotherapy

Opinions on the combination[2] of psychotherapy and pharmacotherapy have been gradually changing since the first psychopharmaceuticals appeared in the 50's. Some psychotherapists at first refused the combination for fear that the medication would hide important feelings and conflicts which are the subject of psychotherapeutic work (Holub, 2010). A shift occurred when a larger number of people with serious mental problems became psychotherapy patients, e.g. patients with borderline personality disorder or with psychosis. In these cases pharmacotherapy was not a disincentive, on the contrary it allowed patients to manage the psychotherapeutic process and benefit from it.

The last two decades have been a period of rapid development in psychopharmaceuticals. New psychopharmaceuticals emerge with few side effects. These drugs can be prescribed not only by psychiatrists, but also by general practitioners and other specialists. The drugs are prescribed for the treatment of a wider spectrum of psychological states and at a lower intensity of difficulties.

[2] The combination of psychotherapy and pharmacotherapy can be arranged in two ways. Either it is an integrated treatment (the psychotherapist also prescribes the medication), which offers the possibility of exploring the topic of drugs together with a patient; on the other hand it emphasizes the asymmetry of a therapeutic relationship. Or it is a parallel treatment (one specialist provides psychotherapy and another prescribes the medication), which comes with a clear division of roles and external support for the psychotherapist, yet it makes considerable demands on the collaboration of the psychotherapist and the doctor.

As a result, the use of psychiatric drugs is more and more widespread and often replaces psychotherapy even in cases where it used to be a first choice method. As medication provides a fast alleviation of symptoms, patients can perceive psychotherapy as not sufficiently effective or too slow or expensive.

However, when we free ourselves from the dichotomic thinking (medication versus psychotherapy), we can see that these two approaches can collaborate in favour of patients, they can favourably complement one another. The combination of psychotherapy and pharmacotherapy is a very common clinical practise. A great number of researches prove that the combination has a bigger therapeutic effect than using each method separately (Wright and Hollifield, 2006). However, it is not clear to what extent these results may be generalized. Furthermore, they apply only to those patients in psychotherapeutic treatment who were diagnosed with a psychiatric diagnosis[3].

Psychopharmaceuticals can be a significant support to the psychotherapeutic process in reducing excessive, paralysing anxiety and depressive experience. They can also be helpful in bridging interruptions in psychotherapy. On the other hand, psychotherapy can support pharmacotherapy, because it enables patients to be more aware of their attitude to drugs and the experience of using them. A limiting factor (but not always unwelcome) in the combined therapy is that the drugs may keep patients in a more passive attitude and allow them not to assume responsibility for their state and the psychotherapeutic process (Holub, 2010). Medication may be necessary for some patients, but their use is limited by the risk of addiction and a possible decrease both in patients' motivation for psychotherapeutic work and in their ability to build their own skills necessary for coping with difficulties (Williams and Levitt, 2007). It is important for a Gestalt therapist not only to become aware of both abovementioned advantages and limitations of the combination, but also to find a way of exploring them in a dialogue with the patient and to see them in the context of the whole psychotherapeutic situation.

4. Relationships with the Medication

Medication is a part of the wider field of the therapeutic situation, along with other external influences over the patient, such as her/his job or physical illness. The drug is a component of the field which is, just like any other com-

[3] There are also studies not supporting this prevailing opinion. Holub (2010) presents 3 studies, where adding benzodiazepines to psychotherapy when treating panic disorder, agoraphobia and post-traumatic stress disorder aggravated the prognosis of the illness in comparison to a sole psychotherapy (Marks *et al*., 1993; Westra, Stewart and Conrad, 2002; Holub, 2010).

ponent, potentially important in the process of therapy. When the patient for example, due to the medication, is less tensed or sleepy, it changes the whole therapeutic situation, the drug affects the process of therapy and also the experience the therapist has of being with the client. Hence the drug takes part in the current organization of the relational field. It works through its direct pharmacological effect on the patient as well as through its psychological effect on the patient and the therapist. In the text which follows we will explore various possible relationships in the triad of therapist-patient-medication.

4.1. How the Medication Can Affect the Patient and the Process of Psychotherapy

Psychopharmaceuticals change the functioning of the organism on the biological level and in that manner they cause a change of psychic functions. Apart from that, medication (as well as psychotherapy) work through the placebo effect[4]. Further in the text we will focus on the biological effect of psychopharmaceuticals. Gestalt therapists can use their skill of phenomenological observation for a non-judging description of how the medication affects the patient's way of being and contacting as well as the whole psychotherapeutic situation. For that purpose, therapists can use models of contact styles (retroflection, projection, etc.) or the contact sequence (withdrawal → recognition → mobilisation → action → contact → assimilation → withdrawal →). This allows them to observe how the medication affects different stages of the psychotherapeutic process.

According to the kind of effect on the patients' experiences we can classify the most common drugs[5] into two main groups:

1. fast and temporary (benzodiazepine anxiolytics);
2. slow and long-term (antidepressants, antipsychotics, mood stabilizers).

4.1.1. Medication with Fast and Temporary Effect: Benzodiazepine Anxiolytics

Benzodiazepines cause a fast relief of anxiety, which accompanies most

[4] Placebo can also trigger self-healing processes. The changes in the brain after administering a placebo, detectable by modern monitoring methods are similar to those following the administration of effective drugs or after psychotherapy (Libiger, 2003).

[5] In this paper we only deal with the groups of drugs most commonly used by patients who are in psychotherapeutic treatment. We do not describe any other groups of drugs such as hypnotics (inducing sleep), cognitives (improve cognitive functions) and psychostimulants (increase vigilance).

mental difficulties. Psychotherapists should be well acquainted with these medicaments, as they are very popular among patients and also because in some cases they may be a valuable aid to psychotherapy. It is so especially in short-term situations, when a patient experiences escalated tension and anxiety (post-traumatic and crisis states). A disadvantage of long-term and regular use is that the organism may become addicted to these medications at the level of biological functioning. From the psychotherapeutic process perspective, these drugs may present a "short-cut" for some patients in coping with their own problems and they may allow them to depend on expert help from outside[6].

Benzodiazepine Anxiolytics - Psychiatric Use

Characteristics: Anxiolytics are drugs that dissolve psychic anxiety and bodily tension. They have a wide range of usage, since anxiety, mental strain, inner tension, restlessness and aggression appear as a part of many psychiatrically treated experiences. The most widespread group of anxiolytics are benzodiazepines[7]. They affect the symptoms vigorously and quickly, their effect is temporary and relatively short-lasting.
Effects and Indication: Anxiolytic effect: They alleviate all kinds of anxiety. Hypnosedative effect: They help with falling asleep and staying asleep; they attenuate anxiety and aggression (including psychic and physical withdrawal symptoms of addiction to alcohol and other psychoactive drugs). Myo-relaxing effect and anticonvulsive effect: They relax muscle tensions and convulsions of different origins.
Some Well-Known Representatives: alprazolam, bromazepam, clonazepam, diazepam.
Practical Use: With regards to side effects and their addictive potential, benzodiazepines are only intended for temporary or irregular use. When used regu-

[6] A Gestalt therapist does not judge such an attitude if it appears, but sees it as the best available way for creative adjustment and helps to make it an aware choice.

[7] Non-benzodiazepine anxiolytics are used less frequently. Buspiron (BuSpar) and hydroxyzine (Atarax) fall into this category, and also antidepressants and antipsychotics. These drugs are not addictive and their effect lasts longer. However, the anxiolytic effect does not come so fast and expressly as in the case of benzodiazepines.

larly and for a long time, they present a considerable risk of addiction (tolerance to the drug evolves during use; to achieve the same effect it is necessary to gradually increase the dose; if discontinued suddenly, there is a risk of withdrawal syndrome and a fast recurrence of symptoms which were the reason for using the drug). To prevent the development of addiction, it is recommended to only use the drug at the time of acute problems; to gradually reduce the dosage as soon as the anxiety reduces, or when a non-addictive drug (e.g. antidepressant) applied at the same time starts to be effective; in sub-acute states and in crises the lowest effective dose is recommended, with the lowest possible regularity of use.

The effects of benzodiazepines start and subside fast and they are to a high degree similar to the effects of alcohol. If a patient takes benzodiazepine anxiolytics a short time before a psychotherapeutic session, s/he may feel more relaxed, slower and more reconciled during the session than without the drug. Benzodiazepines, similarly to alcohol, make it easier to withdraw from contact and to "dilute the experience", so they contribute to the deflection from an unpleasant experience. *"I don't care... I don't have to deal with it right now.."*.. In this manner they can temporarily enable the avoidance of too painful experiences and therefore the existential encounter with other people, oneself and with life challenges. Therapists may experience the feeling of "pseudocontact" with the patient, as we know it with patients addicted to alcohol (Carlock, Glaus and Show, 1992). The contact process may first seem to go smoothly and easily, yet the full contact may not be achieved.

We can regard taking benzodiazepines as a creative adjustment. For the patient using drugs actually presents the best possible and available way of handling the difficult situation. If we observe the effect of benzodiazepines in a phenomenological way, we can see they slow down the contact cycle and make it smoother. They only have a short-lasting effect, but they can interrupt the vicious circle of anxiety and activate the patient's self-healing forces. We present several examples of such effects:

- Some perceptions can be so strong they lead to a massive anxiety that blocks awareness. If benzodiazepines moderate the intensity of perceptions, they can help the patient become at least partially aware and free to make conscious choices to handle the situation[8].

[8] Benzodizepines can also work through a psychological mechanism and can e.g. help prevent panic attacks. Patients with panic attacks who have a strong fear of a new attack of anxiety are recommended to always have a small dose of benzodiazepines on them, which would help them in case of a panic attack. This safeguard allows them to deflect the fears of a new panic attack. This way the fear of a possible panic attack is diminished, the general

- They reduce the urgency of the situation and slow down the mobilization of energy (e.g. hyperventilation during the experience of strong anxiety) and thus can help the patient make the choice of an appropriate action more easily.
- They reduce the overall readiness (to fight or flight) of the organism and so they help to stop greater and greater mobilization of energy. Thus they can make it easier for the patient to complete a contact cycle and to withdraw (e.g. into sleep). At the same time they contribute to the postponement of the perception of a new need and to the beginning of another contact cycle.

Short-term use of benzodiazepines during an acute crisis is reasonable. Here it brings calmness, during which the self-healing processes of the body can be activated to a level when the further use of medication may not be necessary. It is useful to build skills in psychotherapy which will eventually replace the effect of a potentially addictive medication (e.g. various forms of relaxation or functional deflection). Psychotherapeutic support thus has a significant role in the timing of reducing the dosage or discontinuation of benzodiazepines.

4.1.2. Slow and Long-Term Medication (Antidepressants, Antipsychotics, Mood Stabilizers)

Compared to the fast acting benzodiazepines the full expression of effects of these drugs is developed over a longer period of time (days, weeks up to months)[9].

4.1.2.1. Antidepressants

Antidepressants - Psychiatric Use

Characteristics:
They adjust the concentration of neurotransmitters (serotonin, noradrenalin, dopamine etc.) on the neural connections in the brain and through a complex mechanism bring about such changes in the brain's functioning which lead to the reduction or elimination of not only depressive experiences but also other difficulties related to dysregulation of the neuro-

level of anxiety is reduced and a panic attack may not come at all. "*I only imagine taking Diazepam and I instantly feel the anxiety gets reduces..*"..

[9] To induce the effect a whole series of changes on the intracellular level up to the genome level is needed. This mechanism of effect will cause the change to be of a longer-lasting type.

transmitter system (anxiety, impulsiveness, aggression, suicidality). The most widespread group of antidepressants is SSRI, affecting the regulation of serotonin.

Indication:
Depression, anxiety disorders (panic disorder, generalized anxiety disorder), phobic disorders (social phobia, agoraphobia), obsessive-compulsive disorder, post-traumatic stress disorder and anxiety-depression reaction to stress, food intake disorders: mental anorexia, mental bulimia, personality disorders (especially serotonin has an effect on emotional instability, impulsiveness, aggression and suicidality).

Some Well-Known Representatives[10]:
citalopram, fluoxetine, fluvoxamine, milnacipran, mirtazapine, paroxetine, sertraline, venlafaxine.

Practical Use:
SSRI and other new antidepressants are well tolerated and have only very few side effects. They are commonly prescribed by psychiatrists, neurologists and general practitioners. There is no risk of addiction. The effect of antidepressants is experienced only after several days; the full expression of their effect is experienced only after several weeks. Before the antidepressive or anxiolytic effect of antidepressants arrives it is favourable to temporarily use fast-affecting benzodiazepines as well. Long-term use of antidepressants is recommended especially when the depressive experience appears again after the withdrawal of medication. The length of medication use needs to be longer then the time of remission between two episodes of depression. In the case of three and more subsequent depressive episodes a life long use of antidepressants is recommended (Seifertova *et al*., 2008).

Antidepressants can function as long-term softeners of experiences. Patients who take antidepressants describe the experiences as though they come to them from a greater distance, with a lower intensity and sharpness. That is why it may not always be appropriate to automatically use antidepressants in cases such as the sadness caused by the death of a close person. Here antidepressants may not only postpone, but sometimes even stop the natural process of mourning.

In the case of depression, antidepressants may contribute to a functional de-

[10] Here we only present antidepressants of the 3rd and 4th generation most commonly used nowadays.

sensitization. The feelings of despair and hopelessness are not perceived in such a harrowing way by the patient. This blunting of intensity of hurting experiences paradoxically enables the patient to work and profit from psychotherapy. It can help the patient share such "wrapped-up" experiences with the therapist and not to stay isolated with them. This way the fixed *Gestalt* of depression is disrupted in therapy (see chapter 21 about depression).

Antidepressants can contribute not only to the functional desensitization, but also to the mobilization of energy. In cases of more serious depressions, the antidepressant can help to gradually restore the sources of energy, which is then mobilized for necessary actions by the patient. *"I didn't trust the antidepressants... But after about two months I felt I slowly started to enjoy common things again. And that I became a bit more active.."*..

Antidepressants also attenuate anxiety. In comparison with benzodiazepines, their anxiolytic effect is reached progressively, more slowly and less obviously, it lasts longer and there is no risk of addiction.

4.1.2.2. Mood Stabilizers

Mood Stabilizers - Psychiatric Use

Characteristics: They balance and stabilize mood oscillation, reduce the frequency and intensity of manic, depressive and mixed episodes of mood disorders. The effect becomes fully expressed after several weeks up to months of use.
Indication: Bipolar affective disorder, schizoaffective disorder. Mood stabilizers have effects which benefit patients also with different diagnoses: aggression attenuation; suicidal tendencies attenuation, emotional instability and anxiety attenuation. This effect is often used in treatment of emotional instability of patients with personality disorders.
Some Well-known Representatives: carbamazepine, lamotrigine, lithium carbonate, valproic acid.
Practical Use: In case of bipolar disorder they are prescribed in the 3rd appearance of a phase of the illness (mania or depression) at the latest and they are intended for long-term up to life-long use.

Mood stabilizers are drugs which may help grounding. They reduce intensity and slow down the “upper phases” of the contact cycle (mobilization of energy and action); on the other hand they strengthen the “lower phases” of the contact cycle (being aware of perceptions, the integration of an experience and withdrawal). They reduce excessive intensity of an experience and thus allow for more appropriate action and the experience of contact. The advantages of such effects are evident when the drug tempers the ongoing mania or depression episodes. In between the episodes, when the patient can function as fully fit, the attenuation of energy mobilization and activity is sometimes perceived as unpleasant. Long-term use of the drug is nevertheless usually necessary in order to prevent serious manias or depressions. Psychotherapy allows conciliation with the limitations brought by the illness and the medication and focuses on supporting the functional areas of the patient’s life.

In patients with unstable emotional experiencing (diagnosed as personality disorder) the mood stabilizers may function as an “internal reinforcement” or a “frame”, allowing for structuring and bearing the experience without the necessity to reduce the unbearable tension by impulsive actions. In these cases, psychotherapy has a similar task and can theoretically eventually replace medication.

4.1.2.3. Antipsychotics

Antipsychotics - Psychiatric Use

Characteristics: The drugs intended for treatment of psychotic symptoms of various psychiatric disorders, especially of schizophrenia and schizoaffective disorder. They also have anti-manic and antidepressive effect, they stabilize mood and have a positive effect on personality integration and the ability of self-regulation.
Indication: Besides schizophrenia and other psychotic disorders they are also used in treatment of bipolar affective disorder and behavioural disorders, including aggressiveness of various etiology (personality disorders, mental retardation, dementia, sexual deviation).
Some Well-known Representatives: amisulpride, aripiprazole, clozapine, olanzapine, paliperidone, quetiapine, risperidone, sulpiride.

Practical Use:
The first choice drugs of today are antipsychotics of the 2nd generation, which are better tolerated and are less stigmatizing compared to older medications[11]. They also have antidepressive and anxiolytic effect. They improve activity, sociability, emotional flattening and cognitive damage in patients with schizophrenia.

Antipsychotics can be seen as drugs helping to make clear and strengthen the border between the body and the environment. A person in the acute phase of psychosis does not experience himself as clearly distinct from the environment, in the psychological sense s/he “has no skin” (Spagnuolo Lobb, 2003a, p. 264). S/he may experience an immediate threat from events not directly related to her/him or feel that her/his own experiences have the power to directly affect the environment. S/he lives in a state of being permanently under threat and the psychotic symptoms represent a creative adjustment which helps them survive in such a difficult arrangement of the field (for further detail see chapter 20 on psychosis). Antipsychotics reduce the clogging number of inputs, help create a functional distinction between experiences coming from the external and internal environment and contribute to integration. We can imagine the antipsychotics creating a “hippopotamus skin” (Rahn and Mahnkopf, 2000, pp. 204-214). This function is useful when the patient experiences an acute psychotic state. However, after it subsides the patients often perceive unfavourably the overall inhibition and the experiential stiffness which may accompany taking antipsychotics. Long-term use of medication is an important prevention in patients with chronic schizophrenic illnesses, as it reduces the frequency and intensity of further psychotic attacks. Psychotherapy can suitably complement the drugs’ effects and helps to create the feeling of a long-term safe, hospitable base and the experience of stable relationships (Spagnuolo Lobb, 2003a), which allows a safe delimitation of one’s self and its needs.

In patients with borderline personality disorder the antipsychotics play a stabilizing role, they decrease impulsiveness and increase the ability to self-regulate. They allow patients to structure and integrate an intensive and chaotic experience. It is then easier in therapy to work on bringing the impulses into awareness and controlling them. It could be easier then, to consciously slow down the mobilization of energy and to meaningfully aim the action. Such an action then does not have to result in compulsive repetition of a fixed *Gestalt*,

[11] Older antipsychotics of the 1st generation are effective, but they have a higher number of significant side effects and can contribute to the secondary stigmatization of psychotic patients. Representatives: chlorprothixene, chlorpromazine, haloperidol, levopromazine, perfenazine.

which temporarily inhibits unbearable tension, but instead there could be a fuller experience of contact. This effect of antipsychotics is usually useful mainly at the time of decompensation, which can even reach the level of a psychotic experience. Apart from these periods, psychotherapy aiming in a similar direction, towards building one's own skills and competences for coping with very intensive experiences and impulsive actions, is irreplaceable.

4.2. How a Patient Can Relate to Medication

Medication is present in psychotherapy, although it is rather in the background for most of the time. At a time of crisis or in breakpoint periods the medication can come to the foreground. For example, a patient in crisis needs more drugs and speaks about it in therapy, or feels better and meditates over not needing the drugs any more. In these periods, taking medication becomes a figure. The relationship a patient has with her/his medication affects the whole field. That is why it is necessary for the therapist to help in a non-judging, phenomenological way to become aware not only of how the drug affects the patient, but also of how the patient relates to the medication.

The patient can adopt two extreme attitudes to the medication or can oscillate between them. On the one hand, the patient can be convinced s/he does not want the medication and the psychotherapy should be sufficient. The patient can fear that *"when I start taking medication, it is really serious, I'm a lunatic"*. S/he can be under the influence of introjects such as *"I have to manage on my own, no chemicals can do it for me"* or *"I can't make it easier for myself just like that"*. Such introjects can point to the fact that it is difficult for the patient to receive support from the environment. An offer of medication in the course of therapeutic work or even a mention of this possibility can make the patient feel insecure and ashamed[12]. It could be a substantial and new experience for some patients, to consciously depend on the help from outside in a form of medication, to admit one's weakness and to allow oneself to accept this form of support from outside.

Another extreme attitude may be taken by a patient who desires the medication and by taking it reduces unpleasant experiences in psychotherapy or avoids them. S/he may resign the responsibility for her/his state and from the effort of a general change. They can perceive themselves as a helpless object:

[12] This situation can prove to be a difficult topic even for a therapist, as the Gestalt approach was in the past overburdened by its emphasis on self-support. In order for the therapist to be able to guide the patient to a free choice of source of support, it is necessary that the therapist her/himself has a clear idea of whether s/he is willing to accept support from outside (e.g. in a form of collaboration with a psychiatrist).

"the depression causes the problems; it is the lack of serotonin". If her/his experience changes and s/he feels relief, s/he can say: *"That Prozac I'm using now is excellent, it changed me completely and I manage now what I used not to".* They project their own abilities and responsibility for the change on the medication. They can then get used to reducing unpleasant experiences by means of medication, especially by instantly effective benzodiazepines, at every occasion of discomfort. In this manner they do not make use of the potential of situations in which they can discover possible sources of their own self-support.

Psychotherapy can be understood as a process in which one builds the ability in each moment to balance the use of self-support and acceptance of external support. In the course of psychotherapy, both patient and therapist build a realistic attitude (least burdened by introjects) regarding the particular way the medication affects their cooperation. Thus both can learn to accept the medication as one of the external sources of support here and now. In a period of increased pressure, when the psychotherapy is not available or when the patient experiences intensive inconvenience, the patient has an option to get support from the medication. S/he can consciously and freely consider this option and make a decision in a competent way.

4.3. How a Psychotherapist Can Relate to Medication

During a psychotherapy in which psychopharmaceuticals take a place, a therapist can come up with following questions: What effect do psychopharmaceuticals have right now on the process of psychotherapy: do they speed it up or slow it down? What function does medication serve in a therapeutic relationship and in the whole field of the therapeutic situation? What does it mean for the patient, the therapist and their relationship, if the dose of psychopharmaceuticals is in the course of psychotherapy increased or decreased, when the drugs are discontinued or recommended?

In order for the psychotherapist and the patient to freely explore answers to these questions, the therapist needs to become aware of her/his personal relationship towards psychiatric drugs brought into the field of the psychotherapeutic situation. A psychotherapist who does not reflect and acts out for example her/his persistent scepticism and aversion towards medication harms her/his patients in the same way as a doctor who, focusing only on psychopathological symptoms in complex experiential states, hastily prescribes drugs for each feeling of discomfort and thus prevents the natural flow of the psychotherapeutic process (Fain *et al*., 2008; in Holub, 2010).

The attitude to psychiatric drugs is different with individual psychothera-

pists and it also gradually develops during their practice depending on the working context and selection of patients. For a therapist it is important to realize what relationship s/he has towards a particular drug of a particular patient. S/he can try the following experiment: to sit the medication on an empty chair and talk to it. S/he can for example say: *"Drug, I am glad we complement each other's work. Thanks to you I don't have to worry about the patient so much".* Or s/he can say: *"Drug, I don't like you, because you interfere with my therapy. The patient has become dependent on you and I would really like to get you out of the therapy. But I can't, as the patient wants you. I feel powerless, you make me angry. He likes you better than me. Thanks to you the patient is making progress".* Maybe the therapist finds out s/he does not know anything about the drug, that s/he needs more information on its characteristics, to get to know it and then to continue exploring her/his relationship to it.

The therapist also needs to examine her/his own relationship to drugs in general. For example s/he can be ruled by an introject: "*The proof of a well-done psychotherapy is that the patient does not need any medication".* S/he can have the impression that the drug devalues her/his work and her/himself in the therapeutic role. "*If a patient needs to take medication, it means I am not a good-enough therapist for her/him".* Such a competitive approach by the therapist will necessarily also affect the therapeutic process.

Exploring the relationship to medication will probably open the topic of the therapist's attitude to the medicinal system, to diagnoses, to psychiatrists. The therapist needs to become aware of how her/his attitude to these general matters affects her/his work with a particular patient. Otherwise, there would be a risk that s/he could project her/his approach (disapproving or admiring or dependent etc.) to the medicinal system on the medication the patient is using. The therapist does not need to tell the patient about her/his attitude, but it is necessary that s/he is aware of how the attitude affects their therapeutic interventions and the whole therapeutic situation. It may be useful for the therapist to ask certain questions: What is my opinion on the psychiatric drugs and of the psychiatric system in general? Do I or anybody close to me have any personal experience with psychiatric drugs? What kind of experience is it and how does it affect my attitude to psychiatric drugs? The answers to these questions map the pre-understanding of the therapist, they need to brought into awareness and bracketed, so that they do not block the natural flow of contact with the patient.

5. Medication as a Support on the Journey

It has proved useful for us to describe taking medication in psychotherapy by means of a metaphor. It may be important for each therapist to find her/his own metaphors that will serve as cognitive maps. A therapist can for example imagine that for patients, medication serves the function of a jacket in winter. Some people only need a thin jacket, others need a much thicker one, and some none at all. Some people cannot survive the winter without a jacket, for others it would be enough to have a jacket tied round her/his waist to have it at hand.

We would like to offer another metaphor to readers, which serves us well in our practice. It is a metaphor which depicts psychotherapy as a journey: The patient is on a path and the therapist accompanies her/him. When the patient's legs cannot bear her/him well, s/he needs a crutch. This is the drugs' role. For example an antidepressant can prop up a person who is in a deep depression, so that s/he can continue looking for the path. The drugs will not show the way, but they make walking easier while searching for it. In this manner, we can have a look at the combination of psychopharmaceuticals and psychotherapy. Medication can serve as a crutch to the patient and psychotherapy as a remedial exercise[13].

A crutch can label a person unable to walk without external support as handicapped. We can also see the crutch as allowing the person to make use of the remaining potential for moving. There is an important thought shift: the crutch does not only mean the patient is handicapped, that the patient limps, it also means her/his possibilities with a crutch are greater than without it. The crutch allows the patient to make use of her/his remaining potential – s/he can go to work, go shopping etc. When the psychotherapist does not want to compete with the medication, s/he has to be capable of exactly this kind of thought shift. To perceive medication as an external support enabling the patient to realize her/his potential, which would not be possible without the crutch.

It is similar to other kinds of support. If the patient does not have enough self-support, s/he needs more support from outside. This applies not only to medication, but also to a more structured and active approach by the therapist. At the beginning of the therapy, the patient usually comes with a greater need of external support. Then s/he gradually builds a greater reliability on her/his own resources to balance the external sources of support. Especially at the beginning of the psychotherapeutic process medication can play a significant stabilizing role in cases of substantial psychic difficulties. Thanks to their biological effects they can increase the patients' own competences and activate their own potential. For instance, an antidepressant may enable a depressive patient

[13] We are aware of the limits of this metaphor, which focuses on the patient's functioning as an individual and does not consider the context.

to mobilize energy, to come out of isolation and to establish relationships. Sometimes it is then possible to gradually reduce or discontinue the medication, but the patient's competence stays, if it has been assimilated and strengthened in psychotherapy. In the course of psychotherapy it is important that the patient is able to accept the fact that the medication does not provide her/him with something more and new, but that it helps her/him awaken her/his own potential[14].

The therapist and the patient together thus become aware not only of the role the medication plays in the patient's life and in the process of psychotherapy, but they also explore the new possibilities the medication brings for life and what options it opens for the psychotherapeutic work. The patient for instance experiences an intensive fear of her/his own aggressive tendencies. This fear paralyses her/him so much that s/he is even unable to talk about it in therapy. The only way s/he can manage the fear presents in compulsive rituals. Medication attenuates the fear, reduces it, so it does not block the patient's whole horizon. Apart from the fear the patient can now also see a supportive therapist, who is sitting opposite and listening to him.

We can see psychotherapy as a remedial exercise. When the patient only leans on the crutch and does not take the remedial exercise, s/he does not prepare her/himself for walking without the crutch and may become reliant on it, may stay handicapped. Or the patient puts the crutch away after some time even without any remedial exercise, but then s/he has bigger problems with walking than s/he would have if s/he had been doing the remedial exercise prior to putting the crutch away and preparing for it. Thanks to the remedial exercise, the patient can discover new knowledge of her/his body, can learn how to treat it appropriately, may get new motor abilities and a new relationship with her/his own body.

The patient can for example cope with depression only with medication. If on top of that s/he works in psychotherapy, s/he not only overcomes her/his current problems connected with depression. Thanks to psychotherapy s/he enlarges the spectrum of her/his capabilities. S/he learns to recognize and cope with the warning signals of oncoming depression, s/he learns to make use of sources of support from outside and of her/his own support and s/he may get to hear the existential message hidden in her/his depressive experience.

As Gestalt therapists, in our work with patients we focus on extending the spectrum of capabilities by means of psychotherapy, in the same way that the remedial exercises support the remaining functional muscles. This approach comes to the foreground of our work. At the same time it is necessary to consider that the medication serves the patient like a crutch. In this case, the medication is always present in the background of our psychotherapeutic work.

[14] This is so on the biological level as well: An antidepressant does not deliver any new serotonin; it merely allows for making use of the amount already present in the body.

Medication can play different roles in the life of the patient and in the process of psychotherapy. Schematically we can distinguish two functions of medication: a temporary crutch or a permanent prosthesis. This is a very simplified distinction, but it proves useful for a basic orientation for the therapist, as a rough delineation of a differentiated psychotherapeutic work when the use of medication is present in the background.

5.1. Medication as a Temporary Crutch

With some patients we can imagine the function of psychotherapy as a remedial exercise for a person after a leg injury. The medication can be then seen as a crutch which could be put aside after some time. It may be beneficial to use such a metaphor when the patient takes medication, but would like to function without it eventually and this possibility is real. The patient her/himself comes with the idea of withdrawing from taking medication and is willing to bear the discomfort it may bring. S/he wants to take an active part in the psychotherapeutic work; s/he is willing to become aware of her/his attitudes, to change them if needed and to make changes in their lives. The patient gradually learns to make use of the possibilities brought by medication (e.g. it attenuates a paralysing anxiety when s/he is on a crowded bus) even without the medication (e.g. in case of rising anxiety s/he learns to work with breath and body grounding).

For the therapist and the patient the medication can then become a temporary ally in the process of psychotherapy. They can intentionally and pragmatically utilize the alliance with the medication and work with it in the same way as with other sources of external support, such as the patient's steady job or her/his family background. The therapist helps the patient consider the right moment to discontinue the medication, the moment the patient has sufficient self-support as well as other sources of external support. The therapist also helps the patient explore whether her/his own potential, enabled by the medication, could be available without the drug.

There could be a point at which the patient with affected mobility could manage to move with nothing more than remedial exercises, but s/he has got used to moving with a crutch. In such a case the function of medication has changed, now it is used as a crutch which the patient is not willing to give up. The medication no longer functions as an external support and instead begins to limit the patient in her/his looking for new creative ways of adjustment.

It is important that the therapist does not push for a change in such a case. Using medication is a form of creative adjustment for the patient, the drug has a certain important function for the patient, for example it serves as protection.

The therapist respects the function the drug fulfils for the patient and helps the patient become aware of what the use of medication brings her/him and how it limits her/him. Medication can provide safety to the patient; protect her/him from too much stress in demanding life situations. But it may also inhibit the patient's ability to experience and to be in touch with other people. The therapist may work with the medication as a protective strategy differentially – to value it, confront it, evade it. The therapist helps the client to become aware of and to accept responsibility for the current ratio between receiving external support and depending on one's own resources.

Michaela has been experiencing long-lasting anxiety in connection with socially stressing situations. The anxiety is sometimes so strong that it prevents her from leaving her house. Her general practitioner has sent her for a psychiatric examination, where she was diagnosed with a social phobia. The psychiatrist prescribed Neurol (alprazolam – the drug dissolving anxiety, potentially addictive), which she should use in case of escalated anxiety. The psychiatrist also prescribed Seropram (citalopram – antidepressant with a good anxiolytic effect) for a long-term use and recommended psychotherapy.

For Michaela it proved very useful to take Neurol in the time of anxiety, but she was worried about becoming addicted. It calms her down to carry it with her as a first aid, but not to use it. She has been using Seropram once a day for several months. Apart from that, she regularly attends psychotherapeutic sessions. However, she cannot imagine her functioning without Seropram. The drug protects her from anxiety and allows her to live in the way she was used to. She learns in therapy that the medication allows her not to have to change anything. She is afraid of change and the responsibility attached to it. The medication works as a protection for Michaela, she can't imagine her current life without it.

The therapist helps Michaela realize what function the medication has for her. Michaela says the medication is like "a duvet" for her, which enables her not to be hurt so much. The medication slows down the process of therapy, because when she uses it she feels no need to change anything. On the other hand the medication allows her to continue the therapy at all, as without it she would probably not be able to leave her house. Taking the medication is thus a form of creative adjustment. The drug functions as a retarder of change as well as a prevention from breaking up.

Seropram serves as "a duvet" which the patient needs for her protection. Without it, she would be as though naked, frayed. Without the medication she does not have sufficient support from outside. The medication provides support and increases her competencies. It enables her to go to work and to attend therapy. Michaela feels better with the drug and she functions better in her life.

Michaela sees Seropram as an agent of change. She projects her potential for change and her abilities on the medication. The abilities which do not belong to her self-conception. By using the drug, Michaela increases her competency, but does not perceive it as her work, but as the merit of the drug.

The therapist helps her to own the abilities which she projects onto the medication. Michaela gradually realizes she is the agent of change and that the medication and psychotherapy are sources of support she lacked in her life before. Her attitude: "The drug is the reason I feel better", gradually changes to: "The drug helps me find a way of living life the way I need to".

Patients with a milder depression also often benefit from taking SSRI antidepressants. Here the metaphor of a crutch does not seem to fit so well. People with milder depression do not need a crutch, they can walk, but the way they walk is similar to Andersen's Little Mermaid's walk. She felt pain at every step she took, as if stepping on the blade of a knife. People with a milder depression can perceive their experiences with this kind of increased soreness. Antidepressants can attenuate their perception of the pain, as if The Little Mermaid walked in shoes with thick soles. This allows them also to perceive other things than just pain in their feet; they can look around and make contact.

5.2. Medication as a Permanent Prosthesis

A serious psychiatric illness significantly limits the patient and can reduce some of her/his capabilities for a long time or even for a lifetime. In these cases medication serves as permanent external support, which the patients cannot do without. Using a metaphor, we can say the medication does not stand for a crutch to be eventually put aside. The drug could rather be compared to a prosthesis, which substitutes the missing limb and enables movement. The medication serves the function of a prosthesis especially in cases when the patient suffers from illnesses such as schizophrenia, schizoaffective disorder, bipolar disorder or recurrent depressive disorder with endogenic features.

From the therapist's point of view, the diagnostic evaluation is very important, whether the effect of medication could be rather compared to the function of a permanent prosthesis or a temporary crutch[15]. A realistic evaluation allows one to reconcile to medication and liberates the therapist from excessive

[15] Such an evaluation has to be done in a dialogue with the patient and the doctor who prescribes the medication. We must realize such a diagnostic evaluation is always only provisional and can be eventually changed. Even in a situation, in which the medication seemed to be a necessary prosthesis, it may happen after a long therapy or due to some extra-therapeutic factors that the patient becomes able to function without drugs.

demands from her/himself and from the patient. If the therapist is reconciled to the medication, s/he helps the patient to become reconciled to it too. In the spirit of the paradoxical theory of change, a space for new possibilities opens up by doing so. If the therapist has big demands (*"Therapy should be directed towards the discontinuation of medication"*), s/he would limit her/himself to therapy with patients with more serious psychiatric problems and s/he may even succumb to therapeutic nihilism, claiming that psychotherapy has no use for these patients.

Patients in an acute psychotic condition can be a typical example. Their experiencing of themselves is not sufficiently distinguished from the environment (Spagnuolo Lobb, 2003a). People in this condition are overloaded with a lot of information and thus are unable to differentiate external information from their own psychic creation. The medication (antipsychotics) reduces the amount of information (by reducing dopamine, transmitting the information), reduces the overload and helps the patient organize the information.

Psychotherapy has an important task in the treatment of these seriously mentally ill patients. If we return to our metaphor, we can say the remedial exercise is beneficial even to a person with a prosthesis. Due to the prosthesis, the rest of the body cannot function normally, the prosthesis creates various disproportions in the body, other muscle groups are used. The remedial exercise can at least partially correct this deformation and the effects of imbalance and can keep the remaining limbs functioning for a longer time than without it. In patients with chronic schizophrenia the therapist for instance complements the antipsychotics treatment by working with the background of the patient's experience (which allows for the creation of the figure), spends time on perceiving the time and place as factors allowing for the rhythm and helps the patient with a balanced determining of self, including the clear perception of one's own needs (Spagnuolo Lobb, 2003a, see more in chapter 20).

Jane is a 35-years-old mother of two small children. She has recently returned to work after her maternity leave finished. She has a demanding job as an assistant, where she deals with many colleagues and customers and often deals with conflict situations. She is appreciated for her reliability and responsibility, but she is quite often on sick leave because of problems with her back. None of her colleagues has any idea that it is as the result of her suicidal attempt, in which she jumped off the roof of a house, after which she was hospitalized in a psychiatric ward. Jane has been in treatment for psychosis for 13 years and so far she has been hospitalized four times in an acute psychotic state, in which her perception of the environment and her behaviour was greatly changed by paranoid delusions. She feels she is the chosen one and will save our planet from destruction. She has been using antipsychotics for the whole

13 years, sometimes together with antidepressants and anxiolytics. She attends both individual and group psychotherapy. She tried to withdraw from the medication twice, because of undesirable side effects and pregnancy, but she got so much worse she had to be hospitalized. She got used to taking Zyprexa, although she is tired afterwards, has a bigger appetite and feels emotionally flattened. Lately, she has been overburdened, exhausted from lasting stress. Again she had a feeling her colleagues were talking behind her back and she constructed complex fantasies of conspiracy. She had to increase the dosage. Psychotherapy helped her see the situation clearly and she decided to retire with a partial disability pension, which she had fought for a long time. Now she is glad, as she will have shorter working hours and will be more able to manage the household and her children, in which her husband has also been helpful.

The situation may be more complex in the case of bipolar disorder, where after an episode of mania or depression patients may assume they do not need the medication. Furthermore, they may think the prescribed mood stabilizers flatten their emotionality and prevent them from fully experiencing themselves and their relationships with people. A discontinuation of mood stabilizers will however most likely lead to decompensation, to a manic or depression episode, which could have been prevented by medication or at least postponed or attenuated. The task of therapy in this case is to help the patient become aware of and accept the limitation presented by both the disorder and the psychiatric drugs.

A similar situation can occur in cases of patients suffering from recurrent depressive disorder where patients historically have repeatedly experienced serious depression slumps, especially related to seasons and without any external impulse. It needs to be remembered that the antidepressants serve as a prosthesis for the patient, even though their need in the time between individual phases of depression may not be apparent.

The patient may perceive unpleasant side effects of the medication (inhibition, slowing down, emotional flatness, becoming overweight, physical stiffness), which may then lead to isolation and stigmatization of the patient. At the same time, the patient cannot withdraw from using the drugs without a considerabe threat of a severe deterioration in his mental condition. The therapist understands the patient's problems caused by the medication and also sees realistic reasons for the necessity to use it. The therapist accepts the medication as a limit which reduces the scale of possibilities of creative adjustment both in the patient's life and in the psychotherapeutic work itself. The therapist works with the medication knowing it is an inevitable limit of therapy, similarly to the way psychotherapy works with other limits (e.g. unsupportive background, lack of finances or lower intellectual capacity). The therapist adjusts the therapeutic

style to it and helps the patients become aware of the limits in their lives and in the therapeutic relationship. The therapist helps the patient accept the limitation and apart from that to be able to discover and develop capabilities at hand.

6. Conclusion

The usefulness of a justified combination of psychotherapy and pharmacotherapy is supported by the research of genetic and biological effects of psychotherapy, which exceeds the dualistic separation of the body and mind (Wright and Hollifield, 2006). Williams and Levitt (2007) in their research also come to this holistic approach and they abandon the dichotomy of biology versus psychology. The key word for them is the patient's "agency", i.e. the ability to actively partake in the psychotherapeutic process and to make one's own decisions in life. Psychotherapy helps patients increase their ability to mobilize their "agency" and to use the therapist's interventions for the benefit of self-healing. Medication is useful when it helps the patient increase his "agency" and to become engaged in the psychotherapeutic process (e.g. thanks to medication the patient's mood becomes stabilized and their ability to reflect improves). On the other hand, it is not useful when it reduces the patient's "agency" (Williams and Levitt, 2007). As Gestalt therapists we add that the medication is useful also when it facilitates the patient-therapist contact.

Drugs may be useful in the process of psychotherapy, if they – as one of the sources of support – help reduce the paralyzing extent of anxiety (see also chapter 2. The energy originally imprisoned in an excessive anxiety is then available for the patient as "excitement", allowing for a spontaneous and meaningful contact with the environment. At that point, the therapist is there as a partner willing to establish the working relationship and to open up to a human meeting.

Comment

by Brigitte Lapeyronnie-Robine

These two authors enter into an under-examined topic in specific literature, i.e. the combination, for any given patient, of taking psychotropic pills and a Gestalt therapy. These treatments are two modalities which are, most of the time, considered separately and it is all the more to these authors' credit to consider them together: taking the pills belonging thus to the therapeutic situation.

The authors describe clearly different issues one can be faced with in this combination of treatments: its potential impact on the psychotherapeutic process or on the medical treatment; the kind of relationship with his/her drug treatment established by the patient during his/her psychotherapy; the kind of relationship to medication experienced by the Gestalt therapist.

These issues question our views about health and illness, our ideology about psychotherapy. They will give the reader something rewarding to think about. Limits of effectiveness of any kind of treatment – psychotherapy or medicine – are hinted at in the text. Here I would have valued advanced claims or assumptions: what could be said about the limits of psychotherapy, and particularly Gestalt therapy? As indications for drug treatment are clearly given, so I would have valued indications for Gestalt therapy also being afforded.

Different classes of drugs are described both clearly and concisely; this offers an excellent basic knowledge for Gestalt therapists who are not psychiatrists. For instance, they clearly affirm that a prescription for an anti-depressant must be extended beyond the disappearance of depressive symtoms (I recommend from 3 to 6 months), which might be amazing to any underinformed Gestalt therapist. Similarly, anti-depressants are a primary medication for panic-attacks, while it could be considered that tranquillizers are the most appropriate.

Roubal and Křivková offer in their last chapter two original metaphors about this combination of psychiatric medication and psychotherapy. These metaphors can be of great support for a Gestalt therapist's practice. They substantiate their remarks with two clinical illustrations. The first describes a depressive phase of a patient: her medication met her need for some protection «like a coat during winter». The second describes some psychotic chronic symptoms of a patient whose medication is an ongoing long-term treatment «like a permanent prosthesis».

If we can modestly consider that using medication can be necessary, momentarily or permanently in the course of somebody's lifetime, I must admit that it's difficult to be both psychiatrist and Gestalt therapist, even if we consider every patient as a whole and medication as being part of the therapeutic situation.

Choosing for instance to increase the dose of anxiolytics when I consider that my patient cannot but be overwhelmed by his/her anxiety, or to change an anti-depressant treatment, can be a failure to support the ongoing therapeutic process. But not doing so could also come within a wrong psychiatric assessment and endanger this patient's life. Any Gestalt therapist-psychiatrist cannot forget that he/she is primarily a psychiatrist. His/her first way of thinking is medical.

I join however these authors when they say that it's sometimes better – for

some patients – to be both therapist and *prescriber, in order to avoid reinforcing some splits. That's the issue, I think, for patients with personality-disorders. But to play such a role as an expert in prescription is a very different way to be than as an expert as a Gestalt therapist. The first one displays to the patient that the psychiatrist has some knowledge and knows "what's good" for him/her. The second one offers an expertise in the process of experiencing, thus does not position the therapist in an authoritarian stand.*

In their conclusion, the authors resume the concept of "agency", referring to some other writers, to overcome the dichotomy biology/psychology. Here, as in other places in this chapter, I am reminded of Perls, Hefferline and Goodman's book, and particularly their chapter on the transition from physiology to psychology (and vice versa) comes to my mind as another support to overcome this dichotomy (Chapter 1.5; Chapter 12, A. 1). Gestalt Therapy *considered psychology as a study of creative adjustments. So we might wonder when a creative adjustment is impossible for a patient without medication? This question, which is a central issue for a psychiatrist-Gestalt therapist, could also be addressed by every Gestalt therapist.*

Part II

Specific Contexts and Focuses

Social Context and Psychotherapy

by Giovanni Salonia

In his book on suicide, Emile Durkheim (2007) opens up new research horizons with regards to the relationship between individuals and society through his identification of social influences as concurrent causes of suicide in cases of depression. Indeed, he asserts that suicide – which had always been considered as an entirely mental phenomenon – may be triggered by factors like social chaos. Even if in Durkheim's analysis what is meant by chaos has an evidently conservative matrix, and is only roughly applicable to the present situation of social fragmentation, his insight offers a useful starting-point for considering the connections and correlations between cultural contexts and psychotherapies.

Similarly, historical nosology reveals the existence of different pathologies in different cultural contexts: the pathologies brought to light by Freud (hysteria, phobias, obsessions and depression) were connected to the historical and social context of the Austro-Hungarian Empire whilst new pathologies (narcissism, borderline) are widespread in the post modern era.

New patients, then, and the re-emergence of familiar pathologies (e.g. arise in cases of addiction) correspond to specific cultural changes (Gaddini, 1984; Salonia, 2005a). Consequently, during the last century, not only were there significant changes made to the existing modes of psychotherapy but new ones also emerged. In the Fifties, for example, two psychoanalysts (Fritz and Laura Perls), having understood that the human beings studied and treated by Sigmund Freud were continuing to evolve, initially tried to modify some features of psychoanalysis but ultimately (with Paul Goodman, Isadore From, Elliot Shapiro, Paul Weiss and others) (Rosenfeld, 1987) created a new type of psychotherapy called Gestalt Therapy (GT) (Perls, Hefferline and Goodman, 1994). A new type of human being was appearing on the horizon: one interested in self-fulfilment rather than in the community and to the pronoun "I" rather than the "we"; one dedicated to seeking ever greater personal independence, and inclined to "chew" rather than "introject" laws and the pronouncements of authority. About twenty years later, other psychoanalysts, having recognised

this transition, proposed new theories (that of "object relations", for instance) with the objective of bringing the classical psychoanalytical models "up-to-date".

Even social psychology becomes aware that each society generates a specific personality model to which every theory of health or pathology needs to be related. Kardiner's "basic personality" (1965) is undoubtedly the most successful theory to emerge from this research.

At present, the relationship between individual-society is a given: it is found at the centre of a vast panorama of theories (e.g. institutional analysis, critical Marxist sociology, relational sociology, psycho-sociology)[1].

1. The Basic Relationship Model (BRM) as the Key to Understanding the Relationship Between Cultural Contexts and Psychotherapies

If we take relationships – in their declination of ways-of-being-there-with – as the key to understanding the complexity of the relationship between individual and society, it becomes possible to apply a sort of *reductio ad unum* that illuminates many changes and many connections between individual and society from the point of view of their coexistence.

The Basic Relational Model (BRM) (Salonia, 2005a) answers these needs; it creates, in fact, a sort of Occam's razor that, whilst it identifies essential components of the "individual-society" relationship, also brings out its processes and intersections. By integrating and going beyond Kardiner's theory, we can assert, in fact, that in any society there is not merely a "basic personality" but also a Basic Relational Model. It is based on the idea that any society, in order to respond to its own survival needs, decides who has priority between the individual and society and gives, according to the context, priority to one or the other.

1.1. The BRM/Us

Society's interests are paramount when there is a period of common fear (caused by war, starvation or epidemics)[2] or a phase of *statu nascenti.* In those

[1] See Donati (1983); Bauman (2000; 2003b); Galimberti (1996; 2009). Undoubtedly of interest – even if not pertinent to this analysis – it shows, in addition, the greater depth of research on the specific psychology of every people: cf., for example the study on German hysteria, French fear and Italian insecurity in Bibò (1997).

[2] «The destruction of traditional morality is the effect of the elimination of fear» writes Machiavelli in his *Discorsi* repeating an acute observation of Sallustio's; see Pedullà (2010).

periods expressions like “United we stand..”. if there is danger or “We are the best” (in the context of a *statu nascenti*) come to the fore and the individual thinks spontaneously in terms of the common good. As far as relationship schemata are concerned (or models of being-with) “we” is given precedence, and the model we define as BRM/Us predominates. It is a model in which it seems natural to sacrifice personal interest in favour of those of the group: very little interest is manifested towards people’s inner lives (biographies and autobiographies – rarely diaries – fill bookshops) and all the teachers impart is learnt precisely and in a repetitive manner whilst teachers, thanks to their role, are always afforded respect. The only aspects of subjective experience that can be freely expressed, and seen positively, are those of the leader, of the hero and of... the unknown soldiers (those who have sacrificed themselves for the salvation of the community); on a negative level, those of the traitor are interesting since in this case betrayal of the nation is considered worse than betrayal at home.

The leader – chosen exclusively because he is capable of saving the community or as a charismatic leader – has absolute power and is thanked when he exercises it clearly, decisively and without involving lower levels of society. He is willingly obeyed and much is forgiven him because he has the destiny of society in his hands; society, coherently enough, is organised in a monolithic and autocratic manner.

This BRM/Us model comes to dominate, as we have already said, in situations which are described as *statu nascenti* (Alberoni, 1977) that is, when something new comes into being (at both macro or micro social levels hence, new socio-cultural movements, the mother-child relationship, falling in love). The group becomes “Us” in unity with the leader whose exceptional qualities and prestige are acknowledged and are felt to be shared on a collective level: “We are great and special because our leader is”.

In this context there is no room for dialogue, for subjectivity, for the self-exploration of the single individual because the *mission* has priority over everything else. It is not useful to dedicate space to differences (which are undervalued), but it is essential to support convergences (which are exaggerated).

In both cases (situations of shared fear and *statu nascenti*) the “Us” is perceived as the limit that separates us from “Them”, from others seen as enemies or as unimportant: an “Us against” in times of danger, and an “Us better” in that of *statu nascenti*. The “Us” is created either by the enemy (Kavafis asks himself if it is possible to be united without the existence of “barbarians”; Kavafis, 1992) or by a narcissistic sense of belonging.

In these social contexts, psychopathologies are characterised by fear in its multifarious forms: a sense of guilt rooted in the fear of separation, phobias or obsessions as fear of feelings and action (Salonia, 2010a). The bottom line is

that there is a fear of emerging from the community in order to be oneself, to become independent (Rank, 1932, 1949).

1.2. The BRM/I

When the generalised source of fear or the initial stage of the charismatic leader's reign is over, then the society-community first experiences complexity (Morin, 1993) followed by fragmentation (Bauman, 2000; 2003b; Beck, 2003a): subjectivity begins to emerge and progressively manifests the need to legitimise itself and to attain full self-realisation. On a social level, this process occurs slowly and goes through specific phases (Salonia, 2011a) namely, rebellion, narcissism and, finally, confusion.

The BRM in this stage is characterised by the "I" pronoun: BRM/I. In this relationship schema, interest for the common good becomes greatly diminished whilst personal points of view are given great importance, and people are more concerned with their rights than with their duties (Bobbio, 1990); the leader is neither recognised nor accepted, since every individual feels ready to assume the leadership role. People wish to grow without the effort and mistakes involved in learning, and anything that might end in humiliation is avoided. As far as the law is concerned, the question is not whether to obey or not, but whether the law maker had the right to legislate at all.

Experience – the main expression of subjectivity – becomes the place whe-re learning occurs as well as being the criterion for making judgements. Points of reference crumble: "epics" (Lyotard, 2002) give way to small narratives, those of people "without qualities" (Musil, 1956). The force of reason is contrasted by the weakness of thought (Vattimo, 1984). Any diversity is legitimised and can be presented to the world without prior ontological evaluation. The weakening of ties leads to the fragility of social cohabitation in the *polis* and in the *oikos* (and Giddens' analysis is interesting here) (Giddens, 2000). New professional figures emerge, experts in mediation who do not set themselves up as judges but – by recognising them – express the reasons of both sides in the dispute or difficulty of living together. Much space is dedicated to listening to oneself, both in creative forms of expression (diarists, poets and writers proliferate) as well as in that request for help that is called "accompanying" (of therapists or family guidance, of philosophers or in spiritual matters). Communicative efficacy and competence become fundamental for creating relationships between subjective entities who become progressively self-referential (Salonia, 1999). Unequal relationships are reduced to a minimum and, however, in any case, it is not a social role which endows authority, but the individual caregiver who has to inspire it. A sense

of belonging is perceived negatively as representing a limit to individual potential.

Despite the emphasis on subjectivity, some scared individuals try to free themselves from a horizontal and fragmented society and take refuge in fundamentalist groups led by charismatic leaders, however – as Friedman (2002) astutely notes – even this option is perceived as the fruit of one's free choice towards self-fulfilment. The only places in which an "Us" relationship model is accepted – even if living in a context dominated by BRM/I – are places in which one's life is at risk: on a plane, in an operating theatre, etc. Here living together reverts to the monolithic and autocratic mode: even the most independent person recognises the chief pilot's power.

Let us conclude this *excursus* with a recent example which demonstrated once again how it is society which determines the Basic Relational Model. Anybody who was in New York in the aftermath of 11 September 2001 noticed that for a long time New Yorkers, like many Westerners, had suddenly rediscovered "Us". The banners on cars proclaimed "*United we stand*". People had reverted to thinking in terms of "Us", of accepting the reduction of their liberties and rights in order to be protected. In a moment, danger had revolutionised relational thought. A sociologist (Ackerman, 2008) wrote recently that we ought to learn a better way of living unconnected to situations of danger or war.

Communication and relationship models, however, do not have an absolute value but are functional to the survival of the group.

Forms of psychopathology in the BRM/I undergo radical reassessment: the very term "psychopathology" – perceived with negative resonances – is called into question, and great emphasis is placed on the positive value of illness as a creative choice and survival strategy in situations of extreme danger for the subject. Rather than speak of psychopathology, the terms "malfunctions" or "personal functional styles" are preferred.

The most basic form of anguish consists in the fear of being suffocated by the community, to be unable to be oneself and totally fulfil one's potential. Without experience of strong ties, it becomes difficult to construct one's identity and both create and maintain significant relationships. Pathologies of the past (hysteria, phobias, eating disorders, etc.) take on new meanings, whilst post modern pathologies range from confusion (borderline) to identity crises (panic attacks), to significant relationship phobia (narcissism). Depression, an antique malaise, acquires new significance in BRM/I societies and demands that therapeutic practices be thought through anew.

2. Social Changes and Developmental Theories

It is of interest to note how changes in base relational models not only give rise to different sorts of pathology but also, as one might expect, to a different concept of maturity; the latter forms the basis of any developmental theory and the various psychotherapeutic models that have emerged (Salonia, 1997).

If we look at child development theories of the last century, we realise that there have been changes in them, too; just as they describe the phases of a child's growth differently, they also reach divergent conclusions as to what constitutes developmental maturity.

For Freud, the goal of growth was the attainment of the genital phase, the capacity, that is, to love and to work which one reaches by becoming aware ("Where there is the *es*, there must also be the *ego*") of one's instincts (*drives*) and their repression operated through fear of the *Super-ego*. Maturity is therefore seen as a compromise between social factors (and the *Super-ego*) and those of the individual. Heroes and saints exemplify the highest levels of maturity (Freud, 1989a; 1989c).

In the Fifties, Gestalt Therapy conceived of maturity as "creative adaptation", the ability to "bite" in order to learn how to combine adaptation (belonging) and creativity (subjectivity) (Perls, 1947; Salonia, 1989b; 1989c). Rank (1932) presents the artist as the model of maturity.

Mahler, in the full bloom of a narcissistic society, elaborated an infant development model which emphasised personal freedom in the act of learning to walk (no longer seeing it as going towards the mother but as the ability to move away from her) and defined maturity as "object constancy" (Mahler, Pine and Bergman, 1978). The figure of a strong individual who defies the world is exalted, the hero of a western or, in its adolescent version, Jonathan Livingstone Seagull who leaves the group because he feels special (Bach, 1973).

In the post-narcissistic period the need to take others into account returns with a vengeance (how can many "Narcissuses" live together?) and Daniel Stern (1987; 1999) proposes a developmental theory connected to the theory of self. He refers to the narrative Self, of the ability to narrate and narrate oneself, to live relationships with others in the triadic dimension of openness.

Unawares, he adopts some basic tenets of Gestalt therapy: maturity cannot appertain only to the individual since any type of maturity is relational maturity. The self, in fact, is always and everywhere in relation. In Gestalt Therapy developmental theory, maturity is defined as "contact competency" (Salonia, 1989b; 1989c). New hermeneutics emerge: the Oedipus complex, for example, is no longer seen as a problem for the child, but as the expression of a problem

in the couple (Salonia, 2005b). From the new anthropological setting, which sees males and females both in the home and working outside it, a new developmental prospective emerges which considers growth in relation to the declination of the primary triangle and also of co-parenting (Salonia, 2009; 2012a).

To summarise what has been said so far, it would appear that in times of war children are brought up to "take part", to obey, and to swallow the rules for survival; in a narcissistic period they are brought up to be independent and to express their full potential; in a post-narcissistic period, to express themselves within relationships.

3. Psychotherapies or Psychotherapy?

After these premises, we can ask the most delicate question of all: can one hold that a clinical model is good for all periods and in every context? In other words, can clinical models which were created decades ago, in completely different historical and social contexts, still meet the needs of a world which has completely changed?

The range of answers one can give is a wide one. For some, the theory and practise of their model has a value which is beyond questions of time or space, consequently other approaches (for either before or after) are considered as being partial or superficial. For others (for instance, DSM IV), objectivity is reached through a descriptive approach to psychopathology, forgetting that every description is an interpretation (Salonia, 2001b). The attempt to create integrated models of psychotherapy (perhaps by combining scraps of theory with sketches of techniques) is also a way of denying the necessity of continually up- dating any therapeutic model.

In reality, it is precisely the lack of connection between psychotherapy and social context that renders a psychotherapeutic approach weak. Let us take the example of psychoanalysis – the "mother" of all therapies. Freud tried to anchor his genial and potent intuitions about social life to the stories about the origins of humanity (Freud, 1989b), to Greek myths, to literature, giving indications for the future on this basis (Freud, 1989c).

Paradoxically, this assertion – that of having discovered "the" immutable theory of living together – has become psychoanalysis' greatest weakness. It was precisely a follower of Freud's who acknowledged (even if after an understandable lapse of time) that we have gone from the *Guilty Man* to the *Tragic Man* (Kohut, 1976a): whilst the horizon in which Freud's patients lived was the guilt of not being able to separate themselves from the community, today's patients (from the last twenty years of the Twentieth century onwards) suffer from the tragic lack of a relational identity, that is, they cannot succeed in feel-

ing part of a community which they perceive as being both "necessary and impossible" (Esposito, 1998).

Among the approaches which have always deemed the continual process of addressing socio-cultural changes to be an integral and decisive part of their work, we find Gestalt Therapy. Coherently with the epistemology of its experiential-relational model, it makes use of hermeneutics (Sichera, 2001) because, by using hermeneutical tools, it is possible to achieve a process of understanding which includes, in an inevitable and illuminating circularity, the text, the author, the reader and the cultural context. On the one hand, that is, the therapist, the patient and the model and, on the other, the model itself and the context in which it grew out of as well as the context in which it is being applied. From this perspective – and we will explore this further – the socio-cultural contextualisation of understanding psychological malaise (and its coherent praxis) is an indispensable condition, if not an all-embracing one, of any therapeutic process.

Let us take an example from the history of Gestalt therapy to clarify the reason for making the choice in favour of hermeneutics. Fritz Perls, one of GT's founders, synthesised his theory in the so-called "Gestalt prayer" (1980, p. 12): «*I am I – you are you. I am not in the world to live up to your expectations and you are not in this world to live up to mine. And if by chance, we find each other, it's beautiful. If not, it can't be helped*». In the context in which Perls wrote it (the American society in the Sixties), where people could not manage to separate themselves from dysfunctional relationships, these affirmations had a therapeutic value. Applied in a different context (e.g. in the narcissistic Seventies) they become a non-sense. "Don't tie yourself" and "Follow your own path" is precisely what people who live their relationships narcissistically are experts at: what they find difficulty in doing is quite the opposite, that is, they need to elaborate their phobia towards emotional ties to learn how to trust others and experience a sense of belonging.

Let us look at another clinical example. Fritz Perls, with great clinical intuition, asked patients who continually asked questions (for fear of being different by expressing their own opinions) to transform their questions into statements; in a narcissistic culture, instead, it is opportune to ask patients (who are self-referential and so have difficulty in asking) to turn statements into questions.

Another decisive consideration is that the contextualisation of psychological malaise – i.e. to relate it to the Basic Relational Model – redefines its significance: a person who has a relational model of dependency will attribute a different relevance to his malaise according to whether he experiences it in a context in which belonging is highly prized (how to lose his sense of guilt?) or one which rates self-fulfilment more highly (why am I different from everyone else?).

The Basic Relational Model is therefore the first and decisive paradigm for understanding any psychological malaise and, consequently, for being able to determine the direction the therapeutic process should take.

In the light of what has been said, we can now read the gradual emergence of various psychotherapeutic models (Salonia, Spagnuolo Lobb and Sichera, 1997) within the social changes which have taken place in the last sixty years.

In a society which is strong because it is united against a danger, one perceives the coherence of the psychoanalytic model with its autocratic epistemology: the analyst is the person who will know how to make sense of the patient's senseless products (free associations, *lapsus*, dreams). The Super-Ego is the regulatory instance with which one must come to terms; the Ego is the fruit of the conflict between the Super-Ego and the Es. The patient's task consists in "introjecting" the interpretation (illumination) which comes from the analyst.

When the socio-cultural context starts to evolve towards the supremacy of subjectivity, then the therapeutic value of the patient's ability for defiance emerges (for example, Otto Rank's *Gegenville*) (Rank, 1949). In harmony with that, Perls' first intuition (that, as cited above, began the separation from the world of psychoanalysis and formed the basis of GT) is the importance of teething: the child does not learn by swallowing but by breaking-down[3].

In therapy, the patient's subjectivity also assumes a primary importance: it is the real reason behind the non-directional nature of Rogers therapy (1970) and the value of experience in GT (both often hastily dismissed as superficial forms of therapy![4]). Indeed, these therapists, in different ways, adopt and give a novel clinical slant to Jaspers' great but isolated intuition concerning the importance of the patients' experience and *Einfuhlung* with respect to the explanation (Jaspers, 1968). "*Feeling expression*" becomes the novel therapeutic principle in that it reveals subjectivity's rediscovered possibility of self-expression[5].

To give an example, it is clear that in times of danger it makes little sense to give lots of space for the expression of personal experiences: if there is the need to go and fight for survival it is not functional to listen to your fear and attribute importance to it or express it, unless it is defined as "psychiatric".

From the Sixties onwards, when attention is dedicated towards the risks incurred by subjectivity that loses the sense of belonging, the need to return to relationships, which are not lived as a form of dependence, emerges once again and family therapies proliferate. In any type of psychotherapeutic activity or in

[3] Perls (1947). For a re-reading of Perls' intuition, see Salonia (2011b).

[4] Phenomenologically, the "surface" is the true sense duct of the person; see Cavaleri (2003).

[5] It is the slogan of the humanistic therapies in the Sixties; see Buhler and Allen (1976).

philosophical or social reflection[6] the focus is on relationships. It is the age of the "therapies of the self", which emphasise the ineradicable social and relational dimensions of the individual (Gabbard, 2002). In Gestalt Therapy the theoretical and clinical *corpus* concerning the self is defined and the theory of contact as hermeneutical key of the whole theoretical and clinical set up is elaborated. In particular, a fundamental concept which is revolutionary with regards to the theorising of the Fifties emerges: the self-regulation of the organism must be inserted into a more comprehensive principle which consists in the self-regulation of the relationship (Salonia, Spagnuolo Lobb and Sichera, 1997). It is the relationship which regulates itself. Thus the way of understanding and experiencing the therapeutic setting become radically different.

It is interesting to observe how, in parallel with these movements, psychoanalysis has also moved forward and evolved both internally and through the creation of post-psychoanalytical models. The most famous of these is concerned with "object relations" and, in the last few years – through Mitchell's work (Mitchell and Greenberg, 1986; Mitchell, 2002) and, in the developmental field, Stern's (1987) – it conforms to the "relational model", in which the present value of the relationship, as it occurs in the therapeutic setting, becomes of paramount importance.

4. Gestalt Therapy as Psychotherapeutic Model for the Postmodern Cultural Context

From what has been said thus far, it appears clear that psychopathology and Freudian treatments are part of the hermeneutics proper to BRM/Us (strong society-weak individual) whilst Gestalt Therapy, emerging at the beginning of the BRM/I, elaborates a novel hermeneutics and a new clinical practice for the treatment of psychological malaise; its starting-point is a weak society which is moving into the background whilst subjectivity becomes the figure (Salonia, Spagnuolo Lobb and Sichera, 1997; Salonia, Spagnuolo Lobb and Cavaleri, 1997). It is precisely the crisis which overtakes relationship ties – both as the origin and the fulfilment of subjectivity – that constitutes the great therapeutic challenge that the BRM/I presents to GT. In other words, psychological malaise arises "from" and "in" a disturbed relationship, and it shows itself in the inability to form healthy relationships; it is cured "with" and "in" a (therapeutic) relationship. In GT hermeneutics, the fundamental concept of psycho-

[6] This interest towards the "other", which in philosophy was expressed by the philosophers of otherness and reciprocity (e.g. Buber, Lévinas, Rosenzweig etc.), created the context of sensibility in psychotherapy from which family therapy and attention given to relationships in therapy arose. See Salonia (2001; 1997); Lévinas (1990; 1998), Buber (1993).

pathology is, in fact, the inability to encounter the other, that is – on a phenomenological level – the fact that a desire (intentionality) for contact is interrupted and does not come to fruition.

Completion or genuine contacts do not occur if one dominates the other or submits to the other but by arriving at the "contact boundary" with an in intact self (Salonia, 1989b; 1989c), capable of seeing the fullness of the other, too (Gadamer, 1983; Perls, Hefferline and Goodman, 1994).

Contact, when it happens, gives an existential sense of completeness and pleasure. The ability to create nourishing contacts is innate, but it is developed and is sustained in an appropriate way by parental figures in the moments in which one learns – at the level of bodily relations – the schemata of being-with (Stern, 1987; Salonia, 1989b; 1989c).

In the light of these premises, GT psychotherapy is the description of the various ways in which one fails to reach the other. Tolstoy (2006) was right when he wrote that there is only one way to be happy and many ways of being unhappy! The different types of classic psychopathology or the various styles of malaise (hysteria, phobias, panic attacks etc.) are distinguishable on the basis of the moment in which the subject, on his way towards nourishing contact in the environment, interrupts his journey. The gravity of the illness is found, instead, in the difference between integrity of contact and fullness of the contact. The seriously ill patient has not reached – as Heidegger would say – himself (Salonia, 2001b), and he has not built within himself a sense of integrity; he is incapable of being-there. In less ill patients, the psychological suffering comes from the inability to live "fully" an experience of contact, and that is why he is always tormented by a sense of incompleteness. In the cipher of relations – which in GT is central and decisive at the outset – the symptoms and cure of psychopathology are discernable in body-relationship experience (Salonia, 2008a; 2010b; 2011a). GT focalises the relationship between the subject and others in lived relationships (what I feel in relation to the other) which, in turn, has an inevitable bodily matrix. The "how I feel with respect to the other" is felt and written first and foremost in the body: the phenomenological matrix of Gestalt Therapy finds it place precisely in this affirmation. The failure or success of contact intentionality are "visible" in the body or, better, in the body in relation. It is precisely the "inter-body-ness" (Salonia, 2008a; 2011a) between the child's body and the parental figure's first, and that between the patient and the therapist subsequently, where the fluidity or the interruption of a contact episode is perceived. It is from the body that the first slow but significant movements of opening up of words and body come; the body bears the signs that life is giving birth again, this time to a new relationship and that this relationship is giving birth again to a new life.

Comment

by Philip Lichtenberg

Salonia locates personal functioning within one's larger social existence, including one's place in history. Shaping our living within the larger society includes reconciling the tensions of individuality and communalism. He places psychological theories within the history of ideas and shows how early theory of Gestalt therapy, arising after the heavy collectivist pressures of World War II, emphasizes claims to individuality and personal self-regulation. With excessive focus on the individual giving way to the need for community, he adroitly notes that now we must attend to self-regulation of relationships. With that view, he suggests we go beyond "basic personality" in a society to a "Basic Relational Model" that the society promotes. Further, Salonia places mental health and psychopathology within the relational model. His concept of "contact competency" differentiates these aspects of personal functioning very well.

When Salonia argues that Gestalt therapy was a new psychotherapy when it appeared, I take a different angle on the matter. I want to say "Yes" and "No". With its focus on awareness and the relationship of client and therapist, Gestalt therapy differed from classical psychoanalysis and could be said to be "new". Yet, I believe that Gestalt therapy is in fact a form of what I have called "radical psychoanalysis" (Lichtenberg, 2010). Leading psychoanalysts such as Reich and Fenichel tied psychoanalysis to Marxism and fostered a relational and egalitarian psychotherapy that also spoke to the larger social context. These thinkers were part of a significant group. With attention to face-to-face therapy and the issues of transference and countertransference psychoanalysis was changing dramatically.

Gestalt therapy was a realization of what was subordinated in psychoanalytic theory. For example, the concept of contacting and withdrawing is Freud's "experience of satisfaction". Similarly, the notion of awareness in Gestalt therapy as the organism/environment field derives from Freud's early theory of consciousness. When there is complexity in theory, different components of the whole become focal over time. That is how Gestalt therapy evolved as a form of psychoanalysis.

Gestalt therapy itself is complex in its theory. A close reading of the founding text (Perls, Hefferline and Goodman, 1951) shows that it was both individualistic and relational, somewhat authoritarian and egalitarian, accommodationist and revolutionary. Salonia's chapter is another in the clarifying of these ambiguities.

Political Dimension in Gestalt Therapy

by Stefan Blankertz

1. The Political Significance of Gestalt Therapy

Since Sigmund Freud, psychotherapy has been exerting political influence. Freud's theory that psychic problems stem from social norms, especially sexual taboos, provoked society and as more and more people came to accept his theory, society changed[1]. Wilhelm Reich, to name just another psychoanalyst important to the formation of the theory of Gestalt therapy, claimed even more directly than Freud that society is the origin of problems individuals have to deal with in their lives. By the time the theory of Gestalt therapy was brought up it happened to be in the context of student and civil protest against a conformist society engaged in a distant brutal war in Vietnam. Paul Goodman, a co-founder of Gestalt therapy, was a prominent figure in this protest movement. Lore and Fritz Perls also nurtured strong political interests and their biographies are shaped by experiencing the threat of political and racial persecution in Germany after the National Socialists seized power 1933, yet it is Paul Goodman you have to turn to if you ask for a representative of the political dimension in Gestalt therapy: Goodman incorporated a politically motivated social theory into Gestalt therapy. Indeed, he is the person who gave Gestalt therapy the wording of its theoretical framework because he unquestionably wrote the book *Gestalt Therapy* (1951) which also bears on its title page the names of Fritz Perls and Ralph Hefferline as co-authors[2].

When Paul Goodman (1911-1972) first encountered psychoanalytic theories in his pre-World War II youth, his main motivation had been to comprehend *why* people accept the ruling system and its tendency towards war. Lore

[1] Sometimes it is questioned whether the change had been for the better. Please read the case studies of Freud and especially of Wilhelm Reich first and then make up your mind.

[2] Professor Ralph Hefferline (1910-1974), who had been a Behaviorist psychologist, was the originator of the "experiments" presented in *Gestalt Therapy* (Perls, Hefferline and Goodman, 1951). Calling Goodman its "author" does not, to be sure, claim that the ideas of Fritz Perls left no substantial imprint on the book.

and Fritz Perls must have been fully aware of the predominance of Paul Goodman's political concern when they asked him to collaborate with them in inventing a "new" theory of psychotherapy. Paul Goodman's focus on political issues did not alter. He asked himself *why* people remain silent even when the structure of society makes them sick and unhappy.

As the protest movement of the 1960's is considered to be "left wing", this seems to implicate some concepts of Marxist social criticism, but it can be doubted for good reasons whether they truly define the core of the movement, and definitely the Marxist version of social criticism is not what Paul Goodman stood for, the Paul Goodman who identifies himself to be an "anarchist". Lore and Fritz Perls were not as outspoken about their political credo, nevertheless they definitely knew of Paul Goodman's but did not take issue with him about it.

Next to confusing "anarchism" with "terrorism" it is common to think of "anarchists" as militant Marxists or at least as anti-capitalists. Undeniably there are organizations and individuals labeling themselves as "anarchistic" that follow this direction but they fail to present any coherent theory of how to live together without a ruler (which is the literal meaning of the Greek word "anarchy"). This is not the place to explore this subject more deeply but it is useful to stress the point that Paul Goodman had nothing to do with this type of "anarchism"[3].

The targets of the original 1960's rebellion were the most obvious expressions of the nation-state, for example conscription and taxation to wage the foreign war in Vietnam, compulsory schooling, harassing minorities like blacks, poor people, and non-conformists in the name of public welfare, limitations of the freedom of speech, and the prohibition of some arbitrarily selected drugs. The take-over of the youth movement by the Marxists in the late 1960's deeply disappointed Goodman, but before he died in 1972 he could already hail the first steps in the formation of the "Libertarian movement"[4] as a welcome check on the "statism"[5] of the Marxists.

[3] See for instance *The Black Flag of Anarchism* (1968), in Goodman (2010).

[4] Libertarianism is broader in meaning than anarchism for it includes classical liberals, radical liberals, and "minarchists" next to anarchists. Paul Goodman used the term "libertarian" as early as the mid-1940's. The "movement" was identified by Murray Rothbard (1965) in the late 1960's.

[5] The term "state" is relatively new to Anglo-Saxon political theory, since, throughout the history of political thought the strong liberal tradition did not often employ it in the abstract way as the German *"Staat"* or the French *"l'état"* (there are, to be sure, some noteworthy exceptions like Herbert Spencer [*The Man* versus *the State*, 1884] and Albert Jay Nock [*Our Enemy, the State*, 1935]). The preferred terms still used today are "the authorities", "government", or "administration". Paul Goodman sometimes referred loosely to "powers that be". The European meaning of "the state" has been promoted – with critical intentions – by the Anarchist economist Murray Rothbard (1965), who in turn took it from his teacher, the Austrian economist Ludwig von Mises.

Thus Paul Goodman was a therapist, neither psychoanalyst nor doctor, with no other education than his fascination as a writer for Sigmund Freud and Wilhelm Reich and his experience as a client of Alexander Lowen and of Laura Perls. He was a pacifist talking about "natural violence" who designated the call for strict personal non-violence a "spiteful stalling to exacerbate guilt"[6]. He was an anarchistic critic of the Great Power policy of the US and the principle of nation states, who considered himself a "patriot". He was a "left" social philosopher who did not complain much, except about entrepreneurship. Moreover, he was a social critic who did not consider too much freedom and individualism or lack of societal responsibility or lack of state infringements to be the source of our social and economic problems. Quite the contrary, he regarded the reasons for these problems to be too much constriction, too much conformism, too much centralism, and too much regulation. He was an activist in the gay movement who did not describe homosexuality as a "natural" thing. He was a pedagogue who did not denounce the extent of public education as being not broad enough but as already too broad. He was a teacher who considered erotic interests between teacher and student to be a legitimate and reasonable motive for the achievement of true education.

2. Understanding the "Production" of Unhappiness

The core of Goodman's political thinking can be summarized in the following statement: organized society inhibits the choosing activity of human beings and *this* is the cause for widespread unhappiness, and organized society is the agent that enforces the inhibition. This statement contradicts the mainstream opinion that nowadays people are flooded with too many choices, too many possibilities, and too many individual responsibilities, and that this confuses people so that they become sick of freedom – and in the end they "fear" it.

The highest value in life is happiness, if we are to follow Aristotle[7]. Happiness is the one and only value living matter seeks. Even Stoics, Ascetics and religious or political fanatics, forbidding themselves everything other people think of as pleasure, hanker for some deeper happiness inside or outside the known world. Happiness is, as Aristotle says, an action of the soul. According to Goodman anything that hampers freedom of action reduces the possibility of

[6] See *Natural Violence*, in Goodman (2010), p. 37. Written originally in 1945, the quoted phrase was inserted 1962 when Goodman republished this essay.

[7] It is not by chance that I start this discussion with Aristotle for he being the philosopher Goodman relied on most. Goodman was certainly able to read Aristotle in the original ancient Greek. His academic teacher was Richard McKeon, the foremost American Aristotelian in the 20th century.

reaching happiness, therefore, analyzing the consequences of an unfree society is a task for psychology. How does Goodman prove the link between freedom and happiness, respectively between unhappiness and the loss of freedom? And if we observe that people with a reasonable economic status and minimal limitations on their individual freedom still tend to be more often unhappy than happy – what to do with such an observation? We are here in an either-or situation: "private" problems *either* are due to people not being able to lead a happy life *or* we must find another, socio-psychological explanation.

If being unhappy is nothing but a private plight, should we not deduce from the observation of widespread unhappiness that human beings burdened with the responsibility of taking care of themselves are born to make themselves unhappy? And if so, is it not the duty of the state to intervene in such a way as to reduce the unhappiness by unburdening people from their ill-fated responsibility for themselves?

In *Gestalt Therapy*, Goodman says it is just the other way round. Thus, he neither attributes the widespread unhappiness to a mystic deficit in human nature nor to some diffuse condition of "modernity" but to the distinct fact of what he calls the "*organized* society"[8]. Living in the organized society means that everything is already pre-decided for you. You are not free to choose, and as a living matter choosing and selecting is your natural activity. Suppose if you are stripped of your selecting, choosing, and assimilating activity you become sick of unhappiness. Thus, organized society represses conflicts and aggression that occur naturally in the process of selecting, choosing, and assimilating common to animals as complex as human beings.

The organizer in the "*organized* society" according to Goodman is the actual welfare state. The state organizes all basic structures of life such as schools, courts, streets and transportation, city planning, medical care, economic institutions, the police and the army. The state decides when, where and what you learn, when to go to see the doctor, what doctors you are allowed to consult, what contracts you are allowed to sign, what you should use as money, what property you can keep for yourself and what you are supposed to give as social tasks defined by the government, whether you are allowed to smoke, drink alcohol, take drugs or not, which causes you have to give your life for and which not. The state regulates your working hours, your wages, your rents, your insurances, and the way you should build your house. The state does all this, of course, to *help* you.

There is one decisive sentence in *Gestalt Therapy* that offers a complete explanation of how organized society makes you unhappy and sick.

Instead of either the re-establishment of equilibrium or blotting-out and hal-

[8] Prominently in the title of his most influential book, *Growing Up Absurd: Problems of Youth in the* Organized *Society* (Goodman, 1960).

lucination in a temporary emergency excess of danger and frustration, [today] there exists a chronic low-tension disequilibrium, a continual irk of danger and frustration, interspersed with occasional acute crisis, and never fully relaxed[9].

It is worth taking a closer look at the meaning of this central but complicated sentence in *Gestalt Therapy*. The first part of the sentence refers to natural reaction to "emergency". It is not the normal reaction observed today, but it is necessary to determine what is natural in contrast to what is normal, because otherwise we won't be able to criticize normality. The term "emergency" means that there is a problem or a conflict between the organism and its surrounding environment; this for instance can be hunger and no adequate food at hand as well as a brawl between neighbors. Two forms of natural reaction are differentiated. The first form of a natural reaction to emergency is "re-establishment of equilibrium". Food at last could be organized, the disagreement settled. The second form of a natural reaction to emergency is "blotting-out and hallucination". Hunger, for instance, is blotted-out – that means repressed – with nicotine or coca, and the stubborn neighbor is ignored. Yet the nature of the problems between organism and environment is that they occur temporarily; they may lead to "temporary emergency excess of danger and frustration", but the organism by living on solves the problems, relaxes, and gets ready for the next problem.

However, "instead" of a temporary disequilibrium *today* there exists «chronic low-tension disequilibrium […] never fully relaxed». The chronic disequilibrium must be of "low tension" because otherwise the organism would cease to live on. And this low-tension disequilibrium is characterized as being unfortunately "chronic". Suppose someone is hungry and because of government regulations he does not get the food he thinks is best for him. He will not starve. But he will be dissatisfied. He will not even fight organized society because he knows organized society is always stronger than him and at least he is not starving, so it's not worth the bother.

Thus organized society, the well-intentioned democratic welfare state, produces nothing but unhappiness. In making you believe in the state and the state's altruistic motives, the state deprives people of their ability to act on the basis of self-will and self-responsibility. By trying to solve all problems for its members, the organized society acts against the real interests of their life. What is needed to live better is, in Goodman's words, «a little more disorder, dirt, affection, absence of government»[10].

[9] Perls, Hefferline and Goodman (1951), pp. 263-264 (ed. 1994, pp. 39-40).
[10] Perls, Hefferline and Goodman (1951), p. 301 (ed. 1994, p. 78).

3. “Experts” Against “Professionals”

In the book *New Reformation: Notes of a Neolithic Conservative*, originally published in 1970, Goodman provided a summing up of his central concepts. The title, to begin with, is not unproblematic and leads us directly to the issue. The positive amplification of the “reformation” can only be understood in a limited connection with the subtitle, *Notes of a Neolithic Conservative*. Only those reformers orienting themselves towards the original ideal of the autonomous community could be a role-model for Goodman, not those worshipping the rule of sovereigns. In any case, the title contained even more truth than the author had intended. The protesters of the 1960’s were in fact, as were the Protestants of the 16th century, turned into involuntary executors of the changes that were necessary for helping the regime in an inner crisis and for modernizing it. For example, in the 16th century, the weakening of the – admittedly deformed – clerical authority did not lead to the much-awaited liberation but rather to helping a new regime form and structure itself. In the 1960’s, the attack on the – admittedly deformed – autonomy of the “professionals” did not result in a direct democratic achievement but in the strengthening of an administrative rule of democratic but also bureaucratic and centralized bodies. Goodman’s whole book is pervaded by the contradiction inherent in counting on a protest movement whose concepts had already moved away from his intentions.

With the term “professionals”, Goodman describes people who emphatically fulfill a profession and who are not “just doing a job” and thus who consider their job an arbitrary money making opportunity. The “professionals” endorsed by Goodman are marked by their identification with their function and a certain autonomy, no matter whether they be a farmer, a craftsman, an engineer or a scientist. The author was convinced that to lead a fulfilled life, it was necessary to follow an inner vocation. In this spirit, he turned against the then widespread concept among the New Left and the Hippie movement of a “post-scarcity society”[11]: The work is done by machines, whereas people “do their things”. We know similar slogans today, such as “the working society is running out of work” or that there is a “right to be lazy”. In the light of persisting misery this is more than cynical. With recourse to Thomas Jefferson (1984), Goodman moreover suggested that nobody could be free who could not co-create the resources for the satisfaction of his needs. This is a conclusion drawn

[11] The term probably was coined by the left-anarchist ecologist Murray Bookchin (1971) and expressed the utopia of Marxists like Herbert Marcuse, of the “Yippies” (Youth International Party, a branch of militant hippies founded by Jerry Rubin) and of the left-anarchist “Provos” of the Netherlands as well. Goodman directly mentioned the “Provos” and the “Yippies” (see *The Black Flag of Anarchism*, in Goodman, 2010, p. 97).

from a Gestalt therapeutic and anarchistic concept of the human being as a creature who has to handle his problems and needs in self-organization in order to live and develop in a healthy way.

The link to the discussion in *New Reformation* is the long-term discomfort with and the protest against scientists and other "experts" such as teachers, doctors, therapists, engineers and other professionals, who measure their success only against the fact of whether a problem is technically, formally and instrumentally solved and not whether the problem has been mastered in the spirit of those people affected. Goodman shared this discomfort and he actively participated in the protests. Nonetheless, he did not agree with the prevalent conclusions and the usual requests. The prevalent idea has been – and still is – popular, that the value-free "professionals" should be publicly regulated or controlled, and that such regulations will lead to the right, human direction through societal, ethically motivated control.

Goodman on the contrary considered the ethical orientation of the human as part of being a "professional". For example, it is the profession of a doctor to cure the sick. If a doctor becomes the executor of a mechanistic, publicly structured medical and pharmaceutical industry, he will do a job in the framework of which he will play the *role* of a doctor, but will not fulfill his profession. Freedom of purpose and value is, from Goodman's point of view, part of a process of alienation in which a profession starts to dissolve. According to Goodman, this process becomes visible in the deformed conduct of the "professionals". If so-called social (which in this case means nothing but "public") control is set against this deformed conduct of the "professionals" that are reduced to doing their job, criticism defines a state of alienation. From a psychotherapeutic point of view, this constitutes a classic situation: the treatment of a symptom through oppression that, as we know, can lead to a shift to new symptoms. Politically, it is the paradoxical strengthening of the existing through criticism: this criticism produces exactly what the system needs in order to stabilize itself.

Goodman counteracts the widespread doubt that there even was a value based concept that is organically implicated in a profession with the following argument: if there was no such "ethos", it would have to be assumed that technology is actually free of value and that one could discuss its reason and purpose separately from it. Moreover, implementing technology and evaluating reason would encompass a division of labor, separating technicians and controllers. Those who, in accordance with this division, consider themselves as controllers and advocates of humanity would have, themselves, to make use of a professional ethos – namely the orientation on human purposes – that they deny the "professionals". A reasonable world without alienation could, according to Goodman, not be aimed for if criticism defines and even presupposes the

result of alienation through work: to separate rationality into "technology" on the one hand and "ethos" on the other is the core of alienation and treason against reason.

In the second part of *New Reformation*, Goodman questions the *causes* of the alienation. As a Gestalt therapist, Goodman considered the causes for the mistaken concept of profession among the adjusted as well as the rebellious young people to lie in concrete action – in the long experience of school. Goodman analyses that the publicly monopolized education system only allows for role-play, because it is a ruling system. It prevents inner values of the matter from being emphasized. I interpret Goodman's school criticism as an analysis of an institution that is working with constraint. Psychotherapists are also often integrated into this kind of institution, for example into schools, into psychiatric hospitals, into the medical industry, into the judicial system, into prisons, into social work and into addiction prevention.

Compulsory school attendance and credentialism superpose the work the matter requires and force us to work on something that – at best – has been planned by social engineers and that, in the worst case, has developed at random. On the one hand, teachers as public servants become subordinates that are subject to directives and that do not dispose of professional autonomy; on the other hand, especially the interests of pupils oblige the teacher to practice effective cramming. This efficiency is impossible, not only because the pupils tend to react to constraint with contumacy. It has to be taken into account that the pupils' interests are not the real interests of the pupils but the result of an outer constraint to which they are merely reacting. A reform of contents and methods cannot be the way to resolve the school problem. I say this especially with regard to the applications of Gestalt to the training of educational personnel that, in my opinion, seems to have found a way to reconcile Gestalt therapists with the system. This reconciliation is an illusion, because it is the structure of the school as a public institution, it is its nature of constraint and of a monopoly that prevents the development of non-alienated professions. If grade-pressure is substituted by forced psychotherapeutic treatment it will not humanize but aggravate the school situation: an expansion on the colonization of inner psychic potentials. If the frustration of a teacher is eliminated rationally through psychotherapeutic methods, it is not contributing to the restoration of the profession of a teacher, but doing away with the beneficial "spanner in the works" because the frustration is an expression of the fact that a teacher suffers in the system and through this suffering alone he is able to express his autonomy, his personality and his sincerity.

The school is part of an overall system, the state. Goodman focused on this system in the third part of *New Reformation*. It turned out that the school conflict is just one of many problems for public bodies. Since the state is no alli-

ance, neither guild nor free association, since it does not arise from an agreement or a treaty, what is publicly organized cannot allow for autonomy. The organization of independently acting humans has to renew itself persistently through voluntary agreements. By taking part in a violence-based system, each public organization structures an autonomy that might possibly have been granted.

Goodman applies this conclusion that everybody would agree to as far as dictatorial systems are concerned but also and especially to democratic America. The violence-based system is far from the immediate field of experience of most citizens and can thus be implemented safely. Then, the paralysis of initiative and engagement that the violence-based system is causing seems natural, seems to meet the historic trend, seems human, and seems to be the fault of individuals. Goodman's Gestalt therapeutic assertions refer primarily to the analysis of the pathogenic effects that the hidden violence-based system has on the individual.

The secret of democratic violence is monopolization and centralization. On the supply side, monopolization and centralization turn the autonomous "professionals" into subordinates. Independency becomes submissiveness, pride becomes anxiousness, and professional honor becomes job mentality. Professionals turn into personnel. On the demand side, monopolization and centralization create wrong interests. In order to stay within the field of education, those who plan to exert a "doomed" profession do not orientate themselves on the demands arising from a new interpretation of a profession that has to be developed, but on achieving diplomas, licensures, and accreditations. This orientation on rules – that have been set arbitrarily – itself creates a new demand for deformed "professionals", such as teachers, instructors and trainers. After all, people want to achieve a diploma and get an accreditation. For this reason, they demand to be taken there the easiest and quickest way.

In addition to the quite openly conducted monopolization and centralization of the education system, the modern democratic state has, according to Goodman, created another very productive device in the field of professionals policy: the "professionals" are subjected to rules that they have created by themselves. "Created by themselves" means that there is a central representative authority that was formed. A professional association might seem like a voluntary institution of professional autonomy, but it changes its social function immediately: it becomes a compulsory association in the framework of nationalization. A voluntary association becomes a licensed monopoly that does not represent but controls its members and has the power to disadvantage somebody dependent on arbitrary points of view, whether it be sex, race, religion, culture of professional notion.

Goodman reproached the democratic idea of a "legitimization through for-

mal procedures" as only having changed the decisions about the direction of violence, but not having decreased violence as a societal means of control. As a contrast, he presented his idea of autonomy, whose existence and possibility to exist he wanted to prove with the help of the "professionals", even if only in a deformed state. Thus we have come full circle in *New Reformation*: Goodman's criticism of the "professionals" acts in their defense.

4. An "Unfinished" Society as Ideal

The theory of Gestalt is not be confused with "holism"[12] or "universalism". Goodman's perspective remains radical individualist: the organism with its perception and its movements is the principle of organizing the "wholes". The notion Goodman derived from Kurt Lewin, Wolfgang Köhler[13], and other Gestalt psychologists defines "wholeness" as a meaningful "something" in a boundary of time and space that is highlighted against a background. Goodman refers to this notion as a warning not to totally remodel the life of the client but to intervene as carefully as possible, to be "minimally invasive" so to speak. In this thought Goodman combines Gestalt psychology and pragmatism. According to pragmatism[14] the function of conscience is to analyze the situation pressing for change – "the problem" – as long as a cause can be found which gives you an angle to indeed change and thus to solve it. This means that the analysis goes as far and as deep as necessary but is also as narrow and as short as possible. The more complex the cause the more difficult the intervention. This is not only true in therapy but also in politics. And it is at this point that Goodman's

[12] Much of the confusion is produced by Fritz Perls' reference to Jan Smuts' (1870-1950) book *Holism and Evolution* (1926). We can appreciate that Perls saw both in general Smuts a guard of the English liberal tradition against the tide of Boer racism; nevertheless Smuts had been a military man heavily involved in the Boer war (1899-1902) and his achievement as a politician to protect the country against the flood of racism is more than flawed. The German edition of the book was published 1938 together with a preface by biologist Adolf Meyer-Abich (1883-1971) who took pains to show that the theory of "holism" is totally in accordance with the fundamental beliefs of the National Socialists. To be frank, wherever Perls mentioned Smuts he failed to give but one quote from a book filled with strange and hazy phrases to say the least.

[13] In Perls, Hefferline and Goodman (1951, p. 277; ed. 1994, p. 54) Kurt Lewin is quoted from Ellis, (1938), p. 289: «It is particularly necessary that one who proposes to study whole-phenomena should guard against the tendency to make the wholes as all-embracing as possible. […] It is no more true in psychology than in physics that "everything depends on everything else"». Lewin refers to a paper presented by Wolfgang Köhler, reprinted in the same book, titled *Physical Gestalten* (pp. 17-54).

[14] Goodman refers to William James (Perls, Hefferline and Goodman, 1951, p. 259; ed. 1994, p. 35). John Dewey (1859-1952) he met in person.

concept of Gestalt therapy becomes social criticism: that under the existing conditions everything depends on everything else is not necessarily so but it is the consequence of how we designed the society. We could go back to a condition in which the problems of every day life are solved on the spot and not by distant bureaucracies. Much more «organismic-sef-regulation is possible, allowable, riskable»[15] if we reduce the complexities and the coercive realities of "wholeness"[16]. This would be possible if people are not so haunted by neurotic fears and could become more self-conscious, individualist, and spontaneous – a therapeutic and not a political task because the inhibition of self-regulation by the neurotics is in itself a self-regulated meaningful answer to the "mis-condition" of society.

To overcome any problems in life, be they individual problems or social ones, we need energy. This energy is called "aggression" by Goodman (and this term parallels the term "anger" [in Latin: *ira*] of Thomas Aquinas)[17].

Why must it be such a socially rejected term to describe this process that nobody denies? This is the reason: because the rejection of the term "aggression" by social forces is not due to a semantically misnomer but to a real conflict with society. Fulfilling individual needs cannot but lead to contradicting society. This contradiction is because of the greater power of society always "solved" in the interest of society. But to double this enslavement by also morally claiming the righteousness of society does not make any good sense. A steady frustration of individual needs results, as Freud noted, in a discontent with civilization, hence to aggression against the goods and values of it.

To grasp the correction that Goodman inflicts on Freud we must analyze the wording of what Freud expressed. On the one hand he seems to think that the satisfaction of our needs is to be found in passively getting what we hanker after[18]. This equals the prenatal condition but not even the condition of the newborn. On the other hand Freud describes "aggression" as a need that calls for a satisfaction in itself, thus aggression is not an instrument to get the good that fulfills what I want. In *Gestalt Therapy* quite the contrary the satisfaction of needs is described as an active – that is "aggressive" – suckling; "aggression"

[15] Perls, Hefferline and Goodman (1951), p. 275 (ed. 1994, p. 53).

[16] «The whole is the false», as says Theodor W. Adorno (1947), p. 50.

[17] To be precise, before he started the collaboration with the Perls, Goodman 1945 coined and used the term "natural violence" (see in Goodman, 2010) and only then adopted "aggression" from Lore (who expressed the earliest known version of what later became the Gestalt theory of aggression in a lecture on *How to Train Children for Peace?*, held in Johannesburg in 1939) and Fritz Perls (who published in 1947 his book, written together with Lore, titled *Ego, Hunger, and Aggression*).

[18] «Just as the satisfaction of the drives spells happiness, so it is a cause of great suffering if the external world forces us to go without and refuses to satisfy our needs», in *Civilization and Its Discontents* (Freud, 1929, p. 20).

is part of the functional conscience (not of the structure of needs). Satisfaction of needs that are not self-regulated but controlled by social agencies is seen as the very cause of individual discontent.

Why, again, does Goodman call the positive process of active suckling that is necessary to live a life by the same name as the socially abhorred destruction or "aggression"? Aggressions which really are unacceptable and to be rejected – which are senseless, evil, disrespectful of life, and which provoke pain – are "neurotic derivatives"[19] of the originally useful (although not always comfortable and smooth) aggression. The conditions producing the neurotic derivatives call for therapeutic and political action. However, this action ought not to be directed against the good sense of the aggression itself because if so it would reproduce the discontents with civilization and therefore lead to unhappiness and inhumane action.

In *Civilization and Its Discontents* Freud supposedly concludes that to protect civilization against the destructiveness of the aggressive drives an authoritarian regime would be necessary. Yet shortly before the end of the essay he states that he could «listen, without bridling, to the critic who thinks that, considering the goals of cultural endeavor and the means it employs, one is bound to conclude that the whole effort is not worth the trouble and can only result in a state of affairs that the individual is bound to find intolerable»[20].

At least between the lines you can see that even according to Freud aggression is not only a habit of the individual seeking to rebel against the social inhibition of his drives but also of society or of civilization itself: «The aggression of the conscience continues the aggression of the external authority»[21]. If then it is not the individual aggression against "civilized" tameness but individual aggression against social aggression, you can ask yourself why in this fight must society always win. Even more you should ask how social aggressions are to be limited. These social aggressions, even according to Freud, lead to a condition that the individual feels to be unbearable. The social aggressions, guarded by the moral "good" and "bad", are not always and not predominantly in the interest of the individual: «We may reject the notion of an original – as it were, natural – capacity to distinguish between good and evil. Evil is often far from harmful or dangerous to the ego; it may even be something it welcomes and takes pleasure in. Here, then, is a pointer to an outside influence, which determines what is to be called good or evil»[22].

[19] Perls, Hefferline and Goodman (1951), p. 340 (ed. 1994, p. 120).

[20] Freud (1929), p. 105. My hunch (based on the judgment of Wilhelm Reich himself as told in 1952 to Kurt Eissler, see *Reich speaks of Freud*, Farrar, Straus and Giroux, New York, 1987: that the "critic" Freud refers to here may be Wilhelm Reich).

[21] Freud (1929), p. 83.

[22] Freud (1929), pp. 77-78.

Freud nevertheless kept calling the individual "neurotic" and not the civilization or the society. And he had good reason to do so: «The diagnosis of communal neurosis comes up against a specific difficulty: in the individual neurosis the first clue we have is the contrast between the patient and his supposedly normal environment. When it comes to a mass of individuals, all affected by the some condition, no such background is present; it would have to be borrowed from elsewhere»[23]. Alternatively, put it this way: If we call society "ill" we must conclude that "normality" would be a utopia.

Which utopia can be counted as "normal"? Wilhelm Reich solved this methodological problem by referring to the term "nature" which means nothing more than biological functioning. The argument which Goodman also sometimes employs against Reich, that he would by his very concept of "nature" devalue culture, is not just because Reich always stressed the point that he indeed valued culture, but it is just that Reich could not explain culture positively as "normal", "natural" or "biological" within his theoretical framework. Goodman gives us another clue: therapy should state as few norms as possible and should not submit the client to his scientific theory of saneness.

But what is the utopia enabling Goodman to speak of a "neurotic" society that does not serve the individual? I think the answer is to be found within Goodman's specific anarchist pragmatism: man is a problem-solving animal. He should live within an environment in which he can employ his faculty to solve problems being in direct contract to others. This would mean that society is open to the creativity of the individual, is more flexible to be changed according to the needs of its members and in whose structure not everything depends on everything else but in which different ways adapted to local and individual needs are possible. And this would mean that people are not desperate to be fed by society as the mother feeds her children. It will always be necessary to change society according to one's own needs. An environment in which the organism is able to develop sanely is defined by its openness to creative assimilation. Assimilation, initiative, and destruction are the good meanings of aggression.

The aggressions valued positively, call them "sane", "natural" or "necessary", and the aggressions valued negatively do bear the same name in *Gestalt Therapy* and this must be so even if we like to have a clearer and less misunderstood distinction. This is because the "bad" aggressions are nothing other than the "good" aggressions turned to the wrong. The need is "fixed" or "attached" to a wrong object, or again is made permanent (whereas all needs must have the structure of withering to give way to other pressing needs). The wrong object can be one's own organism or an alien scapegoat. Or the time structure is not boundaried: anger is boiling hot momentarily but cold hatred lasts forev-

[23] Freud (1929), p. 104.

er. The figure is no longer fluid to adapt to one's own needs and to the changing conditions of the environment.

The criterion to distinguish good from bad aggressions is whether the self is damaged. No aggression is good which does damage to the self. This is definitely an individualist notion but it is only "anti-social" insofar as the conditions of society prevent the fulfillment of needs. Goodman includes the real social functions into his definition of the self: someone who does damage to his close environment damages himself. To be social in a good sense we do not have to give up the individualist point of view unless we want to impose "anti-personal" conditions by the social forces.

5. Is Goodman still Up-to-Date?

Dealing with Goodman's social philosophy nowadays, the question arises whether in the meantime, 40, 50 years later, our problems differ from those in Goodman's time. Whether, nowadays, not conformism but individualism, not regulation but de-regulation, not the centralism of the "organized society" but the decentralist corporate power are posing the problems. Was Goodman maybe a valuable "critic" in the 1950's and 1960's, but is irrelevant for our *present* time? My answer to this question is just "No", because everything that Goodman criticized then has grown even more acute today. Goodman was anticipatory in assuming what our society would develop into, if nothing changed in the principle of the "statist delusion". For instance, since Korea and Vietnam, the policy of military interventions "to bring about peace and democracy" has been continued seamlessly. The interlacing of state and economy is growing even tighter; the military industrial complex is, for example, growing without restraint. The percentage of the gross national product that is centralized, controlled, and allocated by "the public" is at a historic high. The expansion of the public school system goes on without being checked. Thus, Goodman's criticism concerning the public school policy can't be "neutralized" by hinting that recently the state is negligent of its social responsibility and that one should, contrary to Goodman, fight for the preservation of the "accomplishments".

The picture of a quasi-"anarchistic" contemporary society, today often conjured up by many old representatives of the "New" Left, in which supposedly the public spending equals near to nothing, in which there are hardly any regulations, and in which, for *these* reasons, everything goes haywire, is not drawn correctly. Considering Goodman, one can identify it as the ideology of those circles that are profiting from expanding the "public" sector.

Taking the educational policy as an example, the following was Goodman's pragmatic approach: if we are endlessly spending money and making efforts

for institutions like public schools and, at the same time, are consistently growing more dissatisfied with them, it would only be reasonable to try something new instead of treading the beaten path. However, Goodman did not represent a radical approach that should turn over the whole system, rather he asked for the freedom to experiment[24]. This does not include abandoning the whole educational system as we know it immediately, but allowing for the development of alternatives for those who want them. His anti-authoritarian concept implied that nobody should be submitted to change if he does not ask for it. Goodman diagnosed the persistent quest for "more of the same", leading us into even greater doom, as the malady of our time.

Comment

by Lee Zevy

Although Gestalt Therapy has always had a strong social political background (Doubrawa, 2001) evolving out of the experiences and beliefs of its founders Lore and Fritz Perls and Paul Goodman, it has also often had an uneasy relationship between clinical practice and Goodman's politics (Bloom 2011b).

Blankertz demonstrates this tension in his chapter by focusing heavily on the Anarchistic Pragmatic Conservative elements in Goodman's writing only touching briefly upon the politics inherent in the Organism/Environment Field process and the way this becomes manifest in practice.

By focusing in this way, the political force that can originate in the clinical aspect of the boundary of contact between therapist and client are minimized and only a narrow slice of what is a very broad discussion of politics in Gestalt Therapy is examined.

In trying to find solutions to the unhappy relationship between the needs of

[24] Unfortunately Goodman was weak on economics, to say the least, so he wasn't aware of the economic mechanism behind the monopolizing of public schools. Although he called public financing of schools a "waste", he did not realize that the zero-price of public schooling is a massive intervention into free competition: It's difficult to out-compete any good or service that is (seemingly) for free (in reality schools are expensive, but the money stems from taxes not from fees), unless you ask the state to finance your alternative and in turn accept its governance over the entire project. Parents who send their children to a really private institution actually pay "double" (i.e. indirectly through the contribution to the education system embodied in the taxes *plus* the direct fee). This mechanism was to my knowledge first observed by Milton Friedman in a 1955 paper and preprinted in his famous *Capitalism and Freedom* (1962). The new-left educational historian David Nasaw used the insight into this mechanism in his path-breaking Goodman-inspired study *School to Order* (1979).

the Individual and the repressive needs of the State, Goodman sought to increase individual responsibility, freedom, creativity and community through action in a variety of ways. Important to mention are his exposure to Philosophy at the University of Chicago where James and Mead had made their mark in Pragmatism and the development of Social Psychology. Kitzler (2002) always pointed out that Mead's Philosophy of the Act was a remarkable template for what was to become the Cycle of Contact and his work is overlooked as a precursor for what was to become Gestalt Therapy theory.

The other critical influence in changing his views on the potential force for change embodied in psychotherapy was his training and association with Lore and Fritz Perls and subsequent training as psychotherapist. It was only within the matrix of their philosophy of creative freedom that Goodman could be accepted and express his views on sexuality.

Although he may have modeled his views of sexual freedom through his openly bisexual life Goodman was never a "gay activist" believing that restricting sexuality to "identity politics" was to inhibit the energy inherent in sexual freedom (Humphrey, 2012). Instead, Goodman's activism was grounded in his conservatism and his agreement with Reich that the repression of sexuality by the constraints of society in interfering with individual freedoms directly correlated to much of the unhappiness. (Goodman, 1977) These beliefs are directly correlated to his focus on the development of a non adaptive therapy.

Humphrey locates the intrinsic nature of Gestalt Therapy as a political force when she writes, «obviously Gestalt Therapy is non adaptive, that creative adjustment includes adjusting one's situation (environment), the door is open to that adjustment becoming political action. In doing so she points the way toward understanding the ways in which the clinical aspects of Gestalt therapy beginning with the relationship between therapist and client inevitably lead toward a need for influencing and thereby changing environment».

Through the creation of a non hierarchical relational therapy where organismic self regulation within the phenomenal field is the ground, the greatest possibility lies for promoting the capacity for individual freedom and by extension political change. This follows Goodman's thinking. As Stoehr (1994) points out, self-regulation for Goodman was a «more complicated matter of continual creative adjustment, involving considerable social and political risk taking», which we might extrapolate to begin when a client walks into the office of a Gestalt therapist.

In the way the therapist avoids the bias of interpretation and the hierarchy of a static relationship where the therapist "treats" the patient a model of an ethical relationship based on phenomenological method and dialogic communication is presented and available for contrast (Bloom, 2011b). By concentrating on a descriptive relational communication that is embodied with this

ethical relationship the client experiences a relationship that contrasts to one of repression and constraint. In addition «it teaches therapists and patients the phenomenological method of awareness, in which perceiving, feeling, and acting are distinguished from interpreting and reshuffling preexisting attitudes» (Yontef, 1993). This understanding is a fine tuning and evolution of Goodman's strong sense of ethics and a «warning not to remodel totally the life of the client but to intervene as carefully as possible to be minimally invasive», (Blankertz, 2010a, p. 10).

This new type of client/therapist relationship is by its nature an experiment for the client to which over time other forms of experiment are embedded. An inevitable outgrowth is the experiencing of the boundaries of constraint and freedom and as part of a process of creative adjustment clients will begin chafing against unhappiness as it arises pushing back and reconfiguring their relationship to the environment. Then as the awareness of a social relational field grows within the therapy so concomitantly does the awareness of the need to additionally change the environment to support a growing interconnectedness.

Oddly enough, although Goodman optimistically believed that honorable communities would always exist within the repression he could not imagine that the therapy he helped to create would be a major force for achieving this end.

Living Multicultural Contexts

by Michela Gecele

1. Introduction

When we want to talk about a multicultural context and intercultural intervention, we must talk about culture first. In doing so, we have to deal with a concept which is hard to define (Geertz, 1977; Hannerz, 1996; Benhabib, 2002).

We can say that culture is a means by which thoughts, knowledge, emotions, relationships, conflicts are expressed through actions, social structures, objects, values, beliefs, stories. Culture is not necessarily linked to a place, on the contrary it is set up at the border. And the borders are created at every contact sequence. Culture is continuously built up, re-negotiated and re-defined. It is the "figure" that is created at every encounter and also the background from which the figure emerges.

Does a Gestalt therapist need specific competence to work within multicultural contexts?

Yes, because it is necessary to focus attention on specific problems in order to widen awareness, knowledge and counselling skills (Gecele, 2008). We cannot be fully at the contact boundary if we have never been through our own prejudices, habits, mental structures and schemes that we take for granted and are natural to us. Nevertheless Gestalt therapy already bears all the elements required to deal with the needs rooted in complex societies.

The concept of identity is continuously interwoven – in thought, theories, experiences – with the concept of culture, warping it. In this context we will try to avoid the term "identity", which recalls a structured idea (Remotti, 2010), so far from the fluidity of experiences, the multiple roots we have, from the continuous creative adjustment of relational intentionality.

When speaking of cultures, we refer also to a history that holds stratified layers of meaning and balance of power.

On the other hand we can also say, in apparent contradiction, that culture is a photograph of an instant and speaking about it we are referring to something

that no longer exists. We have moved on into the future, where all the elements involved have reached a different shape, as in a kaleidoscope, offering an endless number of possible images.

The "world" enters the therapeutic relationship, and every therapeutic relationship goes into the world; this becomes particularly evident when global social processes, such as migration, are concerned. The dual relationship and the macro context are strictly linked to one other (Arendt, 1968). Not only does the therapist embroider the strings of the "relational intentionality", but so does the teacher, the educator, the politician, and whomsoever works within the community, maintaining awareness, directions and boundaries.

When we meet a stranger we realize that questioning ourselves about the differences helps us to explore those prejudices and pre-understandings which influence our daily life. Taking into account the presence of foreign immigrants proposes more general issues on laws and praxis of civil life, on accessibility of services. From our daily experiences we know that services are often built in a self-referential way and not as a response to the citizen's needs. Immigrants rock the balance and make a breach in these practises, revealing how limited these are and enhancing the need for renewal.

We have reached a point in our discussion where we can start to talk about the experience of working with people who come from different places. They have gone through cultures, social relationships, languages, outlooks that differ from ours. The aim is to co-construct relationships in which the expression of distress can contribute and change the way we are able to understand and welcome "the other" (Devereux, 1980).

The question is which instruments in Gestalt therapy can be used and redefined? Let us consider the possibility of using some of them for training and educational interventions in an intercultural context.

The figure-ground dynamics direct us to consider the variety of backgrounds involved in the process, helping us to stay at the contact-boundary, despite the obstacles we find. The definitions of self as a boundary-phenomenon show us that life is a continuous process of exchange and change, opposing the perspective that defines individuals as identities, and then as rigid and fixed structures. The level of support needed for the relationship and social contexts increases when shared experiences are reduced and creative adjustment becomes more articulated.

In intercultural laboratories, the main aim is to make prejudices explicit, so that they can be modified by what has been experienced. Exercises and experiments are proposed in order to decentralise from the normal coordinates (for example describing our culture from "the other's" point of view). Attention must be paid to the support of people, so that they can retain what they have experienced (process of assimilation).

Another way is the autobiographical method. This means entering slowly and thoroughly, as Gestalt therapy allows into “small” steps of our daily life, into the moment of separation, break up, make up, and encounter. All the sudden and ever changing roles in our daily lives can provoke a sense of disruption and loss, if they are not revitalised by the flow of awareness. This applies even more to experiencing the “strong” changes, such as the migration of individuals or family (Gecele, 2006).

The third way used to know the “other” is to go deeply into the contents, cultural differences, habits, life styles and thought schemas of people who live in different latitudes and who have gone through different historical times. This is a “risky” way, if used alone, as it may fix what is in continuous movement and definition.

Within communication and intercultural relationships, it is often the “other” who defines the interlocutor’s behaviours, emotions, ideas, mental schemas as something that comes from a cultural context and belonging to it. The foreigner – particularly if one is a migrant and therefore an object of multiple attributions – remains in the trap of a mirroring game in definitions, that continuously bring him/her to the “other” belonging, for example, being considered European in North Africa or North African in Europe.

2. The Invisibile Backgrounds

Talking about otherness is to speak mostly of the background, as the figure, the moment of full contact, is the moment when differences meet, going deeper.

When the differences in history, in the paths and in the horizons are too great, it takes lenghty listening, patient waiting until we can presume to meet. It is important not to look prematurely for the figure of contact, in the relational background (Salonia, 2001b).

The figure that is formed during the contact process is less vivid, less real and transforming – if there is no awareness of different backgrounds. The wider the differences are, as the base for an encounter, the more the transcendence underlying the relational intentionality risks losing direction and sense. Even after the contact, assimilation is problematic. The backgrounds are all the relationships, all the events, all that has happened and happens. But our awareness, our being part of wider processes can be widened only through a gradual process.

Only after criticism, choice, acceptance – and then assimilation – of our own roots can one be open to other possibilities and present to that boundary of contact, which is where social and cultural processes and exchanges are built up. The process of assimilation of our different “us” is at the same time a path

of knowledge and discussion about where we come from, and the acquisition of a critical eye. Wherever there is a disconnection from the background, from the flow where we are immersed, there is confusion, rigidity and social withdrawal.

Memory is part of the background in continuous movement and construction, part of the field where we build up roles, social contacts, faithfulness and belongings. The process of memory individually and collectively requires a constant cure. We easily lose the connection with this background, or vice versa, we simplify and solidify it, remaining in both cases not ready to face the new figures, too new and threatening.

> I believe that the field in Gestalt therapy has to do with this idea; it includes "things" (or events) we are not aware of, but which *are* there, and they might become aware, changing the whole perception we have of the field. The more we grow in our awareness, the more we are aware of where we belong. The field includes the many possibilities of the phenomenological events (Spagnuolo Lobb, 2001, p. 53).

The context in which we live is very complex and the level of complexity increases further when we deal with intercultural issues. The lack of awareness of backgrounds becomes more and more limiting.

Too many stimuli overwhelm us at any moment. Figures have difficulty in forming and run the risk of becoming «a false integration of experience» (Perls, Hefferline and Goodman, 1994). Creative adjustment means mainly selecting stimuli and being able to "stay" in the background. It is important to tolerate the anxiety that can come from avoiding looking for the figures too early.

But creative adjustment means also to be open to complexity. These two directions, seemingly opposite, are connected because if you cannot comprehend and distinguish the stimuli there are fewer possibilities to choose from. The consequence of this is a random selection that removes complexities but not difficulties.

One of the consequences of globalization is that in the background there is the "whole world", which is not the background that we make up and feel through awareness but the excess of stimuli, lack of breaks and unfinished contacts. Only a small part of this world made up of pieces of information, images, sketched experiences can be absorbed through contact processes and creative adjustment. In a way every item is present and handy but grasping it becomes difficult. This can create confusion and renunciation as one does not feel able to find one's way and give shape to chaos. This can also lead to a simplified path, in order to find a meaning for things around us, and have a safe place to stay. This way, which leads to strict belonging and emphasis on identity, is a reaction that may be interrupted by supporting the relational intentionality.

Being in touch with multiple backgrounds that widen the awareness of the complexity of the field (Spagnuolo Lobb, 2004b) – the community where one lives – decreases the social risks of mystification, manipulation and fundamentalism. Often, the people most sensitive to background are those who live at the boundaries, at the edge of social and cultural contexts, a geographic place or a historical age. Maybe artists live at the boundary (Pezzini and Sedda), and possibly journalists, anthropologists and psychotherapists. These people live at that edge where culture is grounded and defined, where the interaction of different backgrounds makes up new and unexpected figures.

There is always a difference between the map we use and the "reality", but if in societies few people are aware of the background from which dominant narratives emerge, the burden of the single person becomes greater, becomes "prophetic". In all societies, individual voices express the polyphony of the field. But what happens if all these voices fall silent? What happens if nobody gives them any form? That probably means that there is not enough support, and this leads to a sort of deafness and silence. The responsibility increases for the "prophet" who burdens himself with too many perceptions or actions. The figure at the boundary may be prophetic and give voice to the otherness that is being formed.

3. The Otherness

The oversimplification of complexity is duality, to define something or someone – a phenomenon, a context, or values – for or against. At any time this opposition can turn into defect, subordination, defeat or failure of one to another (Salonia, 2004a), and the diversity becomes hierarchy. In the relationship with the "stranger" it is usually well defined who has the power and dictates the rules. We continually run the risk of falling into the perspective of "different from".

Any approach to the experience, or theoretical perspective, comes from a specific point of view, a collocation in time and space. This collocation becomes the centre from which other positions and conditions are measured and defined. No one is exempt from this risk; heritage, cultural level, intellectual and artistic talent do not protect people from beliefs and prejudices widespread amongst social groups. Considering the possibility of another point of view cannot only avoid the risk of insanity, but also restore the imbalance of power in a relationship.

Decentralisation is much more difficult the longer you live in an environment that reinforces the legitimacy of your views, which gives only one vision of the world, history and life. When we live in culturally "dominant" contexts,

to question the assumptions of reasoning and perception could become laborious. As psychotherapists we live within cultural processes that cannot avoid influencing and defining our pre-understanding and our points of view. But, as psychotherapists we must continuously make the effort and widen our awareness of our own background (Devereux, 1980).

Our being fully present at the contact-boundary implies being fully aware, when we are in front of "the foreigner", of both the dynamic for power and the elements that we take for granted. The field always includes both our and his/her prejudices, expectations and codes for and means of decoding differences. We are, and we are seen, as the representative of one – or more – social and cultural contexts.

At the very beginning of psychoanalysis the conjunction of the world and the therapy was based on the concept of super-ego; an inner individual instance, which derives from education. In such a social background the family provided a social order, considered to be consistent and necessary.

Today both the vision of the world and man and psychotherapy theories and approaches have changed. Today relationships create sociality and give a structure to the world. We have gone from a verticistic society, interiorized into a super-ego and where triadicity was imposed through social rules – roles and hierarchies as an always present background in every relationship and transaction – to a triadicity that has to be defined in every single relationship. For this reason much more difficult to build up and to maintain. The relational and communicative processes make a net with vectors that have several different directions. The truth is created within each encounter and only "a third" can be a guarantee against going mad and from self-referentiality. Moreover, a reality-truth that does not take the relationship into account can easily become fundamentalism (Salonia, 2005b).

Psychotherapy is part of the history of the "Western" world, but it went through a history of "boundaries". Various schools were born and developed in harmony or in opposition to their contexts. The epistemological principles of Gestalt therapy – although set up in time and space – already include reaching out to the exterior and the quality of being different, hence their translatability, and the reasoning behind this paper, that the Gestalt therapy is a useful tool to read multicultural situations and to construct an intercultural overall view.

Translation is a specific and complex mode of creative-adjustment. It stresses, but at the same time "resolves", the problem of backgrounds, because it indicates the existence of an irrepressible difference. The need to communicate and become closer is an aim which is hard to reach but simultaneously necessary. Every relationship is, in a way, a translation. Translating does not express only the "figure" of the sentence, it takes into account the background it comes from and by listening, it opens up to a new language, to otherness.

Translation precedes language; it comes from background and changes it, without fixing it. It is the opposite of fundamentalism, which sets the figure, eliminating the background.

The sneakiest expressions of fundamentalism are those that are not defined as such. The official version of those in power wants to eliminate not only differences in the other, but also the different other. Fundamentalism and madness are the sign of a lack of the third on a social (macro) and relational (micro) level. Otherness (the quality of being different) exists only if a third exists; otherwise it is an endless distance or adherence. Triadicity, as translation, defines openness to the world, a variety of possibilities, but also the awareness of human failings and limitations.

4. Linguistic Backgrounds; Giving Birth to the Reality

The word originates from the body, belongs to it, and is also placed "between" the body and the environment; it has meaning and direction because there is the "other" to be reached in an endless, inexhaustible effort. The plurality of languages is both a real experience and a metaphor for a communication that never reaches an ultimate goal, but continuously builds bridges and relationships. The "Stranger" – who lives in a different language – can facilitate the break. He listens to his own words and to others and by doing so the language is opened up.

Language has the power to include and exclude, to define experiences, abstractions and types of relationship. It tries to build boundaries to fix in time and space everything that constantly flows, but it also alludes to the indefinable and unspeakable, not yet present. Many rituals are based on the power of words and names (Nathan and Stengers, 1995; Beneduce, 1998; Moro and Revah-Levy, 1998); using a language, living it, means opening these worlds. Practices with a magical significance – connecting the individual to group, men to nature, the natural to the supernatural – have been produced and developed in boundaries and translations, in the encounter between monotheism and previous traditions, in Africa, in Latin America, in the Middle East.

Language can be considered as a pre-existing and supporting background that transcends us (Heidegger, 1982); but language is also made up from scratch in every single experience, in the here and now of every relationship, and therefore is also a figure. There are endless ways to live in and transform it. Every time the word is re-run and reinvented, again, in a way with many thousands of layers. Every child traces a path starting with his or her native language. Complicities are constructed through linguistic exchange, spreading from the family to other people and other contexts. In his evolution, the child

acquires a relational competence that allows him or her to stay at the contact boundary, and so to feel the void, the absence. The access to language is not a creation or madness between two people but a continuous and arduous process of translation, an attempt to express, reach others and shape the world. The development of language brings us to triadicity; the third, in this case, is the language itself, but also the father, the family group and other affiliations.

Insufficient relational support in childhood has a huge impact on the construction of language, which is likely to lack any significant interest or substance. But even in these circumstances language can be discovered in adulthood, with the support of other relationships.

Language changes through contact with other languages, but mainly due to changing experiences that occur from adjusting to various types of relationship, the balance between structural rigidity and the possibility of adequacy being typical for each language. All this is more evident in situations where migration all over the world leads to questioning, devising modes of communication.

Encounters between different languages are more fruitful if they are within the horizon of freedom, and "creative responsibility". They become pathological when social trends and political relationships define an imbalance, causing phenomena such as Semilinguism[1].

Learning, or not, a language, to be used to express ideas, thoughts and emotions; nurturing or not the memory of old beliefs; for the traveller who does not live in his motherland, each linguistic act contains opposing and conflicting emotions. These also arise during therapeutic work, when the patient is in a different environment from his own (Moro and Revah-Levy, 1998). It is always important to pay attention to the experience of the "other", allowing it resonate within us, give it legitimacy and voice – or vice versa, respecting a refusal to speak the language that recalls an emotional suffering.

What is the experience of a child who lives in a country where the spoken language is not that of his parents? A child whose parents often do not "know" the name of things? A child learning a new language, or more than one language at the same time, can structure a world, many worlds, more or less complete, friendly or threatening. Different ways of telling the same story may interweave or take parallel courses.

As an adult, learning a foreign language may be a desire for knowledge, for professional reasons, or a necessity of migration. Changing the reference language changes the frame of reference in which the person lives and builds a sense of his or her own life. At a given point contents and experiences pass through a junction, turning from an old story to a new one. The narration and

[1] Semilinguism means a mediocre acquisition of two languages. Both L1 and L2 are imprecise, so that individuals who are semi-literate never attain, in either language, the competence reached by autochthons (Di Carlo, 1994, p. 102).

each word develop together, in no particular order. The significance of the words may be inferior to the ones belonging to the mother tongue, but can also be greater when used in expression and narration. The two languages, the two worlds can interact in a constructive or disruptive way.

Living in an "other" linguistic context can lead to an emphasis on retroflection, in which case it becomes more difficult to perceive and express a need or to demonstrate expertise. On the other hand, it is not obvious that people who speak their own mother tongue are closer to spontaneity and the opportunity to get in touch with their environment. When speaking their own language separates them from experience, the potential contact, assimilation and growth are reduced.

Language can be a place to hide in order to avoid contact, as an area of fiction and inauthenticity. When talking and expression are not supported but stuck in the developmental age, language could form "a vacuum" away from the experience (Perls, Hefferline and Goodman, 1994). The dissolution of this superstructure requires a strong relational support, because it involves going through a painful history over and over again.

Learning another language can be a new opportunity. In entering into a new language there is a risk of introjecting empty concepts of experience, but also the possibility of regaining a greater spontaneity and flexibility, linking experience to words and phrases. This mainly happens when there is a relational urge to become part of a new (linguistic) context. Relational intentionality plays a key role in learning a language. Learning a new language can lead to a wider awareness.

The equilibrium of language is disrupted by migration, more so than by any other events. Learning a language is a totally different experience when the environment interacts closely with the new individual, or when, the social context is watertight and the stranger is required only to adapt.

5. Novelty and Familiarity; Relational Intentionality in Creative Adjustment

What is novelty? With a play on words we can say that the answer is not a foregone conclusion; we cannot take for granted that news is seen and recognized as such.

What is diverse and opposing can become utopia, idealized and demonized, and in this sense is part of a well-known account. On the other hand, novelty can be an actual life experience that has not been brought to our attention and therefore not assimilated. From a relational point of view, news is mostly what is achieved at the meeting (Spagnuolo Lobb, 2007a).

Living in environments where continual and repeated stimulation takes place involves the risk of desensitization and may create extreme stress. A short-lived and inconsistent need for newness is not what determines the encounter with otherness. It is easy to confuse and overlap novelty and stimulation. Stimulation opens *gestalts*, creates needs, without closing and answering them. Real novelty challenges, resulting in uncomfortable urges to change. Often, what is defined and described as a desire for a new experience and change involves the need to maintain some parameters, and conditions. The desire for "adventure" does not consider the loss of ground this would provide; interest in the "exotic" does not envisage the possibility of losing basic principles. When we "fall in love" with "another" who is very different from us – not just a partner, but someone who originates from a foreign exotic country – we seek fulfillment and not change. We run the risk that the otherness – also cultural – becomes a myth, a place to locate and look for what we lack, not the real otherness, but a distorted and distorting mirror, which closes the experience instead of opening it up to new possibilities.

Getting in contact with each other, the new experience, always involves a great deal of risk. Adequate support is needed in order to create the right space/time for the meeting, so that the relational intentionality can unfold and the consequences of contact is a new creative adjustment. The support comprises the relationship itself, real life stories, emotional ties, experiences, roles, roots, language, habits, the meaning we give to life and our existence in the world.

If there is insufficient support, both trivial stimuli and potentially the most radically changing experiences may reinforce prior beliefs and ideas, or simply add to and overlap notions, or create chaos and confusion.

A familiar background, a secure relationship, successful roles often result from a history of retroflection, a useful way to adjust to the environment and interact and change with it. In all settings we can learn when, how much and with whom, we can try to express ourselves creatively, perhaps "daring" to progress gradually, as we feel the relationship and background allow us.

A change of context can break this retroflection. But the tendency to retroflect may even increase in a new setting, due to lack of communication, or loss of roles and social networks.

Our past history of sharing can limit or supports us in new relationships. That is to say we can be more or less keen to approach the novelty. Among the known roles, in each group, there is, somewhat paradoxically, that of "not belonging". Going towards a new direction is therefore, not only exciting, but even familiar (Gecele, 2002).

What are the main reasons to emigrate? It is often for specific economic and social reasons; you emigrate to change your status. Somebody might also

feel constrained and confined in his own world, feel cut off from opportunity and prospects.

In any case of migration there is a very strong need for support because the country that has been dreamt about never quite fits into the life actually found. The decision to migrate results in a change of lifestyle, relationships, assets, and changes the way time passes, and the space adjusts. Prior to departure, if the plan is shared and it originates from both a strong impulse and support, time shrinks, nullifies, similar to what happens during manic phases of mood disorders. When the new country is reached the risk is that time dilates and space becomes foreign to the body, so very similar to what happens in depression. The less support you find to cope with so many new things and the losses incurred the more you risk. These steps are common in many migration experiences.

Time and relationship are related to one another (Salonia, 2004b). Those who emigrate, along with the things they want to change, lose those certainties – their background, conversations, friendships – allowing them to connect and deal with new experiences. They can feel the lack of support, of the sense of legitimacy of living and the ability to effectively interact with the environment. In a migrant environment, roles and memories may lose their meaning and ostensibly diminish or strengthen. If the current experience lacks the background – knowledge, habits and environmental support – the newness can be menacing and harmful.

Prejudices as pre-judgments affect the way we can orient ourselves in the world and are determined by past knowledge. When pre-judgments are flexible they are useful. They become an obstacle to creative adjustment when identified as absolute truth, the risk being higher in fragmented social settings. Migratory phenomena may aggravate both confusion and rigidity in such contexts. On the basis of our personal experiences, it is easy to recall how scary the meeting with "the other" is. "The stranger" seems to have the power to undo our innermost feeling, which is the foundation of our narration.

If the figure becomes too rigid, the lack of confidence in exploring the new experience hinders the flow in the figure-ground dynamic. The figure becomes more and more detached from its own background. Supporting the background – with therapy or in a social or political environment – can lead to possible new figures (Perls, Hefferline and Goodman, 1994).

With regard to habits, it is important to underline how much they are connected to relationships and linked to the environment. If spontaneity is maintained, even acquired habits – those we take for granted – continue to take shape and modify in the environment. If during the migration the situation is uncomfortable, the old habits lose their meaning, reducing the resources available to the environmental creative adjustment. It is possible that old habits die

giving way to chaos, fragmentation and disorganization, that the elements in the new environment – lifestyle and relationships – are uncritically introjected. New habits can become obsessive rituals that are a way of getting rid of anxiety and not of giving any form or significance to the field. This leads to difficulties in going through the experiences.

On the other hand, any adequate support in a new context can foster the assimilation of old habits that were uncritically introjected in the past.

The culture that is experienced by the immigrant is often not a dynamic process, but a fixed memory that does not correspond to the continuous transformation of reality. This rigid figure is co-constructed, absorbing the points of view of the host society. From the "outside" we can easily see the way people talk and behave when they belong to the same geographical, social and cultural roots. As therapists, but also as politicians and citizens, the risk is that we consider these ways as pathological, different from a rule and so to be modified. On the other hand, we might consider these ways as too different from us from the outset, and therefore ways not to be changed at all (Hobsbawm and Ranger, 1987).

In the so called "western world" there is often the tendency to set against the cultural models that belong to "the other" a view of the world based on socio-economical models and a scientific mentality, presented as univocal and valid always and everywhere. Paradoxically, with such a point of view we assume the same static and rigid position that we think we have removed.

Our beliefs, symbols and concepts are the result of an endless process within a cultural, philosophical and religious tradition which is continuously flowing (Remotti, 2006). Provided we feel included in a story it is easier for us to try and encounter who is going through other stories and paths. The human groups are self-representing, and this is largely determined by contacts and connections to the outside world, the way "the stranger" represents the groups of people who do not belong.

What is really new and surprising is the emergence of interwoven and structured relationships between distant worlds, a game of reflections and reciprocal references (Pamuk, 2006). The certainties and stereotypes sway as this network unfolds.

This is one of the possible conclusions of our journey.

There may be many more.

Or, maybe, there is not a conclusion, but only momentary pauses for assimilation, in order to re-start and face daily life and novelty, as it is in life.

Comment

by Talia Bar-Yoseph Levine

Comment in two pages on a vast subject like culture presents a challenge, as indeed I would guess was the case for Gecele. It might be the reason why there were a number of places where I felt a loss in not having a much more in depth discussion, and was left with a taste for more.

«Culture is continuously built up, re-negotiated and re-defined. It is the "figure" that is created at every encounter and also the background from which the figure emerges» is how Gecele defines culture in congruence with our school of thought, and leaves me with the wish to reiterate a fundamental reminder to the reader that the work to sustain relationship never ends.

Bar-Yoseph B.A. (2001), originating from the field of engineering compares culture to a tree and by doing so adds a warning to the understanding of cross cultural relationship. His research proves the obvious; that every culture has in its roots a set of non negotiable values, subjective to the specific culture. The practical implication is clear, a meeting between cultures is bound to be at best complex.

Geertz (1977) was the first Anthropologist to point out the subjective nature of an observation, the observer changes the field by entering the field regardless of his level of intervention. By doing so, Geertz challenges the entire anthropological approach up to his time and supports our phenomenological approach. The choice to remind the reader of Geertz is important, as it brings another school/discipline into the discussion. It not only supports our thinking of the wider field but gives a live example of a cross cultural relationship between Gestalt Philosophy of being (Levin and Bar-Yoseph Levine 2011) and Anthropology. This stresses even further the fact that the Gestalt philosophy of being by itself is a "culture" amalgamated from a numerous schools of thoughts and experiences.

It would have been important to take a moment to stress that culture is beyond, the still common notion, ethnic differences. One might not get this impression from Gecele who addresses only migration and ethnicity. Culture happens, is created by any group and defines itself by a clear boundary of difference, be it parents and children, old and young, men and woman, leaders and the being led, teachers and students etc. Language then becomes a wider concept than spoken words language. The ability to "speak" the language of the other is in the heart of therapy. Gecele elaborates on language in an original and illuminating manner predominantly about physical borders and immigration/migration and thus may leave the reader under the impression, again, that culture is about ethnicity and geography and language is only the verbal mean of communication.

«The question is: which instruments in Gestalt Therapy can be used and redefined?», Gecele asks. This question caught my eye as this is exactly the question that we address in The Bridge. Dialogues Across Cultures *(Bar-Yoseph Levine, 2005). Gecele gives an answer and by doing so highlights the open minded and rich offering the Gestalt Philosophy of being (Levin and Bar-Yoseph Levine, 2011), as I like to call it, or Gestalt Therapy as Gecele refers to it, has to offer. It is a privilege to have an opportunity to voice an additional perspective.*

The global traveller still assumes a need for knowledge and understanding of a culture different from their own. Books that promise to educate about this country or another can be found in any book store, selling the illusion that reading them will be enough preparation to bridge difference. Not only am I sure that this is not the right solution, I perceive this notion as dangerous and it negates the need to approach the other with humility and interest to learn from them who they are.

Let me offer a different approach (Bar-Joseph Levine, 2005), based on the three philosophical pillars of the Gestalt philosophy of being; field theory, phenomenology and the Buberian dialogue. When bridging the divide the wish is to enable phenomena to meet in the field. The field, as defined at each given moment. The tool allowing the meeting is the Buberian dialogue. Each participant in the attempted meeting brings their own phenomenological field. The art is in the ability to enter the situation in a dialogical stance and maintain it throughout. Awareness is a necessary support to such position. The more aware one is of their roots, needs, what feels like sacred, what is easier to let go, the less threatening the new environment becomes and the more possible dialogue is.

Gecele writes: «it is possible that old habits die giving way to chaos, fragmentation and disorganization, that the elements in the new environment – lifestyle and relationships – are uncritically introjected».

Dialogue, according to the Gestalt philosophy of being, occurs at the contact boundary, it is where the unknown becomes known, it is where relationship is co created. In order to conduct dialogue the parties to it must be ready to change and be changed, to be present and to be ready to include the other. So, I would drop the "possible" from the above quote and say that old habits will die, give way to a sense of chaos and a new being will emerge.

Indeed, Gecele stresses the importance of support needed at the meeting point of the new immigrant with the local. When all is new, fresh and mostly unknown there are two essential ingredients enabling staying at the contact boundary, internal support to stay in discomfort and heightened awareness to one's phenomenological field. When a person is aware of herself and her cultural make up, able to sustain discomfort, ready to change and be changed she

is ready to enter a dialogue. As a result of the dialogical relationship both sides change. In understanding this the support provided by awareness of the possible/impossible essential or not valued system, becomes key to a successful future. The therapist has the role of sustaining the relationship and providing the ground for the cross cultural dialogue for as long as needed.

In different words, the unique contribution a Gestalt human being, therapist, consultant has is the ability to enhance and support a meeting at the contact boundary. The above is an offering of a tool, an essential addtion to one's ability to meet any other regardless of "knowledge" as such.

To end I want to thank Gecele for a thought provoking essay and for reminding us that what was dreamt never «quite fits into the life actually found». At the same time it reminds us that entering a therapeutic journey is one way to bridge difference and to learn how to be party to a meeting with a culture different to ours.

Gestalt Therapy and Developmental Theories

by Giovanni Salonia

The existence of different developmental theories (Magnusson and Stattin, 2006; Salonia, 2005a; Kopp, 2011), even if enriches our knowledge of the child's inner and interpersonal world, makes us fully aware of the risk of perceptual selectivity[1] in our baby's understanding.

During the therapeutic process, in fact, it is important not to underestimate how therapist's theoretical premises as well as his subjectivity could constitute an obstacle to an accurate perception of the patient's experience (Eagle, 2011) and above all when this risk involve children's development and non verbal communication. Starting form this premise, we are just wondering if it is not perhaps true that several developmental theories are just descriptions of the different ways in which adults relate to children. To reduce the influence of a pre-understanding and also following Gadamer's suggestion (1983), the description of the socio-cultural context could orient in the elaboration of any theory.

Adults' perception of children is determined by the socio-cultural context they live in and, specifically, by the *Base Relationship Model* (BRM; Gaffney, Parlett and Salonia, 2010; Salonia, 2005a; Elias, 1991) which occurs in it.

When a society experiences a shared sense of a common danger, then it gives priority to the sense of belonging, to the "We" («united we stand, divided we fall»): in this context the child is raised through models of introjective obedience and of passive adaptation. On the other hand, when a society does not perceive the existence of an imminent and all-pervading danger, then the push towards belonging is relaxed (the society becomes "fluid") (Bauman, 2000; 2001) and emphasis is laid on subjective experience and creativity: in this context, value is placed on listening to the child's needs and to encouraging the expression of his creativity.

[1] For depth examination of infant perceptual selectivity, see: Cohen and Salapatek (1975); Castelli *et al.* (2000); Grossman *et al*. (2000); Slaughter, Heron and Sim (2002); Reid, Belsky and Johnson (2005).

Specifically, in the *BRM/We* – within a cohesive society which is seeking security, the growth will be aimed at creating functional introjections and will have to reckon with fear, rules as well as a sense of guilt (the *Guilty Man*; Kohut, 1977); on the other hand, in the *BRM/I* the child will be perceived and educated within a hermeneutic subjectivity, of the body and of creativity; he will have to reckon with the duty of self-fulfilment (The *Tragic Man*; Kohut, 1977) and to combine his freedom and his own fulfilment with those of others.

Within this perspective, every new developmental theory does not contradict the previous ones but enriches them.

This paper is organised in two parts[2]: in the first, some important previous and current developmental theories are being read trough Gestalt hermeneutical keys; in the second part, a Gestalt Therapy's innovative contribution to the elaboration of a developmental theory with its clinical declinations is presented.

1. A Gestalt Re-Reading of Developmental Theories

Gestalt Therapy has re-examined itself in relation to developmental theories from different perspectives.

First of all, through the first great intuition of its founders: the realisation of the decisive obviousness of the fact that dentition is a way of assimilation (Perls, 1947).

Subsequently, a model for working with children (Oaklander, 1988; Bove Fernandez *et al*., 2006) and a description of child's body growth phases (Frank, 2001) was developed by Gestalt theory and practice. Another attempt was made in the Eighties to outline a child developmental theory using the ways and times of the contact cycle *(The From We-to I/You model*; Salonia, 1989a or. ed.; 1992).

The hermeneutical cipher with which Gestalt Therapy approaches the human animal organism, might be summed up in a triadic paradigm which weaves together the body (the theory of the Self with its functions: Id, Personality and Ego), the relationship (the theory of the contact with its ways and times: the Gestalt contact cycle) and time (the theory of growth and its relational time experienced).

[2] For depth examination, see Salonia (1992). The author introduces the Gestalt developmental theory into the survey of the developmental theories and after twenty years he arises it again, placing it into the Gestalt tradition.

1.1. Sigmund Freud: Body, Relationship and Time

The *Three Essays on the Theory of Sexuality* (Freud, 1905 or. ed.; 1962) certainly represents an outstanding contribution to understand the child, whose inner life is accurately depicted for the first time. Even if differing on a crucial point (the onset of aggression in the oral stage), Gestalt Therapy has always considered Freud's developmental theory as an indisputable starting-point (Salonia, 2011c). According to the triadic paradigm of Gestalt Therapy, Freud's developmental stages reveal in fact an intriguing interconnection between body, relationship and time: the discovery as well the attention (the *Libido*) toward the different areas of the body (oral, anal and phallic) concern the sphincters which act as bodily frontier zones and as a boundary mediator between inner (the body) and outside (the environment).

In this description, the revolutionary principle which asserts that child's relational thoughts and style emerge from the body is implicitly affirmed: depending on the part of the body activated (by the libido), the child-caregiver relationship is modified in a significant way (*dependence, counter-dependence, independence, interdependence*). The pleasure – the signaller of these stages – reveals itself to be a three-dimensional experience: endowing experience of one's own body, opening to the reality of the body of the other and indicating the experience of time as transitory duration. And it is from the pleasure that the experience of lived intercorporeality (perception of one's own and the other's body) and of the lack of the other's body (that becomes expectation) are being made by a corporeal memory, that builds identity and bodily tension opening to otherness. In other words, every stage remains "memorised" in the layers of the body as muscular tension and as quality and style of breathing. If the child's body has found adequate primary support in the body of the parent figure, the progression of stages follows in every wider waves and generates a sense of wholeness (body-relational identity). If, instead, the body of the caregiver does not provide adequately primary support, then fears will be layered in the child's body, as bodily tension destined to produce various types of interruption of the contact. The fact that the progression of stages occurs spontaneously – without any external input – constitutes the physical base of the concept of the *Organism Self-Regulation* (which – as we shall see – will be decisive in the emergence of humanistic therapies).

The three parts of the body, which Freud indicates as markers of the stages (mouth, anus, genitals), should not be considered as isolated and juxtaposed but rather as each being endowed with libido (attention and pleasure) and intimately connected with the entirety of one's own body (for example: the feet are involved in suckling) and with the body of the other. It's interesting how breathing patterns record the quality of the experience: depending on the fluidi-

ty of the experience, it expands or is held in and it becomes deeper or shallower.

The various stages succeed each other – as has already been said – spontaneously and harmoniously and they progressively build the child's corporeal and relational identity.

In particular, the oral sphincter concerns the receiving of something from the environment (the outside) that enters into the body; the experience of suckling cannot be reduced to the pleasure of feeding (movement of milk from the mother's breast to the baby's stomach)but – at an intercorporeal level – it is resembles a relational dance which involves various parts of the mother's body with equal intensity (nipple or bottle) and the baby's mouth (and entire body). The play with the mother's breast (not as a simply feeding experience) has in this way a relational identity and function.

With the audacity of the scientist, Freud underlines a second stage during which the child attributes decisive importance to the anal sphincter. The action of defecating represents a new relational modality learning: the sensation of one's "own" power to expel or hold in something (faeces) that the child produces and the environment awaits (relational dimension). In this stage the child in fact learns how to relate to the environment with a greater power of negotiation (considering the possibility of expressing anger by holding in the faeces or using them to soil things) and feeling embarrassment (people eat together but defecate alone) or shame (when he is incapable of controlling his sphincter).

Finally, in the third stage the child gives great attention to peeing and discovers his genitals as a site of personal pleasure and as the difference between males and females. In defining the phallic stage, Freud perhaps paid the price of his verticistic social context in which social power was entirely belonged to the males. *Penis envy* – according to the most recent feminist theories (Irigaray, 1990; 1994) – is merely cultural: whilst being vital for males (for fear of castration as well), the visibility of the phallus is not important for the female body, for which it is more natural instead to know the other through the register of the senses (the mother contacts the baby through sensations before using sight). In this stage the change in the relational model concerns the acquisition of major independence on the child's part because now he knows how to procure himself pleasure alone (autoerotic stage). It is the premise – *condition sine qua non* – of any equal relationship of intimacy: to go towards the other not from a position of dependence ("Only you give me pleasure"), derived from the negation of the experience of this stage such that the other's body is merely a prosthesis for one's own.

For Freud, the genital stage – the goal of growth which integrates and completes the previous ones – becomes the point of arrival of a competency that has been built up through the layers of the previous relational styles (depend-

ence, counter-dependence, independence) to reach the interdependence as the synthesis of all these pathways.

This passage (the transition from the dyadic mother-child to the father-mother-child triangle) is also characterised by the overcoming of the *Oedipus complex*: the incestuous desire of the mother and the own identification with the father. For Freud, in fact, it is during the oedipal stage that the child's growth or pathology are delineated. Lacan (1948) will robustly assert that the psychotic does not participate in the oedipal triangle and the neurotic does not emerge from it (Mahler, Pine and Bergman, 1975). But the *Zeitgeist* of the Vienna in the 19th century, as we shall see, had a decisive influence on this theory.

1.2. Margaret Mahler: the Child Walks!

Mahler's categories (Mahler, Pine and Bergman, 1975) move the focus away from the child's body towards his relational modalities: normal autistic phase, normal symbiotic phase, separation-individuation process – with hatching, practicing and rapprochement – and emotional object constancy.

As Gabbard reminds us, Mahler's developmental theory is a response to the premise of the emerging model of relationships that is taking the place of the Freud's pulsion theory (Fairbairn adamantly asserts that «the libido is not seeking pleasure, but seeking the object» Fairbairn, 1952; 1992, p. 163).

However, Mahler's most original contribution consists in having pointed out the relational importance of walking. Becoming able to walk is a physical experience that generates intense emotions on the identity and relational level: the child can now decide the "interpersonal proxemics". In other words, he can decide the distance as well the proximity of the bodies which he interacts with. At the mean time, his tumbles and fears force him to ambivalent rapprochements to his mother (because he feels grown and small at the same time), who has to decide a form of support which does not consist in holding him herself or launching him out into the world. Mahler's definition of maturity (*Internal Object Constancy*; Mahler, Pine and Bergman, 1975) coherently recalls the social context (Lasch's "narcissistic society"; 1978), which requires an education centred on personal independence and responsibility[3].

[3] *Jonathan Livingston Seagull,* the novel written by Richard Bach (1970), represents its literary reference.

1.3. Daniel Stern: the Child Talks!

Stern's developmental theory is situated in changed cultural and social co-ordinates. In a narcissistic society, the urgent need to open up to others emerges with great force and now we could see a developmental theory which shifts attention towards the Self of the child, to describe how the *subject-in-contact with* the world evolves. As Gabbard (2005; 2006) reminds us, Stern's theory is the developmental translation of Kohut's theory of the Self (1977; 1978).

Certainly in an unaware way, Stern (1985; 1995; 1998) incorporates some passages from Gestalt Therapy into his theories: the elaboration of a theory of the Self rather than of the child, the study of "healthy" child in his interactions (and not derived from clinical patients – adults or children); the attention towards the interpersonal (inter-subjective) world; the relational styles (*Representations of Interactions that have been generalized* – RIGs) and the "*being-with" schema* ("the other is a self-regulating other for the infant"; Stern, 1985, p. 102).

The acme of a child's development is the *Narrative Self.* Stern, in spite of his uneasiness regarding the limits of language, captures the identity and the relational importance of the "word": when the child talks about himself, he shows that he has developed a triadic relational competency (*I tell you something*).

We could highlight a point of controversy in Stern's theory: the sequence of domains does not follow a rigid sequence of steps. He asserts in fact that the Self is polyphonic and therefore every stage adds a new music to the preceding ones, because the stages are not correlated in a hierarchical order. But, therefore it becomes difficult to understand – and this seems to be the most significant objection to that observation – how the "narrative self" could emerge before or in an entirely independent way of the "nuclear self" or of the "verbal self". Perhaps, it is necessary to distinguish between communicative-relational competency, which is inevitably constructed on an epigenetic model, and other child technical competencies that do not emerge in a progressive manner.

1.4. Infant Research: Mother-Child Self-Regulation

From the Nineties onwards, research into developmental theories has concentrated on observing the child and his interactions (Stern, 1998).

Beebe and Lachmann's studies and research (2003) have caused significant changes in the paradigm for understanding the child, learning – for example – that the implicit sense of the self and recognition of the other are earlier.

A particular concept which emerges from their research *(Infant Research)* is

the systemic paradigm of self-regulation: during mother-child interactions a process of reciprocal self-regulation is always in action (for example see: the *Still face* experiment; Tronick *et al*., 1978; Tronick, Berry Brazelton and Als, 1978; Tronick and Cohn, 1989). This attempt to link systemic and psychodynamic epistemology is maybe one of the weak points of the *Infant Research*[4].

Finally, a recent area of research in the field of developmental theories, which has brought about significant changes on an epistemological level, was begun by Emde and continued by Fivaz-Depeursinge and Corboz-Warney (1999) in the *Lausanne Triadic play* (LTP).

It concerns the passage from the observation of the mother-child dyad to the father-mother-child triad[5]. Inserting the father into the research and observations brings about a great change in the paradigm, but the problem of regulation remains unsolved: how do mother, father and child regulate themselves? Could the systemic perspective deal with the relational experience? We shall deal with this triangular perspective in the Gestalt Therapy theoretical-clinical perspective, subsequently.

2. Developmental Theories in Gestalt Therapy

Gestalt Therapy emerges in the Fifties as one of the most important models of the humanistic movement. One of the characteristics of this new *Zeitgeist* is the emphasis placed on the present, within an epistemological framework that underlines the *depth of the surface* and aims at reducing an interest in the past and, in particular, in the patient's childhood. Indeed, new types of patients are emerging (such as: narcissistic and borderline patient) who refuse the involvement of the past (Kohut, 1977; 1978).

In humanistic therapies this new sensibility produced – as we shall see – a progressive diminution of interest in developmental theory, seen with suspect as a return to the psychoanalytic perspective. The coeval (or contemporaneus) Carl Rogers' *Person-centred therapy* (1951) concentrates in few pages a synthetic and shortened developmental theory.

[4] It is not easy in fact to find a coherence and an epistemological linearity among remote categories such as: system, experience, unconscious.

[5] The new element of the LTP reveals the limits of each experimental research: without the idea of introducing the third, we would stop – like Stern (1985) – at the mother-child dyadic level. It is evident doing research you find what you are looking for. So, behind research, it is necessary to contribute with hypotheses and ideas to reading child development (this is the real reason for this paper).

2.1. Fritz Perls: the Child Bites!

Paradoxically, Gestalt Therapy emerges from a brilliant intuition concerning developmental theory. A couple of psychoanalysts – Fritz and Laura Perls – whilst they were observing their children found that the teething (the capacity and the necessity of destroying food), develops much earlier than Freud had predicted (Perls, 1947).

Once again the body widened horizons generated new ideas on anthropological as well as clinical levels.

The duration of the introjective phase is reduced, since the appearance of teeth has modified the way of feeding: chewing is a positive aggression to break up food and to render it edible (the physical correlation is: "the child bites!"). Karl Abraham (1966) and others had already spoken about a sadistic secondary stage in the oral stage.

Perls' observation of teething became a departure point for the creation of a new paradigm of understanding the human condition (and in particular the processes of learning and changing) as well as the child development. They also understood the significance of the changes occurring in their social context: the passage from a cohesive and strong society, which demanded the introjection of particular values (BRM/We), toward a "weak" one (BRM/I), in which the subject felt the need to express his personal strength and individuality.

Healthy aggression (not primarily connected with destruction and frustration) is experienced, both in therapy and in life, as a self-regulation and it renders recourse to an external entity (such as the Super-Ego) completely useless, as we shall see more clearly further on. In this way, the patient becomes the protagonist of the therapeutic treatment as a "co-construction" relational experience (and as the Cognitivists will say thirty years later).

Perls' intuition was undoubtedly a fertile one and created the theoretical and clinical horizons of Gestalt Therapy: it is still the paradigm that inspires the reflection and practice of Gestalt therapists. But, the assertion that teething is a forerunner of the aggression which – in Freud's view – should come out in the anal stage, has been subject to criticism. In reality, here the Perls' view that dental aggression anticipates the successive (anal) stage (Salonia, 1992; Salonia, Horney and Perls, 1994), seems not too much clear: when the child breaks up food with his teeth, he is using his own power (dental aggression) with regard to something which comes from the environment and which he wishes to bring inside his own body; diversely, in the anal stage, the child discovers the power of withholding or releasing something belonging to him from his own body. These relational modalities are therefore qualitatively different (Salonia, 2011c).

Some of the difficulties in Gestalt theory and clinical practice have probably arisen from this element of confusion: not much emphasis putting on the

theme of power and an undervaluation of the Personality function of the Self, and similar themes.

2.2. After Perls' Theory: from We to I/You

Until the end of the Eighties, the themes of developmental theory went largely unconsidered in the Gestalt community: Freud's theory was referred to through Perls' critical and pro-positive contribution to it and there was a fear reflecting on developmental theories that would constitute a sort of return to the past, not coherent with a model centred on the *here-and-now* and on the *now-for-next.*

In the Eighties, there is a resurgence of interest in developmental theories (Salonia, 1989 or. ed.; 1992; McConville, 1995; Wheeler, 1991; 2000a; Frank, 2001). This was not a reawakened interest in the past but, first of all, it arose from the need to try and outline the stages through which the Gestalt contact competency is formed.

Secondly, there was a need of a developmental theory as a paradigm, from which to extrapolate (which is precisely what happened) frames of reference and heightened clinical clarity in individual and community therapy with seriously ill patients.

The model emerged was called: "*From We to I-You*" (Salonia, 1989 or. ed.; 1992) and was circumscribed in the ways and times of the contact cycle's phases: the "We" of primary confluence, the "You" which one depends upon (introjection/orientation phase), the "You" towards whom energy is directed (projection/manipulation), the Ego ("I") of self-sufficiency (retroflection), the "I-You" of contact: finally, at the contact boundary two presences have brought to fruition the work of maturation. It is evident – in line with Stern – that every phase has its inherent completeness which is also made up of the assimilation of the preceding phase and the beginnings of the subsequent one. In this sequential form – as typical of a competency – Gestalt Therapy stresses some fundamental bases for the elaboration of a developmental theory.

2.2.1. A Gestalt Developmental Theory of the Self

Gestalt developmental theory concentrates more on the child's Self concept rather than on the child's intrapsychic world (Stern will call it the "interpersonal world" twenty years later; Stern, 1985), in harmony with the Gestalt principle that the organism is always in relationship and into a relational movement: the reciprocal relational intentionality between child and his caregivers is the cipher of the Gestalt developmental hermeneutics.

2.2.2. The Between-ness: a Gestalt Developmental Theory of the Contact Boundary

Gestalt developmental theory refers to the development of the contact boundary (the register of experienced and reciprocal relationships) between the child and his parent figures, rather than to the child's development (as a *monad*). According to this point of view, the development takes place at the contact boundary: different levels of contact boundary will succeed, evolving and depending on the developmental phase of the child and on the parental feedback.

From the primary confluence, which is prevalently physical, a sense of presence/absence of the other's body progressively emerges: through the other's body, the child experiences how his own body is hungry, which body wants and how to live without the other's one (when he can perceive his own body in relationship with the other's one). In others words, at a certain moment "we reach ourselves" when the "I" feels there is a "You" before it. This process – as we have seen – takes place through the development of the succession of different levels of contact boundary, as a consequence of the child's developmental stage and the parental response.

Concerning this point, Stern uses the term of "being-with" schema; but, applying phenomenological categories, Gestalt Therapy prefers to say "being-there-between" (Salonia, 2005b; 2005c; 2012b), where the "between" refers to the category of organism-environment contact boundary and the "there" refers to the phenomenological curve of the here-and-now (and the *now-for-next*) as well as to the *Intercorporeality*, the experienced interaction between two bodies (Salonia, 2008a).

Intercorporeality represents a central concept in Gestalt Therapy, putting the "body" into the category of *intersubjectivity* (Merleau-Ponty, 1951 or. ed.; 1971): in fact, child and parent's bodies live a physical "*between-ness*", where different growth blocks or breakdowns could occur. For example, a parental prohibition becomes a block (and a dysfunctional introject) if it is transmitted by the tension which passes from the parent's body to the child's one: the parental figure's words become significant not just for their content but for the tone of the voice or tension/relaxation of his/her body (Salonia, 2008a).

2.2.3. At the Beginning of Primary Confluence

Gestalt Therapy defines the *Confluence* as the primary relational modality. This reading seems to offer a valid contribution for the solution of many problems connected to the first developmental stage and symbiosis (both Autism and Mahler's Symbiosis are now considered obsolete).

The confluence is an original perspective of the primary "being-there-between" which respects the reality of the child's early independence (how infant researches have brought to light). For Gestalt Therapy, a relationship of confluence between parental figure[6] and child is established in the sense that both experience a reciprocal coming together of their perceptions: each sees the world through his own eyes as well as those of the other. In other words, both experience a sort of "perceptive obsession" of the other, as Stendhal (1993) – referring to the experience of falling in love – describes the phenomenon of the "crystallisation": a sunset is never just a sunset for a lover but a beautiful sunset because she is there or it would be beautiful if she were there.

In this evolution of stages (which follows the rules of Erikson's "epigenetic framework"; Erikson, 1950) if the caregiver's support is not "good enough", some breakdowns can occur and the child will remain stuck in one stage and will not acquire the needful primary competency of the full contact.

The application of this model in clinical practice with seriously ill patients (Conte, 1998-1999; 2008) and in psychiatric communities (Argentino, 2001) has shown the usefulness and value of a Gestalt developmental perspective.

2.2.4. Oedipus as a Crossroads

The *Oedipus complex* – or the oedipal situation – is certainly one of the most delicate points of any developmental theory. The reading of the Oedipus could represent a sort of watershed between freudian and Gestalt developmental hermeneutics.

Basically, there are two different ways of answering the question that lies at the heart of the epistemology of development: should the presence of possible "incestuous" (and dysfunctional) desire be seen as physiological and universally present or does it reveal a relational dysfunction in the primary triangle?

By considering incestuous desire as physiological, Freud has to invoke an external regulative principle (the Super-Ego) and to conclude the "civilization and its discontents" is never entirely eliminable. In the theory of the Oedipus complex, the affections are ordered in the Father's name. Infant researches, instead, have a sort of awkwardness in bringing in the Super Ego and, as an alternative, they make reference to an emotional regulation inside a systemic matrix. Humanistic therapies have always held, in fact, that the concept of the Super Ego can be bracketed off because of the organismic self-regulation.

Gestalt Therapy goes even further by saying the relationship regulates itself; the presence of incestuous desire reveals the lack of a self-regulation in

[6] I find the expression "parental figure" more precise than the usual "caregiver".

the parental relationship (Salonia and Spagnuolo Lobb, 1986; Salonia, 2010a) and it represents the forerunner of what is called "co-parenting" nowadays.

The Gestalt triangle expresses an epistemology in which relationships are self-regulating. As it is clear, there are irreconcilable epistemological differences which generate also different praxes. From the first perspective, the therapeutic work will be centred around containing the child's incestuous desire; in the second perspective, the focus will be on the co-parenting relationship. Unlike the *Lausanne Triadic play*, Gestalt Therapy does not limit its considerations to verbal or non-verbal behaviours, since focalised on relational experiences: parental experience is in relationship to the child but it is also determined by the way a parent lives the relationship with his/her own co-parental partner (not the conjugal partner) and by the way he/she perceives the relationship between the co-parent and the child. For example, when a parent hugs a child he/she will offer a different *holding* style depending on these experiential factors. Consequently, the primary triangle concerns more relationships than behaviours. In the Gestalt triangle, therefore, the third person is already present in the initial dyad and, on a physiological level, it is not necessary that the third appears in order to open up the mother-child dyad: it is not "in the name of the father" but "in the name of the relationship" that affections are regulated (Salonia, 2005b).

2.2.5. Towards New Developmental Perspectives: the Intrapersonal Contact Boundary

If I ask Giorgio (18 months): «Where have you been this morning?», he replies: «Children», to tell me he has been to the nursery. If I ask him: «Do you like being with the children?» He looks at me and then goes away. He could recognises people, facts, presents; he knows how to say "yes" or "no", but he has no words to express his inner world.

Being present to oneself – in the sense of "reaching to yourself" or "giving *you* to yourself" – is not a given but the point of arrival of the primary developmental pathway. As has been said, this destination is defined in different ways depending on the *Zeitgeist*: in a traditional repressive society, it will be the overcome of the Oedipus complex (Freud, 1962); in Lasch's narcissistic society, it will be the independence as "the internal object constancy" (Mahler, Pine and Bergman, 1975); in post-modern individualism, the capacity to engage in a dialogue (the *narrative self*; Stern, 1985); in Gestalt Therapy of the Eighties, it will be the "relational competency" which goes from the *From We to I-You* (Salonia, 1992). In today's fluid society, we propose the "re-reading" of a fundamental element of Gestalt Therapy that might be called the *intrapersonal contact boundary*. In other words, coherently with Perls' great idea

of replacing the "free association" technique instead of the "concentration" one («What are you feeling?»), GT emphasises now «Who are you, who are feeling this?» other than «What are you feeling?».

In a fluid society, the challenge of feeling (Es function) has to be integrated with the task of becoming (Personality function); nowadays, this is particularly complex because of the tendency to «put down anchors rather than roots» (Bauman, 2003a, p. 65) that reduces the phase of the assimilation as well as the sense of belonging.

The profile that emerges as a task in a fluid society is a sort of integration between body and biography: in this re-reading, the theory *From We to I/You* needs to be integrated, emphasising the "Ego of the retroflection" (of the gender phase, of rapprochement, of the verbal self) which emerges from a relational background (as bodily memory of the other/environment as well as from the primary confluence toward its various manifestations ("orientation" and "manipulation" phases). The Ego of the intrapersonal contact boundary is the Ego made mature by relational experience: the awareness which comes out from the womb of the full contact.

Dysfunctions, as breakdowns of the development process of contact and of the intrapersonal boundary competency, will be expressed as *being outside oneself* or *lagging behind oneself*, as losing one's way and as a non-functional contact boundary (a parental figure who does not hold the child's body or hampers its spontaneity).

3. Towards a Triadic Paradigm of Between-ness

The difference between saying to one's child: "Cover up because it's cold" and saying: "How do you feel the temperature? If you feel cold, cover up" refers to very different paradigms: in the first affirmation, the intrapersonal between-ness is denied, whereas in the second it is fostered. The child – in the latter paradigm – will have to learn for himself not only to listen to his parental figure but also through this (that is, by approaching the contact boundary), in a genuine and untouched sense, learn how to listen to himself.

On a basic phenomenological level everybody, when one listens to himself, notices a subterranean and subtle intrapersonal dialogue which forms the background to the interpersonal dialogue. Talking to oneself about everything that has happened is, in the end, an awareness of intrapersonal *between-ness*[7]. Inside a relational perspective, however, the internal or intrapersonal dialogue emerges from

[7] For depth examination on Mentalization and Reflective Thoughts, see: Fonagy, Gergely, Jurist and Target (2002); Main (1983; 1990); Main, Kaplan and Cassidy (1985); Main, Hesse and Kaplan (2005); Dennett (1991).

the *interpersonal* dialogue. While it elaborates and assimilates the interpersonal dialogue which has preceded it, it becomes the background and the premise for the next interpersonal dialogue. Language – unlike what Stern thought – is not a limit but it is a further possibility to enrich interactions. It is clear that not everything needs to be said, but this does not cancel out the fact that everything can be said and so offers an opening space for any interaction. The circularity between "intra" and "inter" personal dialogue is learnt in the primary "Between-ness".

The contribution of the Japanese psychiatric Bin Kimura (2005) in this area has been notable. By giving emphasis to the Japanese word *Aida* – which means "between" – he has identified three types of *between-ness*: *Arché* (primary or proto), intrapersonal and interpersonal: «only an intra-subjective *Aida* can enter into relationship with another intra-subjective *Aida* in an inter-subjective *Aida*» (Kimura, 2005, p. 9).

Intrapersonal between-ness is, in others words, the preliminary condition of interpersonal between-ness and we learn to talk to ourselves in an "Arché-Aida" (or primary between-ness). The primary between-ness (*Arché-Aida*) is the special contact boundary created between the child and the parental figure. The Ego, in order to reach itself, needs to be expressed by a parental figure not once but many times. With a flap of a wing, our Author unknowingly makes a connection between himself and the theories of the Self elaborated in Gestalt Therapy twenty years afterwards (Kohut, 1978; Salonia, 1992; Stern, 1998); he does not consider the child's development in intrapsychic terms (the child's growth) but as the development of a special between-ness in which an Ego, capable of interpersonal between-ness, takes care of a You in which this between-ness is taking shape[8]. As much as the parental figure is able to express his own experience to himself, he will facilitate in the child the emergence of a "proto-dialogue", like a necessary path to be taken since his competency could take shape; instead, if the parental figure has a block in his own intrapersonal between-ness and so that does not have the words for themes of the Self, he will provoke in the child a partial or total inability "to give you to himself" and about some themes of relational identity. Primary intrapersonal between-ness is not only fundamental for the developmental relationships but is required as the *conditio sine qua non* of any relationship in which somebody looks after somebody else[9]. Any block in growth and in care giving, in fact, goes back to a block in the intrapersonal between-ness of the care-giver.

[8] Paul Goodman referred to this connection: «The relationship with parents always remains, in some way, intrapersonal [...] intrapersonal dependency» (Goodman, 1995, p. 134).

[9] A problem with the philosophy of dialogue is the lack of consideration for the primary triad for development and treatment. It is noteworthy how Martin Buber – in the famous dialogue with Carl Rogers – did not see the therapist-patient relation as truly human (Rosenberg, 2003, pp. 210-211). I think any reflection on being-there should unashamedly include (that "there") the category of becoming (i.e. the developmental curve).

Reflecting on intrapersonal between-ness, as a basic moment of interpersonal between-ness (it emerges from it and leads to it), allows us to refine with greater depth the intimate and final sense of the libido. In a succinct but expressive manner, for Freud the libido is the pursuit of pleasure, for the Object relations theory it consists in the search for objects, and for the Gestalt perspective it is the search for one's own soul.

To conclude, this dogged search for integrity (I am here) and for fullness (when the body is seeking for its soul), is the arrow which floats through and sets in motion (*Panta Rei*[10]) every human animal organism. Returning to and paraphrasing Nietzsche's immortal words (1996): «I was born again when my body and my soul were united in a marriage».

Comment

by Peter Mortola

As a scholar interested in the "contact boundary" between developmental theory and Gestalt therapy theory (Mortola, 2006; 2001; 1999), I read Giovanni Salonia's chapter with interest, and a slight sense of déjà vu. *Salonia's chapter reminded me of a strand of developmental theory found in the sometimes overlooked work of Lev Semyonovich Vygotsky (1896-1934). Vygotsky is an important developmental theorist who I believe should be included in this discussion of the way in which the individual child, aided by the tools, signs and symbols of language, learns how to make healthy "intrapersonal" contact with the self, through a mediated process of healthy "interpersonal" contact modeled by significant others in that child's life. As Salonia helpfully writes, «we reach ourselves when the "I" feels there is a "You" before it».*

Salonia also helpfully states in his chapter that, «development takes place at the contact boundary», and then goes on to describe the two kinds of contact that are necessary for healthy development: not only the "exterior" contact boundary between the self and others, but also the "interior" contact boundary between the conscious self and the multiple aspects that make up one's whole self – the senses, the body, feelings and thoughts. One cannot be healthy attending to only one of these contact boundaries at the exclusion of the other. The common tool for negotiating both kinds of contact, at the "interior" and "exterior" boundaries, is language: «Inside a relational perspective [...] the internal or intrapersonal dialogue emerges from the interpersonal dialogue

[10] M. de Montaigne's translation declares: «everything is in movement» (Montaigne, 1966, or. ed. 1580).

[…]. Language […] is not a limit but it is a further possibility to enrich interactions», states Salonia.

Salonia's position here is supported in a number of ways by seminal work in this area by Vygotsky. First, Vygotsky underscores that development is a social process: «Human learning presupposes a specific social nature and a process by which children grow into the intellectual life of those around them» (1978, p. 88). Of particular note here from a "field" perspective, is the fact that Vygotsky's social-based theory of development emerged out of the more social-oriented Russian culture, and serves as an important counterpoint to the more individual-oriented developmental theories of the west. While Piaget may have focused more on the maturation of the individual human organism, Vygotsky's focus was on the dialectical effects of the human organism within a social environment: «We might formulate the general genetic law of cultural development as follows, any function in the child's cultural development appears on the stage twice, on two planes, first on the social plane and then on the psychological, first among people as an intermental category and then within the child as an intramental category» (Vygotsky, 1966, p. 44).

Also akin to Salonia's writing, Vygotsky saw language as the key mediator in the connection between "intra-" development and "inter-" development. Framing language in the much larger discussion of semiotics and the human use of symbols and signs, Vygotsky saw language as an internalized tool for problem solving: «The greatest change in children's capacity to use language as a problem solving tool takes place somewhat later in their development, when socialized speech (which has previously been used to address an adult) is turned inward*. Instead of appealing to the adult, children appeal to themselves, language thus takes on an* intrapersonal function *in addition to its* interpersonal use*» (Vygotksy, 1978, p. 27).*

Over time, I have been interested not only in the ways in which Gestalt therapy theory and developmental theory intersect, but also in the ways in which such intersections in the real work of therapy with children. In my ongoing study of Gestalt child therapist pioneer Violet Oaklander's methods of working therapeutically with children (Mortola, in press, 2006), I have been able to make visible the ways in which a skilled, Gestalt-oriented therapist can help children make better "intrapersonal" contact by first strengthening their "interpersonal" contact boundary. Oaklander's methods of making good therapeutic contact with a child are a clear example of how a child can be artfully introduced to the rich "intra" world of themselves, by first building an positive and supportive "inter" relationship with the therapist.

Shame

by Jean-Marie Robine

In our earliest mythology, shame makes its appearance as one of the first human emotions, if not the first: in the *Book of Genesis*, Adam and Eve discover shame along with their nudity when they taste the fruit of the tree of knowledge. However, shame has long remained little explored or theorized, and only barely distinguished from guilt, which has held pride of place in both religious and psychological traditions, particularly in psychoanalysis.

Certainly shame is present to some extent in some of Freud's writings (1896, 1905, 1929), but I first encountered a consistent attempt to theorize shame when I was working on the concept of contact in the work of Imre Hermann (1943), a Hungarian psychoanalyst who was a pupil of Melanie Klein. Later, in the 1980s, an abundance of writing in English appeared, partly in the context of research on affects and emotions, partly on varying concepts of the self, and also as a result of clinical work on early disturbances of bonding and identity – the narcissistic and borderline disturbances: see particularly Tomkins (1963), Lewis (1971), Wurmser (1981), Nathanson (1987) and others.

Within Gestalt therapy, a number of authors began to focus on shame in clinical practice at the beginning of the 1990s, namely Robine (1991), Erskine (1995), Fuhr (1995), Jacobs (1995), Lee and Wheeler (1996) and others. This contributed greatly to advancing the theory and practice of Gestalt therapy. In fact for some of these authors an approach to this concept led logically to a radical shift from an individualist paradigm to an intersubjective perspective or even to a field paradigm, and thereby to a reconsideration of the whole tradition of privileging intra-psychic phenomena.

1. The Phenomenon of Shame

For phenomenology, what is termed a "phenomenon" is seldom limited to what is apparent and experienced as a given. More usually it requires a real effort of unfolding for the phenomenon to appear.

This is certainly so in the case of shame: this is sometimes conscious and felt as an emotion, sometimes confused with guilt or experienced in attenuated forms like modesty, embarrassment or shyness; it may also often be unconscious, unidentified, unformulated but nevertheless essential. It may then only appear after the kind of sustained effort of uncovering that psychotherapy may provide. Hence it is important to make a distinction between shame experienced as an emotion and essential or existential shame, which, like existential anguish, may form a permanent basis and background for a number of conscious experiences.

Shame relates to how we are and how we have been received, accepted and recognized by our meaningful environment. It relates to lived experiences of indignity, weakness, impotence, inadequacy, dependence, fragility, and incoherence beneath the gaze of another: the feeling that, "As I am, I am not worthy of belonging to the human community". This formula encapsulates the double nature of this experience: one dimension relates to personal identity and the other to connections and the sense of belonging. Shame is a lack of recognition, and hence a breaking of connection.

2. The Shame which Reveals, the Shame which Hides

The eyelids are lowered, the head is bowed and drawn into the shoulders, the breathing quickens, the body contracts, the face and neck turn red, or, alternatively, there is extreme pallor along with bodily weakness. Subjects often resort to metaphors to describe their feelings: wanting to disappear down a hole, wanting the earth to swallow them up. Thus there is an urge to disappear from sight, to become invisible to other people's eyes. People also speak of "losing face", even though the physical manifestations of shame are concentrated on the face.

These bodily manifestations demonstrate the ambiguous nature of shame: how are we to make sense of the fact that subjects express the desire to disappear, at least from sight, while the physical signs they produce inevitably attract the eye?

My hypothesis relates to the showing or demonstrating of excitement: blushing may be understood as the physical sign of an excitement that is definitely intense but is interrupted, as when breathing is blocked. The subject perceives that he is showing what he would rather keep hidden: the desiring self. But this self-revelation is also a source of excitement itself because it gives the subject an opportunity to be recognized in his desire, even if this desire is unmentionable.

The shame which finds expression in pallor, sometimes referred to in

French as “white shame” as opposed to “red shame”, is linked more strongly to the imperative need to disappear from the sight of other people, being more dominated by some experienced deficiency or inadequacy.

Shame is such a painful experience to undergo, especially as it is often intensified by the shame of being ashamed, that any way of avoiding it is preferable, if need be through other affects like anger, scorn, depression or denial.

It is frequently the body which becomes the justification for shame: the slightest physical defect or at least any characteristic seen as such, any deviation from accepted norms can become the support for this affect. Seeing oneself as too fat or too thin, being blond or red-haired, having a limp or a squint are pretexts for shame; a simple spot on a teenage girl’s face can drive her to shut herself in her room until the symptom disappears.

The bodily expression of this suffering enables us to make various assumptions about the process at work. In fact, all experience is primarily an experience lived by the body in the form of sensations, pre-emotional feelings; it is through being received and accepted by the parent or other significant person that the baby learns to transform this bodily experience into an affective and relational experience. This is what Perls, Hefferline and Goodman (1951) described as the passage from the physiological to the psychological which contact provides. When bodily experience is not received, and even more so if it is despised, mocked, or blamed, it cannot be transformed and will stay at the level of the “body”. Thus the subject will be impelled to reduce her means of expression to bodily symptoms (sometimes termed psychosomatic) or to any other method involving excessive investment in the body.

«I cannot be embarrassed at my own body because I exist in it. It is my body as it is for others that embarrasses me» (Sartre, 1939, quoted by Greenberg, 1997). Experience creates the illusion that the body is for oneself, whereas it is actually what Sartre calls “the-body-for-others”.

3. The Gaze of the Other

When the subject experiences shame, she feels alone. She is relegated to a solitude so extreme that she believes that this experience is “her” business, “her” problem, hers, and hers alone. Unlike guilt, when the other is very often present because it is they who have been injured, shame leads to the belief that the other is not involved in this experience. However, it is the gaze of the other which produces the shame, their gaze and their words. Imre Herman (1943), in the lovely passages he devotes to the eyes (“Shining eyes”), wrote of «the fire which blazes in the other’s eyes» which reddens the cheeks of the ashamed. Jean-Paul Sartre (1943) emphasizes that it the gaze of the other which trans-

forms experience: «I have just made a stupid or vulgar gesture: this gesture belongs to me, I do not judge it or blame it, I merely live it, I do it as if for myself. But then I raise my head: someone else was there, and saw me. I am suddenly aware of the vulgarity of my gesture and I am ashamed […] The other is the indispensable mediator between me and myself: I am ashamed of myself as I appear to another».

This gaze of the other may be accompanied by words and/or reproaches, but it may also be silent and thus leave the way open to all kinds of projections on the part of the person experiencing the shame. Hence ultimately there is no need for the other's gaze to be present in concrete form: it will be internalized and activated without the need for intervention by the self's ego-function.

What the subject *is* – some character trait, expression or aspiration – does not seem acceptable to others, and hence is not acceptable to the subject herself.

Exposed – or potentially exposed – to the gaze of the other, shame triggers off the feeling of a lack of harmony between one's experience of oneself and one's experience of the external world. «Shame assumes that you can be seen and that you are aware that other people can see you: in a word, that you are embarrassed. You are visible but not ready to be visible» wrote Erik H. Erikson (1950) in his theory of psychosocial development. He made shame (as opposed to autonomy) one of the eight stages of human development, a major watershed in reaching equilibrium between antagonistic forces, lack of which may interrupt the process of personal development.

Shame is thus, to use Kaufman's striking phrase, «a break in the bridge between people» (Kaufman, 1989). Shame cuts off and isolates the subject to the point that he begins to forget the very existence of the shame-maker. However, the creation of a feeling of shame, or the reactivation of an existing one, is dependent on the existence of another who puts the subject to shame. An expression often used by parents or teachers who make use of shame as a so-called educational instrument is significant here: "You should be ashamed of yourself!" they tell the child, a usage that is found in many cultures and a variety of languages. In this way, the parent tells the child what he should feel (and the underlying paradox is: if he were good!) while at the same time the adult absolves herself of any responsibility for what the child is feeling, as if she were not involved in the affect she suggests to the child. Or, in a similar register, in response to the child who declares that she does not like a certain food the parent delights in repeating the formula: "You don't say '*I don't like it*', you say '*I'm a silly girl'*!". In both cases, the shame-maker invites the other to feel shame, but then retires from the field of experience, refusing to accept the slightest responsibility for the shame experienced by the child.

4. The Gaze of the Other Represents the Gaze of the Community

"The way I am", the person who is ashamed tells himself, "I am not worthy of belonging to the human community". The culture of narcissism encourages us to camouflage and repress our lacks, deficiencies, our feelings of being somehow lacking, in error, at fault and so on. Hence our experience can only be validated if it conforms to the norms and requirements of our social group. The "rest" of our experience, not validated, not received, becomes shameful.

Gordon Wheeler's argument (Lee and Wheeler, 1996) completes this reading: shame is embedded in the individualist paradigm and constitutes one of its major symptoms: individualism sees dependence as childish and considers it inferior. Therefore the individual is forced to repress these feelings as shameful and is unable to feel accepted by the community while he feels beholden to others and thus, *a fortiori*, in a state of dependence.

One of the key studies on shame, by Helen Block Lewis (1971), had already provided an organizing principle for research around what she called "field-dependence or field-independence". Of course her definition of the field is closer to that of Kurt Lewin (the field as "life-space") than that of modern Gestalt therapy but she did show that field-dependent subjects proved to be far more prone to shame than guilt during the first therapeutic encounters, whereas field-independent subjects were more inclined to guilt than to shame. Furthermore, shame appeared to be closely linked to hostility directed inwards than towards the outside world, whereas in the case of guilt, hostility could equally well be directed inwards as outwards. As one might expect, field-dependence often went hand-in-hand with depression whereas field-independence was linked to paranoid conditions (Robine, 1991).

Hence shame is an instrument of social regulation as the feeling of shame makes it possible, to some extent, to make a pact with the person who makes one ashamed. It was probably this possibility of reaching a pact with the enemy that led Perls (1992, p. 213) to refer to shame and embarrassment (as well as disgust) as the "Quislings of the organism". History relates that Quisling was a Norwegian politician who begged Hitler to occupy Norway, which ultimately led to his proclaiming himself prime minister. His name has become a kind of synonym for "collaborator", in the pejorative sense that the term acquired during the German occupation in the Second World War (Robine, 1991). «Instead of assisting in the healthy functioning of the organism, they obstruct and arrest. […] Quislings identify themselves with the enemy and not with their own people, so shame, embarrassment, self-consciousness, and fear restrict the individual's expressions. Expressions change into repressions...» (Perls, 1992, p. 214).

5. Shame as a Warning System and Regulatory System

Tomkins has shown how shame can be an inhibitor of interest and excitement, joy and pleasure in the same way as disgust can act as an inhibitor and regulator of appetite (a *modulator affect*, Tomkins, 1963). He has shown how, right from the earliest stages of infant development, sensory-motor patterns work to reduce or cut off excitement when it becomes so intense as to be uncontainable. We could perhaps say that shame acts to inhibit the prevalence of a self-function in id mode, to the extent that it modifies those affects linked to desires, hopes, needs, wishes, dreams, and goals. When I am desiring I am particularly sensitive to the features of my environment and in particular to how it receives and supports me because I am naked and vulnerable. The ultimate nakedness, and hence the ultimate fragility, is when I am exposed as desiring to another.

In a similar way, in my first study of shame (Robine, 1991), I emphasized that shame appeared when there was a break in confluence, and that a new figure could differentiate itself from the ground and emerge in the form of an urge. Here, confluence should be understood in its original meaning (Perls, Hefferline and Goodman, 1951) as an absence of figure/ground differentiation, a state of non-contact and non-awareness. It may also be understood, following Imre Hermann's (1943) theorization of clinging as an accompaniment to "unclinging", a break in attachment such that the baby becomes sensitive to silence, rejection, and the absence of signs of recognition. Self-esteem may thereby be badly affected.

The different forms of shame I have outlined here have one important characteristic in common: they are actually felt by the subject. They may therefore be described as affects or emotions. However there is another form that we may term essential shame or shame at existing, which is often not felt or not identified as such by the subject. The subject describes him or herself as timid, reclusive, introverted, antisocial, neurotic, and so on. Such descriptions are what Perls et Goodman call "rhetorical attitudes", part of the personality function of the self, which enable the subject to avoid confronting shame… and the shame of feeling ashamed. Shame may thus preside over a number of avoidance procedures, and underlie the strategies which enable the subject to avoid this experience, to avoid having to experience shame at a conscious level.

There are many modalities of avoidance: burying, projecting, unloading the shame onto someone else, using scorn, criticism or sarcasm, inflicting humiliation, demanding perfection, being arrogant and condescending, pursuing power and control at all costs, feeling an excessive need to take care of others, to be nice, to please everyone, and so on.

6. Shame and Guilt

Traditionally, most authors have linked guilt with acting and shame with being. More precisely, shame is related to ourselves, to our own existence, whereas guilt refers to the impact we have on our environment. To put it another way, guilt is an affect linked to acts carried out in our contact with the world, and involves our moral conscience, whereas shame is the result of self-reflexivity (Fuhr and Gremmler-Fuhr, 2000). Psychoanalysis sees shame as linked to the ego ideal but sees guilt as linked to the superego.

Fuhr and Gremmler-Fuhr (1997, 2000) attempt to nuance this oversimplifying dichotomy; beyond the simple differentiation between doing and being, they put forward the hypothesis that guilt concerns individual and societal values relating to good and evil, with the associated fear of punishment, while shame relates to people's values concerning what is important for their feelings of worth and belonging.

This distinction once more throws into relief the isolation of the subject who experiences shame and the concomitant experience of solitude. All the more so since both civil and religious society offer ways of getting rid of guilt through a scale of punishments which supposedly purge the guilt or wash away the sin, through sanctions, fines, imprisonment, penances, mortifications and so on. But society offers no help for dealing with shame. The subject is left face-to-face with herself.

7. Consequences for the Psychotherapeutic Situation

7.1. Extract From the Report of a Female Patient in a Therapy Group

«[…] The therapist speaks to me in a way that invites me to open up, but I still freeze. I feel a stab of shame at having done something, said something badly. I feel other people's eyes boring into me, I am walled up in my shame. I don't want to stay like this, I am angry with him. I clench my teeth, I take short breaths. I turn hard and cold inside, I stretch my body and lift my head up, I stand firm and I say these words to the therapist:

Me: "*I feel ashamed, you make me experience shame*".

I am amazed at the contrast between the content and the energy of my speech and my rather low voice. Anger and resignation are both at work in this episode, but there is something indefinable and different there that I can't yet identify.

The therapist: *"How do I go about making you ashamed?"*

Me: *"You're asking me to be something other than what I am and I can't, and that makes me feel ashamed!"*

I am speaking in a brusque and colloquial way, I am looking for a happy medium between closeness and distance, autonomy and dependence, but none of that is very clear to me at the moment.

I can only respond off-the-cuff, I am just aware of his posture: his whole body leaning forwards to hear what I might say, a searching gaze which holds mine in an effort to understand, a firm and warm tone of voice, mind-body alert to the slightest sign I might give.

I think I see two things in his posture, one is drawing me towards understanding the process that makes me react to what he says with shame, but also his own questioning of what he might have said or done to provoke that shame in me. The idea that he might rephrase or change what he says, his kind but demanding attitude towards me that I have already noticed and put to the test in previous sessions, meant that I didn't cut myself off but started on the work that I can carry on in subsequent work sessions and in the longer term will let me engage in more in-depth reorganization, and come to terms with my petty feelings of shame.

What I think is paradoxical is that I had to be confronted with shame yet again in order to distance myself from it and begin to free myself from it. Using shame to heal shame! But it's also the human qualities of my therapist and his total commitment to the work which have enabled me to build myself up over the years…

Through this work I've been made aware of two aspects of shame: its dark and destructive side, which saps me from within and stifles my day-to-day life, but also its protective side which in some situations has stopped me from getting into extreme courses of action which might have led to my being excluded from my friends and my community».

The therapeutic situation, paradoxically, is not an easy place for those wishing to rid themselves of shame. In fact, as we have seen, since shame is linked to the subject's feeling that he is not as he would want to be, on the one hand, and also, that this experience is lived under the gaze of another, the therapeutic situation seems specifically designed to activate or create shame in the patient. The latter, in effect, comes to see a therapist because he is not satisfied with the way in which he lives, and he displays his ways of being to the gaze of an expert – or so he believes – who is supposed to help guide him towards a more satisfactory way of living.

Furthermore, the individualist paradigm which long dominated therapeutic theory and practice took for granted the patient/therapist dichotomy and tended to attribute all the competence and goodwill to the therapist, and all the resistances, blocks and insufficiencies to the patient. This implicit distribution was certainly not designed to facilitate exposure of the self's most shameful areas.

For these and many other reasons, working on shame in the therapeutic situation is not one of the easiest endeavors. The ways in which psychotherapists are trained (Yontef, 2000) and supervised (Robine, 2007) are equally liable to generate or activate shame in that the student or the practitioner is placed in the position of having the limits of her knowledge and competence observed.

«The most serious obstacle to overcoming the therapeutic impasse, and perhaps the most common contribution on the part of the therapist to the development of an impasse, lies in the therapist's difficulties with regard to his or her own shame» (Jacobs, 2000).

A number of clinicians insist on the need for empathy and a dialogic attitude in the therapist. These are certainly necessary conditions but they are far from being sufficient. They can only provide a foundation on which the complexity of therapeutic work can be gradually built up.

If shame is linked to a lack of recognition of experience, and maybe even more fundamentally, of the right to exist, then these lacks will be the principal themes of the therapeutic work. The philosopher Axel Honneth (1992), following Hegel, offers the therapist an array of valuable conceptual tools corresponding to stages in the development of the need for recognition: *self-confidence* which is built on the basis of loving recognition, *self-respect*, based on legal recognition, the right to exist, and finally *self-esteem*, based on the recognition bestowed by social solidarity.

The recognition of the subject's lived experience and the creative nature of his or her ongoing adjustment to circumstances is an indispensable basis for all clinical work on shame. If the psychotherapist gives the patient to understand that he should have acted differently, she is taking on the role of shame-maker.

The original shame-maker(s), insofar as is possible, should be identified, what belongs to them restored, and each of them relocated and understood in the experience of therapist/patient contact and the dynamic of transfer.

For some therapists, the dialogic attitude provides the opportunity for them to evoke their own shames with their patients. Although I would not endorse this ethical choice (at least in relation to shames lived outside of the here-and-now of the encounter), I would not turn my back on the experience of solidarity ("being-with" and even more) that the therapeutic relation does and should provide. Uncovering and accepting each other's defences is of crucial importance. Lynne Jacobs (1995, 2000), does not hold back from revealing her own fear of shame and her defences against it to her patients and using them as part of the therapeutic process.

Therapeutic work on shame takes pride of place in supporting the id-function of the self. The world of desires, drives and appetites is often where shame strikes, and uncovering and utilizing the "id of the situation" (Perls, Hefferline and Goodman, 1951) help to restructure and "de-immobilize" unfin-

ished situations, retroflections and so on. Being able to be received in exposing one's fragilities, disorganization, and vulnerabilities… and being able to work on shame-inducing interactions in the present of the situation, including – and particularly – those created jointly with the therapist, prove to be of fundamental interest.

Also, in some cases, we might consider transgenerational and/or psychosocial work, particularly when secrets and loyalties are transmitted and create social shames, for example class shames, or symptoms that recur from generation to generation.

(Translated from French by Karen Vincent-Jones)

Comment

by Ken Evans

I enjoyed reading this lucid and well written article.

I agree the study of shame since the 1990's has contributed significantly to the development of Gestalt theory and practice. It has challenged the hitherto classical Gestalt focus on intra psychic phenomena which emphasised awareness and experimentation. The shame literature supports the more contemporary focus which emphasises contact and dialogue. However they need not be mutually exclusive.

I further agree that shame is both an emotion and also an existential way of being in the world that supports a number of conscious experiences. I would also argue that shame is the glue that underpins and holds in place most if not all of our defence mechanisms.

I particularly appreciate Robine reminding us that Perls referred to shame as the "Quislings of the organism"; shame being the internal enemy that restricts and represses, forcing us to hide. I imagine Robine would agree that shame seduces us to repress our qualities as well as our perceived defects. Shame is the emotion that promotes invisibility of strengths as well as weaknesses; we are damned if we do and damned if we don't.

Robine, citing Kaufman (1989) writes that shame arises in relationship when the interpersonal bridge with a significant other(s) is ruptured with the consequent lived experiences of indignity, weakness and inadequacy. I feel, "As I am, I am not worthy of belonging". However, "As I am, I am not worthy..". is a fairly sophisticated cognitive reflection which comes only later in childhood. For the younger child this lived experience is not a conscious thought but an embodied visceral experience that precedes cognition then later accompanies and informs it. Gestalt therapists have tended to be preoccupied

with introjection, which requires sufficient cognitive development for a moderate degree of self other boundary. For many people this lived body experience does not emerge into an awareness distinctly as shame until adulthood, and often comes as a surprise, or even shock. Yontef (1993) first introduced the notion that early pre verbal defences operate via osmosis, an idea I also related to shame (Evans, 1994).

Consequently, while I agree with Robine that existential shame colludes to prevent shame becoming a conscious experience I think it is primarily because the origins of shame lie in the preverbal phase of development before we were able to be alongside ourselves to reflect thoughtfully on our experience. The pre-verbal origins of shame are what makes it so difficult to identify. The confusion between shame and guilt so clearly elaborated by Robine adds to this difficulty.

Robine addresses the manifestation of shame in field dependent and field independent persons. For me both presentations represent opposite ends of the health continuum and are thus polarities. Culture plays a prominent role here. The contemporary nuclear family with both parents working, isolated from extended family and reliant on state or private child care, mean that children have to grow up too quickly. The consequent emphasis on being autonomous and self sufficient hides the longing for a healthy dependency such that we are a generation that is terrified of being seen, but even more terrified of not being seen (Epstein, 1996).

I share with Robine a reluctance to self disclose my own experience of shame if it does not arise within the here and now of the therapeutic process. However, if I experience shame inside the process then I might well self disclose my experience to encourage deeper reflection and/or to surface any underlying transference. In depth psychotherapy sooner or later the client and therapist will, consciously or unconsciously, co create a shame encounter. It is essential to healing. We do not need to go looking for it and neither do we seek to create it artificially. It will happen at some point. What is crucial is that we remain open to the experience and critically reflect on the dynamic. This will almost inevitably be uncomfortable.

When experiencing shame unconscious processes strongly influence the field and the pre verbal "past" may temporarily dominate the "here and now". Words can never fully describe or explain this earliest phase of our human experience (Stern, 1985). This adds to the confusion and sense of being lost when inside an experience of shame, "when we may be too young to think our way out of the hole" (Evans, 2012).

In the midst of a shame laden session a Gestalt therapist needs to maintain compassion for her/himself, view the experience with curiosity rather than judgement, and take the opportunity to turn a crisis into a healing moment for

the client and possibly the therapist (Evans and Gilbert, 2005). In my view shame never goes away but we are healed of the crippling impact of shame when we can turn down the volume and are no longer ashamed of feeling shame.

Shame is also a key issue in clinical supervision (Gilbert and Evans, 2000), in psychotherapy research (Evans, 2006, 2009, 2012), (Evans and Finlay, 2009) and even in humour (Evans, 2012)!

Part III

Specific life situations

The Gilded Cage of Creative Adjustment: a Gestalt Approach to Psychotherapy with Children and Adolescents

by Nurith Levi

It seems that children in the Western world never had it better. In a departure from the past, children's rights are now stated in national laws, international conventions, and social statutes, endorsing unprecedented standards of health care, education, and welfare. We pride ourselves on being a child-centered world and claim that children are the apples of our eyes. Why then, are more children reported as suffering from distress and needing therapy and hospitalization in extreme morbidity at a very young age (Tilinger, Molcho and Harel, 2004; Lahey, D'Onofrio and Waldman, 2009).

1. Children and Adolescents in Therapy

Children and adolescents in therapy are a unique population since in early years the line between health and pathology is even more elusive than in adults. Any therapeutic intervention, which, by definition, creates imbalance and carries long-term effects, demands extra caution on the part of the therapist. To begin with, children are usually *taken* to a therapist, and do not come on their own. It is mostly the adult who defines the problem, its severity, and the timing of turning for help.

Children have only a vague notion of the meaning of "therapy". Their concepts of time, space, and options, differ from those of adults, as do their life experience and grasp of reality. Their threshold of frustration is low, and when they have a problem they expect an immediate answer.

Children may find it bewildering to discuss their thoughts and feelings and their secret world with a stranger. They may feel caught between conflicting loyalties, "betraying" the family's privacy when relating to family issues, expressing negative feelings towards a meaningful figure, or "gossiping" about relatives.

Prior to their meeting with a therapist, children had encountered adults who

solve problems for them, take responsibility, and give them concrete help. (They may have also met adults who ignore or hurt them). They have met few – if any – adults who try to help them *help themselves* – those who "do nothing" but attend, listen, play, and engage with them. Therapists neither expect nor demand nor do they flatter or bribe. Their presence is devoid of instructions, complaints, grades, or praises. Instead they express interest and empathy, are involved, patient and tolerant, and at the same time clear and authoritative. All they do is comment and ask questions that are aimed at directing children to listen to themselves, understand themselves, see their part in a situation, and begin to assume responsibility (Van Riet, 2006).

The therapeutic encounter is containing without being invasive, respectful and supportive, tolerant of failure and non-judgmental. These qualities often arouse the child's curiosity, interest, and eventually some trust and hope that create the first cracks in the child's rigid defenses and fixed coping patterns.

The labeling of young people is an issue that cannot be overestimated. Francesetti and Gecele (2009) discuss the limitations of extrinsic diagnosis as an objective, naturalistic model that defined pathology by symptoms measured according to such categories as specified by DSM or ICD, a diagnosis that purposely overlooks individual personality and circumstances. A label tends to perpetuate a situation that, especially in young people, may be temporary. Files may follow the patient from one therapist/clinic/school/institution to the other, perpetuating a label that defines a child in terms of category instead of describing the behavior or the suffering.

A comprehensive diagnosis is an integration of the clinical examination, the patient-therapist interaction and the etiological background. Just like figure, background is not one homogeneous entity. It is an idiosyncratic configuration of various elements, composed of layers which need to be identified.

1.1. The Developmental Background Layer

Child-parent relationships are different from any other: they are total, intimate, intense, holistic, and demanding. They touch upon physical-emotional-mental-behavioral aspects, and are imprinted upon the child as a formative experience. They originated in a long period of confluent, very loose boundaries between mother and embryo (Stern, 2004), they unravel until they become a relationship between two separate entities that attempt – for as long as they live – to differentiate and regulate the distance/closeness between them, while maintaining a balance that suits their needs (Benjamin, 1995; Friedman, 2011).

The quality of the mutual relationships with their immediate environment is defined by the interaction between self-factors (gender, looks, health, temper-

ament etc.) and environmental-factors (a parent's personality and personal/professional developmental stage, physical and economic conditions, support systems etc.) that determine the development, growth and thriving of children as well as the parents' basic attitude and readiness toward their new roles.

Young children draw upon their primary experience and become active partners in co-creating a reality that serves their developmental needs. They are aware of their growing independent skills and knowledge and are eager to confirm their individuality. When not disturbed, their trust in the environment feeds both their self-confidence and ambition.

Regulating the level of dependence-independence is a leitmotif of human development. This process peaks in adolescence, when young adults openly and directly fight for their autonomy and for the acknowledgment of their separate, individual, differentiated self. Their rapidly changing needs and the fact that the rhythm of development differs in the various realms, coupled with polarized moods and ambivalence towards almost anyone and anything, impose a permanent state of alertness on the whole family. The ability to introduce well-balanced shifts and turns into the regular routine of a system that strives to keep its equilibrium, is indeed demanding and very challenging. At times the effort to appropriately maintain all the needs of each of the system's members, feels like a juggling act. It demands patience, flexibility and fine tuning on the part of parents, especially, as often happens, when children of different ages simultaneously impose different demands on the same parents.

1.2. The Systemic/Family Background Layer

The family system is the first and primary training ground for children to learn and practice the rules of the social game. Role division in the family is a result of transactions that are based on each member's qualities and needs, the family's needs as a system, the availability of the attributes necessary to fulfill the various roles, and the willingness of family members to assume the necessary roles. The smooth functioning of a family depends on clear role definitions, cooperation between role-holders, open communication, the quality with which the roles are performed, and motivation of all members of the system.

From the moment of birth, children are included in the role game, and are expected to know their part. They are praised or punished according to the systems' satisfaction with their performance. Some of the roles are not assumed by the player but are projected onto him/her by other family members. There is a permanent flow of figure and background among the roles, so that in each interaction and situation, one role is "on stage" while others retreat backstage until called upon to perform.

Some roles are universal, others unique to each family. Some roles are popular, and all family members vie for them, while other roles are always avoided. The elements that distinguish one family from the other are the family's degree of flexibility, the way it regulates closeness and distance, its problem-resolution style, clarity of boundaries, and quality of contact. These faculties eventually determine the family's "climate".

Every "symptom" has a metaphorical meaning in the family's context and has a role in itself: the troublesome behavior of one part carries a message to the entire system and may at the same time also be an excuse for a grand deflection from other, more threatening problems. For example, when a child feels that parents are drifting apart, he may develop a symptom that will demand that they work together caring for that child, or become the container for negative feelings, freeing all other parties to go on with their lives, or be an alarm, alerting the wider environment and calling someone (a uncle/ friend/therapist) to come to the family's rescue. Thus, the family field is another background layer against which a figure of children's and adolescents' health or pathology must be discerned.

2. Understanding Psychopathology in Children

By definition, children are at a stage where one of their main tasks is to learn the world. This process involves an automatic process of categorizing and labeling, which provides meaning for each new experience and facilitates the phase of integration into one's idiosyncratic data base – internalizing and owning it (Latner, 1973; Oaklander, 1988: Serok, 2000). From the very early stages of development, although being dependent on their environment, children are also tuned in to observe how their environment reacts to given stimuli and keep an alert, sensitive ear to detect any pretense or falseness. They are perceptive to non-verbal communication and to sensual stimuli, which helps them to invent adaptive reactions as a way to survive situations that they do not comprehend.

One's inner experience and the environments' reaction do not always correspond. Some children, those whose former experience taught them they can trust and risk, rely on their own perceptions and express them fully without fearing to loose their environment's (mainly parents') love and support. These children can sustain a dissonance and may dare to challenge it. Others may be confused, even threatened by any sign of disharmony or criticism, and may easily feel rejected or humiliated. In order to avoid the anxiety and/or real danger they look to disguise their authentic reaction and replace it by what they guess would better match their environments' expectations. They are trading

their individuality and authenticity for a way of feeling more secure, more accepted, more similar, less outstanding.

Children tend to evaluate a situation from an egocentric perspective, and interpret words and deeds according to their limited experience and knowledge, which may turn into fertile ground for misjudgment. *Creative adjustment*, then, is the sophisticated solution that allows individuals to live within painful and damaging situations in a way that they perceive to be as protective of themselves as possible. However, some ramifications of frequent lapsing into one such pattern may mean repeatedly getting stuck in unwanted situations without managing to release oneself.

A Gestalt therapist looks to identify phenomenological signs of disturbances and interruptions of the child's contact/relation with his/her immediate environment. These signs are considered pathological only when they become a "fixed *Gestalt*", namely, when the same set of perceptions and their following reactions appear repeatedly in any situation and become a pattern.

At this point it is important to mention that the pathology is not the type of reaction or strategy selected, or the fact that a reaction developed. The pathology is the setting in of a rigid pattern, which is repeated despite the fact that it is no longer needed or effective. Children are flexible: just as their bones are soft and can be molded, so can their cognitive and emotional attributes. As long as children are unaware of the price they pay for the solution, they are unable to escape it, replace or relinquish it. Pathology sets in when a child's contact with the environment is experienced as painful, frustrating, or worse, as non-existent, or when a child is stubbornly "stuck" in fixed patterns of coping that cause him/her suffering, and that he/she does not dare to change despite offers of help.

For contact to take place both parties must be clearly defined entities that can sustain, endure, and experience the intensity of the occurrence without one party being engulfed or swallowed by the other. Where children are parties to contact, it is easy to overlook or even to ignore the boundaries. Often, this initial experience of children's boundaries being abused (not necessarily in the physical/sexual meaning), is later the source of psychopathology.

"Clear" boundaries are not a synonym for "fixed" boundaries, nor are they the opposite of inconsequential ones. In any relationship, especially with children, the parties must be able to mutually adjust to the varying circumstances, needs, and desires that typify the moment of contact. Contact, as a phenomenological occurrence, will thus differ in quality, because of the flexibility of boundaries that are carefully modified to the uniqueness of the moment, even as they maintain the uniqueness and variance of each party.

Rigidity is a sure contact-spoiler. Boundaries incapable of bending and assuming different attires, will bar the developmental changes the child must ex-

press in the contact. When there is only one acceptable way to feel, to think, to do things, children are actually prohibited from listening to their authentic feelings, thoughts, desires, and from trying something new or extending "given" boundaries. Stated briefly – rigidity precludes growth.

One of the difficulties in the relationship between children and grown-ups is that most of the responsibility for guarding the boundaries, maintaining their flexibility, respecting the uniqueness of the other – the child – rests on the shoulders of the grown-ups. When considering the environment and its layers of background, the facility of unintentionally causing severe harm becomes clear.

During the prenatal period and the first months of life, infants' sole mission, besides growing, is to express their basic needs in a manner as communicative as possible and to learn to adjust to their environment in order to thrive. Such learning, according to Gestalt theory, is completely motivated by existential needs and is almost involuntary, much as the infant's breathing and metabolism. The baby's first encounters with the world outside the womb are sensual: the direct light, sounds and smells, the way they are being held, fed, and bathed. These sensory experiences are the initial representation from which infants learn about their role in the field into which they happened.

Because they are so dependent, babies/children are very sensitive to adults' responses to them. They learn to identify which of their patterns of reaction are well greeted (e.g., cooperation, obedience, "showing off", mimicking, silence), and which are frowned upon (e.g., disobedience, crying, noise, incessant activity, withdrawal). They learn to beware of hurting others so that they will not be hurt, to direct their overt reactions so that they will be willingly received, and to retroflect or introject reactions that they have learned are annoying for their environment, even if in doing so they hurt themselves.

From a very early age babies choose to be passive or active in the reciprocal relationship, to listen – or not, to whom to smile etc. From their environment's response they learn the first signs on their roadmap: authenticity, spontaneity, honesty, as opposed to contradiction and fake, double message, and manipulation. They also learn how to activate their environment, to protect themselves, and to draw attention. All this learning is internalized as patterns of emotion, experience, behavior, and reaction and turn into a life style (Hjelle and Ziegler 1985; Bishop *et al.*, 2004). Sometimes the infant's creative adjustment is his minimizing contact with a threatening environment.

2.1. Nathan, the Baby Who didn't Cry

Nathan comes into my room with his parents and baby sister, with slow, somewhat heavy steps that give the impression he is sneaking in. He doesn't

glimpse at me, looks around several times before he sits on the carpet, at a far corner where he can see the whole room. He keeps himself busy with the threads of the carpet and those of the curtain, from time to time looking around, avoiding my eyes and ignoring my greeting and my out-stretched hand. I sit with his parents and we exchange a few words. I say loudly that I am interested in speaking with Nathan too, once he has become more accustomed to the room.

Twenty minutes into the meeting, he hadn't moved from his "spot" nor made eye contact with anyone. I tell him that I am now coming to sit with him on the carpet. Nathan doesn't react other than a small gesture of "shrinking" in. I sit down, not too close, yet more with him than with his parents – and he starts to move uneasily. I show him a big truck with a bell and a ladder that from my experience attracts every young boy. Nathan is obviously ignoring the temptation, and is measuring my movement as I push the track closer to him. I can sense his worried excitement and I tell him that I am not coming closer, and it is only the truck that wants to play with him. He sends me a puzzled look. Without talking I encourage him to keep his mind on the truck and he sends a hesitating hand towards it. I show him how the ladder can be used and he seems to be interested and stares at my playing hands. Suddenly, three things happen almost at once: Nathan starts to make noises as if he is choking; he screams and flaps his arms in all directions with his fists clenched. Only then do I become aware of what he has already seen, namely, that his mother is moving towards us while his father tries to persuade her to stay in her chair.

Nathan has moved backwards so he is now actually stuck in the corner. He is agitated, his eyes focused on his approaching mother. When she is two steps away from him, Nathan gives a scream that shocks me. Sitting, he continues to scream, taking deep breaths to support his shouts.

His mother returned to her seat and it took several minutes for him to calm down. He is looking at me as though asking if I got the message. His parents remarked that this is typical behavior, which they don't understand, and they don't know how to deal with him.

Nathan is almost five. His parents describe him as an amazingly independent boy who refuses to be helped, who taught himself through trial and error, to dress on his own, eat, wash and clean himself. He is said to be a self-sufficient child who doesn't complain or demand anything and keeps himself busy for very long periods of time. He seems indifferent to his sister. They describe him as an anxious boy who doesn't allow anyone to come too close to him. He never allowed anyone to hug and kiss him. His kindergarten teacher describes him as quiet, soft spoken, very reserved in his social interactions; a loner who is also observant, interested, and alert to everything that happens around him.

The parents report that Nathan was a particularly quiet infant. He didn't

demand attention, did not cry, would lie quietly in his crib, look around and move very little. He hardly complained except when his mother cared for him. He would not calm down until she was replaced by someone else. When she did not touch him, he did respond to her.

Nathan's mother secretly doubted her ability to be a mother, she never wanted to have children in the first place and she worried that her touch would be poisonous, just as her own mother's touch had felt poisonous to her. At first she was bewildered by Nathan's rejection, later she was hurt and angry until she eventually admitted to herself that in fact he read her feelings: he sensed her anxiety and colluded with her when he "fired" her from the maternal role of care-taker. He continued to avoid closeness as best as he could by learning to take care of himself. Such a choice is best defined as the *suffering of the relationship* (Francesetti and Gecele, 2009). Beginning in infancy, Nathan imposed upon himself a denial of some of his basic needs and preferred to interact from a "secure" distance. His self-inflicted intentional deprivation, his choice to do without holding, warmth, and closeness, resulted during his development in a serious difficulty in sustaining any situation that resembles closeness, warmth, and touch.

Nathan's creative adjustment has established a no-man's land, a space that for him feels relatively safe, in which he grows, learns, and plays. The "solution" that he invented as a baby, which also served and suited his environment, has saved him the panic with every physical interaction, yet at the same time it isolates him, deprives him of the comfort that a loving hand may grant. The rigidity of the pattern is still controlling his behaviour.

In Nathan's case, pathology resides almost visually at the barren contact boundaries where there is no interaction. As he grows it becomes clear that the initial "seed" of his difficulty (mother's touch) has sprouted and its shoots encompass not only *mother* and *touch* but a larger, more generalized *Gestalt* that includes various sorts of physical and social communication and any contact. To accommodate this larger need he must expand the "sterile zone" that he occupies. Because Nathan's fears had never been alleviated, the threat and the loneliness that he experiences are deeper and more painful. With this growing pain his reaction becomes wilder and more distressing to his environment.

The "solutions" that he had found were conveniently regarded by the family as "well developed". However, his limited social and emotional skills, and moreover, his distorted perception of contact and closeness, can no longer be ignored, since he is also a member of another system (the kindergarten). Panic is turning the two polarities which Nathan sustains into rigid patterns which demand an extremely high price: the "undemanding" baby, who learned to retroflect, has turned into an angry boy. Worse, however, is that he has turned into a boy that no one loves.

2.2. Yael: Sleepless Nights of a Devoted Grand Daughter

Children who perceive that their spontaneous reactions may bewilder their environment will halt, camouflage, and conceal any expression of feelings to avoid being labeled as "bad" (Oaklander, 1988; Blom, 2006). Their emotions do not disappear. Rather they undergo transformation, such as denial or repression, and may erupt over some unrelated issue at the first "legitimate" opening. When taught to restrain and refrain from expressing their authentic feelings they tend to convince themselves that there is something wrong with the way they feel. As a result they doubt their judgment and easily flatten their affect, becoming confluent, losing the sensation of autonomy, which is essential for their development. Little or no childish joy, playfulness, and carefree laughter is to be found in their behavior. Instead there often is a mask of indifference that does not disclose their feelings. The severing of spontaneity creates deceptive responses and disrupting communication with the environment. As a result a child may feel neglected and insignificant because the environment does not identify the distress and believes the poker face.

What gets internalized is that *to feel* is bad/dangerous/destructive for oneself or for the environment. Introjection, retroflection, and deflection become the child's survival skills from which the creative adjustment emerges. Some life situations with completely different contexts may contain elements reminiscent of similar feelings and evoke similar coping patterns, taking over wide realms of life.

Yael is seven years old. Her parents are very worried because, for over two years she has had trouble falling asleep at night. She lays awake for hours, and wakes up several times every night. She sleeps lightly and claims that she wakes up tired. On frequent occasions she bursts out in inexplicably fierce anger over trivial events. Her parents are convinced that this is because of her fatigue, and Yael tends to agree with them.

She is physically healthy, an intelligent child who functions properly in school, in extra-curricular activities, and socially. The relationships at home are appropriate and warm. She reports a daily schedule that seems very reasonable. There is no apparent reason for Yael's difficulties. Lately the sleep disturbances create a problematic cycle because she is hesitant to host or attend overnight visits. If this continues, she will not be able to go on trips or attend camp.

She reports a very close connection with her grandmother, with whom she has shared a room since she was four years old.

Since there was nothing else in her and her parents' report that caught my attention I focused on this last piece of information that was mentioned by the way.

"How is it for you to be Granny's roommate?" I asked.

"Great! I never have to bother about being alone or being afraid…"

"And how do you think it is for Granny to be your roommate??"

"It's great for her too. She loves me very much…I am her favorite!" she says with a broad smile.

And after a short pause she adds: "Granny constantly reminds me that I am the only thing that remains for her in life…"

"I wonder how it feels to be such an important, precious thing in a Granny's life".

"I love it. I sometimes prefer to stay with her in the room. She teaches me important things about life…"

"For example…"

"That there's no reason to cry…"

"??"

"You don't cry when something hurts you, not about a squabble with a friend, a dog that disappeared or a goldfish that died, and certainly not about a sad scene in a movie we watch together…" Yael's face turned serious and she began kicking a chair with her foot.

"What is this leg of yours saying while it kicks?" I ask.

"Granny always gets angry and starts to tremble whenever I'm almost crying…" she says. Yael withdraws, tears pouring down her face… "She always reminds me that it was much worse during the Holocaust… That's worth crying about!! Not about my nonsense…".

Yael has trouble falling asleep because she is overwrought by too many experiences that she is retroflecting so as not to aggravate her beloved grandmother. She is consumed and cannot find rest with unfinished business with which she does not allow herself to deal. Sacrificing her needs she gains her grandmother's love, yet amazes herself and those around her when she breaks out violently, breaking, tearing, and destroying objects and hitting at anyone who comes near her. The need to legitimize her feelings remains as an annoying and frustrating open figure.

Yael is a high-functioning child who lives on the edge of her faculties/strengths. Her loyalty to granny's values causes her to sever and block her emotions and retroflect. She cannot find a way through the impasse that will not incur her grandmother's anxiety, thus her only outlet is in the physiological, autonomous channel: sleep disturbance. Since her environment is unaware of the effort that she invests in keeping these "high standards" of denying and suppressing her anxieties she is not granted the support that she needs. So she is left all alone to deal with the burden: her ground is shrinking as her vitality is exhausted and fading. Lately she is unable to contain the accumulated anxiety, fears, sadness and above all the responsibility for her granny's welfare.

It was her kicking leg that exposed the way she controls her forbidden emotions. She is authentic only in her inexplicable violent outbursts – yet these moments are embarrassing and bewildering for her, because she is neither in contact with her agony and anger, nor are they contained by her family, who is also unaware of her inner turmoil. The growing frequency and volume of her angry explosions is a combination of the accumulation of retroflected emotions, the weakening of her own boundaries as she is "being swallowed" by her loving grandmother, her growing physical power, and an unconscious outcry for help.

2.3. Ari: Refuge in a Statue

Besides acquiring knowledge and worldliness, healthy adolescents are invested above all in their need to confirm their separate, individual personality and design their differentiation from their core role model in order to experience their own identity. Their maneuvers may create the erroneous impression that they no longer need their parents. This impression sometimes causes the parents to limit their presence and involvement at the time that young people still require a great degree of holding and guidance, though of a new quality. In some families the need for more autonomy brings out the parents' needs for the dependency of their children to fill their own emptiness/loneliness/insecurities.

It is easy to err and confuse non-dependence with no-need-for-guidance/involvement. Parents may buy into their youngsters' new, mature appearance and expect them to take upon themselves roles that are above their abilities. The adult role flatters ("They trust me", "they see how smart I am") and the mere "invitation" to formally join the adults' world, makes the tasks attractive enough, especially when they seem to carry secondary benefits. This is a fairly common transaction, one that is only partially conscious, in which parents and their children willingly collude. It may at times be based on misrepresentation, unrealistic promises, half-truths, cutting corners, overlooking moral and ethical norms – everything that manipulation is made of – and these combine to trap parents and their adolescent children alike.

In Gestalt terms, such traps occur because boundaries are blurred and contact is actually pseudo-contact. The fallacy is embedded in the illusion, the pretense, often experienced and accepted as a creative adjustment, which camouflages an empty human environment, typified by pain, frustration and threat. I refer to these situations as "honey traps", into which one can easily slide, which are hard to escape and extract a high price.

Ari (17.5) is the eldest son in a chaotic, violent family that is in the midst of a long, stormy divorce crisis. I was appointed by the court to recommend custody arrangements for his younger siblings. Each of the parents demanded that their children take a position and support one of them, while badmouthing and alienating the other. Each of Ari's three siblings attached themselves to one of the parents; only he had difficulty choosing.

Aware of the weight of responsibility inherent in his choice and everyone's expectations regarding his decision, Ari felt pressured and refused to participate in the conflict.

At first, he closed himself in his room and cut off communication with other family members. Later, he left home to live with friends. The pressure mounted as the date of the divorce approached and Ari felt helpless. In his despair he withdrew into a catatonic state that led to several months of psychiatric hospitalization and pharmaceutical treatment.

Once he stopped taking part in the struggle, his family, preoccupied with their immediate problems and bewildered by his illness, ignored him to an extent that they didn't even mention his existence to me. I come across his name in the formal records and insisted on meeting him against his parents' advice (it seems that the only fact everyone agreed upon was that Ari is detached from reality, hence irrelevant to the evaluation).

When I met him in hospital I was impressed and intrigued by his stubborn ability to ignore his surroundings completely. I felt as though he literally looked through me and yet that he was aware and attentive in his way. I was challenged and I came back several times.

During each visit, after having reminded him who I was and why I had come, I would mention that if he finds my presence annoying I could leave and try another time. Also, if he finds anything I say boring, tiring, too painful, or incorrect he is welcome to give me a sign and I would stop and not feel offended.

Then I would tell him – on the assumption that he was listening – what's happening in the world. I talked about who won the elections, the latest results of the national basketball league and some factual news about his family. On the fourth visit I addressed him directly and asked, "I wonder, who exactly you are protecting?"

To my surprise, he answered spontaneously: "Myself of course! What's the question?"

"How are you protecting yourself?" I asked quickly, surprised and eager for some more response.

"I'm a statue, a stone, I don't exist", he said, almost whispering.

"How does being a stone, a statue, protect you?" I asked.

"No one relates to me… they leave me alone…"

"How is it for you, being left alone…?"

After a long pause, during which I could see the turmoil that I caused – his face changed colours, he was sweating, his eye movements became very fast, he said: "It's safe, quiet… and… a little sad".

When the nurse who was checking on him advised me to leave him alone, Ari made some gestures that obviously meant I could stay.

Our silent meetings continued for a while, with a clear recognition of my presence and once in a while a word or two from Ari. One of the staff members gradually took over and proceeded with therapy.

Ari presents a dramatic illustration of how creative adjustment becomes pathology. He had reached an impasse, unable to be true to himself and to maintain his freedom of emotion. Having probably lived for years as a conflict-avoiding, confluent child, he feels trapped in a dangerous situation when suddenly he is called upon to make a huge, fateful choice.

It is hard to tell which fear troubled him more – denying his own needs, or his fear of the anger and disappointment of the injured parent and the risk of losing that parent. Quite possibly both combined to create the catatonic solution, an extreme human manifestation of the atavistic "fight or flight" defense mechanism, and an instinctive strategy in the face of danger. Ari, unconsciously "understood" that under the circumstances he cannot please both his parents. This awareness threatened to break his heart. The flight into severe illness was a temporary rescue that became a cruel prison instead of the safe ground he hoped it to be, when not only he himself but also the environment gave up on him.

Being catatonic is the most extreme form of severing contact with self and surroundings. It cut Ari off from his inner world and also from his siblings and friends who could become a support system. His boundaries rejected any attempt at contact, and, by placing himself "off limits" he was isolated from within and without.

Childhood psychopathology does not erupt suddenly out of nowhere, it always has early signs. In retrospect it is easy to identify those visible signals that went unnoticed or that were not correctly encoded. Children are adaptive. Their natural flexibility and imagination produce creative solutions that may help them, temporarily, to bear their pain, albeit without resolving the source of distress. They send out metaphorical signals as to the essence of their sufferings, and it is incumbent on the environment to decode these signals, as illustrated in this chapter or in cases such as:

- The anorectic teenager who sacrifices his health and development needs by clinching teeth, thus fighting to define his individual boundaries to block

what he experiences as parental invasion. The need for autonomy turns the simple act of eating into a stronghold that needs to be protected, even to the point of starvation, by not allowing anyone to decide how much, when, if, and what enters his mouth.

- The teen-age girl, who was always an obedient child, who never uttered a dirty word, always looked neat and helped out, and was always first in her class. At age 14 she began to withdraw into her bed, refusing to leave her room for days. After some months of such glorious solitude, hardly disturbed by her environment, she developed asthma attacks and soon after began making cuts in her arms and legs… She explained the self-mutilation by her wish to feel alive, to re-evoke sensation.

Unanswered signals, which result in unmet needs, leave children with a helpless experience of being ignored and desperately lonely. Their quest for survival drives them to amplify their cry for help and escalates the severity of their behavior in the hope that it would finally draw the attention and produce the desired response.

Becoming the *perfect child* is a common creative adjustment for children who perceive any critique or disapproval as a threat or actual denial of love. It means he/she lacks the basic experience of "ground contact" and is instead, overwhelmed by an "unsayable" (Spagnuolo Lobb, 2007d) experience of existential vulnerability coupled with unbearable pain. Such an enormous emotional challenge requires an enormous creative adjustment – forgetting the experience itself and its context and denying the accompanying feelings.

When addressing the stories of Nathan, Yael, and Ari, the "logic" of creative adjustment can easily be followed. Yet creative adjustment does not release sufferers from their demons, and the figure of pain continues to accompany them even when its initial source has been forgotten, sometimes even when the agony is no longer felt, but one only "knows it's there".

The therapeutic encounter gives permission to be an authentic, spontaneous I-self, leaning on the self-support system and not busy pleasing the environment.

Children need to express their excitement. They also need opportunities to explore new ways of coping and a safe ground where they can take risks in the hope that they may be able to withstand pain, uncertainty, and challenges without surrendering to them. The feeling of self-worth and power, which may be gained through the acknowledgment of denied and reltroflected emotions, is essential for children's development.

To make a sincere, authentic contact with children means to be fully present with them, to allow them to experience their boundaries and to bring to their awareness, that which is happening at the contact boundaries between them and a therapist. This experience is an opportunity to heal a wound and sooth a

sore, thus restoring some of the demolished trust that was whipped away by harsh relationship. No criteria are needed. No definitions required. Gestalt therapy calls for nothing more than the patience to go step by step, from moment to moment, in which a relationship is co-created and to cherish every little sign of healthy response.

Comment

by Neil Harris

Nurith Levi gives us a picture of the complex family world of the child, and entices us with descriptions of some first meetings with child clients. She shows how the child's best efforts to make sense of the world, to develop and thrive take place in contexts that are often adverse, leading to repetitive adaptive patterns that can become rigid. The examples she gives emphasise retroflection as a major interruption to contact. Those children and young people who "act out", fight, rebel, protest and those who form a delinquent subculture also need to be considered as making their own creative adjustment, and having their own brands of psychopathology, their own forms of rigidity.

The Gestalt therapist who works with children works in a world of therapeutic dilemmas. One that stands out is the question of whether it is appropriate to offer individual therapy to a child. Certainly, if that is all that is offered, then the child is unlikely, in my view, to benefit to any significant extent compared to an intervention that actively takes into account their context and relational milieu.

Nurith Levi offers a description of the inseparability of child and context. She does so with a layered approach that focuses on development, and on family context. That allows an emphasis on early relationship, and on systemic issues within the family that shape the child's world. The wider impact of peer group, and of cultural issues are also crucial, and always have to be appreciated in coming to the sort of holistic understanding that Levi is promoting. Winnicott's oft repeated phrase "There is no such thing as a baby" gets to the heart of the matter, and of course relational Gestalt theory would probably say "there is no such thing as an adult". We are never isolated and disconnected; we are always in relationship, shaping and being shaped by the life space that is the field we make and are part of. So, as child therapists we are always treading a meandering line between focusing on the child and their experience as figure, and broadening the focus to the child's whole world on all available different levels, in the complex phenomenon that we call the field.

Levi cautions against extrinsic diagnosis, and describes its limitations. The

reality of the field for me, as therapist and child psychiatrist, is that diagnosis occurs. Whether it is diagnosis that uses manualised descriptions, or the intuitive hypothesizing about which Levi writes so well, we cannot help ourselves but try and order and describe what we see, feel and hear whenever we meet and assess a child for the first time. To hold a fully disciplined phenomenological stance, without interpretation, and to stay "creatively indifferent" as our theory might suggest we should, is certainly beyond me and, I suspect, many other therapists. Of course, at times we are statutorily mandated to set our neutrality aside when we hear of a child at risk of abuse and to take formal steps leading to their protection and safety. So, diagnosis occurs, and in my experience can cut both ways. For example, there are many children who are receiving a diagnosis of Attention Deficit Disorder. For some that leads to a medical intervention that transforms their lives, leads to positive experiences of success that had previously eluded them and allows their family to shift punitive frustration to warmth and support. For others the diagnosis shuts down thinking, cramps possibilities and leaves crucial stones unturned. Anxiety, attachment issues, depression (all potential diagnostic labels) or roles within the system that the child is taking on, may all be missed. In the case that Levi presents of Nathan, my labeling radar would be on alert considering the possibility that he could be described as lying on the autistic spectrum. Overcoming my reluctance to diagnose might lead to a systemic change that would include relieving the mother of guilt that she might have somehow caused her son's condition, to greater understanding of his social difficulties and the impact of those, and to ways of supporting him and intervening at school that might help him engage, learn and even form friendships.

The chapter goes some way towards a foundation for Gestalt practice with children. The case examples are vivid and lively as descriptions of assessment. In terms of intervention, Violet Oaklander has led the way, and building on Levi's contextualization we need to broaden our ideas of intervention to become, to borrow a word, "fieldsmiths", engaging with whatever aspect of the child's world will support healthy contact and thriving development.

Risk of Psychopathology in Old Age

by Frans Meulmeester

Will you still love me when I'm sixty-four?

1. Introduction

When the Beatles asked this question on their famous 1967 album, *Sergent Pepper's Lonely Hearts Club Band*, it was an expression of the fear of getting old and, maybe, not being loved anymore after being 60 years or older.

In the Sixties the age of 64 was indeed by many people perceived as "being old", at least in our Western society[1] and this is not strange, considering the life expectancy in those days was about 67.2 for men and 72.9 for women (CBS, 2010). Now in 2010, we perceive this clearly very differently. Life expectancy is around 78.3 for men and 82.3 for women (CBS, 2010). Therefore, we are much more used to getting older than 65 or even 75 and reaching an age of 85 or 90 is becoming more and more "normal".

I think it is important to realize these changes in life expectancy and the increase in the number of old people, because it helps us to understand the growing interest in the psychology and also the psychopathology in old age. In the Sixties there was hardly any interest in the psychology of older people. First of all, there were not so many old people and secondly, most of the old people themselves were not interested in psychological issues.

People who were born in the beginning of the 20th century grew up in a time where the study of psychology was just starting up. We can say that there was hardly a common or shared awareness on the psychological aspects of life.

The combination of these two facts has led to a situation that the real interest in and with that the scientific research on the psychology of older people has just started after the Second World War and in that sense we are still in a pioneer phase. We are the first generation to do scientific research on old age!

This leads us to the question: What do we actually know about old age:

[1] I would like to mention here, that in the sixties e.g. in countries like China the age of 80 or 90 was not perceived as "being old", considering the number of 80 and 90 year-old people running the administration of China.

what does it mean, when we speak about a "normal", healthy way of growing old? What is normal or healthy in this sense? Do we really know or are we just at the beginning of learning? When we are still at the beginning of understanding, what it means to grow old "healthily", can we make any relevant, evidence-based statements about what it means to be "unhealthy" in old age, especially about psychopathology in old age.

From a Gestalt point of view, in general we can say, that a person is more healthy when this person is in contact with his needs and his environment and capable of creative adjustment to the ever changing situation. So, in this way, we can say that an older person is healthy when he is able to adjust creatively to the changes of aging. But what does this creative adjustment look like? Can we compare the ways of creative adjustment of old people with the ways of 20, 40 or 60 years old people? Or should we be more open to the possibility of totally different ways of creative adjustment?

Another related issue to take into consideration when we speak about the risk of psychopathology in old age, is the view of old age in general. For a long time the paradigm underlying many studies and theories on old age, was the so called "deficit paradigm", which means that after a certain age, getting older was mainly or only seen as a "process of loss", a process of decline.

Erikson (1950) was one of the first to introduce the idea of a life-lasting development into the theories on psychological development, but it took a long time before there was a real shift in this underlying paradigm and still many people perceive getting old as a disaster.

And so, if just getting old is already perceived as a problem, how easily will old people be disqualified or how easily will the behaviour of old people be viewed as unhealthy, dysfunctional etc.

2. Risk of Psychopathology in Old Age: the Concept of the "Fragile Balance"

In 1973 the Dutch clinical geriatrist Dick Sipsma, professor at the University of Groningen (NL) introduced the concept of what he calls "the fragile balance" (Sipsma, 1973).

Sipsma based his concept on the Systemic theory of Lorenz. In this theory, a system is seen as a whole of interacting elements and a human being, as a specific system, is seen as an «open interacting dynamic system, which is in a continuous interchange with his environment in order to maintain himself».

It will be clear, that the concepts of systemic theory are very close to the concepts of field theory, which underlies Gestalt theory.

Sipsma applies this systemic theory to the process of growing up and get-

ting older and sees the process of life span as an ongoing sequence of transformations, which results in a constellation of increasing complexity and more and more individualistic characteristics.

Regarding the process of growth and getting older, this means that in contrast with the deficit paradigm of aging, the systemic theory states that during the life span, until the end, both tendencies are present: decline and development, aging and growth (Sipsma, 1973).

This is a very interesting thought, especially when we speak about psychopathology in old age: from this point of view, psychopathology might be seen as an expression of both tendencies: decline and development, as a creative way of development with regard to the increase of disorder, in fact a creative adjustment towards aging.

So during the life span, the ability for growth and development, the ability for creative adjustment remains present. However the decline is also present and this can influence or even threaten this ability for growth and development. Therefore, the balance between these two tendencies becomes more fragile, more unstable.

In other words: even in old age, we are still capable of creative adjustment towards changes or threats in life, and there is more risk for psychopathology because of the vulnerability of the balance.

3. Possible Risk Factors in Old Age

When we speak about a fragile balance in old age it is good to consider some possible risk factors which might disturb this balance.

A. Losses. It is a well know fact that the older we get, the more people we will lose. In this way we can say, that getting older means scratching names from the birthday calendar.

When I look at my mother, who is almost 94 years old, and how many funerals she has had during the past years... it is almost a monthly ritual, to attend a funeral.

Not every loss will have the same consequences, but especially the loss of close, beloved ones can have a major impact. The loss of a partner is such a major event. It is not a coincidence that quite a number of widows and widowers die within the first year after the loss of the partner.

However, for some people the death of the partner can also be a relief e.g. when this partner had been physically ill for a long time or, for example, suf-

fered from Dementia. In a way, these persons have already lost their partner a long time ago.

A very severe loss is of course the loss of children. For many parents it feels so unnatural that a child goes first instead of themselves that it gives them a very hard time to overcome this loss.

Other losses in old age which can cause problems are the loss of work, having to move to another place or to a nursing home and the loss of some physical abilities.

B. Loneliness. The fact that a person is alone can increase the risk for psychopathology. Of course, this depends on whether the person likes to be alone or that his being alone has to do with a loss or with being neglected, abandoned or even shut out.

In that sense, there is a big difference between "being alone" and "being lonely". Being alone, can be someone's choice or can be a temporary, acceptable situation. Being lonely very often is a more negative experience. It is the feeling or perception, that the person has no-one else with whom to share important feelings, thoughts and experiences.

So being alone and especially, feelings of loneliness can be very hard for older people and one of the risks in those situations of "social deprivation" is that a person gets more and more focused on himself, on his body or his thoughts and starts puzzling all day. Thoughts and worries are filling up his head and make him spin around until the difference between thought or worry and reality becomes more and more vague. The person can get obsessed by his body and possible illnesses or can get obsessed by specific thoughts, worries or fears. Imaginations about other people and their motives can lead a life on their own. In other words, there is a risk for illusions and delusions, hallucinations, anxiety disorders, hypochondria and paranoia.

C. Personality. It will be clear by now, that a very important indicator for healthy aging is the personality itself.

When we define "personality" as the "ever changing interaction or contacting of a person with his environment on the contact boundary", we can imagine that this interaction can vary from very flexible to more rigid or even totally fixed.

From a Gestalt point of view, a person is more healthy, when he is more capable of creative adjustment to the ever changing situations in life. This means that a healthy person has a certain level of flexibility. Therefore, we can expect that a healthy person is quite capable of dealing with the punches of life.

However, if a person is quite restricted because he did not develop this flexibility, every new situation might easily be a threat to or even a distortion of his fragile balance.

Besides these general risk factors I wish to mention briefly two other very specific risk factors in old age.

The risk of intoxication. Especially in old age, the risk of intoxication is bigger. I will name some possibilities.

First of all, there is the risk of intoxication by medication. It is a well known fact that the elderly get quite a lot of medication prescribed (Zuylen C. Van *et al*., 1988).

The risk that these elderly make mistakes with their variety of medication or that these medications work in an adverse way is very present.

On the website of the Dutch Magazine for Healthcare it was stated recently:

> […] elderly, who are living on their own, consume an average of 1 to 5 drugs per day. In a small research on drugs used in nursing homes, the researcher indicated an average use of 4-8 drugs per day. More than half of the patients had an increased risk of adverse reactions due to a combination of inadvisable drugs (Website Nederlands Tijdschrift voor Geneeskunde, 2010).
>
> Besides the number of medicines, there is a higher risk of occurrence of adverse reactions in older people to changing pharmacological dynamics and kinetics (Kerremans, 1988).

Another risk of intoxication, which is quite common among older people, is the risk of intoxication by narcoses. When older people need an operation, the risk of adverse reactions to narcotics is quite big. In fact, the effects of narcotics on older persons can also last for a longer period. Therefore, it is important to take this in account, when a person complains about changing behaviour for himself or his partner after an admission in a hospital.

Finally, there is of course the risk of intoxication because of inflammation. This is also a very common cause of Delirium in old age.

Physical or mental handicap. When people have a physical or mental handicap, this can also be an extra risk for developing psychological problems.

The effects or risks due to physical handicaps are of course totally depending on the seriousness of the handicap. But especially, people who have a sensory handicap are more vulnerable. No longer being able to see or hear can have an enormous impact on a person and asks a lot of the capacities for creative adjustment. Both handicaps can lead to isolation.

We are living in quite a complex society and especially for people with a mental handicap, it is not always easy to find their way in life. In general we

can say that the capacities for creative adjustment of people who are mentally handicapped are less. Aging also asks for creative adjustment and for some, this demand can be very threatening and totally incomprehensible. For us, who are dealing with these old people there are still many questions to be answered.

In fact, we are totally at the beginning of learning and understanding what it means to grow old with a mental handicap and from that, learning to understand what healthy or unhealthy aging means for this group of people. We are dealing with the first generation of old people with a mentally handicap.

4. Possible Psychopathology in Old Age, an Overview

I underline here, how important it is to have a good examination and diagnosis of psychopathology in old age, to be able to distinguish between "real" psychopathology, which might need to be treated by therapy or medication and possibly rare, individualistic ways of creative adjustment towards aging, losses, grieving etc. The latter might not need treatment, but should rather be supported or encouraged and facilitated.

Unfortunately, the quality of examination and diagnosis of older people in many countries is still very poor. Too often, older people get the message: "I am sorry. This just belongs to old age and there is nothing to do about it".

Of course, this might be true when it is based on a thorough examination and profound diagnosis of the older person. However, in too many cases, such a statement is only based on a very superficial, prejudiced impression.

One day I was confronted with the situation of an older man in a home for elderly, who was diagnosed Senile Dementia, type Alzheimer.

However when the geriatric nurses of the residence described his behaviour, it did not fit this diagnosis. Hearing the story of this man, I really had my doubts about his diagnosis. Just a few years back, in one year he had suddenly lost his wife, by a sudden illness and shortly after that, also his son, who died in a fire. He had tried to save his son, but did not succeed. After this traumatic event, this man turned more and more inwards and withdrew from social contacts.

The nurses admitted that the doctor who came to examine this man was only with him for about 20 minutes after which his "diagnosis" was clear: "A clear example of dementia. He is in his own world. Unfortunately, there is nothing to do about it".

However, in my view, this man might very well suffer from a post traumatic stress syndrome, which means that more examination is needed and that something could have been done.

Unfortunately, this example is not an exceptional case.

However, we see a change. More and more study is done about pathology and psychopathology in old age. In The Netherlands, where I have spent many years of my working career in the care of old people, the situation has much improved. Over the last twenty years, we work with very professional geriatric multi-disciplinary teams, who are responsible for the examination and diagnosis of older people.

In those years misdiagnoses in old age are reduced to a very low number, although even in The Netherlands more attention is needed, especially in situations of multi-pathology which is very often the case in old age, and in situations of people with mental or sensory handicaps, for example.

Just this week, while I was writing this chapter I got a newsletter from Psy, a Dutch organization for psychosocial healthcare, which published an article on mis-diagnoses among deaf people who are getting older (Psy, August, 8th 2010).

Now, what is the kind of psychopathology we can encounter in old age? To answer this question, we first have to consider that not all psychopathology we encounter in old age is psychopathology of old age.

There is a difference between psychopathology, which is clearly related to old age and psychopathology which has less to do with old age, because it was already present in the person's life, long before he got old. Maybe, it has increased during old age. In other words, we can make a differentiation between psychogeriatric problems and gerontopsychiatric problems.

Psychogeriatric problems include all the problems and pathology which is clearly related to old age. Before, the person was not dealing with this problem or did not have any specific pathology, but by getting older the problem or pathology came into existence like it is the case of Senile Dementia or other psychological problems related to the decline of cognitive functions.

Gerontopsychiatric problems on the other hand, include all the problems and pathology that were already present in a person's life, long before the person got old, but now, when the person is old, the problems are still there or are there in an increased form because of aging. The cause is not directly related to his old age; however old age can have influenced the situation in a negative way.

A clear example of a gerontopsychiatric problem is having a specific type of personality disorder or a manic-depressive disorder, for example. In both cases the psychopathology has already existed for many years and is not directly related to the fact that this person is getting older. Of course it is possible that the symptoms of this pathology have increased during the last years because of disturbances of the fragile balance.

When an over-dependent person (Personality disorder, Cluster C) has lived all his life with a dominant partner, his pathology and the consequences of this pathology remained rather in the background. Maybe he was never able to take care of himself or to make his own decisions, but in fact, he didn't have to, because of this partner. However, the moment he loses his partner at the age of 78, his situation changes dramatically and his balance will be severely disturbed. Possibly, he will not be able to adjust and now, his pathology becomes very figural in his life.

5. Organic Psycho Syndrome

A second important item to look into (not only in old age!), is the question of how the psychopathology of the person is caused by or related to a physical dysfunction. In that case, we speak about an "organic psycho syndrome".

A very clear example of such an organic psycho syndrome is *Delirium*: in a very short time (sometimes just a few days or even hours), a rather normal, functioning person can totally change in his behaviour and act in a very chaotic, sometimes even psychotic manner (e.g. having hallucinations), having motorical restlessness, concentration problems and other global disorders in the cognitive functions etc.

Characteristic of delirium is that there is a clear physical reason for this sudden change: an infection, intoxication (e.g. by medication) and other diseases.

Another example of an organic psycho syndrome is the psychopathology which is related to or caused by damages of the brain, like after a coma or trauma (e.g. car accident) or caused by a brain tumour, circulation disorders (CVA or Multi infarct), specific diseases like Pick disease (Frontotemporal dementia) or as a result of excessive use of alcohol (Korsakow).

The effects of brain damage and therefore the psychopathology as a result of brain damage vary a lot and are totally related to the part of the brain that is damaged.

When the *frontal part of the brain* is damaged, the most characteristic change we can see is that the person loses control of his behaviour. This means a loss of what we call "impulse control" (thoughts just come out), but also loss of the ability to stop or interrupt what the person is doing: repeating a word or sentence or once starting to cry, not being able to stop it or uncontrolled eating of food or candies.

One day a client complained that her partner had changed in a negative way. He was less social, sometimes made strange, inappropriate remarks when

others were there and sometimes he did not stop what he was doing, whether it was repeating a word or story or continuing some action like eating or singing a dirty song.

Whenever she tried to correct him, he reacted in a strange way. Sometimes, very irritated or even furious and on other occasions, he just smiled at her. She had the feeling that he was not taking her seriously anymore. In fact, she started to doubt if he still loved her.

For me it was clear, that – beside any other support or therapy – an examination of the brain was needed. So I advised them to visit a doctor and ask for a neurological examination.

It turned out that he showed the first symptoms of Pick disease. From here, I could support these people in their process of facing and dealing with this dramatic change in their life.

Brain tumours often bring changes in the personality, sometimes even far before the tumour is diagnosed. Some characteristics are: irritability, uninhibited behaviour, inertia in thinking and understanding, inability to control emotions, sometimes loss of interest in others and loss of initiative and sometimes hallucinations and illusions. Again, the place and size of the tumour, just as it is with other damage to the brain, are crucial for the specific changes in the personality and the other effects.

A specific type of psychopathology as a result of brain damage is of course the illness *Dementia*. However, we have to make a clear distinction here between the illness Dementia as a result of brain damage and the process of Dementia that we also see in old age, which is not always clearly related to changes in the brain (see also chapter 18).

The first type of Dementia can have several causes. The most well known is the type of dementia which is called *Multi-infarct dementia* or *Vascular dementia.* This type is clearly related to the fact that the person has had several smaller or bigger infarcts (TIA's or CVA's) or other problems in the circulation in the brain, which resulted in deterioration.

The main characteristic is the loss of memory (storing and/or retaining information), but beside that, depending on the pace of the damage, symptoms like aphasia (problems with understanding and/or expressing), apraxia (problems with concrete performing) and agnosia (problems with recognizing objects), loss of decorum (uninhibited behaviour), inertia etc.

A second type, which usually starts in a younger age, is *Alzheimer disease*. There are cases in which this disease started already at the age of 36.

Most of the time, the progress of Alzheimer disease is very fast. Sometimes within a period of three years a person can change from a fully adequate func-

tioning person into a person who is totally inwards and very hard to reach with verbal communication. Characteristic of this disease are the so called “senile plaques” which are toxic for the nervous tissue and cause damage on the neurons, which limits their functioning.

A third type is actually a combination of the Parkinson disease and Dementia and is called *Lewy body dementia*. Most characteristic of this type of dementia compared with Alzheimer disease is the fact that the person involved has much more awareness on his own situation, which makes it even harder to deal with it. Because of the combination with Parkinson disease, there is more risk that a person can fall down. This demands that the partner or other caretakers are much more alert to the tendency of the patient to stand up and walk around. As a result, the partner or caretaker, because of this fear for falling is continuously busy trying to keep the person seated, which of course in turn creates more irritation and agitation in the person. This is very often one of the reasons for admitting the person into a nursing home or day-care facility.

6. Depression

Although depression is not exclusive to people in old age, it is a very common problem in old age.

The Trimbos institute in The Netherlands makes a differentiation between a “major depressive disorder” (5-9 symptoms listed in the DSM-IV) and a “minor depressive disorder” (only 2-4 of these symptoms) The major depressive disorder affects, according to their research, approximately 2% of those over 55; the minor depression approximately 10%. The prevalence of all clinically relevant depressive syndromes is about 13-14%. An interesting outcome of their research was that the prevalence of minor depressions seems to increase with age, while that of major depressions decreases with age.

Another interesting outcome was that the prevalence of depression among immigrant elderly was significantly higher: approximately 34% of Moroccan and 62% of the Turkish elderly in The Netherlands were diagnosed with a clinically relevant depression (Directive Trimbos Institute, 2009).

As already mentioned, there are several risk factors which can cause or increase depression in old age. First of all, there are the losses one has to deal with and beside that, possible physical decline which can lead to restrictions in everyday life, loneliness and to a loss of meaning in life.

Another important cause of depressions in old age is the negative outcome of one’s life review. Erikson (1950) described as the main theme of his eighth life stage (55+): integrity versus despair.

> […] as older adults we can often look back on our lives with happiness and we can be content, fulfilled with a deep sense that life has meaning and we've made a contribution to life. Our strength comes from a wisdom that the world is very large and we now have a detached concern for the whole of life, accepting death as the completion of life. On the other hand, some adults may reach this stage with despair because of experiences and perceived failures. They may fear death as they struggle to find a purpose to their lives, wondering "Was the trip worth it?" (Harder, 2009).

It is comparable with what Yalom writes in his book *Staring at the Sun*: «The fear of death is actually the fear that we have not lived our life» (Yalom, 2009).

7. Anxiety Disorder

Ageing can be a very joyful new phase in life. However for some people ageing means, becoming more and more insecure. Eventually, this can lead to anxiety and in the worst case scenario to anxiety disorders.

The Dutch centre for knowledge on Geronto psychiatry reports: «Mild anxiety symptoms are quite common, 17,1 % of men and 21,5 % of women of 55 years and older report these symptoms. Research shows that 1 in 10 elderly in The Netherlands is actually suffering from an anxiety disorder. Anxiety disorders are together with depression and dementia the top 3 of psychiatric disorders in old age».

Many times, anxiety symptoms are combined with symptoms of a depression, but not openly reported to doctors. Mostly, the elderly come with physical problems or with concern about the physical well being and therefore, anxiety is not always recognized.

Some of the forms of anxiety in old age are: insecurity in daily activities or social contacts, panic attacks, worries, reminiscence of traumatic experiences and obsessive thoughts.

A 60 year old client reported severe anxiety and described how she was obsessed with her body and the possibility of having life threatening diseases. She had visited her doctor already many times and therefore, she realized, something else was needed.

By looking into the situation, the sudden death of her mother by an aneurysm, about twenty years ago, became figure. She realized that she never took the time for grief. She was very busy with her career in those days and actually fled into her work. Now, since about half a year ago, she was slowing down and preparing for her retirement and she realized that since then, the anxiety started.

8. Psychoses

As mentioned before, it is important to make a differentiation between psychopathology, including psychoses, which is clearly related to old age and psychopathology which was already present long before old age.

In the second situation, in most cases the person is already familiar with his psychosis and has already had treatment (medication and therapy) or is still in treatment with a psychiatrist.

The situation is worse, when the psychosis is new, when the first occurrence of the symptoms has been recent.

Recent research has found, that unlike former theories on psychopathology in old age, the prognosis of psychoses which started after the age of 65 is much worse than when the psychoses has started at a younger age (Köhler, 2009).

This same researcher, Köhler, also states, that psychotic disorders (related to old age) are much more common than widely accepted and that we can expect that the number of psychotic disorders related to old age will increase in the coming years (Köhler, 2009).

In most cases, the psychosis in old age is characterized by hallucinations and delusions, especially the type of paranoid or relational delusions.

Again, I like to emphasize, how important it is to screen the person with sudden or newly occurred psychotic symptoms for physical dysfunctions or intoxications. However, old traumatic experiences, like concentration camp experiences, physical or sexual abuse, traumatic accidents etc. can also come back to the surface and lead to a total confusion or temporary psychosis.

An old man in a nursing home for the psychogeriatric elderly, was normally quite relaxed and social. However, the moment there were too many people in the room or the furniture was positioned in a way that restricted his moving, he could suddenly change into a totally different, very aggressive man, shouting that "they" were coming again and that he would kill them all. In these situations, he was reliving the experience of being in a concentration camp. The feeling of being "tied up" triggered the experience of the camp and led to these temporary psychoses.

9. Conclusion

In this chapter I have presented a new area for many psychotherapists. For a long time, it was a common idea, that psychotherapy or counselling was not appropriate for older people.

Fortunately, there were others who thought differently and helped to create a situation in which more and more people started to see that older people too, have the need and the right for appropriate psychotherapy or psychosocial counselling.

The Gestalt approach, in combination with other approaches, including physical treatment can offer a lot to this new group of clients.

Comment (All you need is love and understanding)

by Martine Bleeker

Meulmeester gives a good and complete overview of psychopathology in old age. He gives an actual enumeration of factors that can lead to psychopathology. He emphasizes the need for attention to physical causes. This is very important, because in comparison with younger people, physical causes of psychopathology are much more common.

Also interesting is his view on creative adjustment. He points out the difference with other currents in psychotherapy and asks the question: "What is healthy?". Health is an important issue in old age and Meulmeester offers a different view on health, which is very "Gestalt like". What is called "behavioural problems" (the result of the psychopathology), is in fact a creative adjustment to the situation.

I would like to give an example of this: in the nursery home where I work, there lived a lady that suffered from the consequences of a stroke. As the psychologist of the department where the woman lived, I was asked for advice, because the woman was very aggressive to the caretakers. The question was: how to stop this "problem behaviour", namely, the agression? So I collected some information about the woman and found out the following facts.

This woman was Turkish, lived in The Netherlands, didn't speak any Dutch, and lost her son about 15 years ago. Since then, life was very hard for her. She still took care of her family as well as she could, but there was no happiness inside anymore. Then she got this stroke, that paralyzed her and made her completely dependant on others. After the stroke, she stopped eating. Her mind was clear at the time. Because she consequently refused to eat any food, the doctors gave the women a PEG-tube (a tube directly through the belly in the stomach). In this way, she got enough food to survive. Living in the nursery home, she got very aggressive every time the nurses (to whom she couldn't talk, because of the different language) wanted to take care of her or gave her food through the PEG-tube. Is this psychopathology? I don't think so. I think

this woman found her way in handling her situation. The agression was her creative adjustment, but the environment didn't allow her.

At this point, I'd like to take the opportunity to deepen one psychological aspect, that Meulmeester, in my opinion, describes too superficially, namely the perspective of the elder one himself!

Every person has his problems and challenges in life. When you are young and have your life in front of you, you can always look forward and hope for better times.

Are you lonely, or sick? By taking the "right steps" one can improve the situation or sometimes just time heals the wounds. The perspective is: forward.

Even if one doesn't do anything to improve his situation, he can (unaware) always hope that something happens, once, that changes life in a positive way. In Gestalt therapy, one of the things we do, is to make people aware of the pain and the desire, so that people go and take a step forwards – whatever that may be.

Here lies the difference with working with the elderly. There is a completely different perspective in life: maybe, and even very probably, there is no time to change anything. So the developmental need is a different one. One has to deal with what is and how life has been. *This is what Erikson (1950) means by the "task" one has to fullfill in old age and come to "integrity vs despair". Meulmeester mentions this aspect just in the paragraph about depression, while I think it's actual in other kinds of psychopathology as well. Erikson (ibidem) describes this perspective so well. He introduces this concept in the following way: while looking back and not being able to change anymore what happened, people can much more easily surrender to what* is *in the moment (i.e. the suffering) if they are satisfied and in peace with how they lived, than if they didn't mourn enough about losses or suffer from regrets about things they did or did not do. I think that psychopathology that arises in old age, has often to do with this kind of factors.*

The perspective is not so much: "How can I live with my illness, limitations, circumstances?", but "How can I die with what has been?". Although these questions can exist next to each other, there is an existential difference with working with younger people. The question for the elder is: "What I have done in my life, has it been (good) enough?". If yes: the handicaps, limitations, even loneliness, are bearable. If not, there is frustration. The perspective of the old one is the most existential one. This makes the Gestalt approach so appropriate, since the Gestalt counsellor is not working towards making a change, but is simply trying to facilitate an awareness what needs to be lived through, so that the client can live (or die) in peace with what happened. In fact, that is not anything different than with younger people: being there, making aware what is, working with figure and ground. But the perspective is so different. This is important to realise.

Loss and Grief. Sometimes, just one person missing makes the whole world seem depopulated

by Carmen Vázquez Bandín

Living is always an adventure
that the Other leads us to,
an unpunished risk on which
to bet heavily on a destiny
more favourable than Death
(Jenaro Talens, *El espesor del mundo*)

Introduction

March 11, 2004[1]. Antonio, 36 years old, unemployed, was on the train with Rosario, his partner. Parents of two children, they had an important meeting in Madrid that day, looking for work to get them out of their limited situation. Around 7:45 a.m., a powerful bomb exploded in their carriage. "When I regained consciousness", Antonio says, "my first thought was that the train had touched a high tension cable. I started to cry for help, but nobody responded. After, I saw people without heads. I tried to find Rosario, but I couldn't. The carriage was a mess of iron and smoke. Instinctively, I dragged myself out of the hole made by one of the bombs. I needed to look for help to find Rosario…" That was three years ago and Antonio's face still tenses and his eyes swell with tears. "Outside, people were moving like sleepwalkers. Nobody looked at anybody else, everybody looked at nothingness…" (silence) "Some days later, in hospital, I found out that my wife had died on the spot".

He rolls up his trouser leg to show the scar that runs from his knee to his ankle. The operation – one of five – to save his right forearm lasted 12 hours. On his left arm, another scar runs from his biceps to the wrist. "I was in a wheelchair for two years; it was a triumph when I could walk with crutches", he says with a certain spirit. But it is obvious all is not right. "The memories

[1] March 11th 2004: Madrid, Spain, was the scene of Europe's biggest terrorist attack ever when 191 people were killed and 1,858 wounded in ten simultaneous explosions on four crowded rush hour trains. Al-Qaeda claimed responsibility for the early morning attack.

never heal. I can see images of explosions. I go with fear in the street; I distrust people... I still haven't set foot in the underground".

Is Antonio's suffering trauma, loss or grief? In fact, it is trauma, loss *and* grief: suffering in all its dimensions. This chapter focuses more on loss and grief, the topic of trauma is specially elaborated in an other chapter of this book (see chapter 16 about Trauma).

Part 1: General Approach

"Life is a rainbow which also includes black"
Yevgeny Yevtushenko

1. Framing

Trauma, loss and grief have a common denominator: suffering. Life, even for the most fortunate people, includes the experience of suffering. It limits our future expectations or painfully removes them. Suffering cuts down our capacity to act and, in extreme situations, prevails so strongly that it oppresses our hearts and chokes us. We can consider suffering not as a detour on the fluid highway of pleasure, but its other pole.

Suffering is a feeling caused by any condition which subjects a person's nervous system to wear, tainting everything with dark and dull hues. As with any other emotional event, we can be aware of it or not. When aware, it appears as pain and/or sadness; when we are not aware, it shows as physical strain and/or tiredness. In trauma and loss, even if we are aware of having suffered an "atypical" event, we do not always realise its repercussion on our body, nor the need for a process of assimilation of the experience, nor that the situation affects everybody and everything around us like an expansion wave.

People often speak about suffering, not only from trauma but also from grief, as if it was merely an individual process, as if every one of us was an island, pounded by the waves of misfortune, without any connection to anybody else or our circumstances. Although loss has a deeply personal meaning, we must not forget that the human being is not an isolated being, and that «there is not a single function of any animal that completes itself without objects and environment» (Perls, Hefferline and Goodman, 1951, p. 228) – feelings and thoughts included. Further, our relationship as individuals with our environment is not only physical but also social.

Suffering belongs not only strictly to the individual, nor to the environment (Perls, Hefferline and Goodman, 1951; Spagnuolo Lobb, 2001a, 2003b, 2005a) but to both. It is suffering at the contact-boundary; suffering of the relationship.

2. Differential Nuances (Extrinsic Diagnosis)

2.1. Common Elements

One of the elements is surprise. If we are suddenly laid off, if a friend is raped, a close relative suddenly dies or we are diagnosed with cancer, the suffering is increased by the feeling of surprise added to the pain. A sudden pain is more acute than a pain forseen. Suffering loses a part of its fierceness as astonishment decreases.

Suffering is intensified by a change in habits. When we split up from our partner, part of our suffering is due to missing all those shared rituals – those loved rhythms that once made us choose the good things we remember so well. The power of habits shows the limits of reason: we want to preserve the same life style, but cannot. The habit imposes itself like a bloodthirsty despot. We cannot always free ourselves from it by mere reasoning or willpower. It is necessary to create the conditions to change the habit (personality functioning). This passage is often very painful.

A third factor is the horror itself of suffering. Suffering because of the grief that overcomes us and self-pity, because of the injustice we feel. «The part of the soul which cries "Why am I being hurt?" is at the deepest level and it remains from earliest infancy perfectly intact», said Simone Weil (1952, p. 161). As if suffering, or problems in general, were not a part of life. Suffering is inevitable.

Even if many things and events are not up to us, there is something that is in our power. It is the way we react to whatever happens to us. As Epictetus said, «Do not seek that events happen as you want, but desire that, whatever happens, you come out well from them». Card-players do not choose the cards luck deals them but must play as well as they can with what they get.

2.2. Differential Definitions

Definitions of the three vital ways of suffering may help to clarify their nuances. Due to space, once these nuances have been explained, the rest of this chapter will develop the concept of grief, with the understanding that, differences apart, all trauma and loss must be covered.

2.2.1. Trauma

Psychological trauma is not only the term usually used for an event which seriously threatens the well-being – or even the life – of a person but also the consequences of this event on that person's mindset or emotional life.

Psychiatry defines trauma as a direct or indirect personal exposition to a real or potential threat of death or threats to personal physical integrity, and involves intense fear, a sense of incapacity to exercise control, horror (Post-traumatic Stress Disorder, PTSD in *DSM-IV*).

2.2.2. Loss

Merriam Webster's first meaning of loss is "the act of losing", and goes on to give euphemistic expressions for death, including decease, dissolution, departure, loss, bereavement. And the term "loss" is also related to "deterioration", itself related to impairment, damage, detriment.

So, although loss does not always mean death, we will treat "grief", its setting, its meaning and its framing from the Gestalt approach, solely as that of a significant loss related to death, leaving the term "loss" for other traumatic situations. But each reference to grief and its support can be extrapolated to other trauma.

2.2.3. Grief

Grief is the state and process that follows the loss of a loved one. This loss is forever and although some authors consider that grief can "appear" without death, such as on breaking up, it is generally associated with death. Nevertheless, the news of terminal illness makes people feel grief.

Human grief is a normal, natural, and expected adaptive reaction to the loss of a loved one, or to one's own imminent death. It should be pointed out that grief is not an illness, but one of the most stressing vital events that we all have to face, sooner or later.

2.2.3.1. Characteristics of Grief

Grief is a unique process that does not follow universal guidelines. It is dynamic and changes constantly from person to person, and among families, cultures, and societies. It can lead to loss of social networks and many of the traditional resources for the sufferer (family, religion, neighbours, friends etc.).

It is manifestly associated with serious health problems, with the risk of depression multiplied by four during the first year. Likewise, almost half the people suffer general anxiety or panic attacks in the first year and the abuse of alcohol and medicines increases. Finally, the risk of death, mainly from cardiac incidents and suicide, also rises.

2.2.3.2. Nosological Diagnosis

The proposal by Prigerson, Vanderwerker and Maciejewski (2007) for *DSM-V* may be of help in detecting if we face a natural grief or the complex, diagnostic criteria for "Complicated Grief Disorder":

Criterion A. Event criterion: prolonged response. Bereavement at least 14 months previously (12 months is avoided because of possible intense turbulence from an anniversary reaction).

Criterion B. Signs and symptoms:

In the previous month, any three of the following seven symptoms with a severity that interferes with daily functioning:

1. Unbidden memories or intrusive fantasies related to the lost relationship.
2. Strong spells or pangs of severe emotions related to the lost relationship.
3. Distressingly strong yearnings or wishes that the deceased were there. Signs of avoidance and failure to adapt.
4. Feelings of being far too alone or empty personality.
5. Excessively avoiding people, places, or activities that remind the subject of the deceased person.
6. Unusual levels of sleep interference.
7. Lack of interest in work, social, care-taking, or recreational activities to a maladaptive degree.

Criterion C. The duration of these symptoms is at least six months.

Criterion D. These symptoms generate a clinically meaningful suffering or significant damage in social or working life or other significant activities (for example, domestic chores and responsibilities) in the suffering person.

2.2.3.3. Chronology of Grief

Grief also depends on the grieving person's traits: their personal situation and past; "who" the dead person is for them; the cause and circumstances of death; the socio-family relationships; and the social, religious, and so on, customs of the society we live in. To better understand what happens within the

grieving person, it may help to describe the development of grief by artificially dividing the process into stages:

Advanced grief ("fore-death"). A time characterised by initial shock at the diagnosis, and negation in the face of approaching death – maintained to a greater/lesser extent to the end. For close relatives, anxiety and fear, together with the need to take care of the sick person. This period is an opportunity to mentally prepare oneself for the future loss, and leaves deep traces in the memory.

Acute grief (death and peri-death). These are very acute and intense moments, psychologically a catastrophe, characterised by emotional block, psychological paralysis, and a feeling of befuddlement and disbelief of what is happening. It is a situation of true depersonalisation.

Early grief. From the day after the death to around three months later is the time for denial, looking for the deceased person, outbursts of rage, and intense waves of pain, of deep suffering. The grieving person is not yet aware of the reality of the death.

Intervening grief. From three months to some years after the death is a time halfway between the early and later grief, where one no longer has the "protection" of the denial of the first few days nor the relief that arises with the passing of time. It is a stage of emotional storms and contradictory experiences, of inner searching, guilt and self-criticism in which the pangs of intense pain continue arriving in waves. Returning to daily life, one becomes progressively aware of the reality of one's loss: several cyclic periods of grief arise during the first year (anniversaries, festivities, holidays, and so on), and the loss of the roles played by the deceased person, such as those of confidant(e), mate, or "man" about the house.

It is also a time of solitude, loneliness and isolation, and obsessive thoughts. It may be the first experience of living alone, and the grieving person often has no more intimate physical contact, nor even affective expressions, with another person. It is the time to discover the need to modify earlier behavioural patterns that no longer serve any purpose (e.g. prior social status). This process is as painful as it is decisive, because it means renouncing for good the hope to win back the loved one. Eventually, periods of "normality" become more frequent and last longer. Social activity resumes to a certain extent, and the person increasingly enjoys situations and events that had previously been pleasing – without feeling guilty. Memories hurt less, and one accepts that life goes on. Some authors place the start of recovering in the sixth month, but this period can last from one to four years.

Later grief. After between one and four years, the grieving person can build a new lifestyle rooted in thinking, feeling and behavioural patterns that can be as pleasant as previously. Nevertheless, loneliness, for instance, remains, even if it is not as invalidating as before. One starts to think about the future, not only about the past.

Latent grief (as time goes by) However, nothing is ever the same. Nor is the person ever the same. In time the person may suffer latent grief, softer and less painful, which may be triggered at any moment by stimuli which recall the loss. This is not a pathological situation.

There are several classifications of the phases of grief. For example, Kübler-Ross, 1969; Eissler, 1955; Saunders, 1967; Kavanaugh. 1974; Horowitz *et al*., 1997. None hold "the truth" and we should use them with care and with the flexibility our task requires. We must not forget that we work with human beings, not with "syndromes".

Personally, as a background to my encounters with patients in grief, I use the approach established by Dr. Elisabeth Kübler-Ross (1969), a pioneer in articulating a theory and a methodology for working with grief and loss. Kübler-Ross indicates the following: 1) negation and isolation; (2) bargaining and ritual; (3) rage; (4) sadness; and (5) acceptance. There is no space here to enter into detail and I remit the reader to my earlier work (Vázquez Bandín, 2003) devoted, almost exclusively, to this subject.

But we must not forget that according to *Gestalt Therapy*,

> every human function is an interacting in an organism/environment field, sociocultural, animal, and physical (Perls, Hefferline and Goodman, p. 229),

and a loved one's death is an imbalance in the organism-environment field's self-regulation. And the process of grief is restoring this balance.

Part 2: The Gestalt Therapy Perspective

"Solitude is more bearable…
when one has somebody
to talk to about it".
G.A. Bécquer

3. Gestalt Literature

Although our foundational book, *Gestalt Therapy: Excitement and Growth in the Human Personality* (Perls, Hefferline and Goodman, 1951), makes a few express references to grief, there is little Gestalt literature on the subject, and it is often only mentioned in passing or as personal experiences.

A review by Stephanie Sabar (2000) and my own search came up with two books: *The Courage to Grieve* by Tatelbaum (1980) and *About Mourning: Support and Guidance for the Bereaved* by Weizman and Kamn, 1985.

There are six papers: "Grief and Gestalt Therapy" by Anne Clark (1982); "Dying: Towards a more Human Death" by Corbeil (1983); Sabar, mentioned above (2000); "Living with Dying", autobiographical notes by Ken Evans (2000); "La culpa en el proceso de duelo" by Mª Isabel Chávez de Sanchez (2002), and one by Greek Gestalt therapist Katia Hatzilakou, "A Meeting with Life through Life's Death: A Gestalt Approach of Working Through Grief" (2002).

There is also a letter to the Editor of *The British Gestalt Journal* ("Closing the Last Gestalt", 1994) by Dolores Bate, and a paper by myself, "Wait for Me in Heaven" (Vázquez Bandín, 2003), part of a book devoted to different Gestalt Therapy topics (Vázquez Bandín, 2008).

There is other material in more general Gestalt Therapy writings. Perls, in his "peeling the onion" metaphor in *The Gestalt Approach/Eye Witness of the Therapy* (1973), speaks of the implosive layer, connected to death and the fear of death, and the expression of sadness with the explosive layer (Perls, 1973; McLeod, 1993). In *Healing Tasks* (1995), Kepner states that crying over loss is healthy. E. Polster (1995) in *A Population of Selves*, analyses the loss of the sense of self and life after a death. Woldt and Stein (1997) describe the grief that occurs with age and the transferential business of therapists faced with the decline and death of their clients. Zinker (1994) sees the support of mourning as a kind of presence, testimony and rituals. Oaklander, in *Windows to our Children* (1988), presents a method for children who have suffered loss.

4. Intrinsic Framing

1. If we consider the various possibilities at the contact-boundary as variations of the interaction, trauma, loss and grief can be placed in the fourth possibility mentioned in *Gestalt Therapy* (Perls, Hefferline and Goodman, 1951): a situation of frustration,

> of starvation, and illness: if the boundary becomes intolerably tense because of proprioceptive demands that cannot be equilibrated from the environment –that make anxiety the origin of this suffering… (p. 261).

In these cases of excessive frustration, the temporary functions combine, healthily, to stop the danger and to protect the sensitive surface.

Two types of reactions may be observed: subnormal or supranormal. Subnormal reactions include panic flight, shock, numbness, fainting, blotting out or amnesia, which protect the boundary by temporarily desensitising it or paralysing motor functions, waiting for the emergency to pass.

Supranormal devices that cushion the tension by exhausting some of the energy in the agitation of the boundary itself, include hallucinations and dreams, obsessive thoughts, brooding and restlessness.

In either of these reactions, another function of consciousness is set off: to exhaust the energy that cannot reach a balance. But it is not a matter of trying to reach heightened awareness and deliberateness to solve the problem, but a delay for the sake of rest and withdrawal, since the problem cannot otherwise be solved.

2. Suffering is primarily a signal, a call of attention to an immediate present situation we cannot assimilate. The natural and spontaneous response to it, is to get out the way, but when this is impossible because of a trauma or the loss of a loved one, prolonged suffering is what makes us attend to the immediate present problem.

There is a sad conflict between intellectual acceptance on the one hand, and desires and memories on the other. It is sometimes possible to distract ourselves, but we are often inevitably immersed in suffering: we recall the past, see our present hopelessly frustrated; we cannot imagine what to do to get out of the pain, the future is shattered. Grief, confusion, rage and nostalgia are prolonged, for there is much to be destroyed and annihilated and much to be assimilated. During this time it is very difficult to be occupied and carry out routine tasks.

C.S. Lewis (1961) movingly described this situation at the death of his wife: «Suffering from a trauma or grief covers the whole person. It spoils the usual functioning of the self».

3. If, as I mentioned above, the death of a loved one is an imbalance in the self-regulation of the organism-environment field, psychotherapy will consist in returning the balance of the self-regulation of this field, carried out in the therapy setting, session by session.

Taking for granted that a person's suffering freezes the flexibility of the self for the formation of figure-ground, the patient will show this in the therapeutic relation, giving rise to a co-creation of the contact-boundary full of difficulty and suffering between him/her and the therapist. As we know, suffering itself is co-created between both "sides" of the contact-boundary. The self does not exercise its powers.

Self functioning as id is altered by the frustration at the contact-boundary, giving place to the sub and/or supranormal reactions. The perception of time is also altered.

Self functioning as ego is incapable of making pertinent choices and rejections.

Self functioning as personality becomes a set of concepts about oneself that are suddenly obsolete and need to be updated through grief in the process of psychotherapy.

5. Loss of the Structure of Time

Benjamin Franklin said that the stuff of life is made of time. In the grieving person, the differences between the subjective, or interior, time and the exterior time are especially marked. The second hand only knows the present, but the sensation of time in human beings, the highly perfected activity of the mind[2] in which almost all the functions of the brain participate, is destabilised – bodily sensation and sensory perception; memory and the ability to make plans; the emotions and consciousness of oneself.

For most people, time flows toward some place out of them. There is an imaginary line that, starting in the present, concatenates the past and goes towards creating future possibilities, since

> the present is the experience of the particular that one has become dissolving into several meaningful possibilities, and the reforming of these possibilities toward a single concrete new particular (Perls, Hefferline and Goodman, 1951, p. 306).

After a trauma, or during grief, the structure of time has shattered. Time it-

[2] In this sensation of time that forms part of our function personality, our culture also acts interweaving this sensation. How we conceive time also influences our way of perceiving it.

self is fixed and frozen in an eternal present lacking "significant possibilities", and there is a vain need of "recovering" the lost past. The following step, the next, has disappeared.

We can imagine time like a rocking chair in constant movement. In grief, the chair does not rock forward. It remains stuck in the centre with the only possibility of moving backwards – producing vertigo and relief at the same time. It is as if a strong impulse in the backward movement could unblock the chair from that black, eternal present, and push it toward the future again with the breeze of the well-known perfuming the environment.

6. Working Through Grief in Psychotherapy

As we have seen, trauma, loss or grief produce a situation of extreme frustration, engendering sub- and supranormal reactions. The grieving person is hindered in their ability to make creative adjustments with the environment, leading to deep suffering. The habitual environment, at the same time, is empty, dark, without interest. This process breaks, firstly, the perception and sensation of time. Our first therapeutic task is, therefore, to work on the time line.

6.1. When Time Stops

If living is to convert time into experience, and this process of relating to our surroundings is what makes us feel alive, the therapeutic aim of the first few sessions will be to offer the start of a synchronisation of subjective time with objective, or social, time. Our patients are obviously going to tell us their story, their suffering, the events that led to their misfortune. By being co-participants of this narrative, and not mere receivers, we offer our patients an "other" with whom to interweave, in the here-and-now ("social" or objective time) of the setting, their story cut off from the continuum of life. There is another human being that gives continuity to their existence and their suffering. The immediate past and present are intertwined in the co-creation of each setting between patient and therapist. The content would be his/her narrative, the container, the support of faith and hope in life.

Nuria cannot stop crying as she tells me about the death of her 10-year-old son. Her speech is halting. Her whole body trembles with sobs, and she folds herself into a little ball, as if by doing so, she could disappear inside herself, consumed by grief. She wrings her hands… I notice how I hold my breath, and how my throat tightens, my tears sprout. Reaching out, I seek her hands. Bare-

ly started my movement, her hands clasp mine. "Why, my God, why has this happened to me?" she shouts distraught.

The basic therapeutic task is support.

6.2. From Support to Contact

Session by session, the narrative is interspersed with sensations and feelings of the here-and-now which offer and give back the present reality to our patient. And also the relationship.

Juan is telling me how empty his life is after his wife's death. "I walk around the house like a sleepwalker. When I tire of going back and forth, as if looking for her, I fall in the sofa, like a puppet, weak, without energy". While speaking, Juan has gone pale, and his eyes glaze over. I tell him that and then say: "I'd like to know where you are while you tell me this, and what you're feeling now". He looks at me, as if returning from some distant place. A weak smile appears on his face. "Insensitivity", he answers, "I feel insensitivity, and when I look at you again, grief reappears. But looking at you, at the same time, relieves me". And our eyes meet again.

The basic work of the therapeutic relationship is our patient's awareness of the importance of the present, not only in the setting but also in his or her daily life. We could say that it is the awareness of the functioning id of the self.

6.3. The Intensity of the Encounters

As the therapeutic encounters continue and the process of grief progresses, what we could call "de-structuring and annihilation" take place: guilt, rage, the restlessness all come to the foreground. We could say that the loss has been recognised organismically, and as if it were a "strange object", one tries to expel it with spasmodic reactions, as if vomiting. As therapists, we should be especially aware of such reactions. The functioning ego of the self is not well-qualified to make decisions, and the best way to discourage any apparent decision is to work on these contents. There is a lot of work to be done with all the personality functioning of the self, especially the above-mentioned «moral evaluations, judgments of proper behaviour» (Perls, Hefferline and Goodman, 1951, 2002, p. 424).

Ricardo's 25-year-old son committed suicide some months ago. We have already had several encounters in which he has managed to get out of his "sto-

icism", and to repeat to himself (and to me) with the voice of sleepwalker: "There's nothing I can do but accept the inevitable; things are like they are". Today, speaking about what his son liked to do, Juan changes his tone of voice and, again with the monotonous voice of the first sessions, tells me: "I should have spent more time with him. I've been a bad father. I didn't realize how much he needed me". Despite the apparent monotony of his voice, the intensity of his tone and his contracted features literally make my hairs stand on end. "What do you mean?", I ask him with a lot of interest. Staring, and with a tone of a deep contempt, he begins to insult and reproach himself. "He should have killed me, not himself", he says, punching his legs hard. I am deeply moved, with all my senses aware. Risking him pushing me away, I hug him strongly, containing him in the sense of covering him. His fury and insults lead to a liberating and deep crying. Once the crisis situation is over, we talk about it.

6.4. When Sadness Turns Sweet

In a certain moment of the process of grief, moments of calm, of reflection, follow the implosive periods. We could call them moments of integration. Some aspects of everyday life are again viewed with certain interest, with a certain colour. And, at the same time, the internal rupture becomes less intense. The patient interweaves his/her daily life with routine and memories. The therapeutic work continues centred mainly on the functioning of the personality, now more narrowly related to loyalty. The functioning ego of the self enters into action again.

Almost a year has passed since Maria lost her husband, Luis. During this time we have seen each other, in therapy, on a weekly basis. She was not working, but later returned to work. Then she began to go out for a coffee with a friend. Today, Maria tells me that her co-workers have proposed that she go with them on a short trip to Italy. Maria tells me of the plans she and her husband had made for travelling to Italy. Her voice is melancholy, but firm. "First, I thought of saying 'no' to my workmates, but with you I have learnt not to make hasty decisions. I've been thinking, and I'm sure Luis would have liked me to go. It would be like a tribute to him". Suddenly, though her eyes are sad, her face shows a light smile. "How much I like what you are telling me!", I answer. The session continues going from her failed plans with Luis to how the experience of the trip will be for her.

6.5. Life Without You

In the final phase of working through grief in psychotherapy, there is a clear balance between subjective time and *chronos*. Subjective and objective time is stabilised again, and there is a hint of "the next". A glimpse of the immediate future. What makes this the "final stage" is not the external time to the therapeutic process, to the patient/therapist relationship, but this relationship is what signals the beginning of the end of the process of grief. Our patient has the energy and hope to be able to continue life without the "external presence of the loved one". The memory now forms part of everyday life and new projects, and there are new attempts at viewing the future. Before closing the relationship and saying "bye", it is necessary to give a sense and a meaning to the psychological work, to make it conscious. Our work lies in supporting our patient in answering the following questions[3]: What has the loved one meant in my life, and me in the life of the loved one? What did we teach/learn from each other? How did I contribute to his/her life, and how did she/he contribute to my life? And finally, thanking him/her for the shared time, "to let him/her go away", keeping him/her in your heart.

Part 3: Some Specific Support to Gestalt Therapists

7. Generating Possibilities

Although, as Gestalt psychotherapists, we work fundamentally with the process and not with techniques or content, it might be helpful to provide a certain structure and tools to support and facilitate therapy in the process of grief. I have divided them into three parts: exploratory, general and specific. Obviously their use depends, as mentioned above, on the opportunity and on each therapist.

7.1. Exploratory: Profile of Grief (Gathering Basic Data in the Context of a Dialogue in the Relationship)

Exploratory techniques serve to find out key details in the evolution of grief. Data should be collected as follows:

- *General data*: age and names of the deceased and the patient, date of death, birthdays, etc;

[3] This approach on how to close grief has been possible thanks to my training in NLP.

- *Family/friends*: genogram, family relations, friends, economic situation, etc.;
- *Personal background*: mental/physical health, assimilation of possible prior grief, other problems of work, etc., type of relationship with the deceased, length of time together, etc.;
- *Evolution of the process of grief*: cause and place of the death, knowledge of the illness, feelings such as yearning, guilt, rage, anxiety, sadness, and the family's emotional support.

Finally, each of the above sections is summarised as a "profile of grief", which, together with phenomenological observations and our own sensations, feelings and reflections, serve to guide the intervention, prioritizing any problems detected, and also to identify whether we are dealing with an apparently "normal" grief or one of risk.

7.2. General

The general intervention techniques are: Relationship, Listening, Facilitation, Reporting, Normalising, Orienting.

7.2.1. Establishing a Good Relationship

Establishing a suitable professional relationship with our patient is the base and start of everything. As Laura Perls said, «contact can be made easily and adequately only when support is adequate and continuous» (L. Perls, 1992, p. 101).

7.2.2. Active Listening

Active listening is attentive, centred and intense; listening to the other person and to oneself.

- It is attentive, because as professionals we use our five senses.
- It is centred on how we live the here and now of every moment.
- We listen to ourselves while we are with our patient, to connect with our own feelings and to be aware of what is being given in "the between".

When attending suffering people, we have to remind ourselves, almost continuously, that: "I am I, and the other is the other". We cannot ourselves die with each dying: we do not lose our partner or son with each patient. We must not impregnate ourselves with our patient's feelings, and we need to know that they are theirs, not ours.

7.2.3. *Facilitating*

Facilitating is encouraging communication, to wait, to be patient. It is also to provide a space for the other person (our patient) and support her with our attitude and the "safe" setting we are creating so she can express whatever she wants. Sadness, guilt and fear are more or less easy to deal with. We only need to be present and not interrupt. Rage will always be more difficult.

Useful communication techniques include open questions, low reactivity, looks, silences, echoes, nods, summarising to mentally relocate our patient and help her identify her feelings.

7.2.4. *Informing*

To inform the patient, at the right moment, is:

- to explain what Western psychology currently defines as "grief", but always insisting that her own situation is unique and that she is "allowed" to feel whatever she feels and whenever she wants;
- to clarify that the theoretical process is toward a creative adjustment, that all living beings adapt instinctively to new situations;
- to support her most habitual doubts: "Is it a good idea to go to the cemetery? To cry? And to always speak about the lost one? Why does everything seem different? Why do I now fear dying more but at the same time I want to die?".

7.2.5. *Normalising*

Normalising is supporting our patient in what she feels, thinks, and does. That she does not want to stop crying, that she continues speaking with the loved one or refers to him/her in the present. That her reaction is completely normal and natural in her situation. To validate her reactions and feelings, legitimising them. To allow her to continue feeling them.

When normalising, it is better to take our time and bear in mind the "rhythm" of the encounter.

7.2.6. *Orienting*

To prescribe, at times, behaviour or rituals by specific instructions, and at times the opposite; for example, to dissuade a hasty decision: "I want to sell the

flat because there are too many memories. It's like a slab over me". In general, while encouraging the taking of smaller decisions, we discourage taking important ones during the first year.

We can also advise on family re-organisation, explaining how the loss of a family member changes the roles, spaces, economy and so on. It is necessary to re-negotiate and reconstruct everything.

7.3. Specifics of Habitual Use

This kind of intervention is frequent because it is related to the problems our patients often raise.

7.3.1. Anticipation of Dates and Situations

Anticipating difficult situations gives the patient a sensation of forecast. Anniversaries of the death, birthdays, Christmas, etc. are special and bring with them new pangs of suffering that, if they have been predicted, do not surprise or demoralise so much.

To be aware of what we feel in some situations, and why, also alleviates us. So, for example, to know why people at times behave as if they do not see us (they do not know what to say, they feel embarrassed); they do not relate with us as before (we no longer have a partner); or why we feel the loss more at festivities, weekends, holidays.

7.3.2. Taking Decisions, Solving Problems and Acquiring Abilities

At times, grieving people have a real block of their initiative, mixed with fear: their world has collapsed and everything could be extremely dangerous and difficult. In such situations, support in taking decisions is useful, beginning with the simplest problems, helping the person to become autonomous. At other times, it is a matter of doing what the loved one used to do (to fix a plug, to sew a button, to go to the bank, etc.). Or to recover skills our patient once had and lost due to the distribution of roles. Each achievement in these tasks is an improvement of their self-esteem.

7.3.3. Repeated Narrative of the Death and to Tell Stories

Speaking of death alleviates. Narrating a tragic event partly dulls its intensity. Describing the final moments of the death will be spontaneously reiterative in the patient. Repeating the story of the death in great detail takes out intensity to feeling, it is cathartic, it cleanses, purges, opens the tap of emotion and, besides, it frees, puts in order and structures thinking. It makes the death a part of ourselves, normalising it.

Speaking of the dead person soothes. Narrating fragments of the life of the deceased relocates the ties, ensuring that they will never break, but will be different. The patient outlines what he or she once was and now is, reflects, searches, and has the opportunity to see that although the ties are now different, they survive. He/she can make new friends, be excited again with life, without fear. Even though he/she will never forget. Because oblivion is impossible.

7.3.4. Prescription of Tasks and Rituals

The prescription is a contract, specific and personalised, a previously agreed "deal" between patient and therapist that commits both to its fulfilment. Realistic, easy-to-achieve tasks should be suggested at the beginning. The aim is to restructure the routine with healthy behaviour, such as going shopping, going for walks. This obliges him/her to socialise again, behaviour similar to that he/she had before the death of the loved one. We should prevent a sedentary lifestyle and other ways of confronting loss that are clearly damaging. Through suggestions, such as adjusting the visits to the cemetery, apparently uncontrollable situations and disabling rituals can also be checked.

Writing a notebook of letters (Vázquez Bandín, 2003), one a day, in which he/she explains to the deceased the present situation, his/her feelings, changes and what remains the same, is especially helpful. For some people, writing triggers ideas and feelings, clarifies and puts them in order. The items arising from this task can then be used in the sessions, if our patient wants to, as yet another stimulus for sharing in the setting. Suggestions for things to write about include "the things and feelings you would have told him/her and never did".

7.3.5. Speaking About Dreams and "Presences" (Visual, Auditory, Tactile)

Dreams are full of allegories showing the patient's experiential world. They give us information about our emotional state. The "presences" (to see, hear or

feel that the deceased touches him/her) are discharges of the brain, reacting to stimuli, a part of the information that our patient has stored about the deceased, similar to the phantom limb (which is felt although it is not there). As time goes by, the hallucinatory phenomena progressively disappear, but the information never disappears and an intense enough stimulus, such as an anniversary, suffices to provoke forgotten feelings, even several years later. It is important to speak with our patient about such phenomena, normalising them to avoid the idea that the deceased person is intervening in his/her life (wishful thinking), or to think that he/she is going crazy. Both ideas are very "real" due to the novelty and intensity of the feelings.

7.3.6. Emotional Probes and Therapeutic Questions

Emotional probes are questions that try to cross the defensive barriers and facilitate communication. They track feelings and free a part of the inner storm arising at the contact-boundary.

Examples include asking about what the visits to the cemetery mean for him/her or "How do you feel about speaking today about something that remains 'hanging' inside you since the last time we met? Something that you keep turning over in your mind that you can share with me". "When you are in the bed at night, unable to sleep, what thoughts come to you?" or "Do you sometimes think you are going crazy?" or "On occasions, does it seem as if you see or hear him/her, or he/she has touched you?" or simply "How do you feel?".

It is also appropriate to ask, indirectly, about thoughts of suicide and to assess if there is a risk: is it just a fleeting idea, or the loss of the existential "north" (typical of grief), and what things (brakes and anchorages) restrain it and hold on to life?

7.3.7. Social Clichés

It is better to avoid set phrases and uncalled-for advice, such as "You'll see how it passes with time" or "You should go on holiday and forget about everything", which can cause emotional distance and, at times, rage.

Clichés are often caused by nervousness, from not knowing what to say, and the therapist's feeling of helplessness. It may be better to verbalise how we feel: "I don't know what to tell you, I feel nervous, this also affects me", or better still to express oneself with a handshake, a hug, a gaze in silence, and so on. Non-verbal communication is direct and sincere, and it transmits understanding.

8. Closing

Well-being includes, necessarily, pain, suffering and problems. They are a part of life. How do we accept pain? In the same way we learn to speak, to walk, to plan or to excite: by living and learning from living. Traumas, loss and grief do not have age. They can surprise us through our life or in any phase of it. The first large misfortunes (even when they happen at an advanced age) are often the worst. Those who get accustomed to adversities and cope with them, bear them with greater integrity and *savoir faire*. Over the years, we acquire a certain capacity to defend ourselves from anxiety. This does not mean that we become insensitive to it, nor that we necessarily suffer less. As I mentioned above, nobody can avoid suffering – the key is how we relate to it.

I would like to close with some words by Isadore From and Michael Vincent Miller that convey my understanding of Gestalt Therapy:

> taken seriously, [it] offers no cure for all the problems that humans fall prey to by the simple fact of inheriting the human condition. It offers no passage back through the gates of Eden. But it can help one learn to live better in a fallen world (From and Miller, 1992, p. xxii).

In a world increasingly threatened by natural disaster, by terrorism, and by indiscriminate violence of all kinds, it is a duty of Gestalt professionals, and those of any another approach, to strive to find tools that relieve, console, and help us to accompany others on the hard road of human suffering. Gestalt Therapy is a masterly approach to offer hope and consolation, and it is up to us, Gestalt therapists of the 21st Century, to continue to develop our approach, without forgetting its bases.

Finally, I want to thank everybody who has permitted me to share their pain and suffering. With them I have learnt not only the efficacy of our theory and practice, but also the immense generosity of the human heart and the hidden intricacies that hide the pain. As Buber said, «the need of each person leaves a trace in my heart» (Buber, 1949, p. 179) I thank also those who have given me the opportunity to share my experience through this writing, and to those who read it.

Comment

by Gonzague Masquelier

I read with interest this work of Carmen Vázquez Bandín. There are indeed few Gestalt papers on the theme of mourning and the text completes our reflection, as Gestalt therapists, on the subject. Moreover (she has created a very useful reference document). Here are my reactions to reading this chapter.

Some remarks on the first part. The care taken in defining the various concepts of trauma, loss and grief, allows the reader a good understanding of the article. The risk is certainly to generalize, but the author specifies that every individual has his/her unique way of enduring suffering and that modalities differ from one individual to another. The suffering does not belong either to the individual, or to the environment: it lives at the contact-boundary; it is the relationship which is affected.

Personally, I hardly use the DSM for my clinical practice because it excludes the phenomena of field and reifies the patient. We cannot define "Complicated Grief Disorder" without taking into account the environment of the person, her history, her creative or conservative adjustments.

Also, in my experience, people do not cross the various stages of grief in a linear way, but often re-experience the stages several times, and relapse after certain events, for example with the questions of inheritance, etc. In describing a chronology there is a risk of solidifying the stages, as if there were a universal route to be followed.

Second part: the Gestalt therapy perspective. This part seems to me the most enriching: the author shares with us her long experience in several clinical sessions which illustrate her Gestalt practice. She insists on the commitment of the Gestalt-therapist as part of the field. Because the patient lost a dear being, the quality of the therapist/client relationship becomes fundamental and reparative.

The author analyzes the interactions at the contact-boundary and considers them as subnormal *(amnesia, state of shock), which protect the contact-boundary by a temporary desensitization, or the opposite as* supranormal *(excitement, hallucination) as an attempt to exhaust the excess of energy. The regulation of the self, in its id functions, ego and personality, is no longer effective. The notion of time is also altered, with frequent returns to the past, but an inability to envisage the future. This line of time is an important axis in the Gestalt approach. We do work with the here-now, but also with the there-then, such as client's desires and projects.*

Third part: specific support to Gestalt therapists. In this third part, the au-

thor offers us some guidelines to welcome our patients' suffering of loss and grief. However, I would need this part to be elaborated more. Carmen Vázquez Bandín does not give examples of her practice. Paragraphs on the rites or the dream work with some clinical sessions would have been fascinating, although Gestaltists know that they cannot use an exercise as they would use a recipe. The creative adjustment to the client needs is the main ingredient of any experiment. This part can nevertheless feed our creativity: every therapist can adapt these guidelines to develop his/her own resources to experiment with his/her patient.

Conclusion. I missed a philosophical chapter in this article. Grief often invites the patient to face deep existential questions: the good ending of course, but also the solitude, the sense of life, the absurd. Existentialism is one of the Gestalt roots (in the same way as phenomenology); it can give us theoretical and philosophical references to better accompany our patients.

The ending does not concern only the death but also any irreversible loss, such as a divorce, the marks of age, a retirement, and so on. A mourning can make tangible an anxiety in facing solitude or responsibility: what is the sense of the *Life, what do I want in my life?*

The Gestalt-therapist is faced with the same questions, in his/her personal life, in sessions with patients as in supervision. It is important that he/she does not project on patients his/her own answers. For example, if my client finds his/her existence absurd after a mourning, I can accompany him/her in depth only if I question my own values. That is the concept of "sympathy", so important for Fritz Perls. These themes are not approached in this article.

The Power of "Moving on". A Gestalt Therapy Approach to Trauma Treatment

by Ivana Vidakovic

The new millennium started with high distress from natural and man-made disasters. Trauma affects the wholeness of the person; its physical, emotional, behavioural, cognitive, social and spiritual functioning. Still, most people will not suffer long term trauma reactions, depending on their personal characteristics, life experience and support available in the aftermath, as well as the nature and consequences of the trauma itself. However, some traumas surpass the range of human capability to process and to assign meaning to the experiences.

1. Diagnostic Considerations

Trauma related psychiatric disorders[1] are, according to some authors, controversial diagnoses: the etiological factor of the disorder is recognized outside the individual, in the external traumatic stressful event (Yehuda and McFearlane, 1995; McNally, 2004), while many symptoms are not specific only to this diagnosis (Campbell and Lorandos, 2010). Additional ambiguity in the diagnosis is related to the high comorbidity of PTSD with mood disorders, other anxiety disorders, substance abuse and somatoform disorders (Kulka *et al*., 1990; Orsillo *et al*., 1996).

[1] A part of *Post-traumatic sress disorder* (PTSD) described in DSM IV and DSM IV-TR (APA, 1994; 2000), and ICD-10 (WHO, 1992), the other trauma related disorders are: *Acute stress disorder* (APA, 1994; 2000) or *Acute stress reaction* (WHO, 1992), as time-limited reactions to trauma (less than a month, usually 1-3 days) with symptoms overlapping with those for PTSD, but with a greater number of dissociative symptoms. In the literature we could also find references on *Complex PTSD* or *Disorders of Extreme Stress Not Otherwise Specified - DESNOS* (van der Kolk *et al*., 1996; Herman, 1997; van der Kolk, 2001) that refer to the severe and long lasting personality changes (in people traumatized at an early age, or with a history of prolonged interpersonal trauma). DESNOS is not recognised as a distinct diagnosis in DSM-IV, but could correspond to the description of an *Enduring personality change after catastrophic experience* in ICD-10 (WHO, 1992).

The phenomenon of traumatic stress reactions has been described much earlier, even outside medical literature (van der Kolk, 2007), yet only recently was post-traumatic-stress-disorder (PTSD) recognized as a diagnosis and introduced in DSM III edition (APA, 1980).

According to DSM IV[2] (APA, 1994) «PTSD follows a traumatic stress event in which the person has experienced, witnessed, or been confronted with an event that involved actual death or death threatening situations or serious injury to oneself or others» (criterion A1) and «the person's response involved intense fear, helplessness, or horror» (criterion A2). In order to meet criteria for a diagnosis of PTSD, the individual must present symptoms from three distinct clusters: *persistent re-experiencing of a traumatic event*, *avoidance of stimuli associated with trauma and numbing of general responsiveness*, and *increased arousal* (criteria B, C, D), for at least 1 month (criterion E), in a way that causes clinically significant distress or clinically significant impairment in social, occupational or other important areas of everyday functioning (criterion F).

2. The Diagnostic Process and Relational Considerations

In diagnosis and therapy Gestaltists always refer to the relational experience in the "here and now". Before referring to that aspect of the dynamic Gestalt diagnoses here, we will describe what we can observe in a person with PTSD in process diagnostic terms.

Too strong and inflexible or fluid and non-existant personal boundaries - both extremes can be noticed in the contact with people after trauma, that could lead them to social isolation or inability to self-protect and the risk of multiple victimizations.

The basic contact functions (eye contact, voice, hearing, touch/ posture/movement) are often changed after trauma, and suspended in their aim to reach and be reached by others. Furthermore, perceptive, emotional and cognitive processes (sensory integration, emotional reactivity and regulation, mental processing and memory) are distorted, and significant shifts occur in judgement and Self evaluation (Janoff-Bulman and Frantz, 1997).

The dynamic of figure/ground is interrupted. Trauma, as the figure, be-

[2] For upcoming DSMV the following changes are foreseen: criterion A1 will be expanded to include extreme or repeated exposure to aversive details of traumatic events, while criterion A2 that requires a peritraumatic reaction of intense fear will be excluded. The potential diagnostic symptoms for PTSD will be expanded and organized around four clusters: intrusion, avoidance, negative alterations in cognitions and mood, and changes in arousal and reactivity (Friedman, Resick, Bryant and Brewin, 2011; APA, 2012). PTSD will be moved from Anxiety disorders and assigned to the new category of "Disorders associated with trauma and stress" (Friedman *et al*., 2011; APA, 2012).

comes so compelling that the context is lost. The attention is narrowed and the traumatised person is not able to widen the perceptual field to allow other aspects of life to become figural (Avery, 1999).

All self-functions are under a cloud: Id functions ("I need", "I am aware of..".) are suppressed, the person has restricted needs and interests, Ego function ("I choose", "I act..".) is lost in an inability to cope with trauma, continuity of Personality function ("I am…".) has disappeared, the person as he/she used to be no longer exists, the new experiences are not integrated and a new persona has not yet arisen after the life-changing event.

The contact cycle is stuck in demobilisation from traumatic experience, and further interrupted by desensitization (emptiness, numbing) and/or deflections (negation, avoidance, projections, etc.).

Trauma also affects self-representation and interpersonal experiences; and it is always present in the field and in the client-therapist relation. We can observe people suffering from trauma as agitated or withdrawn and inhibited, with overwhelming and mixed emotions, or sometimes with a blocked emotional response, fragmented and generally less available for contact in the here in now. As a part of the field and the relational diagnostic process, the therapist is also active in the co-creation of the phenomenological experience in the interpersonal relating that indicates the post-traumatic reactions or PTSD. The relational dimension in the therapy refers to the capacity for contact, relationship, trust and intimacy, but also to the projections, transference and counter-transference in the client-therapist interpersonal experience. The therapist has to be alert to them since they could bring trauma elements into the here and now and make them available for exploration. The common relational issues in therapy with trauma clients are stability/instability, trust/mistrust and power/-helplessness. It is a delicate and challenging task to meet the client in his/her post-traumatic existence and to co-create a stable and trusting relationship that can allow the client to feel grounded, and to accept getting in touch with painful emotions in order to regain his/her wholeness.

3. Gestalt Model of Trauma, PTSD and its Application

The trauma seen as *uncompleted situations from the past* and *fixed perceptions* was first described by Gestalt founders (Perls, Hefferline and Goodman, 1951). Later, many Gestalt authors referred to these roots to explain trauma as *unfinished experiences, fixed* gestalts, and *inability to disengage*, that interfere with novel experiences (Polster and Polster, 1973; Zinker, 1978; Serok, 1985).

Trauma has been considered broadly as an adverse event or «*rather a traumatic series of more or less frustrating and dangerous moments*" (Perls, Hef-

ferline and Goodman, 1951) and the phenomenology of post-traumatic reactions in intrusion, avoidance, numbing, and hyper-arousal, have been recognized and described: «*Uncompleted situations from the past, accompanied by unexpressed feelings never fully experienced or discharged,... they obstruct our present-centered awareness and authentic contact with others*» (*ibidem*). «*Uncompleted directions do seek completion and when they become powerful enough, the individual is beset with preoccupation, compulsive behavior, wariness, oppressive energy and much self-defeating activity*» (Polster and Polster, 1973). «[...] *the tension of the feeling and the dangerous explosiveness of the response gradually heighten, and the inhibition of these is habitually strengthened until, in the interest of economy, feeling and response are blotted out...*», «*Avoidance is the means individuals use to prevent themselves from completing "unfinished business"... Avoidance exists for good and sufficient reason, and hence the task is to become aware of the reasons for its existence*» (Perls, Hefferline and Goodman, 1951).

Addressing "uncompleted past situations" for closure, by «*returning to the old business or relating to parallel circumstances in the present*» (Polster and Polster, 1973) and «*engaging in many ways besides the verbal*» (Perls, Hefferline and Goodman, 1951), is recommended for re-establishing a capacity for contact with Self, others, and the environment in the "here and now".

Developing further the Gestalt knowledge on trauma, Melnick and Nevis suggested that PTSD is a manifestation of *the difficulties in demobilization*, as the final stage of the cycle of experience, and an individual's inability to absorb and digest an unhealthy experience in order to achieve disengagement (Melnick and Nevis, 1992; 1997a; 1997b; 1998). If the experience is too charged to be easily absorbed, the old figure remains un- integrated and has a perpetually distorting effect on the current and future experience of the individual (Melnick and Nevis, 1997a). Therapy should start with enabling the client to *turn away* from the traumatic figure. Taking the client slowly through a process of a*ssimilation*, emotions will be discharged simultaneously with the development of the ability to cope and deal with them. *Encountering the void* is the most difficult phase but, when completed, leads to *acknowledgement* of the emergence of something new about the self (Melnick and Nevis 1992; 1998).

Some further advances in the Gestalt approach to trauma treatment have been developed more recently. Butollo has written about *post-traumatic development of Self*, with loss of empathy and reactive narcissism as two possibilities for reactions of the traumatized Self (Butollo, Kruesmann and Hagl, 2000). He presented a therapeutic process through the phases of *Safety* (Feeling safety, Establishing therapeutic relationship, Learning techniques of relaxation,

breathing, Differential work with symptoms, Facing avoidance, Activation of social support resources), *Stability* (Overcoming insecurity, Self-acceptance, Self-reflections in contact with others), *Confrontation* (Activation and protection of Self-boundaries, Cognitive and emotional processing of trauma) and *Integration* (Acceptance of what happened, Acceptance of Change, I-Thou dialogue with trauma).

In his reconsideration of PTSD from Gestalt perspectives Cohen (2002; 2003) explained the trauma symptoms as two-dimensional polarities: a continuum from *extreme arousal and agitation* to *low arousal and numbness*; and a continuum from *over involvement* (re-experience, flashbacks and rumination) to total *avoidance* of stimuli related to the trauma experience. He argues that Gestalt could be the treatment of choice for trauma, seeing integral approaches in Gestalt psychotherapy in phenomenology and I -Thou dialogues as effective therapeutic components in trauma treatment.

The Gestalt approach to trauma treatment achieved greater visibility in recent years (Avery, 1999; Fodor, 2002; Cohen, 2002, 2003, Hardie, 2004). Several articles and case studies that have been published demonstrate how Gestalt therapy works with clients who suffer from a variety of trauma, i.e. abused children, adult survivors of child abuse, war victims and refugees, war-veterans, helping professionals: counselors, social services staff, traumatized flight attendants, etc. (Crump, 1984; Serok, 1985; Crump, 1984; Sluckin, Weller and Highton, 1989; Kepner, 1995; Butollo, Kruesmann and Hagl, 2000; Pollard, Mitchell and Daniels, 2002; Cohen, 2003; Gilbert, 2006; Pack, 2008).

4. Trauma Treatment

Different approaches to trauma treatment often include verbal and emotional expressions, behavioral overcoming and cognitive re-processing of the traumatic event with its consequences. Most manuals for the treatment of PTSD recommend trauma focused therapy and exposure as a major tool for treating PTSD patients (Foa, Keane and Matthew, 2000; National Institute for Clinical Excellence, 2005). Exposure-based therapies engage clients in systematically confronting the object(s) of their fears and distress within a therapeutic framework in order to regain control of overwhelming emotions. Relaxation and breathing techniques for lowering physical tensions and hyper-arousal are widely used in trauma treatment protocols. Cognitive Behavioral Therapy works with cognitive restructuring, targeting clients' upsetting thoughts and interpretations of the trauma and its effect on their lives (Resick and Calhoun, 2001). Some of the new developments in trauma treatment are presented within Narrative Exposure Therapy (Neuner *et al*., 2004; 2008) and Emotion-Focused

Therapy for Trauma (Paivio and Leone, 2010). Eye Movement Desensitization and Reprocessing combines exposure, relaxation technique and cognitive restructuring with an alternation between frames of the trauma image for stimulation of mental processing (Shapiro, 1995). EMDR has been widely accepted and used by therapists of different orientations, including Gestalt therapists (Ginger, 2010).

4.1. Gestalt Trauma Treatment

Gestalt therapists have a particular focus on *relational aspects* in the treatment of trauma, working with *dialogical interventions* to strengthen the ability for contact, and helping the client to finish unresolved traumatic experience in a dialogical way (Butollo, 2010). With its *holistic approach* Gestalt considers and treats the wholeness of a person affected by trauma. *The phenomenological method* used in Gestalt leads to the slow, minute-by-minute process of examining the original experience and recognition of interruptions in the process of assimilation and disengagement. The phenomenological stance in the *here and now* offers the possibility of distancing from the overwhelming past experiences and focusing the healing process on the present moment and all resources and supportive elements existing in the Self and its environment at the present time. *The contact* between therapist and patient is important to enable patients to withstand the trauma processing; the relationship and process are more valuable than content and techniques. *The I-Thou dialogue*, with presence, inclusion, and confirmation, is a method, but also a desired achievement in the therapy. For clients who suffer from PTSD it is a challenging but also a healing experience.

Awareness and acceptance, inclusion and dialogue as a basis for the approach in work with trauma affected people can be supported by useful specific Gestalt interventions like experimenting; empty chair or two-chair work, working with the "here and now", reassuring "I statements", etc. Other interventions commonly integrated in a Gestalt approach are dream work and visualization, bodywork, breathing exercises, relaxation, and meditation, rituals, therapeutic writing, etc. These simple curative skills can help trauma survivors to become re-grounded, re-centred and get back to the inherent wisdom of the organism to return balance and wholeness, and live more peaceful lives.

The healing happens in the process between two (or more) persons – client(s) and therapist. Every client has his/her own unique experience, each relationship and therapy is different. Still we will try to present here some occurrences and milestones often seen in the Gestalt trauma treatment.

4.1.1. Re-Establishing Self-Regulation and Boundaries of Traumatized Self

The natural ability for self-regulation and reaching homeostasis is lost, and the therapist has to encourage the client to increase self-care and healthy habits (nutrition, sleep, walk). At the beginning, but also during the therapy whenever the traumatic figure is too prominent, it is important that the client re-establishes self-control and a sense of safety in the "here and now" moment. The therapist supports the client to tolerate sensations, tensions and emotions by directing and focusing attention to the present moment; this helps in introducing distance from an overwhelming past experience. Respecting client's boundaries and willingness is also important in the therapeutic relationship, to avoid slipping into the parallel process with previous victimization. The therapist encourages the client to be an active participant; able to follow and choose what may happen in the course of therapy.

4.1.2. Re-Establishing Self and Context Awareness and Contact Functions

If the person has reacted during and after trauma with a strong dissociation of sensations and affects, the split of the "observing self" and the "experiencing self" could last a long time, causing disconnections from the context, and restricting clients from feeling sensations and emotions. This could be reduced by helping the person to enact and recover Self-awareness. The therapist could suggest some specific interventions as life-assuring "I statements" ("I am safe, I survived", "I am here and I'm alive"), as well as simple exercises for raising awareness of the body with its sensations and feelings. Breathing, relaxation and meditation helps clients to lower hyper-arousal, while some physical activities or exercises could release blocked trauma energy. Bringing the traumatized client back in contact with his/her body is a delicate and long-lasting part of the therapy if the trauma involved physical or sexual maltreatment. Still, the important part of trauma therapy is to realize how trauma is still represented in the body and to externalize it (Kepner, 1995).

4.1.3. Re-Approaching Trauma - Working with Avoidance and Intrusions

Working on the client's traumatic experiences often requires re-approaching or re-enacting the original situation and allowing the associated affect to be experienced and expressed. Trauma victims find it difficult to stand the recurrent and disturbing recollections of the event, including perceptions, images, thoughts or dreams. Self-calming (relaxation and visualization tech-

niques – a safe place, feeling the ground and the roots...) and systematic controlled exposure (setting a 10 minutes each day in which the person will recall or allow trauma memories) with an attitude of "acceptance and let it go" (mindfulness) can enable trauma survivors to regain control over intrusive contents.

The Gestalt experiment can be engaged as an exposure technique to the trauma-related stimuli: the client is guided to approach a particular traumatic situation again: to revisit the scene and re-experience it – retelling the details of the traumatic event, sensations and emotions as if it were happening in the present. With support from the therapist, the client encounters an impasse or the trauma content and emotions that he/she is avoiding. The therapist is involved, reassuring the client to endure and go through the experience, offering awareness of the here and now moment where the survivor's Self in relationship with the therapist is present, safe and alive. The client is helped to reach closure and to gradually disengage from the experience.

Throughout the process, the client is constantly encouraged to practice awareness, inclusion and dialogue. Still, we should always be aware of the high risk of re-traumatisation, particularly in applying exposure techniques without building sufficient support for the traumatized person to endure a new approach to the trauma.

4.1.4. Coping with Overwhelming Negative Emotions and Thoughts - Building Capacity for Acceptance

Apart from the sadness and grief for the real or symbolic losses, shame, guilt, and anger, together with feelings of failure, "what if" rumination and other self-defeating thoughts and adverse emotions are emotions commonly experienced by people after a severe trauma. The expression and processing of authentic emotions is supported. Instead of denying, blaming, overtaking or displacing responsibility for one's experience, the individual is encouraged to accept thoughts, feelings, and actions in the past and present, as parts of the Self and its limitations. Working on the capacity for acceptance helps the client to accept the changes, deal with the consequences and re-build a life with dignity and quality in the given circumstances. Specific Gestalt dialogical interventions are helpful here: "empty chair" as a chance to directly voice anger, or "two chairs" for "top dog-under dog" dialogue when the client is overwhelmed with guilt and self-accusation.

4.1.5. Re-Building a Social Support System and Involvement in Interpersonal Relationships

The interpersonal support, from family, friends and a wider social network, the feelings of belonging and love, prove to have tremendous healing potential. Still, trauma affects relationships and clients often bring to treatment issues related to the disturbance in interpersonal functioning: regulation of emotions, attachment and intimacy. They are often frightened by their emotions or numbness, and try to protect important relationships, withdrawing from contact.

The specific interpersonal dynamic related to trauma often appears in therapy too and the therapist has to be alert to his/her own experience in the relationship. When the client turns away from the trauma elaboration and looks for an experience where his/her new assumption might be tested and evaluated the relationship with the therapist becomes important: boundaries and trust are tested and expectations and demands can be elevated. It is important to remain stable, safe and in a clear setting with the presence of the therapist as a human-being with realistic and limited abilities. In a transference and counter-transference dynamic, client and therapist can exchange the trauma related content that remains beyond the words and out of awareness. Trying new assumptions in relationship and accepting another person with his/her strength but also limitations reassures self-acceptance.

4.1.6. Transformation of Meanings, Trauma Disengagement, Integration and Completion

Before being available for trauma disengagement, integration and completion clients need to re-establish a cognitive support system. Their basic assumptions about the world and oneself are challenged, particularly those regarding personal worth, trust and safety. The task of therapy is also to reconstruct fundamental personal beliefs and to revive positive thinking; to restore a system of values and beliefs, and help clients to regain hope, faith, and a perspective on the future. Gestalt psychotherapy with its emphasis on meaning making and spiritual holding (Polster and Polster, 1977) helps clients to reframe the narrative, reinterpret the event and search for new meanings relating to «the ground that provides a stability that the current moment itself cannot provide and perspective to reach beyond the immediate context for dialogue with something that is beyond the most immediate figure» (Jacobs, 2003b).

Reframing helps the client reach a new perspective beyond the individual experience; client and therapist are looking for a context and a frame that can

give a universal perspective and new meaning to the personal traumatic experience. Therapeutic writing and other artistic expression can help to integrate the trauma experience into life-flow, and to reconnect the past, present and future. Completion and integration are achieved when life before and after the trauma are perceived as parts of a meaningful continuum, rather than as fragmented, disconnected segments (Alon and Levine Bar-Yoseph, 1994).

4.2. Individual and Group Treatment

Most of the interventions described above could be used both in an individual and a group setting. The choice of individual or group treatment is usually a matter of convenience. However, the following observations should be taken into consideration before including people with severe trauma in group therapeutic work. An individual setting is recommended for people with severe trauma, for revelation and initial work on the trauma. It provides a safer environment and more private contact, with better prospects for re-establishing attachment and intimacy. The group context can be an important addition to the individual therapy, where the client can validate his experience again in a relatively safe situation. The group should be developed enough to be able to contain the traumatic content and related emotions and still stay whole and coherent. Sharing strong traumatic experiences at the beginning of the group during the first few sessions can be counter-productive; the group as a unit can be overwhelmed by the traumatic narrative in a similar way as the traumatised person.

5. Individual and Collective in Trauma

The unaddressed and unhealed trauma can be re-enacted through acting-in (alcoholism, substance abuse, depression, work-holism, physical ailment, suicide, etc) or acting-out (aggressive behavior, repetitive conflicts, high-risk behavior, domestic or interpersonal violence, etc.) and can cause individuals to hurt themselves or others, intentionally or not. «Pain that is not transformed, is transferred» (Rohr in Yoder, 2005). Trans-generational transmissions of the trauma have been described, particularly after massive and extreme traumatic events as Holocaust (Yehuda *et al*., 2005; Sorscher and Cohen, 1997). Trauma affects not only those directly involved in trauma but also their family, friends and, on larger scale, their communities. There are always strong social, cultural and political dimensions in defining and treating trauma that the therapist should be aware of (Scott, 1990; Yoder, 2005; Vidakovic, 2009; 2011;

Jankovic *et al*., 2010; Perera-Diltz, Laux and Toman, 2012). A Gestalt therapy includes a field perspective and offers a culturally sensitive approach to PTSD diagnosis and treatment (Chang, 2005; Perera-Diltz, Laux and Toman, 2012).

6. Existential Perspective in Trauma Healing and Post Traumatic Growth

After successful therapy the client will not only be symptom free but also able to acknowledge a gain from the traumatic experience (Melnick and Nevis 1992; 1998). People can not only survive trauma, they can also experience growth as a result of dealing with life's struggle (Calhoun and Tedeschi, 2006; Gilbert, 2006). Post-traumatic growth includes positive transformative dimensions, appreciation of life, shift in priorities, deepening of spiritual life, fostering positive attitudes and emotions. (Hobfoll *et al*., 2007; Grubaugh and Resick, 2007). Continuous transformation occurs both during the trauma and in the post-trauma coping period; it is a process and not just an outcome (Linley and Joseph, 2002).

As a therapist we have to believe in our clients and their capacity to overcome trauma and adversity in life. Still it is important to be realistic and honest, to act within the frame of a professional therapeutic relationship, and to recognize that for some of the severely traumatised clients even limited gains are appreciated. Otherwise we are at greater risk of "burn out" and "compassion fatigue".

From our experience with war-affected clients we can also recognize enormous human potential for endurance and creative adaptation through adversities. A lot can be learned from those people who manage to survive severe trauma, move on afterwards and re-build their lives: *"Going through the deep losses, I have learned to embrace the gift of life", "I am struggling to provide for daily living, but in a way am now more present in my life than before", "I appreciate everyday life with my family, small things, my grandchildren smiling or crying, freshness in the air and sunrise". "I still believe that good is prevailing in human nature, I have no enemies and I am at peace with my God".* The resilience and post-traumatic growth of those people can be recognized through the new spiritual dimensions they have reached and their ability to pass on wisdom to others. The post-traumatic growth continues also in the therapy, and it happens, both for the client and the therapist, through a deep human interaction.

7. Case Studies

Case study 1. The client was a man in his sixties who was captured during the war, imprisoned for eight months and physically and psychologically tortured. Within the diagnostic session he reported intensive post-traumatic symptoms: he had difficulty falling and staying asleep, intrusive upsetting images; often feeling exhausted, tense and easily startled. He started the therapy, coming regularly and talking mostly about a lack of interpersonal contact and enjoyment in his life. He lost interest in meeting people and had no willingness to work, which caused him to feel guilt and inadequacy and reinforced his restlessness. He felt unable to be close to his family; he socialized only with ex-detainees, believing that only they can truly understand him. In a way he seemed to be preoccupied with the suffering in the present while the trauma stayed out of reach of our exchange in the therapy. Only after referring to that could we understand how he was "holding himself on safe ground", being unsure that the therapist, a young female, could understand a terrifying experience of war. His realisation of how he held himself back to protect the other person from his deepest fears and horrors brought a new breakthrough in the course of the therapy. He started to share some of his trauma memories by speaking about the period when he was detained and completely isolated. He did not know anything about his daughter and wife; they remained alone in the war territory and the perpetrators threatened to find and kill them. Among the perpetrators were his pre-war neighbors who knew him and his family, which made his experience of torture and fear for the family even worse. In the dialogue that he created with the perpetrator through the two-chair technique he was able to confront and let the trauma experience go, demonstrating not only his capacity to endure and survive, but also to recall a positive experience where other people helped him to survive. After acknowledging his efforts to protect others even in his isolation, he was encouraged to go further by re-approaching people and re-establishing contacts with his family, particularly his daughter and new-born grandchildren, and to open himself to emotional exchange, without being afraid that he would damage his beloved with everything that he is carrying and coping with.

Case study 2. A young woman, in her early thirties, has been involved in group therapy for more than a year. She was a refugee, living with her mother and two brothers in a collective centre. In the group, she was very serious, reserved and rarely involved in the spontaneous exchange. In the second year of therapy, she gained enough trust in the group to be able to speak about herself. She has been thinking of going back to faculty; before the war she studied to become a teacher. War destroyed her plans for the future, her house and a rela-

tionship with a boy from the neighborhood. She received a lot of empathy and support from the group for her bravery and fortitude; the group encouraged her to go on with her life. After this opening, she started to attend less regularly, missing several group meetings and avoiding any deeper contact. When she was offered an individual session with the therapist, she revealed that she had had an outburst of emotions and intrusive dreams, struggling between feelings of shame and a desire to reveal her deepest experience within the group. She was about to share her suffering from being sexually abused during the war, but she was worried how the others would react. Her Self image was polarized between a strong and brave part, able to cope with all adversities that came with the war, and an unprotected and powerless part of the Self, unable to resist and protect herself when sexual violence occurred. We worked on her traumatic experience in an individual setting intensively for six months, mostly dealing with her feelings of guilt, powerlessness and shame. She went over and over the fragmented memories, and she felt frozen, just as if the trauma was happening in the present. We went back to see how desensitization and dissociation helped her at the moment of trauma; she recalled the memories of looking at herself from above,, feeling nothing, "like watching a movie". The therapist followed her, supporting her perseverance but also her hesitation, reminding her of the present moment and of eye-contact as safe places in the "here and now" that she could refer to. It was important to provide space for processing, maintaining boundaries but respecting her autonomy. She was repeatedly reminded that she had the possibility of choosing when to stop, restoring in that way her sense of control over her experience. However, for a long period of time, she was overwhelmed with powerlessness. The change-point for her was when she was able to recall some particular self-protective efforts and movements that she made during and immediately after the traumatic event, and to recognize this as evidence of personal endurance and strength even in the most adverse moments. She regained reliance and trust in herself. Gradually, some emotions and body sensations related to the traumatic event appeared, and she was increasingly able to tolerate them. The trust in the relationship was strengthened and it was easier to be in contact and to share emotions; she was able to reach and receive support from the other person. Ever since the traumatic events took place she has always been alone with her experience; now she felt accepted, understood, and reinforced. She was ready to join the group. Since then, a lot of work has been done in the group context on emotional processing and the reconstruction of self-esteem. The long journey is still in front of her. Ability for full contact, interpersonal trust and intimacy are seen as a desired destination.

Comment

by Willi Butollo

The paper by Ivana Vidakovic offers a careful selection of technical and interactional tools and principles from the rich fund of Gestalt therapy. It provides any reader with a thorough and sound orientation, no matter whether he or she may be coming from a more humanistic or from any other therapeutic background: how to work respectfully and with close in-session contact with severely traumatized clients using Gestalt therapy as the heuristic basis of therapeutic decisions.

However, reading her paper one wonders: why such a rich therapeutic approach receives so little attention in the fields of traumatherapies nowadays? How is it possible, one should ask, that more specific techniques like exposure therapies, cognitive trauma therapies or even something rather peculiar like EMDR receive so much more attention. Particularly since the main therapeutic goal of those techniques seems to be simply a more or less significant, more or less lasting reduction of physiological arousal following clients recurrent contact with trauma relevant memories or situations ("trauma reminders").

Of course, the richness of the Gestalt approach for traumatized clients seems to me to surpass other trauma therapies around. Why then does it not receive more public acknowledgement?

There might be several answers, one of them being that the broad and rich resources of Gestalt therapy make it very difficult to identify actual therapeutic interventions.

Some colleagues, for instance, would perhaps call their work Gestalt therapy, but if you look more carefully into what they actually do in their sessions, you might find very little in common.

Another answer can be found in the first two sections of Vidakovic's paper: there she gives us a short description of clinical diagnostic systems defining posttraumatic stress disorders, using assessment of trauma symptoms according to DSM IV criteria. A methodological procedure most Gestalt therapists would condemn due to its "static", "object-oriented" and "categorical" nature, remaining comfortably seated in an armchair in their therapy room, complaining about restrictive research methodologies, together with insensitive public opinions which discount the world's best therapy (theirs) by kicking it out of health system services and academic realms. Following those lines, Vidakovic also calls for process and relational diagnostics, which, in her opinion are specifically needed in trauma diagnosis. She claims that in assessing clients' clinical aspects of posttraumatic adaptation a more interactional approach is badly needed. Actually, such an approach has been called for since Gestalt therapy and humanistic psychology first arose. We might even recall

early writings from the cradle of humanistic psychology and could even go back to books by Charlotte Buehler (e.g. 1933, resulting from her work at Vienna University), Abraham Maslow, Carl Rogers and others, some even published before World War II. Strangely enough, nobody since then and even today really seems to succeed in attempts to establish a system of process diagnosis that meets research criteria. And, no surprise, nor did Vidakovic – at least in her paper, she does not give us a glimpse into whether she has ideas on how to proceed in solving this problem of interactional diagnostics and at the same time meeting scientific standards outside the humanistic subculture.

After all, is it my turn to ask the Gestalt community to loosen the anti-mainstream, diagnostic taboo in humanistic psychotherapy? In a way we already did so, by conducting a really strong RCT study comparing a Gestalt based trauma therapy with Cognitive Processing Trauma Therapy sensu Resick at Munich University (130 clients with full PTSD diagnosis, randomly assigned to two treatment conditions; see Butollo, 2010; Butollo et al., in preparation). The results are very beautiful from a Gestalt perspective.

In section three, Vidakovic compares the Gestalt concept of distorted contact processes with posttraumatic processes and found it useful to apply the notion of "unfinished business" to trauma issues. Among the concepts she refers to the ideas around "difficulties in demobilization" (Melnick and Nevis, 1997), conceptualized around trauma-related distortions of figure-ground relationship, seem promising. "Inability to turn away" from a figure becomes an issue in assessing and eventually changing immobilized contact attempts. Referring to our own experience with traumatized people, this notion can be extremely helpful in therapy and it should also be possible to focus on it if one wants to examine the effects of Gestalt therapy empirically.

In section four, after briefly describing exposure and cognitive processing therapies, she selects a few examples of essential elements of a Gestalt based trauma treatment. Rebuilding self-regulation, contact boundaries, context awareness and contact functions are certainly important examples of therapeutic goals. Re-approaching trauma, working with avoidance and intrusions, quite similar to the method conducted in an exposure type of behavioral therapy, are no doubt necessary therapeutic steps as well. But how do they fit into a Gestalt frame of change?

Towards the end of therapy, re-establishing social skills and support systems such as involvement in social relationships, integration and trauma disengagement come into the foreground of therapy. Social support skills are especially important: virtually all studies on social support show that for people with severe and lasting exposure to traumatic events "perceived social support" is far the strongest protector against chronic PTSD (for review of recent literature see Butollo and Asisa, 2012).

Vidakovic provides a very useful overview of possible intervention strategies and techniques, knowing that this is only a small fraction of methods that might be helpful. The list of those treatments, which one could include, would be very long, but it was not the intention of Vidakovic to be exhaustive, of course. Nevertheless, the importance of the in-session relationship is to be mentioned, the most genuine actualization of contact processes, "life" between client and therapist. In this interaction so many variations will merge, which are specific for posttraumatic contact processes and can be brought into foreground easily. In-session interactions, however, are very delicate events, often at risk of causing serious disruptions to the client-therapist relationship. It becomes obvious that in trauma therapy the timeliness of interventions is a crucial issue. What might be disruptive interventions at an earlier stage of work could be right-on at a later stage and vice versa.

Assessing Suicidal Risk

by Dave Mann

In comparison to how often we meet with the need to assess the danger of suicide/self-harm in our clinical work the subject of risk assessment appears to be covered relatively rarely in our theory. The methodology of assessing risk can be difficult to quantify given the abundance of influencing factors in the client's situation. I offer my thoughts on the subject from a Gestalt perspective having spent over a quarter of a century assessing risk of suicide and self-harm in the psychiatric services within the British National Health Service (NHS) and private practice. What follows is one Gestalt therapist's far from comprehensive account of attempting to predict a client's future "risk behaviour" based on past and present behaviour.

1. Assessing Risk Phenomenologically

Whilst there are theories regarding pointers towards suicidal behaviour, if we are to remain true to our phenomenological dialogic approach as Gestalt therapists we need to remain open to what unfolds before us whilst maintaining a tentative grip on indicators of risk in the field.

In assessing suicidal ideation and intent we can use statistics relating to neurological research, diagnostic criteria, class, culture and practical issues such as access to lethal means and the like. Indeed, I suggest that we do explore all avenues in the field that may offer information as long as we do so in relation to the person before us. It would be negligent to ignore such a huge body of researched data[1]. However, statistics alone can be misleading when such a cold science is applied in isolation to the give and take of human relating. We need to hold the information lightly whilst building upon it by making sense of the multiplicity of phenomena that emerges in dialogue. In Gestalt,

[1] Discussing such factors is beyond the scope of this short chapter. For the interested reader I suggest perusing Kutcher and Chehil (2007); Firestone (1997); Joiner (2005).

with our roots grounded in phenomenology, field theory and dialogue we are well positioned to assess the possible emergence of risk not only in the here and now of the therapy room, but also in the "there and now" (Yontef, 1993) of the client's world outside the therapy room.

In our society there is an element of taboo around detailed inquiry into areas such as suicidal urges. However, when suicidal risk is in the air do not shy away from the issue. We need to assist clients in contextualising their experience in relation to their situation. To facilitate description we focus on the how and what of their experience, building a picture of their act of intentionality. Through such inquiry we can assess the level of risk whilst investigating the individual's perception of their phenomenal world. As a starting point a clarification I seek with clients is whether they are experiencing suicidal ideas or whether intent is, or has been, present and what accounts for any movement from ideation to intent and vice versa.

Geoffrey, a middle aged businessman, arrived for his first ever therapy session wearing a pinstripe suit as if it were armour. Although he maintained a fixed stare his eyes were cast slightly downwards as he appeared to look inwards, whilst simultaneously repelling his present environment. His body was tense, his jaw tight as he told me of his "strength" and how he didn't really need to be here. "Then I guess this is difficult for you", I responded. I was met with a more contactful quizzical look from eyes that softened slightly; "What do you mean?" Geoffrey replied. "Needing to be strong and seeking help just sounds like a tough mix for you", I said, simply stating the conflict I saw. His shoulders dropped slightly as he nodded. A silence ensued that I chose to break with what felt like a daring inquiry, "Can you tell me Geoffrey, do you ever think of killing yourself?". He looked up, initially startled before sighing and hesitantly saying that he often did. I noticed that his pinstripe suit appeared slightly crumpled. The ground had been laid for phenomenological inquiry into Geoffrey's ideas of suicide and although describing his urges was difficult his relief was palpable. As the weeks passed and he shared more of his thoughts of suicide, so the risk of him acting on them diminished. No one had ever asked him about them before.

Examples of questions I may ask beyond ("Have you ever thought of suicide?") include: "How often do you think of killing yourself? In what situations do these thoughts/impulses arise? Do you think about how you might kill yourself? Have you ever moved towards action and if so what did you do and what stopped you? Can you describe what happens to you when you think of killing yourself? Are these thoughts with you now?". My intention with direct inquiry is to invite dialogue about a client's suicidality by making it explicit,

rather than a belief in the Paradoxical Theory of Change (Beisser, 1970), when managing risk. We are then in a position to form treatment plans and strategies for intervention in relation to what is and what could be.

Although I build a picture of how the client makes sense of their world this is not a one-way street. How we reach out to the client (or fail to reach out) offers crucial information as long as we have sufficient self-awareness and humility to question even our most sedimented theoretical beliefs. If the maps we use to negotiate a therapeutic encounter are too brightly figural for us, then we risk being blinded to the human struggle before our eyes. We need to appreciate how my phenomenal field and the client's phenomenal field meet in creating that third reality of a shared phenomenal field. This is fundamentally what we do in relational Gestalt therapy, but in assessing risk we direct our attention to areas associated with risk such as isolation, shame, guilt, desperation and worthlessness.

Seeking description is not the same as seeking facts. We are assessing an intersubjective process and our perception of risk will naturally be coloured by our history as well as the client's history. If we are to practice phenomenological inquiry we need to develop awareness of our proactive material in relation to evocative areas of suicide and self-harm in all their forms. In common with most Gestalt therapists, I do not believe that Husserlian bracketing and transcendence of our interpretations of the world is possible. However, if we can venture some way down that road perhaps we can bracket our beliefs sufficiently to gain something approaching "virgin experience" (Husserl, 1931) and so gain a flavour of the world from the client's perspective. To do so requires more than an ability to bracket. The complex process of appreciating as far as possible another's perception of the world and thereby making the other present (Friedman, 1990) demands a swinging over to your side while remaining on my side, with a willingness to flow in and out of confluent moments and "taste" the client's distress. If we are unable to practice such inclusion after using support from supervision and personal therapy we probably need to refer a client on. Failure to acknowledge our limitations and vulnerabilities as therapists increases risk.

Let us not lose sight of the obvious when assessing risk. Before us sits a fellow human being who is suffering in the way he is reaching out to the world and the way in which his world meets him. He is suffering and his world is suffering too. Too often our individualistic cultural bias leads us to explore only one of these relational poles. Yet, if we cannot gain a flavour of the environment's interaction with the client then we can only ever complete a part assessment of functioning. The client's disturbance may be perceived as occurring beneath his skin but it must lie between him and his world. Any phenomenological inquiry needs to highlight the relational nature of existence through exploration of the client's connection/disconnection with his world.

In many ways assessing risk is no different from the on-going assessment we engage with in work with all our clients if we adopt a relational approach. In essence, we need to learn to read what emerges in the co-transference in relation to the person before us and use our reactions as the basis for our inquiry whilst being sensitive to those field conditions that press in upon the client and her situation. All the data we need is present between client, therapist and the situation, we only need to know how to look. In my experience one of the greatest achievements in countering suicidality is to increase awareness of the connectedness between the client and their situation. So often suicidal ideation, intent and action are characterised by disconnection with the supportive possibilities that exist in the person's lifespace. Suicide is, after all, a permanent solution to a temporary problem.

2. Pre-Configuring the Field versus Maintaining Safety

It is my usual practice when working with a suicidal client to insist upon a no suicide contract[2] during the course of our work together. Usually this is readily agreed, but occasionally a client has felt unable to make a long-term commitment and we have needed to renew our contract at agreed intervals, occasionally every session. I am aware that there are mixed opinions within Gestalt on this point but my belief is that there is an implicit pull towards life by virtue of the client walking through the door of my therapy room. I invest in that pull, and with a no suicide contract in place feel free to explore the intricacies of the client's suicidal tendencies.

Within services[3] there is invariably pressure to accurately predict individuals' behaviour, particularly in relation to risk. Such pressure exerted overtly and covertly preconfigures the field in which therapy takes place. Fear of litigation or being called to a coroner's court can lead to defensive practice that permeates the therapeutic frame. When receiving referral information from others, for good reasons and with good intent, the referrer often highlights *their perception* of any risk issues. Such information shapes the field of the new encounter and can negatively influence the level of contact in that new encounter. Consequently, the level of disconnection from the present field where support is available for the client can be reduced. We need to appreciate the co-created nature of reality, for contact with the client is shaped before the actual meeting with the client. Blaize (2003) hypothesises that prior information regarding the

[2] My "no suicide contract" is a verbal agreement that the client will not attempt to kill him or herself during the course of our therapy.

[3] I am particularly familiar with the British National Health Service and Insurance Companies in Britain.

risk of dissociation could increase the probability of dissociation. It seems fair to hypothesise that prior knowledge of risk could increase the likelihood of risk, particularly as dissociation is so often key in suicide and self-harm. From a field perspective risk to self can assume a more prominent place in the client's field if all those around him are focusing on a potential threat rather than the client's phenomenology. It can be a tragic irony that if the lens we see the client through is unduly coloured by issues of suicide or self-harm we can maintain a higher level of those very risks by proactively maintaining it's lurking presence in the ground of the relationship.

Despite the potential problems of preconfiguring the field I believe that we need to take a history. I am not advocating entering the business of archeology, but history uncovers information and patterns from the client's lifespace that not only indicate risk factors but also how the client has successfully creatively adjusted to her environment in the past, «as well as what aspects of the client's experience are likely to be repeated» (Tobin, 1985). Sure, we explore the here and now experience of the client but present experience does not stand in isolation, it is connected to a past and a future (Merleau-Ponty, 1962). It is also connected to a wider field of situations that the therapist needs to explore. This field, that could widely be termed "supports", will include areas such as, the political, employment, financial, aspirations, social, culture, interests, family, friends, input or lack of input from services, and more, all of which are interrelated.

We need to balance the picture that is painted from the client's historical patterns against unduly preconfiguring the present field, but risk assessment by its very definition is concerned with predicting the future based on present and past patterns of behaviour. A history can be taken from the perspective of discovering what situation is unfinished for the client and how the client stops himself from completing.

3. The Wider Field

I saw Sarah, a child-minder in her early thirties who had recently separated from her partner, in my private practice. Whenever I saw her I had the unusual experience of my therapy room – with its soft furnishings, warm colours and pictures – being cold and clinical. Sarah admitted *that she was depressed but forcibly denied ever having experienced suicidal ideation or intent. I was consistently unconvinced by the force of her assertions. Listening to this repeatedly emerging co-transferential theme, I began to explore Sarah's perception of our immediate environment.*

Dave: "We've been meeting now for a few weeks and I just wondered what

it was like for you, as a carer, meeting me, as a psychotherapist, here in this therapy room?"

Sarah: "Uncomfortable (shuffles in her chair). I feel as though I should be the one doing the looking after… I feel useless (looks around the room)… roleless".

Dave: "As you look around the room what do you see?"

Sarah: "Something closing in on me… it feels threatening... I could never do anything like that (points to the artwork on the wall)".

The above dialogue led to further exploration of the impact of Sarah's phenomenal field upon her. The room closing in on her represented what she perceived as her advancing years with imagined losses. Her perception of the environment as "threatening" revealed a fear that if she shared what she truly felt and thought, her suicidal ideas, then she would have her freedom taken away. Her reference to the artwork reflected a detachment from her abilities and her sense of isolation beyond the room. Retroflection of her suicidal thoughts were supported by the societal introject that the words, "I want to kill myself" must not be uttered[4]. By exploring Sarah's wider situation we were able to identify the elements of her situation that pressed in upon her now. It transpired that Sarah's only social contacts were via the Internet; her friends were virtual. As she shared her reality more openly, including her suicidal fantasies, she owned her distress at the lack of "just chatting" and her yearning for the feel of flesh on flesh. In doing so the invisible became visible and the unspoken became spoken (Merleau-Ponty, 1968).

To understand another's "risk behaviour" we need to view that behaviour through a lens that does not lose the multifaceted, multilayered reality of the laminated field. Isolation is a by-product of our Western individualistic culture. Alongside space for individual innovation, creative expression, entrepreneurial prowess and social mobility lies paranoia, obsessiveness, "self-contained" anxiety states, isolating depression and social phobias. Technological advances borne from our cultural need for speed give us virtual contact with others across the world yet lead us towards paranoid-depressive withdrawal and schizoid detachment. This escalating trend of severing ourselves from our natural phenomenal world increases the possibility of «the ultimate form of delinking… death (suicide or homicide)» (Saner, 1989, p. 63). To reduce risk Sarah needed to re-establish her awareness of her energy flow between environment and self. In this process of heightening awareness I needed to be mindful

[4] This conspiracy of silence is probably reinforced by the fact that only half a century ago suicide and attempted suicide was illegal under English Law known as "Felo de se". In 1961 it ceased to be an offence with the passing of the Suicide Act. The same Act makes it an offence to assist a suicide.

of our cultural bias to see energy flowing from the individual to the environment.

«Our own body is in the world as the heart is in the organism» (Merleau-Ponty, 1962, p. 235).

4. Fixed Gestalts as Supports

> What is ordinarily called "security" is clinging to the unfelt, declining the risk of the unknown involved in any absorbing satisfaction.... The secure state is without interest, it is unnoticed; and the secure person never knows it but always feels that he is risking it and will be adequate (Perls, Hefferline and Goodman, 1951, p. 233).

Such an illusion of security may not encapsulate excitement, it may not be growthful, but it serves a function and that function is likely to be supportive. If an illusion of stability is reached through enacting outdated fixed *gestalts* and maintaining field-incongruent ways of being, it could be largely irrelevant as far as averting a life-threatening crisis is concerned. In crisis situations the task is holding rather than challenge, glue rather than solvent (Stratford and Brallier, 1979). Steps towards fully integrated change are likely to take time for the suicidal client. Gaining an embodied sense of being grounded is not, either actually or metaphorically, simply a matter of putting one's feet on the floor when the person's past experience is void of constancy. If the figural new and experimental creative adjustment forms too rapidly and stands upon a shifting ground we create a recipe for fragmentation rather than integration.

Andrea had been in therapy for several months and was making progress in addressing her long-standing self-harm through cutting when her partner, who had been an isolated support, deserted her. To date we'd identified the different ways in which she cut herself, the intention and motivation behind each action. Her controlled cutting across the top of her forearms or legs served to "relieve tension" and was relatively safe. However, the wild impulsive arm and wrist slashing she had engaged in was in reaction to intense frustration and was potentially life threatening. Although this had now ceased there was a risk of her reverting to such behaviour that had previously led to hospitalization. Naturally I offered considerable additional support in the form of extra sessions, e-mail and telephone contact. I recruited a colleague who had acted as locum for me in the past to provide cover, but also to model a process of using support. Andrea said that she did not want to kill herself, but the scars from past "wrist slashing" screamed out that she could. We had explored possibilities regarding a place of safety, but Andrea was adamantly resistive to the

limited options available. I sought the same passion in her assertions that she would not engage in her impulsive slashing.

In therapy we walked a narrow ridge between sensitising Andrea to available supports and her need to desensitize from her pain of desertion. The task was to broaden this narrow ridge, to increase awareness of a continuum between sensation and desensitization, and for Andrea to find a way to safely express her underlying emotions. In one of our "crisis sessions" Andrea described her arm slashing and mimicked the action she made when harming herself. "Could you just do that again", I asked and she repeated the wild slashing motion. With permission I copied the action to gain an embodied sense of it – I felt out of control. "If you hadn't got a knife in that hand, what might you have?" I inquired. Andrea's response was swift, "A fucking big paint brush!". At this point it would have been easy to dive into experimentation but Andrea's speed had shades of her manic self-harming and I felt wary. We experimented with slowing down the movement and as we did the "fucking big paintbrush" became lighter and finer. From that experiment Andrea allowed her gentler side to surface and began to produce beautiful pen and ink illustrations of her hurt and anguish. Over subsequent weeks she further developed her healthier creative adjustments that led to a passion for art that proved to be an on-going support.

In the above work I was vigilant in assessing the client's relationship between her emerging figures and her ground together with Andrea's ability to integrate new figures, particularly those that conflicted with sedimented beliefs about herself. When such conflict arises risk can increase quickly and dramatically, particularly when the emerging figure stands hazily upon the client's newly forming horizon.

There exist within the practice of Gestalt therapy misunderstandings and simplistic ideas around undoing retroflection in relation to suicide/self harm[5]. Whilst I believe there are invariably such processes as retroflection present that are likely supported by ground introjects, one cannot undo such processes with a few cathartic experiments. Though carefully graded experimentation may help in the management of self-destructive impulses, when suicidal intent is present we need to explore what has worked to date for the client and how those successful strategies can be adapted safely to enable the client to hold themselves safely until such time when sufficient support has formed to move

[5] There are of course schools of Gestalt therapy that firmly believe in a more adhesive approach than a "Boom, boom, boom" (Yontef 1993, Resnick 1995) style of experimentation. Staemmler (2009), Lee (2007) and others have articulated the circular nature of cathartic expression of anger. Research in neuroscience suggests that majoring on cathartic expression is often contra-indicated.

towards lasting change. Perls might have said that the retroflective form of homicide was suicide but he also invited us to see resistances as assistances.

5. The Importance of Appreciating the Client's Phenomenology

There needs to be a degree of integration of the self for survival. How that level of integration is achieved is secondary to the ability to achieve a sufficiently stable level. To return to Stratford and Brallier's (1979) metaphors of "glue" and "solvent" what we might perceive as signs of disintegration might actually act as "glue" for the client, conversely what might ordinarily be seen as "the norm" or "healthy" can be experienced by the individual as "solvent". Many people live their lives weaved around what others might describe as delusional ideas, hallucinatory experiences, obsessive-compulsiveness or bizarre behaviours and these experiences are not necessarily life threatening states in themselves. Although they *can* increase risk such ways of being may hold a supportive function.

Margaret had been diagnosed as suffering from schizophrenia and had experienced auditory hallucinations for most of her 55 years. She had attempted suicide in the distant past in response to a crisis situation rather than in reaction to what she described as "the voices". She received regular medication and maintained a relatively high level of functioning. Margaret was then prescribed a new tranquillizer that came onto the market that had proved particularly successful in treating symptoms of schizophrenia. It proved successful in treating Margaret's auditory hallucinations that ceased for the first time in her living memory. However, she was distressed to the point of suicide at the extinguishing of these familiar sounds that over the years had become supports. In failing to inquire into Margaret's experience of her "voices" the psychiatrist had been relating to his perception of health. The decision was reversed and the crisis averted. A lesson in appreciating another's phenomenology had also been learnt.

In relation to what he refers to as "whole-field support" Wheeler (1998) asserts: «in the cases of drastic, sustained failure of that support, the self moves in some way to self-destruct». This severing of the self from support results in an experience of "self-out-of-relation", the client's experience being complete isolation. In such a state the only alternative for the expression of aggressive impulses is to turn the self against the self. In the suicidal client this process of splitting can result in the sense of a force with a separate power that may take them over, or a hopeless topdog-underdog downward spiral. This depressive

spiral may not be life threatening as long as motivation remains low, but any sudden increase in mobilisation can lead to action resulting in suicidal ideation flipping into intent.

Likewise, if a client dissociates himself from a desire to commit suicide he is in a very vulnerable and dangerous position when the desire does surface. Behaviour is likely to be impulsive and hold a borderlining quality (Mann, 2010). Again suicidal ideation can flip into action rapidly as the client loses contact with their support function. In such circumstances we need to assess the function of the dissociative behaviour and work to sensitize the client towards simple everyday supports.

A further life-threatening scenario results when the person has created a fragile self-identity with detachment from their present lifespace. When this person contacts a current field congruent way of being, a reaction of crushing shame can lead to suicidal behaviour. Such a rudderless sense can surface as a result of effective therapy that may indicate a need for a change of therapeutic tack. Jacobs (1995) hypothesises that suicide could be the most dramatic expression of shame due to the shame-fuelled desire to hide forever from the sight of others. If, as Jacobs asserts, there is a strong connection between powerful shame experience and suicide, it follows that building resilience to shame within a grounded relationship increases safety and that a lack of such resilience is a risk factor.

6. The Need for Continuity of Relationship

Risk to self increases when the individual is unable to hold a level of continuity and constancy in relationships. This may present in therapy as the client experiencing each therapy session as a detached event, void of on-going story. In building the client's capacity for holding onto contact sequences it may be beneficial to offer the client something physical to hold onto, what we might think of as a transitional object, in addition to other forms of contact between sessions e.g. telephone, e-mail, text. Any resources need to be built from solid relational foundations responding to the client's relational need. Someone who has not had an experience of a holding environment will need such an experience to increase their ability to contact supportive elements in their environment.

A client I worked with for many years in the psychiatric services in the UK experienced great difficulty in "joining the dots" between our twice or thrice weekly sessions. Lacking a sense of on-going support he retroflected his frustration at a perceived lack of care into severe self-harming behaviour that could

quite conceivably have resulted in suicide. Persistence and patience were the order of the day (or first few years!), meeting the client where he was in working towards gaining an understanding of his fragmented experience of our relationship; that mirrored his experience of his relationships in his world. The nuts and bolts of therapy involved plenty of common contact together with closing the space between the dots by supplementing our sessions with telephone contact until he was able to carry more of an on-going sense of my existence and care. Initially it helped him to carry my card together with a small stone from my therapy room. It was important that as a service we did not clutter the client's field by involving too many professionals, to have done so before his ability to integrate his experience had increased risked inviting fragmentation. I provided the therapeutic input but worked closely with my colleague, a female psychiatrist in doing so. I'll leave you to imagine the possible co-transference!

8. Risk Assessment in Relation to Aesthetic Criteria

Aesthetic criteria are described as «sensed actualities» (Bloom, 2003, p. 72) – rather than an abstract map or hypothesis of what is, was and could be that affect the stream of contacting. Both the client and the therapist feel interruptions. We are discussing a moment-to-moment form of assessment and diagnosis, so how can this assist us in assessing possible risk? Or to put it another way how can assessment in the present help us hypothesise about the future? The present moment does not exist in isolation; therefore aesthetic criteria cannot exist without being connected to such criteria from the past. There will be a pattern and style of forming (or inability to form) aesthetic criteria that span time and can lead to an assessment of possible future behaviour. As ever, we need to hold any predictions lightly, but patterns do repeat and how they repeat is informed by history. «The intrinsic sensed qualities of the forming figure contain the vitality of the organism/environment and is the radical core of Gestalt therapy's understanding of life» (Bloom, 2005, p. 54).

Conversely, I wonder whether it is implicit that poorly formed figures through habitually diminishing, diluting or distancing contact (resulting in a lack of flexibility of the contact boundary) can provide pointers to Gestalt therapy's understanding of death. I suggest that a persistent failure to achieve good form can be seen as a significant risk factor with processes such as projection, retroflection and confluence figural being supported by ground introjects. With this in mind I agree with Crocker that «[…] therapeutic processes that are informed by aesthetic criteria are important aspects of Gestalt therapeutic work. But these are not the *only* criteria with which to evaluate human functioning» (Crocker, 2005, p. 58, original italics).

Autonomy and identity develop over the course of our lives and their development will be restricted or facilitated depending on the range of permeability and rigidity at our contact boundary in relation to our situation. In this respect the fullness and richness of our development will be dependent upon the aesthetic criteria of the *gestalts* we form. We cannot learn how to be creative, we just are creative, whether we use our creativity to nourish, diminish or destroy our being-in-the-world is ultimately our choice. It is one of our tasks as Gestalt therapists to assess the degree of risk present in our client's creative adjustments.

9. Repetitive and Recursive Loops

The therapeutic process is often circular. Risky behaviour, like any other way of being, so often repeats. Without an ability to develop recursive loops (Resnick, 1997; Jacobs, 2003a) the client can simply move into repetition compulsion. «The repetitive loops reflect imprisonment in, and also investment in, a closed system of negative expectation, dread, and despair… Recursive loops, on the other hand, are the manifestations of the fluidity and movement of present-centredness in which one's history and one's future are intermixed oscillating grounds of each other» (Jacobs, 2003a, p. 38).

In essence, recursive loops are ways of gestalting present experience in relation to the present situation rather than an archaic situation. Recursive loops serve to re-orient the client to the present situation and free him from the elastic chains that rebound him to past trauma and imprison him in outdated ways of being. However, as ever things are not quite so black and white. Like so many aspects of human behaviour repetitive loops and recursive loops cannot be neatly separated as invariably there are aspects of both repetition and recursiveness in any behaviour, including risk-taking behaviour, with varying degrees of each. As an illustration I refer back to my work with Andrea. Recursive loops were evident in her developing expression and passion for art, and in doing so experimenting with new creative adjustments. Repetitive loops continued to present in her a less severe controlled form of self-harm in cutting her forearms and legs. When she eventually ceased cutting altogether, subtle forms of self-harm continued to present in her smoking and exercising excessively. In assessing risk with Andrea I monitored the development of her recursive loops whilst tracking risky repetitive loops.

10. Making Sense of our Perception in Relation to Risk

«The secret resentments, unmentionable and inexpressible, are retroflected and turn into feelings of guilt and worthlessness – from the torture of which death is the only feasible escape» (L. Perls, 1989, pp. 8-9).

As already discussed there are obviously more inter-related processes than retroflection weaved into the matrix of a suicidal person's relating to their world, but to make sense of the whole we need to first make sense of the parts. In the business of assessing risk we need to be thinking about what such processes look like and what interventions might be indicated and contra-indicated.

Whilst acknowledging that listing processes that may indicate risk will be limiting and dichotomising, as a starting point I offer the reader the following thoughts upon which they may build, adapt or discard. From my experience I hypothesise that self-harming and suicidal behaviour is characterised and/or exacerbated by:

1. Failure to appreciate that I am part of the client's contact boundary and that they are part of my contact boundary.
2. A fragility and lack of consistency in the client's ability to make sufficiently supporting contact with her environment.
3. A fragility and lack of consistency in the client's environment to make sufficiently supporting contact with the client.
4. The forming of a rigid contact boundary marked by impermeability and resulting in isolation and detachment between client and environment.
5. Conversely, the contact boundary could become too permeable resulting in a lack of differentiation from a poisonous environment.
6. A rapid mobilisation of energy in response to an impulse that is then retroflected.
7. The whole process is likely to be supported through introjection, most probably ground introjects.
8. Failure to take a field view of the individual's process resulting in an increase in detachment and isolation as behaviour is viewed separately from the whole situation. Tragically this key area can inadvertently be reinforced in therapy that fails to take a field theoretical approach.
9. A lack of groundedness in the present leading to the client being unable to tolerate uncertainty.

Within a Gestalt framework embracing the principles of phenomenology, field theory and dialogue we need to develop our own styles of assessing risk. In doing so we attend to the between of the relationship when encountering the other in an ongoing series of fluid moment to moment events that can never be adequately covered by a theoretical map or checklist. The map can never be the

territory but maps are needed to negotiate territory, the art of successful Gestalt therapy and risk assessment is to know when the map fails to adequately describe the human being before us in their situation.

«To attain knowledge, add things every day. To attain wisdom, remove things every day» (Lao-Tse, 1993).

Comment

by Jelena Zeleskov Djoric

The chapter Assessing Suicidal Risk *by Dave Mann is a very significant contribution to the subject of suicidality in the context of Gestalt therapy. In his considerations of this subject the author points out several important concepts of Gestalt theory and methodology starting from field theory, dialogue relationship between the therapist and the client, phenomenological method and support systems.*

Speaking about field theory in treating suicidal clients, Mann highlights the importance of exploring everything that can be significant for the client in the context of their history, stressing that what is happening in the session here and now is just as important as there and then, that is, that the client's world outside the therapy room is very important in understanding people with suicidal tendencies. From my point of view this is very important, because when we work with people with suicidal tendencies we must know their history, their outside world, and their support systems more than when working with other clients. It is important for therapists to enable the client to contextualize the experience relative to the situation in which they find themselves and to investigate the phenomenological world of the client. In this context, the author supports his claims with examples from practice, in a clear and precise manner. In addition, the author's opinion on direct interventions instead of belief in the paradoxical field theory in working with suicidal clients is very important, as well as directing attention to the feelings of guilt and shame and with having a relational approach in the background, is a good proposal for working with suicidal clients. I definitely agree with Mann's proposal for direct intervention instead of using paradoxical field theory, because a client with suicidal tendencies needs to hear words of acceptance and support from the therapist, needs to feel that the therapist understands him/her and needs to have very clear directions from the therapist, because of his/her tendencies. Previous researches on the work with suicidal clients confirm the author's recommendations about interventions (Ellis and Goldston, 2011).

Further in the text, the author points out that the phenomenological ap-

proach in dealing with such clients should involve inclusion as part of the therapeutic process, as well as the therapist's awareness of their own limits and vulnerability in relation to the subject of suicide. Studies have shown that vulnerability of therapists working with suicidal clients is significant (Gutin, McGann and Jordan, 2011) which is consistent with the author's proposal. In addition, Mann points out that it is important to work on the client's awareness of the connection between them and the environment, because suicidal tendencies are actually a response to the disconnection between the client and people in the environment. It should be borne in mind, as the author points out, that people from that specific environment such as relatives and friends will provide information that is most often focused on the suicidal threats of the person, not the client's phenomenology. These could influence the presetting of the work with the client, which the author discusses in great detail. The importance of verbalization of suicidal thoughts and sentences in working with these clients is very important, and the author confirms that again by giving practical examples. My opinion is that verbalization of suicidal thoughts is not only very important for the client, but also for the development of the therapeutic process, the relationship with the client and the possibility of working with the client at a deeper level in the therapy session.

In the next section of the chapter, the author discusses the importance of a gradual introduction of new and creative adjustments in crisis situations, to avoid clients' fragmentation instead of integration. It seems that the therapist must be very careful in using experiments in working with clients who have suicidal tendencies, which applies not only to this category of clients, but is one of the postulates of therapeutic work in general. Writing about the importance of recognizing the client's phenomenology, the author discusses the ways the splitting process manifests with these clients. Apart from this, in my opinion, the importance of motivation is not sufficiently elaborated. Motivation is a a very important part of initiation, mobilization and actions that lead to suicide, so it needs to be included in the explanation.

The author sees another manifestation of such life scenarios, in the creation of fragile self-identity and disconnection with the environment in the present. The author believes that a person who has built a fragile self-identity in contact with the environment, as a result of unsuccessful communication, may experience shame, which then leads to suicidal behaviour. In this context, shame refers to hiding forever the fact the others see me, which makes the connection between suicide and shame very clear. However, in this part the author elaborates insufficiently on how to build resilience to shame that could help the client. The text mentions the importance of resilience, but it is not further discussed, which might be interesting for future considerations of this subject, given the researches showing that resilient people are less susceptible to sui-

cidal attempts (Nrugham, Holen and Sund, 2010). My opinion is that resilience is a very important capacity for overcoming stressful events, but also for everyday communication with the environment. Some dimensions of resilience need to be taken into consideration when working with clients who have suicidal tendencies, such as self-related characteristics, perception of time and generalization etc. Interventions in this direction could be useful for the client and the therapeutic process. Moreover, resilient people are able to maintain continuity and consistency in emotional relationships (Mikulincer and Florian, 1998), which, as the author points out, is very important to develop with people who have suicidal tendencies, while proposing the introduction of the transitional object or other forms of contact between sessions. In addition to that, the author touches upon his view on the assessment of suicidal behaviour in relation to aesthetic criteria, pointing out that the therapeutic process is an important aesthetic criterion, but not a sufficient one, with which I agree. Finally, as proposed by the author, in assessing suicidal risk one should take into account the fact that we can not only talk about retroflection, but that the person's inter-related processes should be included in understanding suicidal behaviour.

Mann's view on the problem of suicide risk assessment is certainly an important contribution to the field of Gestalt therapy, particularly bearing in mind the concept of process and highlighting the importance of certain therapeutic interventions in working with these clients. Finally, the proposed explanations of suicidal behaviour and self-mutilation in the context of therapeutic work can certainly be useful to therapists working with people with suicidal tendencies.

Part IV

Specific Clinical Sufferings

"What Does it Look Like?"[*]. *A Gestalt Approach to Dementia*

by Frans Meulmeester

Dementia
is
at the end of your life
dealing with your past.
To fight now
what you did not fight then.
To cry out now
what you did not cry out then.
To speak out now
what you did not speak out then.
One big psychodrama
with you in the leading role.

1. Introduction

In a traditional, strict medical culture, we can draw a clear line or boundary between healthy people (of course, that's us!) and sick people (of course, that's the others, the patients). Especially in the care of people with psychological, psychiatric, or psychogeriatric problems, we like to keep this boundary very clear and hard to cross. Behaviour that we don't understand is called a "behavioural disorder" and we see it as part of the pathology, regardless of possible meaningful motives underlying it or any possible influences of our presence or interaction with the person concerned.

In many areas of modern healthcare this paradigm has changed. However, in the care of old people with psychogeriatric or gerontopsychiatric problems this paradigm is still quite present.

Therefore, I would like to present another, much more person-oriented perspective based on the Gestalt approach to this group of people. In the context of this chapter, I will restrict myself only to the view of and approach to people with Dementia. Hopefully, the reader will be able to translate this approach to possible other groups, for example a group of old people with gerontopsychiatric problems or with mental handicaps.

[*] This title comes from an old lady, diagnosed with Alzheimer's disease, third phase, according to the doctor "totally confused and out of contact with reality", answering to this doctor who saw her lying on the floor, asking her: " Are you ok, Mrs Lintz?".

2. Dementia: a Terrible Diagnosis

The diagnosis Dementia is, of course, a terrible diagnosis. Firstly, for the person himself, although he might not have any knowledge of this diagnosis because of the simple fact that nobody tells him[1].

However, in most cases the person *is* aware that something is going on with him, but does not always know or understand exactly what it is that is going on. I will come back to this later.

Secondly, it is a terrible diagnosis for the partner and/or for the children. As with most severe, chronic diseases, it is not only the patient who suffers: the whole family suffers.

In fact, in a way people do lose their partner or father, but at the same time, this person is still there. In chapter 2.2 on risks of psychopathology in old age, I already mentioned Susan Roos, who wrote a book on the concept of "Chronic sorrow": the process of grief that people go through when they or their partner are confronted with a chronic disease or handicap (Roos, 2002).

Actually, the diagnosis Dementia is also a terrible diagnosis for another reason and that is because of the meaning of the word "dementia". Almost literally, it means "without mental abilities". In other words, the word "dementia" suggests that a person who is suffering from this disease, loses his mind, which means that what he is saying or doing, does not make any sense anymore.

Can you imagine what it's like if this idea underlies all interactions with you, and people are dealing with you from the perspective that whatever you are doing makes no sense, has no rational meaning?

Therefore, it is not so weird that many people with Dementia have the feeling that nobody is taking them seriously anymore and that some, for that reason, become aggressive, out of their impotence to make themselves clear to others?

In the past we used words like "idiot", "imbecile" and "moron" to indicate certain levels of mental handicap. We all know that these words have turned into invectives and nobody uses them anymore to indicate these people. We can only hope that within a few years, nobody will use the word "demented" either, but rather speak of people who are confused or disoriented[2].

[1] It is astonishing, but actually Dementia is one of the only diseases where they don't give the diagnosis to the patient himself. The diagnosis is given to the partner or the children, but kept a secret for the patient himself.

[2] The word "disoriented" as a better name for people with Dementia is introduced by Naomi Feil, who worked with this group of people for more than forty years. She is also the founder of the so-called "Validation approach", which is also a person oriented approach to people with Dementia (Feil, 1993).

3. The Process of Dementia: Three Phases

I like to describe the process of Dementia in three phases: beginning, middle and end. However, when I speak of "End phase", I do not mean that this is the end of life, but rather a third phase which can last until the end, even when this end may finally come after five or ten years.

How fast these phases will follow each other and how fast a person will develop from a totally well-functioning person into a person who has totally turned inwards and is hard to reach by verbal or non-verbal communication, is hard to tell.

A crucial factor of course, is the progress of the deterioration of the brain, but here we have to make a differentiation between the types of Dementia. Progressive damage to or deterioration of the brain is the case with Multi-infarct or Vascular Dementia and the Alzheimer's disease type of Dementia with early onset. These can be contrasted with the type where the link between deterioration of the brain and the progress of dementia is not so clear, such as Dementia which occurs in old age. In the latter case, there is not always clear damage or change in the brain structure underlying the Dementia and, therefore, it still is partly an open question what the cause of this kind of Dementia is. However, I will not go into this discussion further here because there is so much still unclear and because it is beyond the scope of this chapter[3].

In this chapter, I will describe how the person perceives his world and how his basic needs fall into the three phases, as I understand this from being in contact with these people for more than 30 years and of course from literature and discussions with colleagues (Brooker, 2006; Feil, 1993; 1994; Kitwood, 1997; Miesen, 1992a; 1992b).

With each phase, I would also like to describe how we as Gestalt therapists or counsellors can support the person and his environment.

3.1. First Phase: I Know That I Don't Know and That is Bothering Me

The first phase is characterized by the fact that the person notices that he sometimes forgets what he is doing or forgets important aspects of his daily life or that he makes mistakes which he can't remember afterwards. The person is confronted with these mistakes by his partner or caretaker, which of course easily leads to conflicts with a partner or caretaker. Well known examples are:

[3] However, it is very important, when meeting a client with first signs of Dementia, to refer him also for complex somatic examination to exclude types of Dementia which can be cured or treated.

losing track during a conversation, forgetting where things are, forgetting appointments, putting things in strange places (e.g. the kettle in the fridge or food under the mattress) and more seriously, forgetting to take necessary medication, to turn off the gas after cooking or – even worse – forgetting to light the stove or oven after opening the gas.

In the beginning these omissions or mistakes are so minor and irrelevant that anyone could make them. Maybe only the person himself notices them and explains them to himself as due to losing concentration momentarily or being a bit tired.

However, when the omissions and mistakes increase, others, such as a partner or children, will also notice and possibly start to criticise or correct the person with the result that he now becomes more aware of it, and starts to become more and more insecure.

Therefore, this phase is also called: the phase of "the threatened I". The person feels threatened by what is happening to him. He knows that he sometimes does not know (anymore) and this makes him insecure, doubting himself and afraid of what is happening.

We can really see this as a severe identity crisis.

"Can you tell me, what is happening to me? Sometimes, I know what I am doing and then suddenly, I do not remember where I am or what is going in. It's just like a switch, that somebody turns on and off".

"Please can you tell me, what is happening? It is as if there is a hole in my head. As if my head is getting empty. Am I losing my mind?".

In this phase we can notice a clear difference between people who only notice and those who, not only notice, but also have the knowledge or awareness of what is going on. It is the difference between the phase of "sensation" and the phase of "awareness" in the cycle of experience.

For those who only notice, it means that they become insecure and start to doubt and wonder what it is that is going on; for those who have awareness, it means that they know what it is they are dealing with. Some of them also know quite well what their future will possibly look like. For them, there is the frightening imagination of a terrifying future.

"Can you please tell me, am I becoming demented? I have seen it happen to my mother and I have a strong idea, that now, it is happening to me too".

"Listen, you don't have to lie to me. I know exactly what is wrong with me. I was a doctor you know and I am quite sure, that what is happening to me is this Alzheimer's disease. Am I right?".

At the same time, people around the person have the same kind of questions and worries and with them too we can make the same differentiation.

At first, people who do not have any insight or knowledge about what is going on will probably become rather irritated by the omissions and mistakes, which they possibly interpret as lack of concentration or lack of interest or sometimes even as a lack of good will. This often leads to misunderstandings and painful conflicts in the relationship.

Later, when this partner or these children find out about the diagnosis and do understand what it is that is going on, they have feelings of shame and guilt because of how they treated their partner or parent.

And for those who do realise what is going on, a long and painful road of grief and processing lies in front of them. A road filled with painful confrontations, an increasing loss of contact, an increasing need to take over responsibilities and in the end a total change of roles in which the partner or children become the "parent" of the totally dependent person.

Fear of this situation in the future is of course frightening for everyone involved[4].

3.1.1. Figure-Ground Formation

Let us go back to the person with Dementia himself. In this phase, in which the person still has quite a clear knowledge of his present and past situation, the figure becomes more and more the fear of "losing your mind" against the ground of a clear life story.

Therefore, we can see that several people try to solve or finish old unfinished experiences.

They are dealing with memories and feelings of sadness or shame and guilt.

Literally, someone asked me: "Do you know how I can get back in touch with my ex-wife because I would like to speak to her and say, how sorry I am for what I did to her".

And very often, they added: "Now, I still can, but I am afraid that in a short time, I will not be able to anymore".

This makes it clear that the person realises that he is losing his memory and other abilities and, because of that, his life will change dramatically and irreversible in just a few months or years.

[4] In Holland, several partners or children have been writing a diary during the years of illness of the partner or parent. These stories are very important to read for professionals as well as for the relatives. For both, the books can be very helpful, in recognizing the suffering and the impotence of the others.

In general, we can say that people will respond to this crisis with the same sort of creative adjustment or contact style they have probably used all their life. Some will try to process it by facing and sharing reality and all the emotions that come with it, like sadness, fear and anger, while others process it more in a deflecting, projecting or retroflecting way.

Of course, there are many other variations, but I will restrict myself to describing just these three styles or responses.

1. Deflection or the flight response.

If a person has a tendency to deflect or flight, he will diminish the problems and try to avoid confrontations. If however, there is a confrontation, he will use explanations or other stories to build up a *façade* and cover up his mistakes or lacunae in his memory. This is called "confabulation".

On the question "How many children do you have Mr. S.?" the man answered: "Well, we had quite a few. It was always a lot of fun. My wife took them to the playground and later I insisted that they should go to study, because that is important".

Therefore, if you don't know the person and his history, it is quite difficult to estimate what he really knows and what he is just making up.

For the partner, this sometimes becomes very embarrassing because when she is calling for help, the moment the psychologist or nurse comes in, this man "puts on" his façade and nothings seems to be the matter. Of course, the person does not do this on purpose, but still, it can give a strange idea of the situation.

2. Projection or the fight response.

This is a much more difficult response do deal with, especially for the partner and children. Instead of covering up or denying his mistakes or omissions, the person has a tendency to project all the mistakes and omissions onto others; he blames them for it. His first impulse is to push the other away or fight whatever is said to him.

If someone asks a person like this, how many children he has, there is a big chance that the answer will be: "Why do you want to know? Can't you mind your own business?".

When the person cannot find his watch or wallet, for him it is totally clear: it is stolen! Trying to assist a person like this is not easy.

"What do you think???? I don't need any help. I can do it all by myself. Go and bother your mother!".

It requires a lot of patience and a lot of creativity to find the right way in, to avoid conflict. I always have a lot of respect and admiration for partners and nurses who are able to stay out of the fight and who are able to "seduce" the person to cooperate.

As I stated before, these partners need a lot of support, partly purely practical, partly in the sense of finding some free time to relax, but above all, a lot of understanding and emotional support.

In the support groups for partners and children the common topics are: feelings of impotence, sadness, shame, guilt etc. But beside those, there is the feeling of anger, sometimes even rage towards the person. Of course, people feel ashamed having this anger or rage and therefore it is a big relief if they can express these feelings and feel accepted and understood by the others. Sometimes, when I have the feeling that the anger and rage stay implicit, I make it explicit: "I can imagine that some of you sometimes wish you could kill your husband/father. Am I right?".

Of course, there is shame, but at the same time, they are very happy and relieved that I name it and we can speak about it.

3. Retroflection or the freeze response.

With retroflection I mean here, that the first tendency is to blame themselves and to feel depressed by everything that goes wrong. They feel insecure and sad because they do not understand themselves and their world anymore, and blame it on themselves. Most of the time here too, this tendency for retroflection and descending into helplessness, has been their usual creative adjustment during their whole lives.

Maybe, they were used to having a "big momma" around them and now that they feel so totally lost in their world, they constantly look for a "big momma" again.

If we ask a person like this about his children, probably we will get "tears" for an answer: "I don't know anymore and I don't know where my children are. I am all alone and nobody is here to help me. Can I come with you tonight? Do you have a place for me to sleep? Please, help me!".

The most difficult aspect for a partner or for the children and later on also for the nurses, is that a person like this wants to be attached all the time; he will not leave you any breathing time. These demands can really strain your nerves and again, require a lot of patience from the caretaker.

Although, it is not evident in every response style, insecurity and fear are the main drives behind the behaviour in this phase of a person's life.

Therefore, the person is also looking for support in holding on to reality. He will ask for facts, because facts are a hold, a straw to catch. When the person is very insecure, he can ask others over and over again the same questions just to reassure himself that he still knows.

"Is it true, that my wife has died?"

"Is it true, that I have to stay here in this nursing home?"

"When can I go home again? Is my wife coming to pick me up this afternoon?".

3.1.2. Support

In the first place, we can be a great support, both for the person and for his family when we are willing to listen. Because, when a person is in such an intensive existential crisis, the most pregnant need is to share and to be understood; to share the pain and fear and to get help in sorting out the feelings and worries.

The Gestalt approach with its roots in the existential phenomenological philosophy and in the philosophy of Buber on the "I-Thou dialogue", is a very appropriate approach, because it is focused on creating a sincere, open and genuine relation between therapist or counsellor and client.

The Gestalt therapist has the courage to stay in the here and now and has the willingness to share and be touched by whatever occurs, even if he knows neither what the future will bring nor what is the best thing to do now.

He will trust the fact that he does not know because he can see it as a phenomenon of the field that needs to be shared and explored. This impasse – being stuck in not knowing how to move on - is an inevitable and essential aspect of the process. In this way, we can function as a "trustworthy anchor in the chaos of life" for both the person and his family.

Secondly, we can support the person and his family by being honest and giving them the information or facts they are asking for, not in a confrontational manner, but in a way that enables them to deal with it, to process these facts of life. Withholding the diagnosis for a person, even when he is asking for it, is actually a crime: we restrict the person in processing his situation.

Both for the person himself and for his relatives, encounter groups or support groups can be of great help. For this reason, Bère Miesen founded the concept of the "Alzheimer's café". The Alzheimer's café is an informal monthly meeting of patients, relatives and professionals, where all aspects of the process of Dementia can be discussed (Miesen and Jones, 2004).

Normally, the meeting starts with a short lecture on a specific topic and after that people can share questions and experiences.

Because the accent is on meeting and sharing and learning from each other, the lecture can also be given by a person with Dementia or by a partner or child, who speaks about his experiences with Dementia.

The idea of the "Alzheimer's café" has already been introduced in several countries throughout Europe.

3.2. Second Phase: I Don't Know and I Don't Care That I Don't Know; My Past Is Bothering Me

In the second phase, the person is no longer trying to hold on to reality. There are moments, where the person is again totally aware of the here and now reality, but he is no longer desperately trying to hold on to it.

A crucial factor here is how much we reach out to the person. If we neglect a person and leave him just to himself, he will drift away much faster than when an approach is made to him.

It is a fact that people with Dementia stay much longer in contact with everyday reality when an approach is made to them offering them responsibilities, having conversations, inviting them to activities, keeping them engaged in normal daily activities etc. – in fact, taking care that they participate as much and as long as possible in our society.

Often, we have seen really astonishing examples of people with dementia, who showed hardly any interest or ability to communicate while in a department of a nursing home, but the moment they were transferred to a smaller unit or went on a vacation for three or four days, they totally livened up again. The staff's increase in connection with them always had a very positive effect: they were communicating again, did not need any help with eating, sat up straight again etc.

In the second phase people with Dementia live more and more in a world of their own, a world of feelings.

In this world, feelings become associative, which means that they become foreground, because of something in the person-interaction with the environment triggers these feelings.

For us, as an outsider, it is not always easy to follow the person in his associations. First of all, we are not always aware of what is happening in the person in his interaction with the environment, and secondly, we do not always have knowledge of the biography of the person, and therefore, we do not always know what experience is triggered.

But here, the Gestalt approach again has a lot to offer. From a Gestalt point of view, we do not need to know the why of a behaviour or feeling to be able to be in contact.

We are aware of the behaviour and the feelings being expressed and perceive them as functional for this person in his field. Otherwise, he would not act or feel that way.

So, if we meet a person who is sad, we do not need to analyze this sadness, we can connect with him, on the assumption that his sadness has a reason and a function in the present field.

And as we all know, experiences and feelings in the present can trigger old unfinished experiences and feelings from the past. This also applies for people with Dementia.

The only difference might be that in this phase of Dementia, the person is less able to differentiate between the present and the past, and therefore has less awareness of the fact that what he is experiencing is not happening in the present situation, but is a reliving of an unfinished experience of the past.

But actually, younger persons without Dementia can also have this confusion, this transference of old experiences and feelings. Nor do they always have the awareness of their transference in the field.

Another difference is of course that the person with Dementia may be less able to express his experience and feelings verbally, he will probably express them more in a symbolic way.

3.2.1. Support

When we go from the idea that, in the present, the person regularly relives unfinished experiences from the past, we can say that the figure has become the "unfinished past" against the ground of a chaotic life story.

Because of lacunae in the memory and these moments of confusion, the person is not always clear about his life story anymore. There are all kinds of memories that get mixed up in several ways: mixed up with each other because of the common feeling underlying them and mixed up with the present, because the present triggers these memories from the past.

This is why this phase is also called the phase of the "wandering I"; the person is wandering back and forth between their memories and between past and present.

We can support the person in several ways. However, the baseline is that we accept the person in his experience and feelings and acknowledge that the feelings are real and not just some kind of imagination, delusion or mistake due to his confusion.

In this sense, I like what George Wollants writes on the phenomenon of transference: «The idea that the client transfers onto the therapist feelings and ideas that belong elsewhere is basically a form of injustice to the client. This suggests that these feelings are misplaced. According to the field theoretical, phenomenological, experiential principles of the Gestalt approach, we propose in this contribution, that whatever the client thinks, feels, or does in relation to the therapist is appropriate, because it becomes foreground in the current field» (Wollants, 1996).

If we transfer this to the world of people with Dementia, it means that whatever a person feels, thinks or does in a present situation, is related to and appropriate in this situation because it became foreground here.

We can help the person to express and explore these feelings and thoughts, just as we do with younger clients.

During a night shift Mrs. S. is in her bed, but still awake and crying.
"You look very sad, Mrs. S., has something happened today?"
"Yes, they told me, about my son".
"What has happened to your son, Mrs. S.?"
"He had an accident and he is now dead".
"That is terrible. That must be very hard for you". (....silence....)
"You know, I never told him, how much I loved him and how proud I was".
"That makes it even harder, doesn't it?"
There is a long silence, in which we hold hands and Mrs. S. cries softly.
After a while, I notice that she has stopped crying and her breathing has changed. She is calm and slips away in a deep sleep.

In this example, the fact is that this son of Mrs. S. has died in a car accident more than 50 years ago. However, today she went to the funeral of her sister who died at the age of 98. Being at the graveyard and sharing the sadness had triggered this old, unfinished experience.

Maybe Mrs. S. never had the chance to grieve or to share her feelings of guilt and this experience is still unfinished. By listening to her and accepting her feelings and thoughts as being very realistic and appropriate, Mrs. S. has an opportunity to express and share them now and to find some relief.

The question is: "Does this help her? Does it help her to complete or finish this experience?".

In a way: yes. Of course, we cannot solve the past and we cannot solve what has been carried and hidden away by the person for such a long time.

What we can do is help the person to express what has been implicit all this time and to share what is bothering him, and by doing that we might be able to

lessen the heaviness of these feelings and thoughts, of this burden. Maybe just for a moment.

It is a fact that, in situations where a person-oriented approach (e.g. Gestalt or Validation) is applied in nursing homes, people have more inner peace and need less medication (psychotropic). The relatives as well as the workers report a much better contact with these people.

However, an important principle here is that it is not for us to decide if Mrs. S. or whoever should express what is still hidden or repressed, but that she is the one to decide.

This means that we will follow the old person in his needs just as we do with younger people: we accept their particular creative adjustment, even if we have the impression that he might be better of if he did it another way.

Especially with persons in old age, I ask that we be careful and cautious in opening old unfinished experiences. They have not been closed for such a long time for no reason.

Therefore, working from a Gestalt approach with Dementia is not a matter of going for the big success. It is a matter of being able and willing to be with the person in his world, taking this world seriously and following him in his direction and tempo. By creating a holding environment and validating the feelings and thoughts that become foreground, and giving words to what is hard to say, we can help the person to express and share and as a result, to experience moments of inner peace.

The most important support we can give to the relatives in this phase is our deepest understanding and condolences for how hard it is to see the partner or parent change in such a way. Losing your partner or parent this way, means – as mentioned before – an intensive process of grief, especially when the person also starts to express himself in a way the relatives have never experienced before.

In this phase, often, people start to express very openly and in an uncontrolled way their desires, impulses and feelings (loss of decorum). What might have been repressed or stayed implicit all their life comes out now and unfortunately, sometimes in a very extreme form. We meet a totally different, hidden side of the person: cursing, calling someone names, being violent, behaving in a sexually uninhibited way, etc.

In some cases, also the opposite can happen; the nicer side of the person, which has always been implicit and hidden, comes out: becoming gentler, or showing a more romantic side.

An old man in the nursing home was very nice and gentle to the women in his department. He made friendly remarks, caressing someone's hair, kissing someone on the hand or giving a hug; all very respectful and never intrusive.

When his wife saw this, she sometimes sighed: "Look at him. Can you im-

agine? I have been waiting for this all my life; just a little bit of romance? He was never able to show it".

Of course, for the relatives it is hard to watch when the person is behaving more and more disgracefully. We can give support here by giving information on the process of Dementia.

3.3. Third Phase: You Don't Know Anymore, What I Still Know

The main difference between the second and third phase is, that the person "loses" more and more the ability for verbal communication. Already in the first and second phase, there will be moments when the person cannot find the right words or that he loses track while telling a story. In the third phase, the "loss" of verbal communication will be more severe.

However, I would like to underline here, that we should be careful in saying "loss of abilities" because this suggests that the person loses his abilities to speak because of the damage or changes in the brain structure as may be seen, for example, after a stroke in the left part of the brain (aphasia).

With Dementia in old age, this link with damage or changes in the brain structure is not always clear, as we have already stated at the beginning of this chapter, and therefore, the decrease in verbal expression is not always related to this kind of damage. If this were the case, the loss would be definite and then it would not be possible for a person to speak clearly and coherently again the moment he gets more attention or the moment there is more connection with him (as in the example of the vacations).

So, the explanation for the decrease of verbal communication cannot only be found in the physical aspects of the brain, we should also look for a possible prolonged lack of attention or lack of sincere communication.

One day an old woman in a nursing home, who was diagnosed as not being able to speak anymore, opened her mouth and said: "Thank you, you are a very nice nurse". The nurse who was addressed was shocked and stumbled: "Mrs. T., can you speak? You never speak".

The woman explained: "Yes, of course, I can speak, but what is the use of speaking here, when nobody takes me seriously or even listens to me?"

In this third phase, the person will express himself more and more by what we call "repetitive motions" and sounds.

Although it might not seem this way at first sight, even this non-verbal behaviour has a clear function for the person himself. The movements are very

often related to the past, for example they represent activities the person has performed for a long period in his life: rubbing his hand on tables and chairs as a symbol for cleaning the furniture, knocking on the table or chair with his fist as a symbol for working as a carpenter with a hammer, folding folds as a symbol for the work a person has done as a tailor, etc. etc. So, the person is not restless; he is busy!

Also with sounds we can recognize a lot. First of all, the tone of the sound expresses very clearly the present mood or emotion and secondly, the whole structure of the sound is comparable with the "pre-social talk" of little children. Children do not have the words yet, the older person does not have the words anymore, but both are trying to communicate and make something clear to others.

We can say that in this phase the figure has become the "basic needs and feelings" against the ground of a blurred life story. As far as we know, the person does not have a clear awareness of his past history anymore. The life story has become a vague ground from which experiences and feelings become foreground because something in the field triggers them.

The person is no longer able to differentiate between the different experiences and feelings that arise all at once: very often, what is expressed is a mixture of several situations or experiences linked to each other because of the common underlying feeling or emotion.

When an old lady is sitting in a chair, her eyes closed and a smile on her face, while caressing her left hand softly with her right hand, it is possible that, what she is reliving is a mixture of several situations or memories: memories of the times that she was caressing her baby, memories of being a young woman, in love with her husband and memories of sitting in her garden with the cat on her lap. All these memories come together in this one movement of the hands and the joy she has in caressing.

Our support for a person in this phase can consist of offering contact by means of touching, eye contact, and especially by stating the obvious. It means giving words to the movements and sounds and the possible underlying feelings we assume. We regard someone's behaviour as an expression of his life story.

Mrs. Stevens is sitting in her chair, eyes closed, rubbing her armrest and moaning.

"Mrs. Stevens, are you so busy today? Is it hard work you are doing? You always worked a lot. Didn't you?"

Mr. Peterson is walking up and down the room, putting one chair after another on the tables, while humming his favourite song.

"Well, Mr Peterson, clearing the furniture again. I guess you have done this a lot of times in your bar, haven't you. You must have been a great bar-keeper".

In this way, we still can give acknowledgement and respect to a person and function as a "trustworthy contact to the outer world". Further on, we can offer security and containment by taking care of the environment (e.g. by choosing appropriate colours, furniture, light, music or other sounds etc.).

Support to the relatives in this phase can consist of helping them stay in touch with the person e.g. by showing them ways of being in contact, like touching or using specific words etc. and by explaining to them how the person is still noticing their presence and how important this presence is to the person, although he might not express this anymore in the way he did.

Often relatives have the feeling that it is no use anymore visiting the person or speaking with him. Again, this is a big cause for sadness and grief: the person is still there, but they have lost him totally.

However, the moment we can make clear to them that there is still a level of contact, it might be less frustrating visiting and being in touch with the person.

4. Conclusion

The world of people with Dementia and their relatives is a hard one. It is not easy to be confronted with the fact that the way your life will end is in "losing your mind" and ending up as an infantile person. For the same reason, it is not easy for the partner or children to be confronted with this fact of losing your beloved one in such a way.

As Gestalt therapists or counsellors, we know and realize that we cannot change the situation, that we cannot "undo" this existential crisis these people are dealing with. However, what we can do is of great value: being a supportive listener, helping to face and process this dramatic event.

Comment

by Katerina Siampani

For the last five years I have been working at a Day Care Centre for the Elderly run by the Greek Association of Alzheimer's Disease and Related Disorders, where I provide psychological support to individuals suffering from

dementia, following the principles and goals of Gestalt therapy. When I began, the first person who helped me gain an understanding of dementia and the way Gestalt psychotherapy views it was Frans Meulmeester. Thus, it is an honour for me to comment on his article: What Does It Look Like? A Gestalt Approach to Dementia*, which provided me with great help and strength in my work with dementia patients.*

When reading Frans' article, there were many times when it brought to my mind people suffering from dementia. I recalled emotions, reactions, sensations and thoughts coming both from the people suffering from dementia and the people who take care of them. While reading, for example, the first chapter on diagnosis, I thought of the description given by Frans: "a terrible diagnosis". Although it scared me, there could not be a better word to express what it means for someone to learn that s/he suffers from some type of dementia. Moreover, I wondered how many times along my professional path with dementia, I have had to hold the hand of a person suffering from dementia, and simply say that I am here and that I understand. This text by Frans helps me to keep in mind the things I need to stand by the person suffering or care-giving. It offers an image I need so as to be "soft" with the suffering people and with whatever they bring and open up to me. I need it so as to be at their disposal, recognising what they experience through the picture presented by Frans. I am also helped by everything that Gestalt therapy has taught me, so as to be able to offer emotional and psychological support to both patients and their caregivers. This way I help my clients to accept what is happening to them and to seek help.

The first time I ever got in touch with Frans' text, I felt excitement, surprise, warmth and lots of "clicks" occurring within me; a text that, right from the very first words, a poem written by him about dementia, has the power to convey and inspire love and desire for closeness. As I was reading his article another poem increasingly came to my mind, presenting an opposite sense of the elderly – tough and ironic, which represents, probably and unfortunately, a "racist" conception of the elderly – written by a Greek poet named Kiki Dimoula. In her poem The Rare Gift*, she uses irony to describe the new theories that encourage us to treat children affectionately and give them what they ask for and hug them when they cry. However, when an older person is, similarly, in tears asking for something, then:*

Don't you ever be fooled into hugging them.
They will wrap themselves savagely
around the rare neck of this gift,
they will choke you.

Nothing. When they ask to be hugged,
come and get it, baby, come and get it, should be your answer.
(Kiki Dimoula, 1994)

*However, through my clinical experience I have often witnessed the elderly persons' need to be touched, for physical contact. A very good way for me to meet this need of theirs is to play games that encourage being touched by others. This is why Frans' article is an inspiration for me: it shares valuable facts about the role of the Gestalt therapist, who is active and participatory in the therapeutic process, focusing on the creation of a living "I-you" relationship with a focus on the "here and now" and a willingness to stand by the person suffering from dementia. For me, it seems like an answer to the "*come and get it*" by Dimoula and that might be the reason why this poem came so strongly to my mind. Frans has a deep, tender and sometimes "challenging" way of showing us the way to approach the elderly suffering from dementia. He encourages touch, song, and any human contact, beyond words and reasoning. Moreover, as the fox says in* The Little Prince *by Saint-Exupery: «*It is words that create misunderstandings*».*

*Furthermore, through his pages he brings us all closer to the "unknown" world of dementia. Frans manages to describe the terrifying diagnosis, bringing us in touch with the etymology of the word "dementia", which means "without mental abilities". It is true; who would not have felt terror if faced with the prospect of losing his mind, of simply going crazy. The proposal and horizon Frans opens is interesting; it gives hope that in the future the characterisation "demented people" would be best replaced by definitions such as: "confused or disoriented people". Therefore, I would add to the words said by the fox during the previous talk with the Little Prince: «*and logic/reasoning as well*».*

Another point that really shocked me in the article is the example given by Frans of the way the person experiences his existence; like being in a canoe drifting towards a waterfall. Whatever he might do will not help him. Eventually he will fall and be drowned. If the person is experiencing the first phase of the disease that way, we can only imagine the fear and anxiety he might experience as his dominant emotions. It is important to point out that I have rarely heard a person expressing these feelings. Usually, they do not express any emotions; this is not exclusive to those suffering from dementia. I notice the same thing with their caregivers as well. This is indeed a very basic part of the psychological support, especially of the caregivers; to recognize, to name, to express the feelings they experience, as their loved ones change. The dominant emotion experienced by caregivers seems to be anger, which they do not even dare to name. Anger seems to be a taboo feeling for many of the caregivers.

Anger is often surrounded by guilt, which follows behaviour such as shouting at the person suffering from dementia. A frequent case is when patients do not understand caregivers or when caregivers feel like hitting patients. Quite often, the behavior of caregivers and the mishandling of their own feelings triggers corresponding feelings in the sufferer as well. I have often witnessed such events, when patients become aggressive and may swear or even hit in their effort to be understood by their environment or the people who take care of them.

In my opinion, support for caregivers and their psychological education are very important at this stage, in order for them to understand that the person who suffers is changing and, as a result, so should they. This basically means work with acceptance. Gestalt psychotherapy has much to offer in the field of acceptance, with regard to announcing the diagnosis to the persons suffering from some form of dementia and to their carers. We have at our disposal one of the basic principles of Gestalt psychotherapy, i.e. the paradoxical theory of change, which can help us work with those involved on acceptance. The energy blocked by the person in their effort to resist the reality of the change they are experiencing due to the dementia could be made available to support themselves actively. This energy can be channelled into "reviewing" their relationship with their significant others, into planning and preparing their future, aware of what the consequences of their condition might be. Similarly, by recognising the present state of affairs and its potential impact, carers can direct their energy towards managing the changes they experience in the best possible way. Otherwise, it is very easy for them to block their whole energy in their attempt to change or correct the person suffering, maintaining the idea that whatever the patient is doing is done on purpose and in order to get on the caregiver's nerves.

*In conclusion, Frans, through his work with dementia and this recording (testimony?), sends us an important message. It is true that we cannot change the reality of a terrible diagnosis such as dementia. However, instead of answering the older person who asks for our hug with: "*come and get it…" *we can answer with "…being a supportive listener, helping them to face and process this dramatic event".*

Dependent Behaviors

by Philip Brownell and Peter Schulthess[1]

The spontaneous consciousness of the dominant need
and its organization of the functions of contact
is the psychological form of organismic-self-regulation.
(Perls, Hefferline and Goodman, 1951, p. 274)

Perls, Hefferline and Goodman (1951), hereafter also referred to as *Gestalt Therapy*, stated that the classification, description, and analysis of the structures of the self are the subject matter of phenomenology. Gestalt therapy is a phenomenological system. Thus, the experience of self – the perceptive and proprioceptive sense of being situated – deserves a phenomenological scaffold upon which to hang the features of dependence, otherwise known as addictive and self-medicating process. This chapter provides both a description of the self-other boundary dynamics in addictive experience and the phenomenological constructs involved with assessment and treatment of addiction and self-medication. It provides a Gestalt therapy orientation to the "what" and "how" of dependent behavior and its treatment, including Gestalt assimilations of current trends such as motivational interviewing, mindfulness, and acceptance and commitment therapies.

1. Definitions and Diagnoses

An orientation to the subject helps one understand the discussion that follows. While experienced Gestalt therapists and substance abuse or chemical dependency counselors would be familiar with various terms, clinicians from other disciplines will benefit from a brief establishment of ground. Both will

[1] The original author of this chapter was Peter Schulthess. He wrote a first draft but unfortunately he couldn't finish it for sudden unexpected reasons. The editors asked Philip Brownell to integrate the missed parts. Due to the difficulty of working on a text written by another author, he wrote the chapter from the beginning. Starting from the two texts, the editors made the integration you are reading. This final version is based on Brownell's chapter with integrations from Schulthess' text.

benefit from descriptions of phenomenological constructs relevant to addiction and recovery.

1.1. Tolerance

As defined by the American Psychiatric Association (2000), tolerance refers to the need for ever-increasing amounts of a substance to achieve the desired effect or to bring about intoxication. It can also refer to the diminished effect with continued use of the same amount of such a substance.

1.2. Withdrawal

Withdrawal refers to physical symptoms resulting from a decrease in the amount of substance in a person's system. The specific symptoms vary according to the substance in question, but they can include headache, joint and body aches.

1.3. Recovery

Recovery is a term associated with the disease model in medicine, generally speaking, but also specifically with addiction and dependent behaviors. It refers to overcoming or healing from the disease and as with chronic illnesses it refers to the maintenance efforts aimed at controlling the disease. Thus, in terms of addiction, one is either "in" recovery or one is not. One is either following an organized program designed to combat the addiction and the tendencies for relapse, including long-term expansion of one's quality of life, or one is not.

1.4. Co-dependence

«Co-dependence is a disease of lost selfhood» (Whitfield, 1991, p. 3). Melody Beattie (2009) defined co-dependency as being affected by another person's behavior to the point that one attempts to control that behavior, but a more technical definition was provided by Des Roches (1990) in saying that co-dependency is a learned behavior associated with an excessive focus on the needs of others and the attempt to take responsibility for or control the thoughts, feelings or behavior of other people, and it is motivated by the need for safety, acceptance and self-worth.

1.5. DSM IV Diagnostic Criteria

Substance dependence is identified by the DSM-IV-TR (American Psychiatric Association, 2000) by the following criteria[2]:

a. tolerance;
b. withdrawal;
c. larger amounts than intended;
d. continual desire or unsuccessful attempts to control use;
e. use has become centrifugal (preoccupation with obtaining and using that usurps other social, occupational, or recreational activities);
f. use continues in spite of increased emotional/psychological cost or suffering and decreased functional capacity.

According to the Treatment Improvement Protocol 42 issued by the United States Department of Health and Human Services in 2005, substance dependence is a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by the need for increasing amounts of the substance to achieve intoxication, markedly diminished effect of the substance with continued use, the need to continue to take the substance in order to avoid withdrawal symptoms, and other serious behavioural effects occurring at any time in the same 12-month period (Sacks and Ries, 2005, p. 323).

This is not to be confused with substance abuse, which is a maladaptive pattern of substance use accompanied by adverse consequences that follow the repeated use of the substance. Substance abuse does not include tolerance and withdrawal.

1.6. Abstinence and Harm Reduction

There are two significant approaches to recovery from addiction: abstinence

[2] According to the *Web's Free 2012 Medical Coding Reference* (2012) the ICD-9 descriptions of substance dependence are similar to the DSM IV TR: 1. A state of heavy dependence on any drug, including alcohol; sometimes defined as physical dependence but usually also including emotional dependence, i.e., compulsive or pathological drug use. 2. Physical and emotional dependence on a chemical substance. 3. Psychological craving for or habituation to the use of a chemical substance which may or may not be accompanied by physical dependency. Used for animal or human populations. "Drug dependence" replaced the more stigmatizing term "drug addiction" and is defined as a state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterized by behavioral and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependent on more than one drug.

and harm reduction. Referring to arguments by various Gestalt therapists for one or the other approach (Fairfield, 2004; Clemmens, Thomas, Brazier and Wheeler, 2005; Fairfield, 2005), the goal of abstinence is complete sobriety while the goal of harm reduction is to modify in some positive direction the dynamic of addictive and self-medicating behavior. In the first case people count days sober and if they take one drink, they go back to zero and start over in counting their sobriety. In the second, people may relapse but they do not actually go back to "zero", because they learn and grow and change over time. They may cut down on the amount they are using or alter their drug of choice; they may make significant changes in their pro-drug-use social network, and yet not quite be ready for abstinence. They may substitute one drug for another, as in the case of someone who replaces heroin with methadone. I[3] have worked myself in both approaches and have seen that both are practised with good effect. The decision of which one is right depends on the kind of person who wants to be treated, the kind of experiences he or she has had in former therapies, and if it is possible to build up motivation and support the therapeutic relationship.

1.7. Phenomenological Concepts Relevant to Dependence and Recovery

A few specifically phenomenological concepts relate to the centrifugal nature of dependence and, thus, also to the way out of dependence while developing a richer life and rebuilding one's world in recovery.

1.7.1. Attitude

Attitude is the phenomenological construct related to interest. People are never simply passive in the way they do what they do. We move in our fields with interest (Luft, 1998). If I am hungry, I see a grocery store as a place where I can get something to eat. If I am a designer, I see the grocery store as an expression of someone's creativity and sense of efficiency. If I am an artist, I see that grocery store as a potential object for one of my paintings. Conversely, if I am hungry, I am less likely to see the grocery store as an object of art... The attitude is the atmosphere we breathe; it envelops us and affects how we perceive. It is the scent one carries and the tint through which one sees the things around about. The attitude organizes ones perceptions according to a central interest (Brownell, 2011a, p. 112).

[3] Peter Schulthess.

1.7.2. Horizon

Horizon is the phenomenological construct related to potential: «Horizon can be thought of as all things held possible for a given world, and for each attitude there is a horizon and a corresponding world. When one's horizon is closed, not much is believed to be possible, and one's possibilities seem slim» (Brownell, 2011a, p. 113).

1.7.3. World/Life World

World is the phenomenological construct related to context. The world is the natural setting for our lives. It is at once the ground of our knowledge of anything in life and the place where we encounter and use the things in our lives. It's our physical neighborhood – but more than that, it's the mindscape we inhabit. If your life were a story, your world would be the unique setting of that story. It is the correlate of our possible experiences (Moran, 2000). Each attitude comes with its own horizon and world. Thus, the designer's attitude and horizon correspond to the designer's world. The musician's attitude and horizon correspond to the musician's world (Brownell, 2011a, p. 115).

2. Case Example One[4], Part One

Casey is fifty-three. He is married to his first wife, but she is married to her second husband. Her first husband was an abusive alcoholic. She does not want to lose a second marriage, but she hates Casey's drinking, sees him as broken, and she has taken over management of their finances.

Casey likes to drink wine. He started off drinking wine because his wife liked it. He learned to like it too, and he began to experiment with the way various wines tasted with various foods. He studied wines and became an informed wine connoisseur. He also likes to drink vodka. He drinks every day. He often has three or four glasses of wine and several shots of vodka. Sometimes he drinks more. Sometimes he stumbles and falls, because he is too intoxicated to balance his gait. He's been numerous times to the emergency room of the local hospital for minor injuries related to these falls. He cares less and less what kind of wine he is drinking as long as the first sip still has life in it – the burn of alcohol on his palette.

In order to keep himself out of an argument with his wife, Casey hides his

[4] From Philip Brownell; this case history is an amalgam formed from various cases in clinical practice.

drinking. He stashes the wine and vodka bottles in various places in the house, and when his wife finds one hiding place, he looks for another. When she asks about his drinking, he lies or otherwise obfuscates so as to avoid a direct answer. It has become a difficult game they play with one another. He, on the one hand, finds ways to purchase the alcohol and hide it, while she on the other spends a lot of energy searching for where he has it hidden and then confronting him with what she has found. There is heated criticism, disappointment, threats, apologies, tears, and renewed promises, but there is no substantial change. There is outrage, and there is shame. Both feel desperate and lonely.
The amount of alcohol Casey consumes has grown over time, and there is no indication it will decrease. He has marvelled that he seems to be able to "hold" his liquor better than ever, because it seems to him that it takes a few more drinks than usual before he gets drunk. When he tries to quit drinking, however, he experiences extreme discomfort faster; he feels jumpy and irritable sooner. He feels emotionally fragile and whines like a child with a bad tummy ache. That annoys his wife. He sweats and has headaches. Sometimes he feels nauseated and vomits, and he almost always loses his appetite. He has trouble sleeping, and sometimes he feels as if his heart will beat itself right out of his chest. These experiences are all so unpleasant that he usually takes a drink of something in the morning each day, just so he can feel "normal".

His wife wants him to quit. She badgered him into going to a residential treatment center where he spent six weeks detoxing, learning recovery jargon, and sitting in on relapse prevention groups. He did what she wanted to avoid feeling belittled, but he had no clear internal motivation to stop drinking. In fact, he got a couple of glasses of wine on the plane ride home. In his first week back in his familiar environment he was drinking just as much as he had before he left.

Something did change, however. The treatment program, and meeting and living with people who were serious about their recovery affected Casey. Especially after coming back and going right back into his old pattern so quickly, Casey realized he was out of control. For the first time he is seeking out therapy for himself. He comes to a Gestalt therapist by chance, and with a sense of what he could lose if he does not change.

3. Gestalt Therapy Case Conceptualization and Theory of Dependence

Although various writers have described a Gestalt therapy approach to addiction/dependence (Zarcone, 1984; Browne-Miller, 1993; White, 1995, 1999; Matzko, 1997; Clemmens, 1997; Friedman, 1999; Shub, 1999; Carlock, Glaus and Shaw, 2000; Kappeler, 2004; Clemmens and Matzko, 2005; Brownell,

2011a), there is no explicitly direct treatment of dependent process in *Gestalt Therapy*. People have extrapolated from various statements and made logical connections to current understandings of the processes of dependence and self-medicating, and that is what I will do in this section of the chapter.

The Gestalt therapist Hans Peter Dreitzel speaks about persons in addictive processes instead of addicted persons. With this terminology he avoids labelling persons with fixed diagnoses. He shows that the suffering of an illness with a certain label is a process that someone is going through. And processes can be influenced. He characterises addictive processes as behaviors dependent on certain substances or fixed behavioral patterns. The basic underlaying experience (or basic introject is: "I can't stand life without my drug" (Dreitzel, 2010).

It neeeds also to be pointed out, that addictive behavior is not always connected to substances. Addiction can be understood as an irresistable and compulsive demand to a certain emotional, experiental and cognitive state that either will be caused by drugs (i.e., psychotropic substances such as alcohol, nicotine, or benzodiazepines) or by certain patterns of behavior that are developed in an addicted way e.g. excessive eating, working, gambling, sexual activities, internet-computing (Shub, 1999; Wardetzki, 1999; Schulthess, 2006).

3.1. Field Dynamics

The field perspective is an old concept (bear with me). Paul of Tarsus (Acts 17:28) asserted that in God we live (ζωή), move (kίνέω), and have our being (εἱμι). That has long been a fascinating thought to me. The Greek preposition "εν" (i.e. "in" God…) denotes location within and one that relates to the Gestalt therapy concept of field. Sylvia Crocker (1999) claimed that a field is a sphere of influence within which an organism makes contact in order to self-regulate and meet its needs. Gestalt people characterize the organism as "of" such a field. In his understanding Paul linked living in the sphere of God's influence with movement and being; it was an appreciation of daily, mundane, and physical activities-life as an embodied and situated spiritual field (Brownell, 2012)[5].

That accords nicely with Heidegger's conception of a worlded existence known as *Dasein*[6] (Stolorow, 2011). The starting point of our existence is that

[5] See also Brownell (2010b; 2011b).

[6] To be clear neither Heidegger nor Stolorow have postulated a spiritual field, but I am making that extension, and it is one that enables Gestalt therapists to work effectively in collaboration with 12 step-recovery programs (which are spiritual systems) in the service of their recovering clients.

we are already “there”, situated among things and people in a world with given cultural elements that convey values and expectations. We certainly construct our own experiences of being in such a world (we make meaning from our experience), but just as the baby is not a totally blank slate at birth, neither is the world into which he or she is born a totally empty or neutral starting point for living.

Dependence, and the symptoms of addiction, are never a simple matter of the individual addict, somehow isolated from his or her contexts of living and relationships. What many times starts as a social and recreational activity carried out with others, and is fostered and supported by a community of people who are themselves at various stages of use, abuse, and dependency, becomes a fixed pattern of contacting within an increasingly shrunken world. Yet, from early stages of use to late stage recovery, dependence is a field phenomenon involving people in groups and dyads that is also related to the developmental history of the person in question. For instance, people working with those caught up in compulsive and repetitious sex offending have to deal with the developmental processes that occur in a person’s life at various stages over time and to understand how they influence the feelings and behavior of their clients (Ryan, 1999). People who develop addictions often grow up in families where self-medicating is an element in one’s early coping strategy.

While it is necessary to understand the individual characteristics of subjective experience, it is also necessary to grasp the intersubjective and field dynamics that are crucial to treatment and recovery (see below under therapeutic process in working with dependent clients).

3.2. Intersubjective, Dyadic Relationship

There is a non-independent dynamic in dyadic processes. In a book on empirical research, Kenny, Kashy and Cook (2006) described dyadic data analysis saying:

Many of the phenomena studied by social and behavioural scientists are interpersonal by definition, and as a result, observations do not refer to a single person but rather to multiple persons embedded within a social context… The error of thinking that a dyadic measure refers to only one of the interaction partners has been called pseudo-unilaterality… In general, a dyadic measurement reflects the contributions of two persons, although the function of those contributions can be quite different” (pp. 1-2).

Gestalt therapists have been saying as much for decades, and we have un-

derstood such non-independence as intersubjectivity, using Martin Buber's relational philosophy as a heuristic. Accordingly, people can relate to one another with an I-Thou or an I-It attitude. In the first, one is simply present and available for authentic relationship, to know and to be known. In the second, one is goal-oriented, and the figure of interest is taking care of some kind of business. People are often used to reach a goal.

I-It is the dominant attitude involved in dependent process. On the face of it, that would not be unusual, as I-It is dominant in the general population; however, in dependent process people are used to obtain substances and people are pawns in self-medicating behaviors. These dynamics become stylistic of contact. The primary relationship becomes the substance or behavior that soothes and the people become the secondary relationship serving the first. Furthermore, in co-dependent behavior there is a give-to-get dynamic that makes the security of the relationship the target and not intimacy with the other person in the relationship itself.

Introduction into substance use often takes place in relationships. The existence of such relationships implies various ways in which two people are connected and influence one another's use of various substances (Mrug, Borch and Cillessen, 2011; Ferguson and Meehan, 2011; Kreager and Haynie, 2011). Branstetter, Low and Furman (2011) found that the most consistent predictor of substance use was the substance use of a friend. Of course these relationships all occur in social groupings of various kinds, but more importantly, they comprise characteristics of friendship, kinship, and partnership in dyads within such groups.

In an interesting study by Fujimoto and Valente (2012) it was found that reciprocal friendships were the most influential on smoking and substance use. That is, the influence was not unidirectional, as might be expected (the effect of "bad" friends). Rather, it was bi-directional and intersubjective.

I[7] grew up in a family in which my mother smoked cigarettes almost constantly. As a child, I hated the ambient, second-hand smoke I was forced to endure. I told myself I would never take up smoking. However, in high school a close friend and I began to ride to school with a guy who drove his parents' Buick Rivera (at the time a really hot automobile) and played guitar in a band. He usually smoked a cigarette on the way to school. At first my friend and I looked at one another, laughed a bit, and said, "No thanks". One day I noticed that my friend accepted and lit up himself; I looked at him as if to say, "What are you doing?" but he just shrugged his shoulders. Eventually the driver offered me a cigarette, and I accepted.

[7] Philip Brownell.

3.3. Subjective, Phenomenal Experience

Addictive experience is the retreat from novel stimuli, from contact in the current field and a desire for repetition of previous experience – the field that was. It is a fixed *Gestalt*. As such, there is a delusional character to dependence. That is, the person deludes him or herself, and it is as if he or she is perceiving something that is not actually there. In speaking about such "hallucination", Perls, Hefferline and Goodman (1951) stated something helpful in understanding addiction and self-medication from a Gestalt perspective. They indicated that the appetite is usually vague «until it finds some object to work on; it is the work of creative adjustment that heightens awareness of what one wants. But in cases of extreme need, extreme physiological deficit or surfeit, the spontaneous appetite may make itself definite, bright, and sharply delineated to the point of hallucination. In the defect of an object it makes an object, largely out of the fragments of memory. (This occurs, of course, in the neurotic "repetition", when the need is so overpowering in its influence and the means of approach are so archaic and irrelevant than an ordinary creative adjustment, assimilating a real novelty, is impossible.)» (p. 404).

This is the spike rather than the sine wave in Michael Clemmens' (1997) depiction of the addict's cycle of experience. Instead of a gradual development of sensation leading to the natural emergence of a figure of interest (the awareness of an intentional object), followed by a process of creative problem solving and then a choice among various alternatives for satisfying the figure, the addict goes from sensation, bypassing the natural emergence of an intentional object, and instead "hallucinates", or substitutes an old and fixed *Gestalt* – using or engaging in some self-medicating behavior – and goes straight to action. He or she picks up, takes a drink, gambles, eats things not good for the body, engages in sexual activity (which does not have to involve another person), etc. It is the substituting of a previous figure, a figure formed from contact in the field of some bygone time, but in the current field it is a fixed *Gestalt* and what *Gestalt Therapy* referred to as a neurotic hallucination. Furthermore, it does not provide anything new to assimilate; consequently, there is no learning from experience. There is simply repetition.

The attitude becomes increasingly an alcoholic, a using, and self-medicating interest. The horizon loses options of possibility for other behaviors or solutions for meeting a person's needs or satisfying his or her interests, and the person's lifeworld shrinks. The person's subjective experience becomes centrifugal, spun out and around a preoccupation with using, drinking or otherwise self-medicating, focused on only those possibilities, and filled with people, places, and things that belong in the alcoholic, drugged up, self-medicated world. After some time, nothing else even occurs to the person.

Now, the addict is still moving through time, and so his or her situation is evolving even though he or she may have little awareness of that fact. This is the ontic dimension of the field. Because the person's contacting has become muted and self-delusional (what could be called "being-in-denial") the dependent person cannot truly grasp the strain in his or her relationships, the loss of standing at work, or the significance of various bodily indicators that something is wrong with his or her life. The situation usually has to get bad, including loss, before the addict or dependent person will contemplate a different way of viewing his or her situation – the possibility that he or she is out of control and in decline.

Another way of looking at this is that the person, the human organism, is not growing. Healthy functioning leads to growth, and this is why people assert that Gestalt therapy is growth model. Perls, Hefferline and Goodman (1951) claimed that contacting is the growing of the organism.

An organism preserves itself only by growing. Self-preserving and growing are polar, for it is only what preserves itself that can grow by assimilation, and it is only what continually assimilates novelty that can preserve itself and not degenerate. So the materials and energy of growth are: the conservative attempt of the organism to remain as it has been, the novel environment, the destruction of previous partial equilibria, and the assimilation of something new (*ivi*, p. 373).

This is ego functioning, and more specifically, this is the organism identifying figures of interest and choosing to move toward them, to satisfy them. It is in contrast to the id function in which the addict is stuck. In addiction, the id's contents are "hallucinatory and the body looms large" (*ivi*, p. 381); thus, there is vague awareness of sensory data, but the stuckness is that a person does not truly pay attention to that in regards to its novelty (he or she cannot because the novel has truly dropped out of his or her horizon). The ego does not identify with a novel figure and choose it, because contact has been broken at id functioning and the hallucination is that there *is* a novel figure. There is not. There is sensation and neurotic anxiety. The choice is a pseudo choice and a delusional ego functioning that "chooses" a fixed *Gestalt*, made possible by first a retroflection and then a confluence with the substance or the self-medicating behavior.

4. Case Example One, Part Two

Casey picked up the phone book and pointed his finger at the page. He might as well have been swinging blind at a pinata. His finger landed on Brighton Smythe, Ph.D. Brighton was a doctoral level, registered psychologist

who had no big advertisement, just a name on a small line with his phone number. Brighton was also a trained Gestalt therapist.

When they met for the first time, it was in the wating room, and Brighton handed Casey the intake documentation, which included informed consent about policies. Casey read and signed them. It seemed customary.

Brighton then welcomed him into his office, and the two sat down facing one another. The room was painted in soft, earthy tones. Two leafy plants rested in the corners. The couch where Casey settled had a woven fabric he could feel on his fingers. Brighton sat in a black leather recliner. Behind him was a semi-transparent screen, and Casey could see a desk with a computer on the other side of it.

Brighton said, "What brought you in today, Casey?"

Casey said, "I have a drinking problem"

Brighton said, "What makes you think that? "

Casey said, "Because I do. His voice broke when was talking, and he resettled himself on the couch". "People have been telling me. I drink too much; it gets in the way of my job and my relationships"

"I noticed you had a bit of emotion in your voice".

"Yeah. This all feels a bit much".

"A bit much?"

"I never thought I'd be talking to a shrink".

There was a pause and silence, but the two men looked at each other. Brighton took a deep breath. Casey resettled again on the couch.

"Can you say more about that?" asked Brighton.

"I feel weak, like I'm defective. If I were stronger, I could control my drinking and then people wouldn't have to be telling me to get a grip and I wouldn't have to be talking to *you*".

"I am wondering if you are a bit peeved to have to be talking with me".

"Yes. Don't get me wrong. It's not you. It's just... What the hell has happened to *me*!?"

"Tell me", said Brighton, "what do you want to accomplish by coming in here today? Do you want to quit altogether or do you want to be able to drink socially, to drink in moderation?"

"I would like to drink in moderation, but I don't think I can do that. I have tried to do that, and it's just disastrous. I think I need to quit altogether".

"I'd like to get a better sense of this; so, imagine you are somewhere on the following line: all the way over here, at ten, you would like to quit drinking altogether; all the way over there, at one, you would like to keep drinking as usual. Where are you right now on that line?"

"Ten is quit and one is keep drinking? I'm at a seven".

"You want to quit altogether?"

“Yes. I want to quit”.

“Okay, well let’s imagine another line. You are somewhere between ten, which this time is that you absolutely intend to quit and will quit, and one is you would like to quit, but you have no intention to quit and probably will just keep right on drinking”.

“I am at four”.

“Hm. On the one hand your wish to quit is at seven, but your intention to quit is at four. Why the difference?”

“Because I don’t know if I *can* quit”.

“Ah. Well let’s try another line”.

Both men laughed, and Casey said, “Didn’t think I’d be doing lines with my therapist!”

Brighton smiled. He said, “Imagine on this line that ten is absolutely capable of quitting, but one is absloutely incapable of quitting. Where do you think you are today? ”

Casey said, “I am… I’m at five”.

Brighton said, “Let’s imagine that you *can* quit if you want to. Now, if it is possible to quit, where are you on the line between intend to quit and intend to keep right on drinking? Ten is absolutely intend to quit and one is intend to keep drinking”.

“I would be at eight”.

Brighton said, “Hm. Your goal is to quit drinking completely, your purpose is to quit drinking altogether, but you are unsure that you can. Is that right?”

Casey said, “Yes. That’s right”.

“Casey, I believe it is possible for you to quit drinking. You have told me here today that you intend to quit, and I would encourage you to remember and to think about the “lines” we did here together”[8].

Following that session both men began meeting twice each week. Brighton got Casey into the care of a physician to monitor his withdrawal. Brighton emphasized dealing with “what is” rather than with what anybody thought “should be”, which meant that if Casey relapsed and drank some alcohol, that the two men would simply discuss it rather than play games with one another, either trying to catch one or keep one from getting caught around the use of alcohol. They would investigate how the relapse took place in order to learn from it. In addition, Brighton suggested that Casey start going to AA meetings. Brighton explained that while he believed in harm reduction and that AA followed the total abstinence model, he supported Casey’s goals of abstinence and thought the support from AA would be helpful.

[8] It is relevant that the answers are given by the patient her/himself, so it is a selfrated prognoses that arises awareness and responsibility, supports the therapeutic process and will prevent from illusions.

At first Casey was reluctant to attend AA, and he wanted to know why he needed to go there if he had Brighton as his therapist.

Brighton said, “I believe you need the most resources in the total context of your life that you can get. It would be helpful if you expanded your recovery network. Attending 12-step meetings such as AA is a simple way to do that”.

Casey grew more quiet in sessions. “Are you trying to unload me as a client and dump me off with them?”

“No. You and I are solid. I am just suggesting something I believe to be in your best interest. What I notice is that you have been saying less in sessions these days and now I see that you have been imagining things about me. I invite you to check out your imaginations as much as you can, but I suggest that you don’t do anything you feel uncomfortable doing, even if I suggest it”.

“Wouldn’t that be a bind? You suggest AA for progress, but if I don’t want to do it, then I’m going backwards. I want to make progress, but I’m just not sure”.

“You feel stuck between ‚can’t go this way and ‚can’t go that way?”

“Yes”.

“Okay. That’s where we’re at. Let’s not push it one way or the other”.

Eventually, Casey suggested he attend an AA meeting with a friend of his from work just as an experiment, with no commitment to keep going. Brighton agreed. Casey was surprised to hear the stories of other people struggling with addictions and self-medicating behaviors, for although there were mostly people there admitting to alcoholism, there were also people counting sobriety from narcotics, gambling, and sex addictions. Casey found himself going back, and eventually he bought into the whole system, 12 steps and all. He even got himself a sponsor.

In their ongoing work Brighton suggested that Casey develop other interests. He encouraged Casey to work out at a local gym. He advocated cosulting a nutritionist and expanding the kinds of foods that he ate. He suggested developing hobbies.

Brighton worked with Casey to develop a recovery program from the ground up that fit Casey specifically. He helped him discipline himself in the way he was thinking, learning to identify rationalizations that served relapse, and he helped him to identify and process his emotions. He helped Casey think ahead to identify his triggers, the kinds of events and situational elements that might prove especially difficult for Casey and tempt him to drink again.

All of these things he did within the scope of their relationship and with an experimental attitude. His suggestions were always followed up with inquiries about how it went when Casey attempted something new. The quality of contact between the two men became quite high so that the flow of their dialogue became more fluid. Brighton explored Casey’s subjective experience, calling

him back over and over to pay attention to his bodily sensations, his emerging concerns and interests, and then to the contemplation of his various options, leading to purposeful decision-making.

Casey kept his weekly appointments, meeting twice each week until he had a few months of sobriety under his belt, and after he had established a routine of attending AA meetings every week, Brighton suggested they meet once per week for therapy. His life became much less centrifugal, spun around drinking, getting alcohol or hiding his drinking from others. His horizons expanded, and his world became larger. His wife did not undersand these things, and she actually attempted to get control of the process and keep him from changing (she confessed that she was not sure the relationship would last if Casey no longer needed her to run interference for him), but they worked through those relationship issues in therapy as well. Casey continued to work with Brighton through middle stage recovery and then spaced out his appointments as he moved into late stage recovery.

5. Gestalt Therapeutic Process in Working with Dependent Clients

Gestalt therapeutic process involves the phenomenological, dialogical, field, and experimental elements of the overall Gestalt approach (Brownell, 2010a). This is true as well for its application to working with dependent clients. When Gestalt therapy is practiced, there is a fluid movement from the exploration and development of capacities in the client's cycle of experience, his or her contacting and self-regulation[9], the quality of the relationship between client and therapist, and by extension that of relationships outside therapy, an appreciation of developmental and other elements of the field exerting an influence on outcomes[10], and all is done tolerating the anxiety that contacting and experiential work creates.

Psychotherapy affects the abilities of the client, as described by Malcolm Parlett (2000):

(1) try new things and to become more creative in meeting his or her needs (referred to as experimenting);
(2) develop the ability to be more in touch with his or her body (referred to as embodying) and the senses that inform about contacting in the environment;

[9] Which can be evaluated using neuropsychological assessment of executive functions. This might be a good idea if the client has been using drugs or drinking for some time and there is a question of the client's current neurological capacities.

[10] Outcomes studies have shown that field dynamics, otherwise known as client or extra-therapeutic factors, account for about 40% of change, while the working relationship between therapist and client accounts for about 30% of such change.

(3) expand upon abilities to recognize (referred to as self-recognizing) and appreciate his or her experience of self;
(4) the capacity for relationship (referred to as inter-relating), and
(5) the ability to take responsibility for his or her own experience, including the choices the client makes and the natural consequences of making those choices (referred to as self-responsibility).

Research has shown success in the use of motivational interviewing (MI) and mindfulness in dealing with substance dependence[11]. MI works in the impasse between the polarity of relapse vs recovery and helps the client resolve that impasse by exploring his or her own subjective experiences and figures of interest in an accepting and non-judgmental fashion that is consilient with a modified phenomenological method and dialogical relationship in Gestalt therapy. Expressions of pro-recovery purposes early in therapy have been shown to be especially conducive to positive outcomes. Also, the awareness work commonly associated with mindfulness is consilient with Gestalt therapy and ubiquitous in the research literature. In addition, acceptance and commitment therapy (ACT) should be just as applicable since ACT is consilient with Gestalt therapy's paradoxical theory of change (people change by actualizing themselves in the current moment and accepting what is rather than attempting to live in the goals associated with one's future – what is yet to be). As such, the positive outcomes for MI, mindfulness, and ACT in substance dependence work should be applicable to Gestalt therapy as well.

Gestalt process has long been associated with awareness and tracking of the client's phenomenal field, claiming that everything having effect is relevant to the current situation. Gestalt therapists working with dependent clients need to not only understand field effects, they also need to deliberately and strategically intercede at the level of the field to provide support and influence while working in a multi-systemic fashion to expand the attitudes, horizons, and worlds of their clients and provide multiple pro-recovery resources. As such they might need to consult with other service providers in order to secure services in the best interest of their clients.

Contemporary Gestalt therapy has escaped the one-person psychology that would focus exclusively on the client's intrapsychic conflicts, introjects, and subjective experience. Much is said now about the nature of the relationship between client and therapist and the positive outcomes associated with such a relationship. However, the escape from a one-person psychology extends beyond the dyadic nature of the therapist-client relationship. It extends to the

[11] The reader is advised to consult chapter three "The Will To Change" in my book, *Gestalt Therapy for Addictive and Self-Medicating Behaviors* (Brownell, 2011a). There is an extensive description of motivational interviewing, its consilient use among Gestalt therapists, and the research literature associated with the subject.

overall situation or field. Thus, therapists may find themselves working with self-help and support networks in which their clients have become active. They may find themselves addressing the anti-recovery influences in the client's life – such as the friends he or she associates with using or drinking and who co-opt the client's progress. Therapists also often need to work with family members to deal with the destructive co-dependent dynamics in the client's familial relationships.

Gestalt therapists work to expand the client's lifeworld, and that takes the process beyond the uni-dimensional exploration of the client's subjective experience.

Therapy with addicted persons has to be multidimensional and multimodal. It has to include the therapy of body, soul, spirit and the social environment. Through social skills training therapists can faciliate learning to socialize after long periods of relative isolation or self-selected association with drug-using cultures, and to integrate into more healthy social systems.

Recovery, and the Gestalt therapy associated with it, also often includes the spiritual dimension of a person's life. The 12-step approach is a typical example. It is a spiritual system. While it is beyond the scope of this chapter to develop the spiritual aspects of recovery, Gestalt therapists would do well to consult Gestalt-oriented discussions of spirituality in psychotherapy[12]. For many clients this is an essential part of their recovery.

6. Other Clinical Examples

6.1. Paul

I[13] have worked recently with a politoxicomanic patient in an ambulant setting who consumed dependently several drugs: alcohol, ecstasy, tobacco, cannabis, cocaine, amphetamines and others (but no heroin). He still seemed to be socialy integrated and still had his work (dealing with wines and selling them to good restaurants. He had to organize degustations for his clients) and he needed his car for work. Usually he had a well functioning consumption system in taking drugs: only a little alcohol during work just as much as was needed to taste wine with his clients – never emptying a glass, so that he still was able to legally drive his car. On evenings a joint and some more alcohol, but just as much that he was OK next morning to get to work. His boss was

[12] See for instance chapter 14, "Your client's ultimate beliefs. The spiritual horizon" in Brownell (2011a); Brownell (2011b; 2012); Elliott Ingersol (2005); Williams (2006); Brownell (2006).

[13] This and the following two examples are from Peter Schulthess's clinical practice.

very satisfied with him and gave him a responsible position in the business. But on weekends Paul exaggerated: from Friday evening to Sunday morning he was usually at parties, needing no sleep due to the effects of drugs. One Sunday at noon on his way back home he had a small crash with another car. He bumped into its back. It turned out that in the other car there were two policemen. They carried out an alcohol and drug control and were surprised at the amounts and the variety they found. He lost his driver's license immediately and the authorities told him that he would need to go to therapy and that he would only get his license back if he could prove that he was clean from all drugs found on him for at least a year. Fortunately the boss kept his employment, supported therapy and, on the advice of one of his friends, recommended him to me and even offered to pay for the therapy, because he felt that stress on the job might have been one of the factors for this employee's crisis.

At the beginning of the therapy the patient started to look at this car-crash and it's consequences not only as damaging but also as an opportunity for therapy, because he was already often thinking of doing so, but never managed to motivate himself to go to therapy. The pressure now pushed him to a decision. He seemed quite motivated to withdraw from the lifestyle he was caught in. I explored with him step by step what usually happens on Friday evenings, because I was curious why he only took cocaine and ecstacy at weekends and not every day, but alcohol daily. It turned out that all his weekends started with alcohol abuse in bars. And in this drunken state he started to feel the demand to consume other drugs as well. So I proposed as an experiment that he withdraw from alcohol for just two weeks, to see what would happen. He agreed to this. This was difficult for him because he had to cope with the degustation customers in such a way that they did not realise that he was not tasting these wines himself. He reached several insights: he discovered how much the other employees at his work were drinking (except his boss); and he found out, that it was easy not to consume other drugs when he did not drink alcohol, because he did not feel any demand for them. So we identified alcohol as the most dangerous drug for him and I explored with him if he could imagine living without alcohol. He agreed that he would try this for at least a year, until he got his driver's license back and then would try to drink in a controlled way. He hoped, with the help of the therapy, he might reach a point where this could be realistic. He really stopped drinking and in addition he also stopped consuming other drugs (except tobacco). He changed, became more open to his emotions, so that we could work on events in his life history, his actual family (he was living at his parents house, separated from the mother of his child who forbade him to visit his child) and other therapy topics that lay behind his pattern of narcotizing himself and playing the hard guy. After some months he unexpectedly did not show up for a therapy date. I tried to reach him by phone, but he

never picked up. After three weeks he called again and asked for another date. He had had a relapse and had disappeared to an isolated house in the mountains to be alone and clear with himself. He did not even inform his boss, he just did not go to work. Feelings of shame and disappointment about having failed had prevented him from calling me, his boss and his parents. It turns out, that he was under pressure in his job. The boss did stop reimbursing the costs of therapy, because he told him that he should stop drinking alcohol as his new lifestyle. In the next phase of therapy he was withdrawn from drugs again and we focussed also on his job situation. Finally he found another job. When he told his boss this, he became quite angry and made him feel guilty for leaving, after having been supported by him for so long. But Paul left and this was a good change, he was not in touch with alcohol anymore. He also managed to regulate his relationship with his ex-girl friend and to regulate seeing his child (since he was clear there was no good reason anymore to keep him away from contact with his child). After a year he was examined by a specialized physician, to see if he was really clean, in order to get back his driver's license. This was the moment when Paul quit therapy. He seemed optimistic that he could stay clean and was happy with the change he had made in his life. He said that his life had a better quality now. I have not heard from him since then and do not know if this is a good or a bad sign.

An important aspect of the therapeutic relationship was for Paul to find someone who was critical but honest with him and who supported him in expressing emotions and personal needs in the moments when he lost his poker-face-attitude. He needed someone who backed him up in the existential need to be seen for what he is and as worthy of being loved as the human beeing he is. This was a correcting experience to his life background as the son of immigrants, who was never appreciated in school, in peer groups or in his family, where his successful father preferred to demonstrate that his son would never reach his level.

6.2. Claudia

Claudia, a woman at the age of about 40, was the wife of a quite well known physician. They had been married for several years and had two children aged 7 and 9 when she came to therapy. She was a nurse before her marriage but gave up her profession in order to be a fulltime mother and houskeeper. At the time she started therapy, she participated in her husband's work by keeping adminstrative aspects of his medical office in order. She did not earn money for this. She did it because her children did not need a 100% presence any more and she wanted to be useful.

She asked for therapy, because she felt sometimes depressed, tired and bored with her life, feeling it to be meaningless. She had existential questions about the aim of her life. She felt like a nobody compared to her husband. She did not speak about alcohol at the first sessions, but something in her behaviour and way of expressing herself made me curious to ask more about her drinking habits. It showed up, that her difficulties in getting up in the morning and preparing breakfast for the children (her husband often did get the childern ready for school, because he had to get up at the same time), were not just a symptom of depression, but also a result of drinking in the evening. The couple used to drink a glass of wine together in the evenings, but she had developed drinking habits, where she drank more and more. This was a topic for quarrels in the partnership, but neither of them took it seriously enough to acknowledge that it would have to be cured with professional help. In therapy we spoke a lot about her self esteem, the moment of changes in her life when she married and now as the children got older and about what she would like to do as a new professional challenge. Also conflictive topics in her childhood came up and we did work in a Gestalt therapeutic way with this. And we continued to keep an eye on her drinking habits and patterns. In what situations, when, with whom, with what effect. She was drinking often in social situations, but she herself observed that it was more than that, that she needed to drink and the moments of being drunk occurred more frequently. She was also drinking when she was alone and tried to hide this. So in therapy she stopped hiding that she had a severe drinking problem and that this was connected with her depressive side. We worked out that these drinking patterns also showed something auto-aggressive and became destructive against herself, having consequences for both her social relations in the family and for friendships. One day she called me half an hour before our meeting, totally drunk, wanting to cancel. I invited her to come anyway to the meeting even if she was drunk and that we would see what we could do in our session. She came on time, but with shame and she was really quite drunk. I offered her a cup of coffee and stayed friendly and interested in her and asked what had happened that she got so drunk today. Of course in this state we could not work on a deep therapeutic level, we just had a coffee talk and she reported. Next week she came again, without beeing drunk. She told me how important it had been for her to experience in that session that I did not send her away or judge her morally. She had felt accepted still and welcome also in this state, even if she felt some shame again. We spoke about the possibility of going to a clinic for withdrawal from alcohol and to find out what would happen with her depressive emotional state. I told her that I could look around for a clinic where she might be in good hands. She was sceptical but started at least to think about it. She also hesitated because she was afraid of what people in her village would think, when the wife of the doctor would

have to go to a clinic because of drinking problems. We continued to meet, but some weeks later she did not show up at one of our appointments and did not answer the phone. Some days later she called me and told me that she was in a psychiatric clinic. She had had a crisis, got drunk and was speaking about ideas of suicide. Her husband was trying to calm her down and proposed to give her antidepressive medication the next day (in order not to combine the effects of alcohol and medication), but she refused to be his patient and called the emergency psychiatrist herself to ask to be taken to a psychiatric clinic. I congratulated her on making this important step in taking a responsible decision for herself and agreed with her that she should stay there for two or three weeks and then we would continue our therapy again in the ambulant setting. It was important for her to decide herself that she wanted to go to the clinic now, using neither her husband's nor my professional network.

After her four-week stay in the clinic we continued therapy, she stayed abstinent and it was much easier to work therapeutically on the topics of what she wanted in life, who she is and to discover what she really needs. The symptoms of depression disappeared without medication and she found new self-esteem and orientation as a mother, wife and professional (she took a job where she was no longer in dependency on her husband).

This case-example shows how important the therapeutic relationship and attitude toward the patient is in difficult moments of the process. And it shows how delicate the process is, to start to observe addictive habits, to identify them as addictive, to confess that the drinking patterns are out of control, to capitulate and re-start afterwards with a new orientation. It also shows the interaction of depression and alcoholism.

6.3. Some Final Clinical Considerations

Writing this chapter many memories come back to my[14] mind of patients who where suffering with dependant behaviors. And I look back on all of them with some tender feelings and being thankful for having met them and had the chance to get in touch with them and see how they managed to change important aspects of their way of dealing with themselves and social and intimate relations. Sometimes these changes are surpising and unexpected. Anyway, we have to consider that therapy for addiction is usually a long-term therapy and not always successful the first time. And of course there are also other examples, where therapy fails. I remember Jack, who also had a very difficult biographic background and also was a victim of others as the outsider to make fun of. He once told me in group therapy: "You know what my injection that I car-

[14] Peter Schulthess.

ry with me in my pocket meant to me? It was my girl friend in my pocket. She was always with me and immediately ready to help me when I felt bad. Because to find a real girl that would be my friend seemed to be beyond my possibilities". In the therapeutic community he made a lot of progress, also in social training, but after that he fell back to drugs, got caught by the police and the court obliged him to undergo some therapy again, this time in an ambulant setting. He did choose me, because he had good memories of me and was optimistic that I could help him again. He made good progress again and was motivated, but after several months he unexpectedly did not show up any more and I could not reach him. After three weeks I received the message from his social worker, that he had died of an overdose. He took his last shot of heroin sitting in a tram, as if his "girl friend in the pocket" would have helped him one last time. They found him, because he did not get out at the terminal station but stayed sitting there on the return route.

Therapists working with patients that are severely suffering from dependent behaviors have also to learn that there are limits in therapy, that they cannot help or save all patients in getting free of their dependency. As said at the beginning, drug dependency is a lethal illness and it cannot always be cured.

7. Conclusion

As with many issues in current mental health, substance dependence treatment is ruled by the cognitive-behavioral perspective in psychotherapy. It need not be that way. Gestalt therapy is an effective approach that assimilates and organizes nicely many of the salient features in addictions work. This chapter has been offered as an alternative and as a suggestion. We have used Gestalt therapy for years on the intensive care unit of a co-occuring disorders treatment facility and in outpatient practice when working with people who are self-medicating and have become dependent on drugs or alcohol. Gestalt therapy is a consistent and satisfying way to work, and it allows for a deepening of the supportive relationship between therapists and clients who struggle while feeling out of control and desperate for change.

Comment

by Nathalie Casabo

Peter Brownell and Peter Schulthess have perfectly described the processes at work, both in addiction as well as in recovery, and have shown the extent to

which Gestalt therapy is pertinent for the accompaniment of dependant behaviours. They have emphasized the important involvement of the therapist, and my commentary will focus on this hallmark posture of the Gestalt therapist, drawing from my clinical experience.

We have seen with Casey and Paul how difficult it is to spontaneously knock at the door of a psychotherapist. If addicts self-medicate, it is precisely to be self-sufficient. What Jack said to Peter about his injection: a girlfriend always in his pocket, ready to help him when he felt bad, illustrates this well. Alcoholism and toxicomania are often defined as a link pathology (Lemay, 1979; Roussaux, Faoro-Kreit and Hers, 1996). Unlike people, a drug is always available, soothing, boosting, euphoriant, etc. and especially not confrontational. Going beyond denial and asking for help is an extremely difficult step for these people used to being self sufficient [15]*. Thus, the first contacts, by phone for an appointment, or face to face during the first session, are especially determinant since, paradoxically, shame, mistrust and guilt form an integral part of their "being-in-the world". Being where the patient is not expecting us to be, as Philip did with Casey during their first appointment, is a good way to "snare" him/her.*

The contact mode of dependant persons – from sensation to action (Clemmens, 1997) – sometimes brings us to engage ourselves even before meeting with the person. Grasping the instant when the addict wishes to undertake a process of recovery (in a way just as impulsive as the one leading him to drink, sniff or shoot), can allow him to effectively engage himself in the process before the desire for recovery disappears as quickly as it appeared. Thus I have sometimes begun to create a link by SMS when an immediate consultation was not possible.

Also, requiring abstinence before beginning the therapy, as was the case for a long time in France (and still is sometimes!), is counterproductive, even though, obviously, deeper work can't be done during massive intoxications. Doing the consultation, even with the person heavily drunk, as Peter did with Claudia, seems essential to me, in spite of possible excesses which we need to know how to contain. Many patients quickly abandon their commitment to obtaining help if they feel judged and/or treated like a child. Feeling accepted as they are, including in an intoxicated state, reinforces the therapeutic alliance and allows the achievement of new stages. This implies adhering to the therapeutic framework, whilst also being flexible and able to redefine it regularly. For instance, my sessions with one patient took place in his home. He was agoraphobic and had not gone out for a year. His wife and his son had become co-

[15] «No human being, no woman, no poem, no literature, no painting can replace alcohol in this function it has for man, the illusion of utmost creation». Marguerite Duras, *La vie matérielle*, p. 22 (informal translation).

dependants, and they were bringing him his alcohol and tobacco. It was a big step, after three months, to have a therapy session walking outside in his neighbourhood, and another one when he was able to come alone to my office.

Being both alcohologist and psychotherapist also requires being readily accessible. Indeed, many people come to the alcohologist for advice, without having the intention to start therapy. Their goal is often to become abstinent, and they imagine their problems will be solved as soon as they have reached abstinence. But if abstinence is a necessary condition, it is not sufficient (Clemmens, 1997) for a profound transformation that they can maintain. Frequently, the people with whom I begin to work refuse to see a doctor regularly or to attend nephalist meetings such as Alcoholics Anonymous. If you insist on this there is a risk of "failing" the therapy. In these cases, I take on both functions, and during the physical withdrawal period, my phone is on day and night, not the usual practice if one is "simply" an alcohologist. For a period, depending on each particular person, you have to be as available as the drug, and accept being a kind of transitional object. This availability beyond therapy sessions is also precious during the "accidental" re-alcoholizations. In sharing, if possible, these times of extreme distress, we can sometimes defuse the relapse. Indeed, the relapse can be precipitated by discouragement and shame, and some, like Jack, never come back from it.

By his total engagement in the situation, his measured disclosure, the Gestalt therapist inscribes himself in a co-creation with the patient. The patient, recovering responsibility and reassured in his ability to create and maintain links, finds in the therapeutic relationship the ground for the Next. The self can thus unfurl at the contact boundaries.

Beyond the Pillars of Hercules. A Gestalt Therapy Perspective of Psychotic Experiences[*]

by Gianni Francesetti and Margherita Spagnuolo Lobb

1. Introduction

This work takes as its starting point a phenomenological and Gestalt understanding of therapeutic experience with psychotic patients. Although a rich literature exists in the phenomenological psychiatry of psychotic experiences, the written contribution of Gestalt therapists to this field is much more recent and still rather sporadic (Stradford and Brallier, 1979; Serok, Rabin and Spitz, 1984; Harris, 1992; Spagnuolo Lobb, 2002a, 2003a; Yontef, 2001a; 2001b; Philippson, 2001; Conte, 2001; Brownell, 2010a; Arnfred, 2012).

In psychiatric nosology, forms of psychotic experience have traditionally been divided into schizophrenia – Kraepelin's *Dementia Praecox* (1903) – and manic-depression (Schneider, 1955). Such a division, however, has never covered the full spectrum of clinical manifestations of what we define here as psychotic experience. Over the history of psychopathology, many links have been described between these two main psychoses and with other disorders (for instance, all agree that schizoaffective disorder is a link between the two), with many variants introduced through successive classifications, up to the current DSM-IV-TR (2000). Today, psychopathology is seeing a revival of the concept of "unitary psychosis" (first introduced by Griesinger (1845) and employed by Kraeplin in his later work in 1920 – Ballerini, 2011) and of the importance of affective aspects of schizophrenia. From this perspective, the psychoses of schizophrenia and manic-depression are not two totally separate entities but rather the polar limits of a continuum that can take on different forms in different people, in different situations.

This is the perspective that we adopt in this work, considering psychotic experience as a particular way of constructing experience, which can assume different clinical *Gestalten* and which has its own characteristics that distinguish it from neurotic experience. It is a basic dimension of experience that can take on very different clinical forms. We will work with what would appear to be its

[*] Originally this topic should have been developed in two chapters, then the authors decided to write together the whole chapter in order to integrate their visions and provide a comprehensive perspective on this suffering.

common ground, present in all the different ways in which such suffering can manifest itself, characterizing psychotic experience as the impairment or loss of the sense of being part of a common world. Generally, this datum of experience is taken for granted; in psychotic experience, it is instead problematic or missing. The loss of *common sense* is the consequence of a sensorial and perceptive mode that renders I-Thou differentiation problematic, of a constant primary confluence. Recent studies in neuroscience (Ebisch *et al*., 2012) have discovered that first-episode schizophrenia is associated with a dysfunction in the activation of the insula, the cerebral region involved in deep-seated, archaic sensations and crucial in distinguishing in experience what belongs to the I from what belongs to the Thou[1]. These findings confirm the idea, widespread in Gestalt therapy, that psychotic experience is fundamentally a disorder of a confluent state, in which the I and Thou are not yet distinguished and the sense of co-creation and co-separation, of "being-with", is not possible.

Hence we will read these experiences as an expression of an altered relationship with the environment, ranging from the impossibility of differentiating oneself (the schizophrenic spectrum) to the impossibility of feeling oneself to be connected (the melancholic spectrum), with all the various shades and overlaps lying in between. Among the various clinical forms that psychotic experience can assume, apart from schizophrenia and manic-depressive illness, there are other psychotic disorders in the schizophrenia spectrum[2], as well as schizoid and schizotypal personality disorders[3].

[1] This difficulty would appear to be correlated with a vulnerability of a genetic or perhaps epigenetic nature (transmitted via gene expression though dependent on the lived experience of the parents).

[2] In the DSM–IV–TR, the schizophrenia spectrum includes: **1. Schizophrenia**: a disturbance persisting for at least six months, including at least one month of active-phase symptoms (for instance, two or more of the following symptoms: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms). **2. Schizophreniform Dis.**: characterized by the same symptom criteria for schizophrenia, with the exception that the duration is shorter (one to six months) and there may be no impairment in social functioning. **3. Brief Psychotic Dis.**: where symptoms persist for more than one day and resolve completely within one month. **4. Schizoaffective Dis.**: where an episode of mood alteration occurs together with the active-phase symptoms of schizophrenia, preceded or followed by at least two weeks of delusions or hallucinations in the absence of mood symptoms. **5. Delusional Dis.**: where non-bizarre delusions are present for at least one month in the absence of other symptom criteria for schizophrenia. **6. Shared Psychotic Dis.**: developed in an individual influenced by another person afflicted by delusions arising from another disorder. **7. Psychotic Dis. Due to a General Medical Condition**: where psychotic symptoms are the direct physiological result of a general medical illness. **8. Substance-Induced Psychotic Dis.**: where psychotic symptoms are directly caused by substance or drug abuse or by intoxication. **9. Psychotic Dis. Not Otherwise Specified (NOS)**: psychotic cases that do not meet the symptom criteria for any specific disorder in the category.

[3] Many authors have stressed the contiguity or overlap of such personality disorders with schizophrenic disorders lacking any striking symptoms (subapophanic schizophrenia –

The aim of this chapter is to give an outline of the underlying perspectives enabling the peculiarities and sense of psychotic experience to be grasped, within the framework of Gestalt therapy, and to suggest general therapy guidelines for the spectrum of schizophrenia and schizoid and schizotypal personality disorders. The approach we propose falls within a perspective that in recent decades has brought the relational phenomenological field to the fore as the constitutive matrix of subjectivity, to which the literature of Gestalt therapy has also contributed (Wheeler 1991; 2000a; Staemmler, 1997a, 2002, 2006b; Spagnuolo Lobb, 2001d; 2009c; 2011a; Yontef, 2001a; Robine, 2003; Wollants, 2008; Jacobs and Hycner, 2009). We will not address the etiology of these experiences, that is the causes that lead to psychosis, working on the assumption that the biological and the relational form the indissoluble ground of all experience, and that the polemic between genetic and cultural influences has largely been put aside. We believe that this approach, and the understanding that it gives, can bring to light useful elements for psychotherapists in their encounter with psychotic experiences. We will then conclude with some clinical examples from the schizophrenia spectrum, and with the presentation of a model for intervention in psychiatric institutions, while leaving the discussion of clinical work with manic and depressive psychotic experiences to chapters 21 and 22.

2. A Terminological Note

In approaching this discussion, we will encounter terminological issues that we will attempt to clarify. Nevertheless, we are aware that, given the complexity of the subject and its philosophical implications, in spite of this terminological note, some terms will remain ambiguous while others will only become clearer as the discussion is developed.

2.1. Self/Life-world

In *Gestalt Therapy* (Perls, Hefferline and Goodman, 1951), the authors speak of the *organism/environment* field, adopting the usage made of the terms in Gestalt psychology, in particular by Goldstein (1939; 1940). This pair of words lends itself, however, to a third-person description of experience, that is a description *from outside* the interaction of an organism with its environment.

meaning without evident symptomatic manifestations, Blankenburg, 1971; Ballerini, 2011), while the ICD-10 classifies schizotypal disorder under schizophrenia and not under personality disorders (WHO, 1992).

In the phenomenological literature, the terms I/world have often been used instead for this purpose; however, "I" is a term with too many different connotations in psychotherapy, so we feel that using it would be confusing. To refer to the first-person experience – *from the inside*, that is the subjective experience – of being a "me" separate from the "world", we will instead speak of the *self/life-world* field, as proposed by Dan Bloom (2011a). The terms *self/life-world* express the fact that, phenomenologically, the self and the world co-emerge at the contact boundary. Nevertheless, an ambiguity remains that is not only terminological, but which also reflects an irreducible conceptual complexity: the self emerges together with the world, and at the same time it is the function that generates this distinction and connection. As such, we will use the term "self" in its original acceptation, as defined by the theory of Gestalt therapy, to mean an emergent function of contact, and not a structure or I. This self that emerges through contact is also what generates experience (Spagnuolo Lobb, 2001d; 2005a; 2011a).

2.2. The Pre-personal Dimension of Experience

A second term we wish to introduce is that of the *pre-personal dimension of experience*. In this work we will encounter a dimension of experience that is not the ordinary dimension that people usually have in figure. By *ordinary* experience we mean the experience which allows us to take for granted that we are part of a common world in an unproblematic way. In ordinary experience, we live in a world made up of objects and persons that are different and separate from us, with which/whom we establish a relationship (the computer, the table, a friend, a tree, etc.). However, there is another way of experiencing that we will call the *pre-personal* dimension. This dimension of experience emerges as figure only in certain conditions, although it is always present as ground. It is this pre-personal dimension that appears necessary to us to understand what in the clinical field we call psychotic experience.

We have borrowed the term "pre-personal" from Wilber (1981), who uses it to denote precocious experience in children where the self is not clearly differentiated from the world[4]. Nevertheless, it is not our intention here to enter into

[4] The pre-personal level of experience refers back to the *emerging self* described by Stern (1985) in the first two months of a child's life. At this time of childhood development, there is no definite sense of self, nor is it distinct from the world; rather it is the *emergent process* of the self that is figure. This indefinite experiential background is a dimension that is present in all our experiences, throughout our lives. This dimension of experience is non-verbal and pre-verbal, thus it is implicit in Stern's acceptation of it (Stern, 1985; 1998). Our proposed use of the term "pre-personal" is, therefore, consistent with this conception, as it is a level of experience that emerges as figure in the early months of a child's development,

a discussion of childhood experience, and we will use the term in a limited sense to denote a radical dimension from which experience is originated continually: it is the root of the *Gestaltung*, of the process of co-creating experience.

To clarify the concept further, an analogy can be drawn with physics. The Newtonian world is made up of discrete, stable objects that interact with each other according to laws that assure their predictability. But in the physical world, there is a subatomic dimension in which the definite boundaries of objects do not exist; here it is the continual exchange between matter and energy that reigns supreme, an incessant, vertiginous movement, a realm of unpredictability that is far from the stability that we know. Just as this subatomic world is grasped only in specific experimental situations, though it is always present at every instant, similarly we grasp the pre-personal dimension only in certain moments. For instance, when we come across psychotic experience.

3. The Relational Constitution of the Subject

3.1. Where the Subject Is yet to Be Constituted: the Root of the Gestaltung

There are different ways of viewing a subject. One way is to consider it a given, original element which then makes contact with the world and other subjects. This perspective, which Husserl called the "natural attitude" (1969), lies at the basis of our common experience, and it is generally adequate for living in the world and interacting with others. This is the ordinary experience of common sense (Stanghellini, 2006), which guides us and enables us to live in a shared world. Similarly, an engineer required to build a bridge considers steel sheets and bolts as constituted objects; there is no need to think of how the metal, at the subatomic level, is continually being constituted via incessant interactions between matter and energy. As psychotherapists, however, when working in a psychotic field, we do not encounter constituted, definite subjects, hence this way of considering things is neither sufficient nor adequate. It is as though the engineer has to work now on the subatomic level, where she has to take on a quantum mechanical perspective in which particles appear and disappear continuously, and abandon the Newtonian vision of discrete, stable objects. Just as it is necessary sometimes to take into consideration the subatomic world, with psychotic experiences we need to consider a pre-personal dimension that is not "thought out" but taken for granted – a dimension that is rarely

and which remains in the ground as the root of experience and as a possible way of experiencing throughout life.

addressed, if not by phenomenological philosophy, and rarely rendered problematic, if not by psychotic experience. Just as we encounter the subatomic world only in specific experimental situations, likewise we encounter the pre-personal world only in unordinary situations, such as psychotic experiences, which, by no coincidence, Binswanger called "experiments of nature" (1963). Just as the subatomic world is always present, even in the hardness and solidity of a metal, the pre-personal world is always active in the generation of experience. Thus we need to be ready to shift perspective and view the subject as the emergent outcome of the relational field of the given situation. This is the perspective of Perls, Hefferline and Goodman (1951), and it is the one that we are interested in taking up to try and understand psychotic experience.

What are the game rules of this pre-personal world? The fundamental condition is that subjects and objects are not yet definite, that is they are yet to be separated by clear boundaries and constituted by the fabric of space and time, in the way we are used to experiencing them through our common sense. Let us take a closer look at these aspects.

The transcendence of the subject does not refer merely to the fact that the subject is always in contact and communicant with the world, but, more radically, to the consideration that the subject itself is an emergent property, a derivative of the relationship with the world. The link between the relationship and the subject is circular and hermeneutic, which means that the subject creates the relationship and is created by it at the same time. It is a paradoxical circle which is impossible to break – like the Escher drawings in which one hand draws another, which in turn draws the first. We can only pause in awareness in this hermeneutic circle (Heidegger, Gadamer[5]). This implies that the subject should be considered not as an original datum that then makes contact with the world, but rather as an event that emerges from phenomena at the contact boundary, in a precise place/moment in which person and world are not yet distinct from each other[6] (Maldiney, 2007). Even the etymology of the terms bear the memory of this constitutive passage, as *sub-jectum* and *ob-jectum* precisely denote the outcome of an action that separates two entities, casting one on this side, and the other on the other side, of an energetic act of distinguishing something that was not separate before. From this perspective, the isolated individual is a reduction that we ordinarily make and which obscures the very roots of our experience. The ability to neglect the continually

[5] See Sichera, 2001.

[6] Erwin Straus writes: «I become insofar as something happens, and something happens (for me) insofar as I become. The Now of sensing belongs neither to objectivity nor to subjectivity alone, but necessarily to both together. In sensing, both self and world unfold simultaneously for the sensing subject; the sensing being experiences himself and the world, himself in the world, himself with the world» (Straus, 1963, p. 351).

present pre-personal world is useful for simplifying our ordinary everyday lives, just as it is useful to perceive discrete objects rather than chaotic subatomic movements.

This intersubjective perspective is also supported by research in neuroscience from over the past decade. With the discovery of mirror neurons, for instance, which do not distinguish whether an experience belongs to the self or to the other, «intersubjectivity thus becomes "ontologically" the foundation of the human condition, in which reciprocity defines existence in a foundational way» (Gallese, 2007).

From this perspective, the deepest seat of our being is constituted by the senses, where the organism and environment border and converge. The self continually creates and is created by experience at the contact boundary (see Spagnuolo Lobb, 2001d; 2011a, pp. 66ff.), a "third party" that lies at a whole other level of complexity with respect to the organism and the environment: a level which is not accessible in the environment analyzed as an object, nor in the organism analyzed, in its turn, as an object. Instead, the phenomenon lies at the point where experience is continually created, where the now gushes up and explodes (Maldiney, 2007). In this sense, the self is the function through which we draw from the *life-world* of phenomenology, by which we mean the continual flow of lived experience at its pre-verbal and pre-reflexive stage. This flow is the underground stream which we can access by stopping to listen to our sensations, to the continuum of self-consciousness. Since it lies in the senses and «sensation is literally a form of communion» (Merleau-Ponty, 2003), this stream is not *in me*, but *between us*.

3.2. The Passage from the Pre-Personal Dimension to Ordinary Experience: Two Acts of the Self

Ordinary experience is not, therefore, an original datum, but an action that follows specific steps. In particular, as we will see shortly, it is an act of differentiation and an act of connection. This action is a co-creation whose rationale is one of relational economy; it is, in fact, necessary that sensory data be reduced so as to focus on a figure that becomes the possibility of social interaction. Thus it follows that our experiences can be constituted in different ways. For instance, experiences under the influence of drugs or anesthetic, psychotic experiences and mystical experiences each have different constitutive rules, and we can experience worlds that are qualitatively different. In psychotic experience, it is possible to observe variations in these constitutive steps of experience. Such states show that, in order to give ordinary form to experience, the self performs two acts. On the one hand, it anchors experience in the situation;

on the other, it differentiates the person from the world. These two acts are situated at a pre-reflexive and pre-verbal level; they happen without the intervention of thought, and what happens at this level cannot be verbalized: it is implicit, as Stern understands it (Stern *et al*. 1998b; 2004). Language, in the West at least, is grounded precisely on the plane derived from this act, using as its foundations the outcomes of these two acts of the self; language, with its *subject/verb/object* sentence structure, always comes after the root of experience. Hence we can say that the self, as it is conceived in Gestalt therapy, contains both nascent experience (the id-function) and its social definition (personality-function), as well as the creation of figures (ego-function).

These two acts form the *ground* (in Gestalt terms) that we take for granted, on which our ordinary everyday experience rests. In an unproblematic way they allow us to feel alive, situated in time and space, to be subjects differentiated from the world as well as agents in the world. These acts can be called *transcendental* (to use Kantian terms), insofar as they do not concern the content of experience, but rather the conditions for its possibility, coming before the constitution of the subject. It is these acts of the self that allow us continually to rest on the presumption of which Husserl speaks: "The real world exists, only on the continually delineated presumption that experience will go on continually in the same constitutional style" (Husserl, 1969, §99 pp. 251-252). This allows us not to concern ourselves with the question of whether the world will end in the next few seconds, something of which, in truth, we have no guarantee. We are sure of it in the etymological sense of the Latin *sine cura*: we simply do not concern ourselves with it.

In Ancient Greece, the Pillars of Hercules marked the limits of the known world. The acts of the self stand at the Herculean pillars of our experience. On this side of the pillars is everything we can experience as subjects; on the other side, beyond the pillars we erect as subjects, is the realm of emerging experience, about which no words can be said, and where we cannot step foot as subjects.

The consequence of this is that we live in a common world precisely because we continually construct a common world out of a common ground. If we did not, we would be strangers, completely alone in an alien world.

4. Two Relational Dimensions of Experience

Experience, therefore, has two different (though simultaneous and circularly intertwined) dimensions.

The first, the pre-personal, constitutive and foundational dimension, is the root of experience, which is anterior to the separation of the self and the life-

world. Such happening is a given; it is not deliberate. It is where the root of experience lies. As Goodman (Perls, Hefferline and Goodman, 1951) puts it, it is the region of the id of the situation, and not the id of the organism or individual (Robine, 2011; Wollants, 2008). It is an experiential dimension, but also a relational one. Here, from the indistinct *inter-esse*[7], from the sensorial flow that has yet to constitute itself as a definite boundary, experience takes shape to become *my* experience.

The second dimension, which we might call the personal, gushes out of the first and flows parallel to it. Here, the self/life-world distinction has been accomplished. Existence as a definite subject – the sense of being here, of occupying a place in the world and enduring through time – is thus acquired, and it is on these bases that the dimension of contact emerges, in which the subject co-constructs contact with another subject, building on their reciprocal intentionalities. It is in this region that we can act on our decisions, via the ego-function.

These two dimensions are bound together by a hermeneutic circle that is indissoluble. Since both are always present, when we speak of a relationship we should specify whether we are speaking of the pre-personal relational dimension or the personal dimension in which two constituted people make contact.

The first experiential dimension is continually produced by the silent work of the id-function of the self, and constitutes the ground on which our experience of contact with the environment rests, via that which is first perceived as nascent and indistinct and then situated inside or outside one's skin (see Spagnuolo Lobb, 2005a). It is thanks to this work that our lived experiences have continuity and are situated in space-time, and that we perceive ourselves as subjects connected to the world and differentiated from it[8].

In the second dimension we find the deliberate commitment of the subject to contacting. It is not, however, a continuous act; it emerges only when an interest arises that mobilizes the ego-function of the self, and unfolds according to the laws governing the sequence of contact, as understood by Gestalt therapy. This sequence, thanks to the ego-function (capacity for contacting the environment by identifying or alienating oneself with a part of it), enables the organism to encounter the new and to grow (Perls, Hefferline and Goodman, 1951).

[7] From the Latin: *to be in the between*.

[8] Naturally, the experience of the self is one of unity, and even the personality-function contributes to experience by constituting the ground of our acquired contacts.

4.1. The Pre-Personal Dimension and the Concept of Endon in Phenomenological Psychiatry

The pre-personal dimension that we are describing has characteristics analogous to the realm of the endogenous, as understood in phenomenological psychiatry, in particular by Tellenbach (1961). Twentieth-century psychiatry searched long and hard for the causes of psychosis but found them neither in biological research nor in the psychological field[9]. Thus the term *endogenous* was introduced to indicate that such suffering must have a more profound, somatic cause in the subject, whose nature was not yet known. For Tellenbach, as the Endon is the moment of experience that is anterior to the constitution of the subject, it represents the background from which subjectivity emerges. The Endon is not reducible to either the somatic or the psychic. It is another moment of human experience: it is the phenomenological moment that precedes the act of cleavage that produces, by separating them, the self and the world. It cannot be reduced to the individual because it comes before it; it is pre-reflexive and pre-verbal. Hence, it cannot be reduced to the intrapsychic, to the cognitive and emotional dimension of the individual who already perceives herself as differentiated. But it also cannot be reduced to the intrasomatic dimension of the anatomical body (the *Körper* for the German school) (Galimberti, 2003). The Endon is relational, lived inter-corporeality (Merleau-Ponty, 2003); it is Straus' pathic moment (1963), the *Leib* of the German school. Gestalt awareness (Spagnuolo Lobb, 2004b), various meditation practices, mindfulness (Siegel, 2007) and phenomenological *epoché* itself, in its various expressions (Merleau-Ponty, 2003; Varela 2009), are all ways of grasping experience in that vague, confusing moment/place (Minkowski, 1933; Blankenburg, 1971; Robine, 2011) where it emerges prior to the establishment of what is *me* and what is the *world*. What is grasped is not a definite perception, however, but rather an atmosphere; something that happens now, though it is impossible to say where or what it belongs to. Instead one finds oneself immersed and partaking in something which transcends. It is no coincidence that this atmosphere is present in the psychotic field, perceptible to both the patient and the therapist as a strange, diffuse sensation that does not refer to any specific perceptive element[10].

[9] For a review see Aragona (2009).

[10] To quote the words of the Japanese psychiatrist Bin Kimura (2005, p. 87): «Undoubtedly, it may not be easy to grasp, in its original pureness, this immediate reality that precedes the verbally determined "I"; it is the immediacy of the "original spontaneity" anterior to the separation of the subject and object. Thus, we need to perform a sort of phenomenological epoché of the linguistic determinism that covers practically all of our everyday world. Likewise, the aim of *kensho* in Zen Buddhism is, ultimately, to grasp this immediate reality. It is neither an empty hypothesis nor an illusion of mystical experience, but […] a

This insight highlights the theoretical and conceptual bridge that links Gestalt therapy to the twentieth-century phenomenological tradition of psychopathology. It allows Gestalt therapists to draw from phenomenological psychiatric understanding within a theoretical framework that is consistent with the Gestalt therapy model.

5. Psychotic Experience as a Disturbance of the Id-Function of the Self in the Pre-Personal Dimension

This description provides a horizon on which to place psychotic experience as a disturbance of the id-function of the self, paving the way for the possibility of understanding and working, in psychotherapy, with psychotic states.

Let us return to the two acts of the id-function of the self that we described as part of the pre-personal dimension. On the one hand, we said that the self anchors experience in its transcendental root, thus generating the experience of being connected to the flow of life and situated in the present; on the other, it draws a boundary distinguishing the person from the world, thus generating the experience of a "me" separate from a "world".

5.1. Disturbance in the Act of Anchoring: Depressive and Manic Experiences

If the first act is disturbed, the result is that of feeling separated from the flow of life, and we find ourselves in the world of manic-depression. Instead of connection, it is the abyss that is experienced. Naturally, different degrees of such dysfunction are possible, as the functioning of the self diminishes, potentially down to zero, where it is characterized by a state of stupor in which nothing happens. It is a disturbance of the id of the situation (Perls, Hefferline and Goodman, 1951; Robine, 2011, pp. 146 ff.), which draws from that original mesh out of which subjectivity, time, space and intentionality all gush: life. If this function is disturbed, our anchor is diminished in the root of experience ("I feel nothing, nothing happens") – where life flows unceasingly ("time has stopped"), where interest is whetted ("nothing affects me, nothing is meaningful") and action spurred ("I can't do anything"), where being-here-with takes shape ("I feel detached from everything"). For it is at the root of experience that we are unceasingly created and we unceasingly create the situation. The disturbance of the id-function entails the impossibility of co-creating a figure

reality that can be seen if one accepts seeing it. Without presuming this reality to be infinite, it is impossible to argue in respect of the finite I».

of contact, and it is what underlies the difficulty in contacting the patient, in sensing that therapy space-time is traversed by the usual ebb and flow of resonances, consonances and dissonances. Nothing reverberates in the *in-between*. Ultimately, the sensation of non-life – perhaps the most emblematic sign of melancholic depression – is what clearly represents this condition. Even the very *other* experience of Cotard delusion – of *being neither alive nor dead, of having no body and no longer existing* – can be understood in this way (Francesetti, 2011). We refer you to chapters 21 and 22 for psychotic disorders in the manic-depressive spectrum.

5.2. Disturbance in the Act of Differentiation: Schizophrenic Experiences

Let us now see what happens when it is the act of differentiation of the self that is disturbed. Here we find ourselves in the world of schizophrenic experiences, where the distinction and boundary between the self and the world is not established and the "continually delineated presumption that experience will go on continually in the same constitutional style", that is the security of the ground, is not acquired. As described in Gestalt therapy terms by Spagnuolo Lobb (2002a; 2003a), what happens outside the subject can have effects as though it happened on the inside, and vice versa. One patient, a few days after the Abruzzo earthquake, said: "The other night I saw footage of the earthquake on the news. In that moment, I felt the earthquake inside me. Something had collapsed inside my body and I was terrified". Vice versa, what happens inside the subject can have an effect on the outside. Another patient related: "Yesterday I dreamt my wife might have an accident. Since then, an irrepressible anxiety has taken hold of me. I feel like the thought of it could somehow make it happen". This understanding of schizophrenic experiences appears to us to be consistent with the analysis of many phenomenological psychiatrists, and may provide a common denominator for their views: the loss of natural self-evidence[11] (Blankenburg, 1971); the problematic constitution of subjectivity out of the *Aida*[12] (Kimura, 2005); the *idios kosmos* of the *Daseinanalyse*[13]

[11] Blankenburg identifies as a basic phenomenon of schizophrenic experience the loss of *natural self-evidence*, that is a loss of the common-sense belief of belonging to a common world, which characterizes in an unproblematic way our ordinary experience.

[12] Bin Kimura considers schizophrenic experience to be a disturbance of the emergence of subjectivity from the *Aida*, a Japanese term meaning betweenness.

[13] Binswanger calls the psychotic world "*idios kosmos*" to indicate how it is still a world, with all the dignity which that implies, but at the same time it is a world that is not shared, from the Greek *idios*, "one's own, pertaining to oneself".

(Binswanger,1963); the loss of vital contact with reality[14] (Minkowski, 1998) – to cite just a few.

5.3. Delusion and Hallucination as Creative Adjustments

The two most striking psychotic symptoms, delusion and hallucination, are an attempt to make sense of an experience of non-differentiation or of disconnection. Delusion is a creative adjustment that builds a web of unilateral and rigid meanings where it is not possible to access them through the co-construction of meaning and boundaries. Delusion gives a meaning that is narratable and, therefore, at least communicable, albeit at the lower limit of what can be shared, to an experience that is constitutionally ineffable. It is an extreme attempt to reach the other through communication that is not shared, but which always holds within it a grain of truth to be communicated. Delusion steps in to give shape to the shapeless when the id-function of the self is not able to anchor the subject to the world, or differentiate it from the world. The melancholy sufferer stands apart, separated from the shared world, in a "no-world". Delusion saves her from total shipwreck by imparting meaning (incomprehensible to others, but nonetheless a meaning) to this experience, – "I'm in this situation by fault, by ruin or because I'm sick". The schizophrenic sufferer stands separated from the shared world in his own world. Delusion saves him from the terrifying confusion of a universe without bounds by establishing boundaries (poorly placed, but boundaries all the same) – "There's me and then there are evil people who persecute me", or "I can hear what happens kilometers away". The very form of delusion, which imposes itself on the subject as a revelation emanating from things, instead of as a product of the ego, reveals a boundary that is misplaced, whereby the I is undersized with respect to the world (Ballerini, 2011, p. 27). Delusion is an action that saves the sufferer from an even greater anxiety when the two acts of self are not possible, and that nonetheless launches a message towards the other – a message that is very difficult to grasp because it is not tuned to a common, co-created language. It is a protective and creative phenomenon that constructs a rigid figure because the possibility of co-constructing meaning is lacking, since pre-personal connection and differentiation is disturbed. However, as we will see, it is also a desperate attempt to tune in and return within the Pillars of Hercules. Hallucination can be a creative adjustment by constructing a *res ob-jecta*, something cast out, to become a reality that can be relied upon; the boundary may not be accu-

[14] Minkowski identifies the loss of vital contact with the world as the disturbance that generates schizophrenic experience, thus positing the world/subject relationship as the key to understanding such suffering.

rate, but it constitutes a reality that placates a more sinister and more distressing atmosphere. Clinical examples will provide, further on, an outline of clinical work on the ground and on the experiential truths that lie in psychotic experience.

5.4. The Clinical Relevance of Distinguishing Neurotic Experience from Psychotic Experience

Naturally, individual experiences can involve dysfunctions of the self that entail, to varying degrees, both the impossibility of establishing boundaries and the impossibility of feeling connected. As we said at the outset, psychotic experiences can be posited along a continuum in which they take on different forms. The model we have presented explains the various forms that arise on the basis of how the actions of the id-function of the self are altered. In effect, from our perspective, all psychotic experiences belong to a specific moment of experience which is anterior to self/life-world differentiation, and which represents their common denominator. At this level, however, it is two acts of the self that can be disturbed, and they can be affected either individually or in different interconnecting and overlapping ways.

Borderline experience (see chapter 30) can be viewed as a situation in which unceasing effort is made to hold anchor and draw a line that needs to be sought, affirmed and adjusted moment by moment and in every relationship. It is an ongoing battle on the borderline between the constitution and dissolution of a boundary, a life lived in the flickering glow of the Pillars of Hercules.

It is fundamental for the therapist to understand in which dimension of experience the patient finds herself, as it can change the meaning of the relationship and communication profoundly. A clinical example illustrates this point.

Having asked her how she is, a patient – Antonella – stopped for a minute to seek the answer from within. Then she said, "Like a stone". Her experiences of depression that I knew of made me think of a deterioration, but something was not right with that interpretation – the calm, perhaps flat, way of telling me so and the tranquility I felt in her presence. I realized we were in a psychotic dimension so I asked her what it is like to be a stone. She answered, "Um… fine. It's there, in the river. Nothing disturbs it; it's untroubled". The answer, on this horizon of meaning, signaled a conquest: a stone is not invaded by the world; its boundaries are clear, albeit rigid. Sure, it is not active, but it manages to persist in time, maintaining the continuity of the experience and partaking in the experience of being in the river. Recognizing that this was a conquest to support and consolidate, instead of a way of being defective, was fundamen-

tal so as not to devalue and lose how precious this mode of relatedness was. The self was managing to establish an experience in which Antonella was starting to feel present, a participant in life, differentiated and not invaded.

According to Gestalt therapy language, we might say that in neurosis, what seems new is defined as "not for me;" via the ego-function; the support of *personality function of self* is lacking in this case. The self cannot adjust creatively to the changes in social relationships, on account of a split between the definition of "who I am", as assimilated from previous contacts, and the new social requirement.

In psychosis, because the ground of security arising from assimilated contacts is missing (*id-function of self*), the ego cannot exercise its ability to deliberate on this ground. Contacting is thus dominated in the psychotic by sensations that invade a self with "no skin", and so invade the world (Spagnuolo Lobb, 2002a; 2003a).

5.5. Comprehensibility as a Limit to Aim For

For Karl Jaspers (1963), incomprehensibility is a criterion for identifying psychotic experience. We would like to stress, however, that psychotic experience is incomprehensible insofar as it is abstracted from the relational field of which the subject is a creative expression. «The madman often raves much less than we might think; indeed, perhaps he never raves»[15] (Minkowski, 1998, p. 45). Comprehensibility is thus a precise goal to be aimed for in the therapeutic relationship, driven by the faith that meaning can be found if we plunge into the relational field that the patient and therapist continually create in their rela-

[15] To cite a passage from Minkowski's *La schizophrénie*: «One of the first cases described by Jung remains impressed in my memory. It concerned an old "demented" woman who had been in hospital for many years. She had arrived there before the director, the assistants and all the nurses. Nobody knew anything about her, nobody came to visit her. She was not able to say anything about her past, as her only external expression consisted of a stereotypical and continuous rubbing of the hands. The skin on the palms of her hands had become thick and tough like leather. Everybody had always known her to be like that and they were accustomed to seeing her in the same place, performing her stereotypical gesture like an automaton. One of the ward nurses though, the most senior, said she could remember that once, many years earlier, the old woman's movements were vaster and most singularly resembled those of a shoemaker at work. At that time, the nurses referred to her as "the sick woman who makes shoes". One day the sick woman died. An old cousin came to attend the funeral. Jung asked him if he could remember how his cousin had fallen ill. The old man searched his mind: "Ah yes, I remember", he said. "The illness began after a great disappointment: she had a friend who abandoned her". "Who was this friend?" "He was a shoemaker"» (Minkowski, 1998, p. 84).

tionship (Ballerini, 2011). The fact that in psychotic experience there can be a perceptive mode that is neurologically different from non-psychotic experience does not mean that individual suffering in psychotic states is not an expression of a disturbance in the relationship (Francesetti and Gecele, 2009). To the contrary, it confirms that psychotic experience, originally different from non-psychotic experience, shows a constitutional difficulty in being communicated, and hence in finding a relationship that is able to co-create a common world that includes the peculiar perception of the psychotic world.

The issue of comprehensibility highlights another aspect of the matter: the limits of spoken language. As we have said, language has universal transformational rules (Chomsky, 1969) suited to describing experience after the self/life-world cleavage. Such a limitation implies a degree of ineffability with respect to all that which precedes this separation and, as we will see, presents an important hurdle for therapeutic communication in the psychotic field. Perhaps it is for this reason, as Heidegger stated, that the truth is often revealed by madmen, poets, mystics and children – by those, that is, whose words, since they are immersed in the life-world, at the ephemeral, glowing boundary where time and space, the self and the world gush forth, are still imbued by the ineffable fount of life-generation.

6. An Underlying Clinical Problem: Communicating from Another World

A crucial point in the treatment of patients with psychotic experiences lies in the fact that their experiential truth is both extremely fragile (because it is not rooted in a common world), and incommunicable in the usual ways of the common world. The act of therapy consists precisely in finding a way to grasp that truth, despite all the difficulties inherent to the situation.

One of the conditions for children's psychological development is the acquisition of a sense of validity of their subjective experience. One of the fundamental supports for this conquest is the confirmation of perceptions and emotional states that comes from parental figures. These relational tunings allow the self to develop its capacity to construct experiences complete with boundaries and connections, and to perceive them as reliably real (Stern, 1985; Tronick, 2008; Stolorow, 1999). When such confirmation is deeply disturbed, faith in one's own experience of reality is lost (Stolorow, 1999, p. 130). The patient with psychotic experience brings to therapy this need to have his experiential truth confirmed, but also the impossibility of communicating that experience through a language that is immediately comprehensible. His truth comes from a peculiar perception that dwells in another world, a pre-personal world

that is not shared, and reaches us in the form of extravagance, agitation, derangement, delusion or hallucination. These are simultaneously an attempt to communicate the incommunicable and a way of reducing anxiety through experiential certainty: delusion and hallucination are, in fact, certainties. Jung's would-be shoemaker cited in note 16 is an example of how the psychosis sufferer remains faithful to her attempt to convey her relational truth for years on end, despite failing continually. Her truth cannot make use of shared speech because it dwells in the realm of the unspeakable.

Thus the therapist continually runs the risk of not comprehending the experiential truth of the patient, and every time he does so he repeats a tuning failure that contributes to maintaining the psychotic state in therapy. This difficulty in comprehending the patient's truth is also a protective defense for the therapist, because truly accepting the definition of reality of a delusional patient means questioning one's own conception of reality and one's own mental health. The way out from this impasse lies in the fact that the truth to be grasped requires a shift in meaning or in context with respect to what is apparent. The truth over which the therapist and the patient can make contact is the truth of the intentionality expressed in contacting. Here is an example.

A colleague under supervision conducts a group for psychotic patients. He was telephoned by the mother of one patient – Anna – and he correctly abided by the rules of doctor-patient confidentiality. At the following group encounter, Anna began the session as always; it was a period in which she is not having delusions and was altogether quite well. After opening the group, the colleague told Anna that he had been contacted by her mother. Anna asked what they had said and he told her truthfully; she listened, apparently quite calm. The group carried on as normal, but after a few interactions Anna began to become delusional, saying that the group leader was controlling her, that she could not trust him, that he was persecuting her.

Here we see a delusion in its nascent state. In informing Anna about the telephone conversation, the therapist failed to acknowledge that the mother's phone call had overstepped the line into their field, even though nothing confidential was said. Anna found no acknowledgement of her experiential datum in the words of the therapist, who believed that by communicating truthfully he had cleared the field. Instead, a fragment of truth remained unacknowledged in the pre-personal, leaving Anna with the burden of having to bring it up to the surface as best she could. Anna's intentionality in contacting is to seek acknowledgement of her perception by the therapist, confirmation that is necessary for her own integrity and sense of reality. The therapist has two options: he can react to the delusional accusation by denying it, which will augment

Anna's delusion, as it is the only way she can defend her reality; or he can acknowledge that contact with her mother did indeed overstep the boundaries, bringing to light Anna's truth and clearly and empathetically acknowledging that she is right. Choosing this second possibility will diminish the delusion. Here we assume a perspective by which psychotic phenomena are an attempt to preserve one's own reality and integrity (Benedetti, 1992; Stolorov, 1999), which is different from Freud's original view, by which delusion was a rejection of reality. If the therapist excludes the possibility of bringing to the fore this perceptive truth, contact with the psychotic patient will become a loss of identity for both – also for the therapist because he constructs his identity through an act of violence which, however involuntary and imperceptible to him, will remain with him after the encounter as a form of distress. The patient is in no condition to give comprehensible form to her truth; if even the therapist does not manage to do so, he too will suffer. This is why after a session in a psychotic field, it is easy for the therapist to continue to feel distressed, because something is suffering in the pre-personal dimension. Alternatively, the therapist can protect himself by abstracting himself from the relationship, objectivizing the patient, denying her reality, and creating another experience of impotence, solitude and desperation – an experience that will also be unspeakable, if not through delusion. It is an iatrogenic risk that is continually present in therapeutic contact.

7. Psychotherapeutic Praxis with Psychotic Experience

Let us now see what implications this conception of psychotic experience has for therapeutic praxis. For a more in-depth look at aspects of therapy in various individual, group and community settings, we refer the reader to other published works (Harris, 1992; Yontef, 2001b; Conte, 2001; Spagnuolo Lobb, 2002a; 2003a; Francesetti and Gecele, 2009; 2011; Brownell, 2010a; Francesetti, 2012; Arnfred, 2012).

To begin with, we will list the points that we believe are fundamental when working with psychotic states in the schizophrenia spectrum. We will then give a series of clinical examples of how the psychotic field emerges in therapeutic contact, and how the therapist needs to modulate the quality of her presence so as to maintain the tuning and support of therapy. Finally, we will outline a series of guidelines for working in psychiatric institutions.

7.1. The Setting

An important point is the choice of setting. Often a context of treatment is necessary and not just the individual therapeutic relationship alone, such as that which can be offered at a private practice. When this is possible, however, it is nevertheless essential that the therapist is not alone in working with a patient with psychotic experience, but supervised. In fact, there are times when the psychotic experience is so unanchored in the ground that it is essential that the therapist is firmly anchored to a third person who can stabilize the setting and developments in therapy. This can take place by organizing a group setting in the context of the venue where treatment is provided, such as community psychiatric centers, or through a dual setting which can make use of the therapeutic support offered by the environment – for instance, the patient may be in the care of a psychiatrist colleague for drug treatment, or may live in a community or other context for treatment. The supervisor, as the third person, is also of fundamental importance, both to anchor the therapeutic relationship and to "clear up" the psychotic field experienced with the patient and then carried away by the therapist. Any post-contact distress must be clarified and given an explicit, shared meaning so as to prevent it from clouding the judgment of the therapist, and to prevent the therapist from taking the suffering encountered in that field into other professional and personal relationships.

Another fundamental element to be taken into consideration is the support provided to the family, in a context of support that can consist of psychotherapy, psychoeducation or mutual assistance. The family, in fact, will generally be traumatized by the failure of its attempts to communicate with and contain the suffering. It needs help to understand what is happening and the possible developments ahead, to deal with the pain felt for the derangement of a family member, to support and situate the sense of impotence and guilt tied to these failures, to reorganize itself so as to support the developmental stages of the various family members, and to access the financial and social support to make all this possible.

7.2. Work on the Ground

From the premises cited above, it follows that to apply Gestalt therapy in the treatment of seriously disturbed and psychotic patients, we need first of all to accommodate a change in perspective from that adopted when dealing with neurotic experiences. With psychotic experiences, treatment must start from the background so as to construct the figure, whilst with neurotic patients the opposite is true. In fact, for neurotics, the learning process is built on the dia-

logue between the therapist and patient, on the history/figure which, in its evolution, also causes a “re-shaping” of the background. In psychotherapy with seriously disturbed patients, the starting point is in building the background, and the figure emerges later, in the post-contact phase, as the therapeutic result (Spagnuolo Lobb, 2002a; 2003a).

The difficult field must become a welcoming field.

Hence, a fundamental difference for the treatment of seriously disturbed patients is the balance of the attention to be paid to the figure and to the background of experience. Everything that constitutes the ground where the intervention is carried out (such as the armchairs we sit in and the pictures on the walls, or even a thought which may momentarily distract us), while in neurotic experience it is normally taken for granted, in psychotics’ experience becomes the first code of access to their experience.

Second, it is important to approach the basic existential anxiety in treatment, and to possibly use behavioral tools or rehabilitation techniques (such as training patients to keep themselves clean and behave – social abilities that they are less interested in) in a way that must be pertinent to the therapeutic relationship. A psychotic patient is, for instance, ready to shower every day or stop cutting her wrists only if she feels that this is important for the therapist and that the therapist is in touch with her “real” anxiety.

Third, more than upon an analysis of archaic experiences or in support of unexplored potentiality, the therapeutic relationship must be focused on the coherence between the *what* and the *how* things are communicated, a coherence in all that Stern *et al*. (1998) mean by “implicit knowledge”. In fact, the perceived permeability of boundaries, the quality of the relational “transparence” (see Spagnuolo Lobb, 2003a) with which the patient feels that he is on the one hand “read” by the therapist and on the other hand capable of “reading” the therapist, is the basic condition from which the patient must construct a background of existential security on which to base himself. If he is to emerge as an individual capable of knowingly choosing between what he identifies with and what he alienates from, he must first experience, that what happens at the boundary is not threatening. As we are going to underline in the next paragraph, every time a seriously disturbed patient tells us anything about our relationship, which seems untrue to us, like a delusion, such as, for instance, if he says that we are angry or in love, it is always very informative, instead of labeling these utterances simplistically as paranoia, to consider what might be true along the lines – “In what way is this patient right? How am I expressing anger or love at this moment?” – rather than to look at what is untrue. The ability of the therapist to answer these questions largely determines the success of the treatment.

7.3. Grasping the Patient's Truth

When we move in the dimension of psychotic experiences, therapeutic praxis must grasp and sustain subtle movements in the inter-corporeal dimension. The relational field is so sensitive that, to paraphrase Lorenz (1979), even the flapping of a butterfly's wings outside the window can trigger a storm *in-between* us. The therapist needs a delicate sensitivity, for those who work in a psychotic field face the risk of walking on a void, like the patient in their care – on the chasm of an *in-between* that is the abyss and chaos. This requires the therapist to pay close attention to the quality of her presence, which needs to be capable of grasping, like precious pearls, even the slightest signs of presence at the contact boundary, supporting the co-construction of the experience (first act of the id-function of the self) and the establishment of the boundaries of lived experience (second act of the id-function of the self). It takes training not to ignore or underestimate the feeble quivers that occur in the *in-between*, and which can be sensed through their resonances, consonances or dissonances, especially at the bodily level. One needs to be patient and to trust that every experience of this kind, no matter how small, is never insignificant and will leave a trace. One needs to be sensitive to the beauty of small things, of minimal gestures, of resonances that are almost silent. Thus the therapist can orient herself and tread delicately, confident in taking each next step along the pathway constructing the road being taken.

One needs to trust that the perceptive truth brought by the patient, even in delusion and hallucination, encloses, stores and conveys a grain of unspeakable truth, which the therapist must grasp. Though acting in good faith and warned of the risk, the therapist will nevertheless tend to protect herself from the patient's definition of truth, assuming a position that, by denying the patient's perception, becomes iatrogenic and heightens psychotic intensity. To break the vicious circle, the therapist has to trust that the patient's definition of reality encloses an intentionality for contact that will open up a new possibility for the therapeutic relationship. A crisis can be the signal of a truth that cannot be communicated, and the therapist must be open to the possibility of a new perspective that was inconceivable before that moment in time, though it may appear obvious once it is understood. She must also weather the storm by resting firmly on the ground that is given by her own body, by her faith in life, by her clinical experience, and by anchoring herself to a third person – the supervisor – who, in such phases, becomes as necessary as ever.

7.4. Clinical Examples

Let us take a look now at some clinical examples that illustrate these points[16]. Each case has been chosen for the degree to which it exemplifies the perspective we are presenting. We are grateful to the patients for all that we have learnt with them.

7.4.1. Arnaldo

A patient – Arnaldo – sat down in silence for a few minutes, elbows planted on his knees as though oppressed by the weight of a terrible burden.

"*What's up Arnaldo?*"

"I don't know. I feel like I have no skin – everything hurts me and enters inside, as though I had no boundaries. At work today, everything went straight through me".

I took a breath. His anxiety, crystallized in his body, now hung in the air between us. I breathed it in, and in doing so, supported it.

"At other times, I'm detached instead, and everything flows past me".

His gaze was distant, lowered and fixed on the floor or far away, as though seeing through the walls of our room, astray in far-away places.

"Arnaldo..". I tried to call him back to contact me. He looked at me.

"Try sensing your body. What do you feel?"

"My neck hurts here, and my shoulders are a bit stiff". His reply was anatomical, coming from the *Körper*, the body-machine. In a neurotic universe, I would have tried to amplify these sensations, but here it would take us off track. What I wanted to see emerge between us was his lived inter-corporeality, his *Leib*, for him to experience being present, simultaneously in touch with the situation and the sense of boundary. We had been working together for two years now, and this was finally possible.

"Okay, and what else do you feel?"

His gaze sharpened. Perhaps sensing himself alarmed him somewhat. His neck stretched slightly towards me. There was a moment of hesitancy and tension, then he relaxed. We breathed.

"I feel a little tense..".

"Okay", I nodded. I felt in that moment that we had established a listen-and-speak rhythm between us.

A musical chord had been struck between us, transient and ephemeral as in all music. Perhaps it was the third-temporal-place that many authors speak of,

[16] These cases are taken from Francesetti's clinical practice.

the *Aida*, the "in-between" that for Bin Kimura is a temporal and not just spatial "in-between", like the interval between two musical notes.

"How do you feel you're breathing?"

"... It's getting slower".

"Good.".. (Pause.) *"... And how do you feel in the chair?"*

"Um... I'm getting comfortable". We looked at each other for a second in silence. Things were happening inside us. I had the feeling that something between us was adjusting itself and falling into the right place. We were dancing slowly with our living bodies. It was the little things, things which are invisible if we do not take the time to sense them, which become impossible to grasp if we speed up at all. It was an aesthetic sensation that also told me how long the process going on between us would last, and how long our gaze would last.

"Are you anxious at the moment?"

"No, not now..". A pause... time to savor the moment whilst it unfolded, before it went by.

This savoring was interrupted abruptly, unexpectedly. A sudden change of music that took me by surprise.

"But then? Here I manage to distract myself, but then the anxiety returns". I felt a crack in the contact between us. Anxiety was taking hold of Arnaldo again and dragging him away from me, away from the rhythm to which we were moving together in time. It is a jolt out of our time. Just like *delusion* is a falling out of the furrows cut by a plough, a slipping out of place.

"Arnaldo, what's happening here now is not a distraction. It's the feeling that the body can withstand anxiety". Arnaldo was struck by what I was saying. He saw me and looked at me intrigued, with a hint of a smile. I had not let him go, and the sensation of warmth that I had felt before in our contact had returned. We had re-found our rhythm of look-breathe-speak-silence. Time was once again our time. We let our bodies take in the experience with a pause. Then we spoke in tranquility about other things.

At the end of the session, Arnaldo shook my hand and for the first time I felt it was warm, soft, definite and consistent. His eyes smiled in a new, grateful way. I sensed in this the fruit of much work.

I accompanied him to the door.

Arnaldo turned and shook my hand again, naturally; his hand was still firm and definite, capable of deciding how to shake mine.

His hand was learning the inter-corporeality between us.

7.4.2. Maria

A second example concerns another patient – Maria – who for many years had suffered ongoing psychotic experiences, with frequent delusions.

At our first encounter, her presence in contact with mine immediately created an intense atmosphere of suspension that was incredibly tense, a climate in which anything could happen. Tragedy hung over our heads. From one moment to the next, the unimaginable, total catastrophe, could happen.

I breathed... I tried to handle the anxiety and withstand the oppressive, sinister atmosphere, but every now and then a sudden dizziness took hold of me. I continued to think of a session with another patient, years earlier, when at a certain point I felt I was floating. For a fraction of a second I was disoriented, but then looking at each other, we both realized it had actually been an earthquake. It was in this climate that the session with Maria began.

T: *"Good morning".*

M: *"Good morning".*

Silence.

T: *"How did you get here?"*

M: *"My daughter brought me... yes, I believe it was my daughter... as far as I know..".*

The way she said these words, so usual for her that they sound like a refrain, threw me into a universe in which nothing was still or consistent – a whirl of fragile *papier-mâché* objects that come apart, where actually and ontologically there is no certainty.

T: *"Your daughter Anna?".*

M: *"Yes, my daughter's called Anna… as far as I know...".*

The search for answers did not pass through the body, as though nothing had settled in the certainty of memory, experience, or feeling. Everything was concretely possible, hence nothing was acquired, and her answers came from deductions that had no root whatsoever in anything we could together call body or reality. "As far as I know" is all that a person with no direct access to experience can say, like an accountant who at the end of the quarter prepares the books and crunches numbers abstracted from tangible trade and the objects of experience.

I stumbled along as well; I stumbled a thousand times with her.

I returned to my body, I breathed, I re-anchored myself. I noticed that while I did this, she almost imperceptibly leaned her torso back, as though to rest it against the back of the armchair. I realized, through the rhythm of our resonances, that if I anchored myself to my body, she could lean back on the chair – a small certainty for me, for us. It was an example of the marvelous possibility of co-constructing our experience at the contact boundary. From then on, I would be able to address my corporeality with her better.

A few sessions later, she said: "*Well, at least one thing's sure: we're sitting here, together",* and in saying so she finally leaned back and rested against the armchair.

This was not the outcome of a strategic interaction and in itself cannot be reproduced as a technique. Instead, what happened was that we progressively co-created an experience with more ground to rest on. It was from that ground that an experience (our experience) gradually emerged, becoming, little by little, less psychotic.

7.4.3. Luca

Luca was a 35-year-old man. The first time I saw him, he came into the session with an almost arrogant air, sat down and immediately asked me:

"I've come here to find out if I'm mad. Am I mad?"

The question was so direct and without any background that it caught me off guard. Before even taking a breath, I replied: "*I think I need to get to know you better to be able to respond..".*

My answer sent Luca into a rage, who shouted:

"*You're a liar! I'm surrounded by lots of them, but I don't care: you're a liar too. I want to know if I'm mad. When I was little I cut the eyes off snails and I beat up a school mate. I want to know if I'm mad! But you're a liar, a liar!*".

His reaction surprised me and frightened me, though I managed not to lose contact with the need I felt to make sense of what was happening. This gave me back my bearings, as it guided me in sensing myself. I felt disoriented and I realized that I had actually thought Luca was a bit "weird" from the very start, but I had denied this perception of mine by saying that I needed time to get to know him better. The answer was, of course, tactful, but it was also a lie. I already had an answer in mind, even though I did not know how to put it to him. In this sense, I really was a liar. So I said to him:

"*Luca, I understand now how your question was important and my answer wrong..".*

Luca stopped raving and looked at me attentively. I continued:

"*I just want to know whether you need to know the answer now or if I can tell you another time".*

Luca replied:

"*Not now..".*

"*Okay then*", I said.

We calmed down, and it seemed we could start over again. The denial of truth that Luca sensed in our contact was driving him crazy. I asked myself from what experience of having his truth denied he came from.

Luca never again returned to this question, and we gradually constructed a ground that was sure enough for us to draw out our own truths. One day, for instance, he asked:

"*How come you're frowning today? Has something happened?*"

"*Let me think",* I replied.

I asked myself if there was effectively something wrong, but I honestly could not find anything. Then we talked a while, in an effort to understand more clearly how I felt, given the interest that Luca had shown. But we got nowhere, nothing was cleared up, and we were both left with an unpleasant sense of confusion, a sensation of time not flowing – but it was not calm, rather it was like a pause between sobs. So I stopped, listened to my bodily ground, heard his, and a question arose in me: "*And you, Luca, has something happened?*"

It was the right question to ask, opening up a clear line of dialogue. Luca's interest in me had grasped something which needed to emerge. There was indeed something wrong, but he had attributed it to the wrong subject. In making contact it had not been possible to distinguish what belonged to him and what belonged to me, revealing a disturbance in constitution in our pre-personal dimension.

About a year later, Luca came to therapy raising a new, and for me shocking, matter. He started saying that he was afraid I would kill him. I tried to understand where that thought came from. I asked what had happened between us the previous week, but he simply repeated that he was afraid I would kill him. So I tried to reassure him, saying I had no intention whatsoever of killing him. Luca reacted to this in a way I was already acquainted with: he said his words more forcefully. He shouted that I would kill him. I stayed still and sought in my breathing and in my ground the calmness to remain where I was; it was very hard. He seemed to me to be out of his mind. I tried to situate this thought of mine in a framework of meaning between us, but I was not able to. Our encounters continued like this for another two sessions. It seemed to have become impossible for me to contact him, and being with him was very hard. If I tried to explore the matter with him, he would just keep repeating the same refrain; if I tried to reassure him, he would fly into a rage. At a certain point I managed to tune in to how Luca might experience the threat of death at my hands. Over the last year he had found with me the hope of feeling better, so the idea of betrayal by me must have been terrible. But how could I ever betray him? I did not know, but I began to sense his anxiety a bit more, and less my own. I said to him: "*I understand that if I betrayed you, it would hurt you terribly*".

Luca replied in a new way: "*But you will betray me!*"

"*Well, then, we had better prepare ourselves for it*", I responded immediately. Luca's face lit up. That was the point: nobody can guarantee they will

not betray. He had experienced betrayal countless times in life and has been wounded by even the most intimate relationships. Anyone betrayed by their father, their mother, or by life knows that everyone is capable of betrayal. Once again, Luca was right. A few sessions later, he said to me:

"*If you were to die now, do you realize that you'd kill me?*"

This turn of events paved the way to addressing the limitations of a therapeutic relationship, the question of how true a relationship can be when one pays to see the other, and above all we talked about the end of therapy – a distant, though inevitable event. His "you will kill me" expressed the intensity of our relationship, the risks that Luca felt he was running, and the need for them to be made explicit and acknowledged. The intentionality for contact – conveying his truth to me – had finally been grasped and his perception confirmed. The delusional raving was no longer necessary.

Another fundamental development in our relationship happened after around two years of therapy. Once again, Luca raised an issue which I was unable to make sense of. "*Everything is predetermined. Everything that is about to happen is already written. There is no freedom. Everything follows predefined tracks".*

He said this with a profound sense of desolation. The atmosphere that it created between us left no room for life; everything was mechanical now. A patient suffering a strong form of depression had once brought delusional experiences like this to therapy; we gradually overcame them by reigniting the life between us. This time, the experience seemed different. There was not only desolation, but also a sort of suspension, as though besides defining a state, Luca expected something from me. Once again, exploring the issue took us nowhere, while reassuring him only led him to raise his voice. We were again at a standstill, and I was again disoriented, incapable of understanding. Sure, I could remember the experiences in which we had found our way again, but the reality of this desolation was stronger this time. My memory supported me, but it did not guide me. Moreover, I almost found this delusion convincing. It could not be demolished logically – everything could very well already be written. This "slide" into his delusion actually helped me. If I let go of my presumption that there is free will, a whole new world could open up. It was the fact of taking his assertion seriously and considering it true that gave rise to a different atmosphere between us. At a certain point, I felt that our chairs were too close, so I said: "*How about we push our chairs back a bit?*" Luca changed expression. He seemed to light up and said: "*Okay*".

From then on, the issue of predefined tracks gradually disappeared and we started talking again. The turning point came in three moves: Luca raised the issue of the impossibility of feeling free between us; I confirmed his truth; and then I felt it necessary for there to be a greater distance between us. Once this

was done, the issue was developed and Luca began to speak of the differences between us – our different likes, our different histories, our different plans. Luca had sensed before me that our closeness and intimacy did not allow him to move freely between us, in a differentiated way. Through communication that was, at first, incomprehensible, he had taken care of himself and of our relationship.

7.5. A Gestalt Therapy Model for Addressing Psychosis in Psychiatric Institutions[17]

Gestalt therapy, given the importance it attaches to group processes and relationships, is well-suited to psychiatric settings. Beginning with Buber's (1923) concept of "betweenness", it supplies an analysis of the here and now of the relationship (the process of contact), which makes it possible to trace and understand aspects of pathology and their treatment, via a dialectic between the individual and society. According to Gestalt psychotherapy, we need not refer to inner (e.g. the super-ego) or external (e.g. society) elements to resolve Freud's supposed irreconcilability of the relationship between the individual and the community. There is no need to create a dichotomy between the individual and society (Spagnuolo Lobb, Salonia and Sichera, 1996). Today, it is possible to consider psychotherapy – even in the case of seriously disturbed patients – as a way of integrating individual needs and perceptions, and social requirements. Both "needs" and "social adaptation" are the fruit of relationships and are, therefore, achievable through contact.

Paul Goodman's idea of creating a community made up of individuals who are fully themselves, one that is rich and harmonious like a Greek chorus, which is not rendered uniform by the imposition of external rules, but rather discovers harmony through spontaneous social self-government, is the guideline for the application of Gestalt therapy in a psychiatric structure. Nowadays, we tend to consider that the therapeutic approach for seriously disturbed patients treated in psychiatric settings needs to be directed toward fostering the *relational potential* that is being expressed, in its own language, through the pathological behavior.

There are aspects that are peculiar to the treatment in psychiatric institutions, which deal with two separate, important elements: the chronic (dormant) nature of the disturbance (in effect acquiring a social role that is defined as "disturbed") and the context of treatment (which is not a single figure, but an interdisciplinary team of workers and the physical structure where the treatment occurs).

[17] This part of the present chapter is taken from Spagnuolo Lobb (2003a).

In-patients in psychiatry often lose ordinary personal and social skills, on different levels, depending on the individual process of involution. One person is incapable of making her own bed and has to be helped by another to do it; another person is incapable of "tuning in" to the normalized language of the world around him. As a result of a long history of failures in their attempts to solve a situation perceived as threatening their own existence, sometimes caused by a long history of medicalization and/or institutionalization that has merely dramatically reinforced their sense of personal failure and dependence on a doctor or on drugs, such people cannot easily operate within normal social modes of behavior.

With regard to the second peculiar aspect, the psychiatric team, the new perspective of working on the ground should correspond to a multi-modal and interdisciplinary treatment, in which various levels are integrated (clinical, psychotherapeutic, pharmacological, personal, and family/social) as well as various professional figures (psychiatrists, psychologists, social workers, educators, nurses, and psychotherapists).

In the case of treatment of psychotic patients in an individual or private setting, it's important to maintain this focus on the ground: the housekeeper or the secretary can be an important influence on treatment as the psychotherapist him/herself. This peculiar perception of psychotic clients has to be taken into account by the psychotherapist, who will consider, for instance, the sentence: "the housekeeper has looked at me with envy today", not as a figure to be developed and made more aware (maybe the client would like to say something to the housekeeper, or is retroflecting a projection to her), but as a preoccupation about the sureness of the ground: an appropriate answer from the therapist could be: "the housekeeper maybe is not reliable today, I appreciate that you tell me about your preoccupation. How do you feel with me? Do you feel safe with me in this room even if the housekeeper seems bad today?".

What seriously disturbed patients particularly need – both in psychiatric settings and in private ones – is the sureness that comes from long-term consistency of the helper and the environment. While the private setting can give this consistency via regular sessions and the personal stability of the therapist, psychiatric settings are often characterized by the turn-over of personnel. How is it possible, then, to help guests of psychiatric institutions build a sense of security, something that only a physically and emotionally stable context can provide. The answer to this question is fundamental for any psychotherapeutic model applied to chronic patients in residential psychiatric settings.

Success in creating a therapeutic context for severely disturbed patients, not only in a specific psychiatric setting but in the wider context of the mental health culture with which they have to deal, requires, as a first step, that we acknowledge the depth and nature of their individual experience. That is, we

must develop a uniform therapeutic intent (obtained through the necessary group process among the staff) and hence provide a sense of security that is derived from a stable relationship. It is important, here, to accept the idea that it is the setting that treats the patient, and not one particular member of staff. Even an excellent psychiatrist in isolation can only have a limited effect in the long run on a therapeutic level, compared to a setting which, in its human and structural dimensions, communicates treatment. The role of the psychotherapist in a psychiatric setting should be defined as that of promoter of a ground condition. It is therefore necessary to create a healthy perceptive background – a "cradle" or mother's arms: a series of learning experiences that constitute the ground; a background of security that can be taken for granted. Obviously, it is not possible to give these patients the security they lacked in their infancy, but we can give them a new experience of security that can help them to balance an interest in the present and anxieties connected with their past.

7.5.1. Therapeutic Goals of the Model

How is the healing environment evolving in the perception of the patient and of the therapist? If this line of inquiry is fundamental in the treatment of any kind of disorder, in the case of the treatment of psychotics it becomes, as stated above, the figure of the therapeutic intervention.

The first goal is to create a therapeutic environment capable of fostering in the whole community the experience of a healthy ground. As from an environmental aspect, the setting becomes the most important focus of treatment, especially insofar as it affects the relationship in this context, the group relationship that is created in the psychiatric structure involved is likewise the primary place of treatment.

From attention given to the ground in the form of the therapeutic setting and climate (the first goal and an indispensable premise for any future progress in the relationship), it is possible to foster other important experiences for the harmonious differentiation of the self, such as creative differentiation (second goal), the perception of time and space as categories that orient and give a rhythm to the self (third goal), and the clear and distinct perception of one's own needs (fourth goal). These four goals constitute the therapeutic journey for residents in a psychiatric setting. They are evolutionary phases in building a well-grounded experience of oneself. Since they are holistic acquisitions, they also integrate with each other. Each phase represents a *Gestalt* of new contact capabilities that are added to the *Gestalt* of the previous acquisitions, just as new notes follow each other in a melody, creating a new melody (see the concept of poliphonic development of domains in Spagnuolo Lobb, 2011a).

7.5.1.1. Goal 1 - The Therapeutic Environment

To create a therapeutic environment means to arrange a welcoming, reassuring, and flexible setting in relation to the patient's needs for separation and fusion: "closed" enough to transmit a sense of security, "open" enough to give the necessary support to independence, but also "flexible" enough to adapt itself to the patient's attempts to integrate her inner and outer needs. This is a fundamental requirement, a platform to reach further goals. It concerns two fundamental aspects: the physical structure in which community life is lived and the communicative attitude adopted by the staff.

As far as the physical structure is concerned, it must be capable of fulfilling the basic psychological functions of any home (Giordano, 1997): holding, supporting, integrating. Studies of environmental psychology (Fisher, Bell and Baum, 1984; Bonnes and Secchiaroli, 1992) highlight other structural characteristics that should be taken into account. For instance, the staff's overall communicative attitude must be considered, such as their ability to convey empathy, unconditional acceptance, esteem, and congruence (Franta and Salonia, 1981). They represent necessary and specific competences for communicating with seriously disturbed patients. Important "relationship guarantees" are, for example, *clarity* (the opposite of confusion), *encouragement* (seen as faith in the organism during anxiety crises), and *absolute respect for the rules* (the rules are like a containing wall, and to leap over them would mean losing a significant sense of security). In this context, verbal communication by the staff must be empathetic and at the same time normative, making the resident feel that she is accepted as a person – as a unique being with individual thoughts and needs – who is nevertheless able to respect the rules of the community.

Non-verbal communication on the staff's part must express *welcome* (a smile is always more relaxing than an angry face), *being there* (these residents have a special sensitivity in perceiving if a person is "absent"), and respect for boundaries (communicating familiarity beyond what the role calls for is always confusing for these patients, given that roles, like rules, protect them from "invasion" by external elements). Particular attention must also be paid to physical contact, which is obviously necessary in a health context. It is also important to remember one is touching a person who has "no skin" and that any physical contact has fusional reverberations.

The imprinting of the therapeutic atmosphere is transmitted to the person from the moment of admission. A new resident's arrival is pre-announced to the community, and preparations to welcome the new "guest" follow. On arrival, the newcomer is introduced to the community in a group setting, whilst drinking a cup of coffee and eating a biscuit. A warm round of applause greets

the new in-patient. Then he is introduced to the group by a member of staff; an open sharing follows, where the new resident is invited, if he wishes to do so, to tell the group what hopes and fears he has about this new experience. Thanks to this welcoming moment, the newcomer knows that he is considered as a person in the community and not simply as a case-record.

Here is an example: *Once a newcomer said, at the end of this introduction – referring to the chaotic manner of the patients' participation during the meeting: "This is the best possible organization of total disorganization". The Gestalt therapy leader said: "Each of you has felt the need to distinguish yourself from all the others. In fact, nobody has continued to talk about a point raised by anybody else. You have reacted against your fear of being wiped out by taking refuge in individual chaos! This chaos is the community group's lifeblood"* (Argentino, 1997).

This is a good example of how the Gestalt therapy leader can organize the various remarks, the climate, and the group process into a single *Gestalt*, a global, harmonious, and meaningful configuration with which both the individual and the group can identify.

7.5.1.2. Goal 2 - The Sense of Creative Differentiation

For these patients to feel positively different from the others, as unique human beings, it is necessary for them to feel integrated with the environment. In other words, once the person experiences being accepted, she can begin to focus on herself and recognize her own uniqueness. Many activities can support this discovery, an example of which follows:

I was in a group, running a drawing activity. I had asked participants to concentrate on themselves, on their breathing (a very delicate thing to ask of this kind of patient, since it connects the person immediately with her strongest anxieties). I then asked them to draw a figure on a sheet of paper, whatever in that precise moment they wanted to draw. One person drew an old lion walking alone in a desolate field; another drew a beautiful sea in a storm, full of rough waves, with no evident boats, and a very small line that might represent a distant boat. One person drew a tree, with very weak lines; it gave a sense of loneliness. I told him that I could feel that drawing, that it said much of him. I also told him that I was sure that he could play this tree if he wanted to. So he did: he played the tree. He was so much inside the experience that the whole atmosphere changed. The rest of the group remained looking at him as if at

something magical. At the end, he said: "That's me", and the group spontaneously applauded. He felt so much himself, and after this experience, he changed; he participated more in the activities of the group, his face was more open, especially when he was in front of some of the people who were with him in this experience.

If you consider that psychotic patients are usually desensitized and do not distinguish how the person who is in front of them is different from another person, because they are wholly taken up by their anxieties, this experience shows how it is possible for them to see others more clearly when they can experience "their being", themselves as unique human beings.

Giving residents space and time to concentrate (as far as possible) on themselves, to discover the spontaneous movement of themselves toward the environment, is the therapeutic goal at this stage. All the while, therapists are providing them with adequate support to complete interrupted spontaneous contacts (in this example, the patient's wish to express his loneliness, to say it to someone).

Activities connected with the care of the environment, like cleaning one's room or looking after common areas with others, are perceived by residents as a necessity that regulates life together. Perhaps this behavior also acts as a concrete duty that leads to an alternative experience to anxiety (since it contains and confines anxiety). It is important to help patients to overcome their sense of inadequacy or failure, through productive or socialized activity, so guaranteeing them a point of reference that, although normative, calms their anxiety.

7.5.1.3. Goal 3 - Time and Space: The Rhythm of Self

Once a person is able to experience his own unique being, to experience the "I", he is ready to dance, that is, to orient himself in time and space. When the baby acquires a sense of "I am hungry, I can wait for mom", her sense of herself can be placed in time and space. The voice of the mother, who calms a crying baby from another room, acts as a container for the anxiety of the child. It fills the void in space and fosters a trust in "time". The experiential dimensions of time and space, and how we handle them, frame that feeling of "stable continuity" we attach to the self. Because of the experience of time and space, we acquire the certainty that we continue to be ourselves, although things change, both inside and outside. (I remember when my daughter was three, and she used to look at herself in the mirror with my glasses on and say "I'm Mommy", then wear my husband's T-shirt and say "I'm Daddy". She laughed a lot at this very interesting discovery: the possibility of changing outside while remaining the same person inside.)

This goal consists in favoring the perception of space and time as experiential containers, capable of directing the patient's multiple sensations and perceptions in the sense of rhythm (time) and spatial placing (distant/close, etc.). This helps in calming anxiety, since in seriously disturbed patients, sensations, emotions, and general perceptions are experienced in a confused manner (without I-Thou boundaries, now-then boundaries, here-there boundaries) and with much anxiety.

The patient who represented himself as a lonely tree was taking part in a daily group with other patients and staff members. All the participants were saying, in turn, something of their experience. When he was ready to speak, he said: "It's sunny today". The Gestalt therapy leader asked herself what the relational meaning of this sentence could be: what the sunny day had to do with his actual being in the group. Up till then he had proposed himself to the group as the sad, lonely tree, and the group had accepted him. She said: "What are the trees like when it's sunny?". He answered: "They stretch out towards the sun. I'm an oak today, not a weeping willow". The Gestalt leader said supportively: "There are many more oaks in our Mediterranean area than weeping willows". The patient stood up and opened his raised arms; he continued to look around; he did not close his eyes. He was experiencing himself as a new tree, with great courage, trusting the environment to overcome the "normal" anxiety he so often connected with novelty.

Many activities conducted in psychiatric settings mark a periodical rhythm, such as meals, medications, a Christmas party, going to the beach in summertime, and so on. These help residents to get a sense of continuity and of the passage of one moment to another. But it is important that caregivers notice a person's readiness to use these categories to contain experiences and thus calm psychotic anxiety.

7.5.1.4. Goal 4 - The Differentiated Perception of One's Own Needs

Once a person has acquired the sense of continuity of himself in a changing field, he has conquered an important step in building a sense of self-integrity. This ability will lead him to differentiate his own needs from others' needs, to emerge from the symbiotic confusion in which the self and the environment were previously perceived.

A group of residents were busy preparing lunch for themselves. To decide "what to cook" implies, first of all, a capacity to define what one wants to eat

(second goal); it then presupposes a consideration of space and time in choosing ingredients and knowing cooking times (third goal). It also means knowing how independently to define and try to satisfy one's individual needs, given what the environment offers (fourth goal). A staff member was assisting them, and she wanted to cook something appetizing for them. In the group there were people with different developmental needs. Those who were in the first phase of needing to be welcomed by the environment, accepted gladly "being fed" by her (a piping hot dish of spaghetti with tomato sauce can be irresistible). Some were wondering whether they wanted spaghetti or something else (phase of creative differentiation), while others were curious about where to buy spaghetti and how long does it takes to cook (phase of the rhythm of self). One of the group, who was already well ahead on his therapeutic journey, said he wanted a scrambled egg, which he wanted to cook himself. This was a beautiful example of becoming autonomous. The Gestalt leader said how much she appreciated both his clarity in declaring what he wanted and his ability to resist being swallowed up by the desires of others. Notice that she did not appreciate his will or determination, which is more a neurotic stance, but his ability to experience boundaries between himself and the rest of the group, which is more part of the psychotic experience.

Readiness to look after themselves (personal hygiene, care of possessions) as well as to respect nature by not throwing their litter on the ground (bad habits often acquired in institutions), to be involved with the staff in doing the cleaning, and to respect those who are different are all important signs of the residents' ability to belong to the community in a differentiated and integrated way, without giving up their individuality or running away from the rules of society.

8. To Conclude

By establishing a dialogue between Gestalt therapy and phenomenological psychopathology, over the course of this chapter we have sought to situate psychotic experiences in a specific dimension of the contact experience, as the disturbance of the id-function of the self in the pre-personal dimension, from which subjectivity and the world emerge. Thus we have placed the dimension of psychotic experiences on a horizon that is different to that of the individual, understood naturalistically or psychically. The moment/place that makes psychotic experience possible is a dimension that constitutes us all continually: the pre-personal dimension.

This helps us differentiate neurotic experience phenomenologically from

psychotic experience, and to situate borderline experience in relation to them. This understanding thus presents an alternative perspective to biological reductionism, that is to the intrasomatic view, as well as to psychological reductionism, that is to the intrapsychic view, both of which can only capture the shadows of a disturbance that is constituted before the differentiation of a "me" from a "world", and of a "body" from a "psyche", in the palpitating mesh constituted by lived inter-corporeality.

From a psychotherapy point of view, this perspective appears to us to offer important pointers for the treatment of and for being-with seriously disturbed patients. To make contact with psychotic experiences, the therapist must plunge into the lifeworld, where psychotic experience acquires voice (that is body and words) and meaning. It is precisely the grasping of this meaning that is the event that reconstructs a common world – an event that by definition changes the ground of psychotic experience, pushing it onto another terrain. «If the therapist can build an empathetic bridge with a person, in that context the person is no longer psychotic» (Kohut, 1995, p. 251).

In this work, therefore, we have sought to shine a light on the world that lies beyond known lands, beyond the Pillars of Hercules: the world in which we encounter psychotic experiences. In order to do this, to paraphrase Eugen Fink (Merleau-Ponty, 2003, p. 22), we need to be prepared to be "amazed" before the terrifying power, the delicate fragility, and the ephemeral beauty of the world that gushes forth in every "now".

Comment

by Gary Yontef

I applaud this needed contribution to the Gestalt therapy literature on specific mental illnesses. The chapter deserves more discussion that my allotted space. The discussion of the id-function of the self in the pre-personal dimension and the differentiation from ordinary experience was excellent. The clinical examples were reports of excellent clinical work and a stimulating discussion of rationale. However, I have disagreements over the explanation of psychotic experience and the discrimination of treatment of psychosis and neurosis.

Explaining psychotic process

This chapter explains psychosis as a failure of the «id-function of the self in the pre-personal dimension». «[...] from our perspective, all psychotic experi-

ences belong to a specific moment of experience which is anterior to self/life-world differentiation». I cannot ascribe to that as stated. I have no doubt that the primary confluence they discuss is significant. I think this is a difficulty in psychotic process, but not the only causal process, and I think the I-Thou differentiation for those suffering with psychotic process is very difficult but not impossible. I believe all of the boundary disturbances and functions of the self are manifest in organizing the phenomenal field.

Attempts to account for clinical syndromes using Gestalt therapy concepts have often not done justice to clinical complexity, and lacked sufficient empirical support. These explanations were often rational rather than phenomenologically derived. For example the attempt to explain clinical syndromes by interruptions at a single point in the Cycle of Experience or the Contact Cycle. This chapter has a similar problem.

The background sense of not being part of the ordinary world, is indeed part of psychotic experience and the explication in the chapter describes that. That pre-personal experience does affect the other self-functions. But other aspects of psychosis, e.g., the positive and negative symptoms, and e.g., distortion and fragmentation, are also disturbance of ego and personality function not attributable just to the id experience.

Many schizophrenics were differentiated and then lost it in the late teens as the disease process set in. They lose it in acute psychotic states and can find it in recovery. This chapter does not account for such variability.

Understanding the schizophrenic spectrum in terms of impossibility of differentiation and the melancholic spectrum in terms of the impossibility of feeling connected has some intuitive resonance to it. But I believe "impossibility" is wrong. We are always already "of the field". Even experiencing not being of the world is an experiential phenomena "of the world". The schizophrenic has some sense of differentiation and the melancholic is still impacted by the environment and in turn impacts it. I believe that the explanatory theory overlooks the range of processes in both spectrums.

Clinical attitude

I totally agree with a clinical attitude displayed in this article. But I don't subscribe to this attitude only for psychotics. It is just good therapy.

Delusion and hallucination, and other clinical experiences, are treated as attempts at creative adjustment rather than just as a defect. They talk about the importance of the establishment and maintenance of a therapeutic relationship that supports the patient. There is an excellent discussion of organizing the clinical setting and valuing a kind, safe, empathic contact in individual work. I

whole-heartedly agree with this clinical attitude – as a general clinical attitude.

I think the phrase commonly heard "building ground" is misleading. One builds relationship, trust, confidence, belonging that will often operate in the background but that can be made figural. This is not "building ground". It is building support that operates in the ground (unaware) and can be aware.

Our clinical work is to make sense together with the patient, to make comprehensible that which was not grasped in a useful way. The discussion of treating psychotics in the chapter illustrates the process of focusing on what is really important to the patient, both what is experienced and that which is important but not in the patient's ordinary experience. This seems to me to be undeniably good therapy. I think understanding the diagnosis helps the therapist be sensitive, more accurate, more understanding, and more effective in responding. But it does not give a cookbook response or algorithm for correct intervention.

While I believe that the interventions illustrated in the chapter were excellent and well thought out in terms of the individual, the rationale of doing this intervention because the patient is psychotic and would not be done if the patient were in the neurotic range creates a cookbook rationale that is simplistic. I have non-psychotic patients who need a choice like the ones in this article and there are psychotic patients who would need the interventions reserved for neurotics.

The authors define neurosis as the ego and personality functions defining what is new as "not for me", preventing creative adjustment. The "who I am" from past contacts is split from new social context. While psychosis differs in many respects, this process is shared.

The general clinical issue is to make dialogic contact and make figural that which was background as needed. This is organized around needs of the particular patient at a particular time. Understanding clinical syndromes sensitizes the therapist but does not dictate a particular technique.

In response to the patient who says "my neck hurts", the therapist asks what else and does not try to "amplify these sensations". It makes good clinical sense not to jump into the first statement. Paying attention to what else is in the active background and not yet explicit is appropriate for patients of any diagnosis. I think the cited intervention was excellent, but I think that the stated rationale is too simple. I suspect that the clinical reasoning and intuition of the therapist was much richer and more nuanced than the stated rationale.

Interpreting the image of the stone as "conquest to support and consolidate, instead of a way of being defective" is an excellent therapeutic attitude – for neurotics as well as psychotics. It is in line with the contemporary turn in Gestalt therapy from the more confrontive, theatrical, and cathartic stage of

the 1960s and 1970s back to the relational core of Gestalt therapy theory. What the patient presents, what the patient experiences, is best seen as a creative adjustment, needing to be made sense of, and not a defect or manipulation to be fixed. The attitudes discussed for those with psychotic process are too good to limit only to psychotics.

Finally, I see this chapter as part of a beginning and hope for further development.

Gestalt Therapy Approach to Depressive Experiences

by Gianni Francesetti and Jan Roubal

"Hell is where nothing connects"
(T.S. Eliot)

We are aware that entering into the issue of depression implies opening up many resonances in the reader: it is a journey through some of the most desolate and painful lands of the human soul. And it is impossible to go through it without being touched by its atmosphere and spidernets. Anyway, from these black holes, light and new life can emerge. So, as Alexander Pope says in his poem, let's enter with a light and careful step.

1. Diagnostic Considerations

The World Health Organisation rates depression as the fourth most urgent global health problem and has predicted that by 2020 it will have risen to second place. It affects hundreds of millions of people worldwide. At least 20% of women and 12% of men experience depression during their life and 15% of depressed people end their life by suicide (Akiskal, 2000). Despite the widespread use of antidepressants, their efficacy remains unsatisfactory. 15%-30% of depressed people do not show a response to antidepressant medication.

The use of the term "depression"[1] in psychiatry to describe a state of low mood began at the end of the nineteenth century. Previously, such phenomena were diagnosed as *melancholia*. According to psychiatric diagnostic systems (DSM IV, ICD 10) the depressed person suffers a mood disorder characterised by low mood, decrease of energy and activity, reduced ability to feel pleasure, poor concentration and increased tiredness. The depth of depression is measured according to a list of criteria. The term "depression" is used to refer to a wide range of experiences which vary in seriousness and which may also represent a natural response to significant life transitions[2].

[1] From Latin, meaning *downwards pressure*.
[2] For a more detailed consideration of this theme from a Gestalt perspective, see Roubal (2007) and Francesetti and Gecele (2011).

Traditionally, depression used to be categorised etiologically[3] (Schneider, 1959), in terms of somatogenesis (i.e. caused by a known organic pathology, mental or otherwise), psychogenesis (i.e. reactive depression, resulting from traumatic events, or neurotic depression, caused by neurotic conflicts) or endogenesis. This third category refers to depressive experiences characterised by a devastating *melancholia* which differs phenomenologically from psychogenous depression and its incomprehensibility seems to suggest organic roots. Various other forms of depression have since been identified, such as those which lie between the endogenous and the reactive or between depression and schizophrenia, or those which are linked to a specific type of personality or to psychosomatic disorders etc.

Further careful research showed it is not possible to make a clear distinction between reactive (neurotic) forms of depression caused mainly by psychological and existential factors and endogenic (psychotic) forms of depression with biological roots. Endogenic depressions appeared also to have external precipitating factors and neurotic depressions have a partly biological correlation too. Today we consider rather a continuum of transition from one type to another between the extreme forms. Current psychiatric diagnostic systems have stopped looking for causes of depression. They describe the seriousness of the depressive state and distinguish between unipolar (only depressive experience) and bipolar (depressive and (hypo) manic experience)[4].

DSM IV divides depressive disorders up into categories (reproduced here in a simplified form).

[3] M. Roth and The Newcastle School in the middle of the 20th Century.

[4] The adoption of this kind of classification, which draws no clear line between melancholy and other forms of depression, was instrumental in catalysing the increased of pharmaceutical treatments for depression (Borgna, 1994). The use of pharmaceuticals is no longer restricted to melancholic forms of depression (which represent a tiny minority of cases), but has rather become the norm. Various authors have argued that the DSM classification «did little to improve our understanding of depression» (Jones in Barron, 2005, p. 275) and that there would be much to gain, in our understanding of this and of other disorders, from passing from a categorical to a dimensional approach (Vella and Aragona, 2000). We should also emphasise that the DSM IV criteria are of an over-inclusive nature, leading to epidemics of false diagnoses which, once again, benefit pharmaceutical sales (Wakefield, 2010).

1. Depressive Disorders are subdivided into:

1.2. Major Depressive Disorder

This is characterised by an episode of Major Depression in a patient who has never experienced manic or hypomanic episodes. At least five of the following symptoms should have been present for at least two weeks: a depressed mood, a lack of interest in activities (these first two symptoms are essential for a diagnosis), weight loss or gain, insomnia or hypersomnia, agitated or slow motor activity, lack of energy or fatigue, feelings of low self-worth or guilt, reduced concentration or indecision and contemplation of suicide. In addition, these symptoms must cause clinically important distress and impair work or social functioning.

1.2. Dysthymic Disorder

Chronically depressed mood lasting at least two years is accompanied by at least two of the following symptoms: decreased or increased appetite, insomnia or hypersomnia, fatigue, reduced self-esteem, concentration or decision-making difficulties or feelings of despair. No Major Depressive Episodes should have occurred over the two years in question and there should be no history of mania or hypomania. The symptoms must cause clinically important distress and impair work or social functioning.

2. Bipolar Disorders, subdivided into:

2.2. Bipolar Disorders I and II

Characterised by Manic or Mixed Episodes. Patients will often also have experienced one or more Major Depressive Episodes. Bipolar II Disorder is characterised by one or more Major Depressive Episodes and at least one Hypomanic Episode.

2.3. Cyclothymic Disorder

Chronic fluctuation in mood with a recurrent alternation between hypomanic and depressive episodes. The criteria for Major Depressive or Manic Episodes should not have been met.

3. Other Mood Disorders

Include manic and depressive mood disorders due to an organic illness or substance abuse.

The question which we now face is the following: what does a psychotherapist need to orient him/herself in the face of a patient with depressive experience? From a pragmatic point of view, we divide the depressive experiences according to the diverse dynamics and different apt therapeutic approaches:

1. Mourning (Assimilation of Bereavement)[5];
2. Depressive experience[6];
3. Melancholic experience[7];
4. Depressive experiences linked to personality[8];
5. Depressive experiences resulting from organic causes[9].

We can observe very similar phenomena across these different kinds of experience. To justify this classification we need to understand the function of the symptoms which can be seen as manifestation of a suffering of the patient. Generally, there are three manifestations of a suffering (called disease in a medical paradigma) (Nesse, 2000). Firstly, its direct harm; for example bodily injury, that requires urgent treatment. In a psychotherapeutic context this would be a *traumatic experience* when crisis intervention is needed.

The second manifestation is a defence of the organism; for example, pain or vomiting. What we consider to be pathology actually prevents more significant harm to the organism. Elimination of this protection can be dangerous for the organism. For example, if we intervene to stop vomiting artificially, the patient will not get rid of poisonous food. If we anaesthetise the pain, we are switching off the signals with which the body lets us know that something is wrong. In the case of a natural *mourning* over an important loss (e.g. the death of someone close), the "depressive adjustment" (Roubal, 2007) works as an adaptation

[5] This category includes experiences that do not need to be labeled by diagnostic categories. The psychiatric diagnostic systems however often use the category "Adjustment disorder with depressive mood" (DSM IV) or "Depressive reaction" (ICD 10). For the DSM V there is a proposal to delete the criteria that impedes the diagnosis of Major Depression if there is a loss and grief. If this is confirmed, the confusion between what is clinical (depression) and what is simply existential (sadness), the false positives and drugs prescriptions will probably tremendously increase (Horwitz and Wakefield, 2007; Pignarre, 2001).

[6] This category includes a continuum of experiences from mild to severe, the external influences (relationships, life events etc.) are well recognisable as contrubuting factors. These states are primarily psychotherapeutically accessible.

[7] The terms *psychotic depression, melancholic depression or endogenous depression* are partially overlapped – even though they come from different frames – and we can use them in an interchangeable way inasmuch as we refer to neither symptoms (e.g. the presence of delirium or otherwise) nor cause, but rather to the type of depressive experience involved, a type of experience which differs qualitatively from other depressive experiences. We prefer, however, to use the term *melancholic depression* for a number of reasons. It is less pathologising in its implications than the term *psychotic depression* and it recalls the DSM IV category of *Major Depression with Melancholic Symptoms*. Moreover, it refers to the quality of the patient's experience, whilst the term *endogenous depression* refers to its causes.

[8] Here we will only refer to the depressive experiences of dependent or introjective personality types. For a description of other personality types, see the relevant chapters in the book of Francesetti and Gecele (2011). Dysthymia would also fit into this category.

[9] These are depressive experiences caused by pharmaceuticals or physical illnesses, which we will not be able to treat in this chapter.

and defence. Trying to work therapeutically to generate a more optimistic reaction can actually be harmful. The patient may not have sufficient inner resources to cope with demanding situations at that moment. The depressive adjustment serves as a protection, as a survival mechanism.

The third kind of manifestation is dysregulated or extreme defence. The mechanism deployed by the patient that originally prevented greater harm gets fixed and stops meeting its original function. The pain signalling harm becomes a chronic paralysing pain. Vomiting that helped the body get rid of the poisonous food remains, and exhausts the organism by causing dehydration. Similarly initially natural depressive adjustment becomes fixed and manifests itself as a dysregulated defence. At that moment it loses its original usefulness for the individual and society and turns into *depression*. It would be appropriate to talk about "fixed depressing" when a person becomes rigid in his self-organisation and loses flexibility in meeting his actual need in the contact with the environment. Very severe depressive states can be seen as manifestations of extreme forms of depressive self-organisation. A psychotherapeutic approach is not sufficient as an early therapeutic intervention in these cases.

2. Depressive Experiences: a Gestalt Approach

We will now seek to frame the depressive experience within a meaningful frame originating in the relational field (Roubal, 2007; Francesetti and Gecele, 2009; 2011). We will approach the phenomenon with the theoretical tools provided by Gestalt therapy theory, taking the existent phenomenological[10] and Gestalt approach[11] understanding on the topic as our starting point.

We diagnose how the patient and the therapist together create a depressive relationship. Although we sometimes (for communication reasons) use the expression that "the patient is depressed", our basic attitude is always field relational, we keep in mind that the patient and the therapist are here-and-now *depressing together*. Making this kind of diagnosis is the first step in the therapy. Through this comes awareness of those rigid patterns by which the patient relates not only to the therapist but also to his environment and himself. Diagnosis then serves as a tool for change (Melnick and Nevis, 1998).

[10] See Galimberti, 1987; 2003; Borgna, 1988; 1992; 1994; 2008b; Blankenburg, 1971; Kimura, 2000; 2005; Callieri, 2001b; Rossi Monti, 2002; Minkowski, 1933; Binswanger, 2006; Stanghellini, 2006; Maldiney, 1991; Gozzetti, 2008.

[11] See Salonia, 1989b; 2001a; 2001b; 2005a; 2008a; 2010b; Melnick and Nevis, 1998; Greenberg, Watson and Goldman, 1998; Amendt-Lyon, 1999; Spagnuolo Lobb, 2001a; 2001b; 2005b; 2007b; Staemmler, 2004; Vázquez Bandín, 2005; Roubal, 2007; Baalen, 2010; Bloom, in preparation.

2.1. Mourning: the Presence of the Absence

We must differentiate between *sadness* (as an expression of mourning) and depression. This differentiation can be found already in the early psychoanalytical work of Abraham and then of Freud (1917; 1925) in his classic article *Mourning and Melancholy*. The experiences of depression and of sadness can both show similar symptoms but in practice it is very important to differentiate between them. To work psychotherapeutically with depression and sadness using the same approach can even harm the patient (Smith, 1985a). Mourning is a way of assimilating important loss[12]. Here we focus on bereavement, similar experience can be observed with other kinds of important life events containing loss, like abortion, dismissal, refugeeism etc. The assimilation process required is analogous to that required in cases of bereavement.

Mourning helps the individual to assimilate not only the loss suffered, but also her/his relational experience with the lost one. One of the gifts which death gives us is its revelation of the beauty of the one who has gone. His/her absence reveals the depth and worth of his/her presence. The negative side of this for those who remain is the discovery of their own absences in the presence of the loved one: "*Why didn't I realise how important, wonderful and rich it was to be with him/her?*". The mourning period serves to establish a *double loyalty:* to the relationship which has been lost and to life which must go on. When this double loyalty has been attained, the mourning period comes to an end (at least for that specific period of life). Mourning enables life to preserve the wealth to be derived from the past relationship (Cavaleri, 2007) and to launch itself once more into the ever-springing fount of the new.

Whilst in the immediate wake of a bereavement, the unattainability tends to dominate the foreground, with time memories beginning to surface, the awareness of having-been-with the lost one and of all that you have experienced together. In this way, the experience of the relationship is assimilated and the subject gradually attains a state of *presence in absence*. The remaining one learns to carry the lost one with him/her, developing a new capacity of "being-with" the other and a new form of fidelity.

Mourning is essentially a period of assimilation, of post-contact. It is a stage of the contact sequence whereby the other is no longer present to the senses. Yet it is not a purely reflective phenomenon. The senses are acutely involved, because it is through the senses that the loved one's absence is perceived. In mourning, I am with the other in the very impossibility of reaching him/her: I am fully in the presence of his/her absence. Mourning is therefore a necessary and creative period, which enables me to assimilate who I became with the one I have lost and who I am to become without him/her.

[12] See also chapter 15 (*Loss and Grief*).

2.1.1. Suggested Therapeutic Approach

Sadness is an emotion that accompanies a healthy process of mourning. The therapist does not try to prevent, interfere in it or avoid it. The therapist stands besides the patient and supports her/him to go through the mourning period, to experience it in a safe place and assimilate it. The therapeutic approach is different here from the work with depression. Mourning constitutes a work-in-progress which must not be interrupted but rather sustained. It reveals an ongoing fidelity to the relationship which has been interrupted and requires the elaboration of the kind of double loyalty described above – of a fidelity at once to the relationship and to life itself.

At this stage, the individual's experience may correspond to the DSM IV criteria for Major Depressive Disorder. However, there is nothing really pathological about this state of events. It rather simply constitutes a healthy reaction to an existential checkmate. The psychotherapist must always bear this in mind, making sure that support is not geared towards eliminating the patient's pain but rather in providing the support needed to help the patient to feel the pain in its entirety. What we are dealing with in such cases is a difficulty in assimilating an existential limitation, and the specific support required consists in sustaining the patient in overcoming this difficulty. The therapist assists in closing the cycle of experience, helps the patient to go though the demobilisation (Melnick and Nevis, 1998) to fulfill the "tasks of mourning" (Sabar, 2000, pp. 152-168).

If the subject is to elaborate upon the event, his/her life prior to the loss suffered must somehow pass into the present. A brief example may be useful to illustrate this point.

A man who was beginning a prison term had cut himself off from all those around him, remaining mute and refusing to communicate with other inmates, with the prison's personnel or with the psychologist called in to handle his depressive behaviour. The psychologist had sought to get him involved in the various activities on offer in the prison, thus looking forward to the future possibilities after his sentence, but had had no success. After a supervision, the psychologist began to take an interest in who this man had been prior to his problems with the law. This new approach revolutionised their relationship. The patient began to open up and to re-live the past in the present. From then on the patient was increasingly open to contact with his psychologist.

We can fully understand this process when we bear in mind the fact that closing oneself off from the present represents a kind of fidelity to one's own history. To move on (after a loss) we need to carry the fruits of what we have

already experienced with us. To push the individual to move on, "leaving the past behind him/her" neglects to take this intentionality into account.

2.2. Melancholic Experience: the Absence of the Presence

Melancholic (endogenous or psychotic) depression, generally unrelated directly to events in the patient's life (but they might be important as triggers), represents an extreme form of depressive experience where qualitatively new phenomena can appear[13]. The person experiences not so much just a sense of despondency, rather a continuous physical heaviness: *"As if there were a stone constantly pressing down on my thorax"*, *"It's as if it were squeezing all the life out of me"*. S/he may experience a lack of any kind of sentiment, a sensation of numbness, of being stranded in an emotional wasteland. The body is desensitised, often feeling heavy or empty. The person experiences a lack of energy, which can lead psycho-motor functions to slow down to the point of immobile stupor. There is a loss of appetites. The person wakes up unnecessarily early in the morning. S/he can contemplate suicide and may become delirious, with delusions usually involving guilt, ruin or hypochondria.

The personality function also undergoes alterations, ranging from simply not feeling up to fulfilling one's normal roles to a grave loss of identity. The resulting impairment is such that the person is unable to function professionally and socially and to fulfil parental and family responsibilities. "*I am holding your hand merely because I know we used to do it. But I experience just emptiness*". The person comes to lack the capacity to take decisions, to lack lucidity, ambition and responsibility. Personal history may be twisted, even to the extent of deludedly "reconstructing" past faults which have no foundation in reality. In the face of such a profound dysfunction of the *id* and *personality* functions of the self, the *ego* function may be completely vanquished. If it cannot coexist with the *id* function, there can be no identification with or alienation from elements in the field and therefore no choice.

Remission after an episode (which may have gone on for weeks, months, or, without suitable therapy, years) is usually complete, and patients describe their melancholic experiences as a living nightmare, as *another dimension*, so far removed from their normal life that it becomes hard to remember it clearly. Episodes can recur throughout the individual's life, in some cases in alternation with manic periods. There may also be situations in which melancholy is mingled with euphoria. The prognosis with regard to any single episode is relative-

[13] Some specific (psychotic) phenomena appear in the case of melancholy. We can imagine the continuum of depressive experiences as water that becomes colder and colder and then at some point becomes ice.

ly good, since these frequently end in complete remission. However, we always remain uncertain as to whether and how often symptoms will recur. A milder chronic depressive state can also develop in some cases.

2.2.1. The Self and its Functions in Melancholic Experience

In the mourning experience a specific person or objective becomes unreachable and therein lies the loss suffered. The experience of melancholic depression differs: what is lost is that which anchors the subject to the fabric which connects him/her to the world. In the former case, one loses the other to whom one is attached, in the latter one loses the conditions which make it possible to form such a tie[14]. This experience of melancholic depression presents an extreme form of a continuum of depressive experiences and as such it offers us a possibility of understanding the dynamics of the depressive experience. The more serious the case of depression, the more evident this becomes.

The gravity of a patient's depression can be measured in terms of their detachment from the *in-between*, of the degree to which they are absent from the contact boundary. The in-between is the common ground which we constantly co-create at the contact boundary. It is the fabric which connects us to the world and to life moment by moment. In cases of melancholy, this common ground has ceased to exist and can therefore no longer be traversed. Herein lies the unique quality of melancholic experience. The in-between is no longer a meeting place. It has instead come to represent an insurmountable cosmic abyss. In such a condition the ego function is potentially reduced to nothing, to a state of stupor in which nothing happens. The id function (the pre-reflexive function which connects us to the world prior to the rift between the self and the world, the organism and the environment), instead assumes a more significant role. It is a disorder of the id of the situation (Robine, 2011), where the very fount of subjectivity, time, space and intentionality – life itself – are generated.

The profound dysfunction of the id function means that it is impossible to co-create a figure of contact. This dysfunction lies at the heart of the therapist's difficulty in connecting with the patient, in ensuring the usual comings and goings of resonances, consonances and dissonances which should fill up therapeutic space and time. In short, nothing reverberates in the therapeutic *in-between*. A central facet of depressive experiences is the lack of any interest. This does not simply mean that the subject is not attracted to or involved in an-

[14] We here diverge from the psychoanalytic perspective, which suggests that melancholy consists in the unconscious loss of an object which is transferred to the ego – and herein lies its difference from mourning, where loss is transferred to the outside world (Freud, 1925).

ything. It also has the more radical implication that s/he is no longer in the *"inter"* of *"esse"*, that s/he in some sense is removed from being in the *in-between* itself, from the nerve centre where all the infinite strands of life knit together (Bonani, 2009). The sense of lifelessness, which is perhaps one of the most distinguishing features of depression, is clearly a manifestation of this condition. The healthy growth of the self requires that the organism be at once separated from and welded to the world. This connection with the world is what is lacking in melancholic experience, whilst in cases of schizophrenic experience it is the development of separation and boundaries which is lacking (Francesetti and Gecele, 2011; see also chapter 20).

2.2.2. The Figure/Ground Dynamic

Severe depressive experiences are characterised first and foremost by a certain sluggishness in the figure/ground dynamics: the figure strains to emerge from a ground which is devoid of energy. There are neither interests, stimuli nor impulses of intentionality. The patient often remains silent and immobile on the chair throughout the session. Not even the vaguest hint of a figure peeks through. Nothing is relevant. Nothing means anything, since meaning itself is developed at the contact boundary in the figure/ground dynamic, where the figure acquires size, depth and meaning through its relation to the ground.

No intentionality emerges, since intentionality does not belong to any one individual but rather emerges and reveals itself through contact: it is the force that drives all our encounters at the contact boundary. When we enter into a severe depressive relational field, our senses encounter a nothingness, a torpid wasteland which seems at some times to be made of stone and at others of a fluid, all-engulfing fog. *"My head's full of a kind of fog, which shifts continuously without ever taking on any distinct form. I'm really confused. I don't know what to do".* At other times again, it seems as if nothing has any meaning: *"I look out at the view as if it were nothing more than static pictures on a flat screen. The mountains, which have always been a source of joy to me, are now just there: unreachable, inert and useless. Nothing appeals to me. There's nothing I can relate to, nothing that means anything to me".*

The therapist perceives the lack of direction in a dilation of time and space. These two transcendental cornerstones[15] of human experience have been altered. It would be inaccurate to say that the figure makes use of space and time as pre-existent categories. Rather, time and space emerge at the very moment at which the figure is co-created in the present. When melancholy creeps up,

[15] In the vein of Kantian and phenomenological philosophy, we use the term "transcendental" to refer to those conditions which make experience possible.

the present moment fails to emerge. It lacks the support of both the previous moment which is coming to an end (*retentio*) and of the subsequent moment which is coming into being (*protentio*). When the therapist situates him/herself in the relational field of the patient, s/he will become immediately aware of this modified sense of time, which has been dilated to the point of suspension, to a point at which it has almost come to a complete stop. And space, meanwhile, is in a state of constant expansion. The distance between the therapist's chair and that of the patient seems ever greater, to the extent that it comes to appear insurmountable. The energy required to traverse it comes to appear impossible. However, the very fact that its apparent absence causes such acute distress demonstrates that intentionality[16] is actually present. It is present in the very pain which derives from the perception of its absence. If the painfully felt absence of intentionality exists in the figure, then intentionality must be present in the ground.

The depressive experience is situated within a relational field. Time and space are the roads which we conceive of ourselves as we make our way towards that which is loved and necessary. They are relational-dependent variables, generated through the impetus of the journey itself, which is never just a single movement but always a co-movement. When this movement fails, what we experience is the abyss which separates us. The affective bridge, upon which our very selves are constituted and from which subjectivity springs, is lost. Depressive experiences are the expression in the individual of a specific relational experience: namely the impossibility of reaching the other. To be more specific: *depression is the way in which the subject experiences the surrendering of hope in the face of the ineffectiveness of his/her vain attempts to reach the other.* Depression can be understood as a co-constructed relational phenomenon with three intrinsic and essential features: a profound attachment, whereby the other is loved and necessary, the failure of all efforts to reach the other and the emotive absence of the other from the relationship.

2.2.3. Suggested Therapeutic Approach

A specific support is required for the patient experiencing the melancholic depression. First of all, the therapist should never try to handle such a case alone. Often the patient also needs pharmacological support. Right from the beginning of the psychotherapeutic contract it is important to stress the fact

[16] The word "intentionality", used by phenomenologists, refers to the emerging push towards co-creation of a figure at the contact boundary. It is related to the id of the situation, described by Perls, Hefferline and Goodman (1994) and focused on by Robine (2011) and it is different from "intention", that is an act of the ego function and deliberateness.

that the consultation of a colleague will sometimes be necessary. This measure protects the patient, puts the therapist's mind at rest and makes it possible to discuss pharmaceutical options in a moment of calm, and not in a possible future moment when a crisis could happen.

Psychotherapy in the cases of melancholic experience should function on two distinct horizons. The *first horizon* is the actualisation – in the therapeutic relationship – of the depressive field in a moment when the therapist is so important for the patient that he continues to perceive him as a possible *other* to be reached. This possibility sometimes opens up spontaneously during the course of therapy, but cannot be deliberately decided on or planned for by therapist or patient. The problem is that when the patient is in a depressive phase, s/he is unable to recognise the stable ground offered by the therapeutic relationship and the therapist is hardly perceived as a significant other. On the other hand, when the episode has passed s/he is unable to vividly recall what has happened, since the abyss is no longer present.

The only hope is that such a deep therapeutic relationship has been established that even at a crisis point some glimmering of a sense of co-existence will remain. The therapeutic relationship is so strong that it can withstand even the depressive detachment which stems from the dysfunction of the id function. It is important that the therapist is aware that his/her presence is essential even in the patient's depressive phases.

In these periods, the patient may seem completely cut off from the therapeutic relationship, and the therapist may find it a struggle to keep his/her eyes open during sessions, to refrain from rejecting the patient outright, out of fear or frustration. S/he may feel completely useless. Yet after the episode, the patient will often express his/her gratitude for the therapist's perseverance. The therapist's persistent presence offered a faint glimmer of warmth and support against the isolation of the cold cosmic vacuum in which the patient found him/herself. Although the patient was unable to reach out and take the proffered hand, it was at least there.

The therapist must be particularly sensitive to the emergence of aggression. These are the moments at which energy is born and at which contact intentionality raises its head – both extremely precious ingredients in the cure of this disorder. Notwithstanding this, therapeutic support should be carefully regulated, the therapist making sure that s/he is supporting the patient's awareness of aggression, rather than aggression *tout court*. This difference is fundamental: awareness provides the necessary ground upon which aggression can become contact, instead of a movement blind to the situation and to the other.

If we sustain aggression precociously or without awareness, we risk facilitating an "acting-out" of aggressive impulses, which usually takes on an auto-aggressive form. A patient lacking an anchor in the id function of the self will

find it difficult to assess a given situation and to place these sudden emotional outbursts which seem to emerge from nowhere. Aggression towards oneself is a more immediate impulse in patients suffering from depression than aggression against others. This is because the patient's energy is still withdrawn into him/herself and there is often a basic powerful sense of inadequacy or guilt.

Therapy cannot always be instigated exclusively upon the request of the patient. Sometimes it is down to the therapist to take the decision to work together. S/he offers up his/her own ego function into the depressive field and makes those choices in areas which cannot yet be co-constructed.

The *second horizon* will occur primarily in periods when the patient is not in acute crisis, when s/he is able to distance her/himself a bit from her/his experience. The psychotherapist needs to support the patient in managing his/her symptoms. The patient will need support in learning to accept the limitation (as any other kind of existential limitation) in finding the best ways to express his/her own vital creativity. The therapist's aim is not to "cure" either the depressive episode nor any potential relapses. S/he should rather provide support and help the patient to put these episodes into perspective, integrating them into the broader context of his/her personal history.

The therapist provides a support which is primarily geared towards the personality function of the self and helps the patient to give limits to her/his suffering, to put it into a meaningful frame. To obtain a clear perspective on one's own history (*"Have you already experienced such a state? When was it and how long did it last? What helped and what did not help then?"*) and identity (*"What function have the episodes of depression in your life?"*) and recognising depressive and manic experiences as an integral and inextricable feature of the overall picture, is a fundamental first step towards being able to make decisions about one's own life.

2.3. Continuum of Depressive Experiences

The depressive phenomena of field dynamics described in the case of melancholic experience appear with less intensity also on the continuum of milder depressive experience. The figure that predominantly rules the co-constructed figure/ground dynamics of the field is *a loss of hope when facing the inability to reach the other*.

The experiences of mourning and melancholy represent extreme forms of a depressive experience. The continuum of depressive experience between them is very complex and can be seen as a changeable mixture of different kinds of experiences. Moreover, depressive experience is not a constant, it changes over time even within one depressive period. The therapist needs more concepts to

get a useful picture, to be able to conceptualize these states. The concepts offered above (mourning, melancholy) will now be supplemented by two other concepts, that enable us to see depression either as a form of a *creative adjustment* or as a *fixed Gestalt*. When a therapist becomes familiar with these concepts, they can serve her/him as an anchor, as a "third party" (see chapter 3 on Diagnosis). This anchoring in a conceptualisation of the therapeutic situation helps the therapist not to be overwhelmed by the heaviness, emptiness and hopelessness when meeting a person with depressive experience. It helps the therapist to become grounded and then s/he is able to open her/himself again and again for a contact in the "between" space which is so heavy with the depressive experience. This persistent availability is the most important and also the most frustrating part when working with a person who experiences a depression.

The depressive experience of each person is a unique one, it is always an inseparable part of the unique person's life story. The depressive experience also has an interpersonal nature, it is a co-created phenomenon: it appears in relationships and there it is maintained. Considering the context of the life story and web of relationships, the depressive experience can be seen as a function of the field, as a form of *creative adjustment.* It can help a person to survive a difficult situation, it can signal a life transition and re-focus the search for life meaning, it can facilitate a change in frozen habitual relationship patterns etc. However, if a person uses a depressive way of relating in a rigid and stereotypical way in her/his life, the depressive functioning becomes a *fixed Gestalt*. It can be described as a vicious circle which decreases the ability of the organism to cope with its own mental and physical processes as well as external demands. It leads to more frequent failures, subsequent deepening of the depressive state and further decrease in the capacity of the organism.

Seeing the depressive experience either as a creative adjustment or as a fixed *Gestalt* is a useful diagnostic tool that can serve as an anchoring third party. However, using this division, we keep the perspective of health-disorder dichotomy and focus only on the individual who experiences depression. It is important to realize the limits of the described concepts and use them not as an explanation of a reality but only as a tool for giving meaning to our experience, as a working hypothesis. In the therapeutic situation we then always come back to the relational field perspective, where anything the client does and experiences is a kind of creative solution to a difficult situation, the best solution available at the time. The depressive experience of an individual appears always within a relational field, it is a co-created function of a field. In therapy we can explore together with the client how the depressive experience fits into the client's life story and her/his relationships (including the client-therapist relationship), how it protects the client and how it limits her/his potentials. And

also what does the depressive experience indicate, what kind of guideline or longing does it represent.

2.3.1. Depressive Adjustment

Every emotional state affects the functioning of the whole organism and in a specific way regulates the interactions between the organism and the environment. The important function of an emotion is to create such a state within an organism that enables it to handle a situation effectively (Nesse, 2000). The functional emotional state of *low mood* or *sadness* can be observed as a depression from outside. But it can also be seen as the best way of handling a difficult situation. It is not only a change of mood but also a switch of the organism to a "standby mode". It leads to limiting activity level, lowering of energy, and a limiting of the intensity of experiencing. These symptoms are similar to those of depression. However, this is not a pathological disorder but rather an adaptive mechanism.

Optimism usually helps deal with difficult situations. But there are situations when a person cannot satisfy her/his needs and an effective action is impossible. This can happen for example after loss of a partner or a job. An optimistic attitude that encourages the person to repeatedly try to get back the already occupied job position or bring back the ex-partner can make things worse.

If a person uses a depressive way of relating to her/his environment as a kind of creative adjustment, we can speak about *depressive adjustment* (Roubal, 2007). It is not a malfunction but rather a specific form of creative adjustment which helps deal with certain life situations, when the inhibition of striving and signal submission may be profitable[17]. Depressive adjustment serves as a mechanism for coping in unpromising situations. It regulates economically the personal investment and prevents activity that would be wasted, helps to let go of the drive towards unproductive effort. It inhibits dangerous and worthless action at times when an organism lacks inner resources or a viable life strategy. Depressive adjustment saves energy in situations that lead to inaccessible goals. A person, when sad, conserves personal resources (Nesse, 2000).

There are advantages in depressive adjustment that have preserved it through evolution as a profitable adaptive mechanism. When an individual loses interest in the not achievable step in his/her destiny, he does not fight for it and is not hurt or killed. Moreover, if s/he gives up her/his social position voluntarily and avoids fighting, energy is saved for the whole society (Price, 1967). As with hibernation in the animal world, the subject has reached a point

[17] Ethology describes this for example in a situation when challenging a dominant figure that cannot be overpowered (Price, 1967).

where continued activity (i.e. to continue to struggle with, flee from or manipulate the environment) would be a waste of energy.

Depressive adjustment also enables (or even pushes) the person to take time out, consider the changed situation and make a decision on alternative strategies. Depression can then be seen as a life "implosion" in the sense of life direction, the person experiences loss of ego function (*"Doing what I always do does not work any more"*) and faces the existential question: "*What do I choose?"* (Philippson, 2001, p. 232). It is important for the therapist to have this way of understanding the depressive experience at hand. It helps her/him to avoid attempts to cure what might look like a depression but rather to give value and explore the unique process of creative adjustment together with the client. They can then discover what possibilities this way of understanding opens in the patient's life context.

2.3.2. Fixed Depressing

The originally useful adaptive mechanism of *depressive adjustment* may turn into an exhausting and devastating fixed *Gestalt* of *depression* as a kind of suffering that significantly limits a person's capacity to creatively adjust.

Fixed ways of relating develop during the course of life. In the formation of depression both biological and socio-psychological field conditions play a role. *Genetic predispositions* are responsible for a certain specific vulnerability of a person, who in a demanding situation reacts in a depressive way[18]. The role of *psychological and social factors* is well described by Greenberg, Watson and Goldman (1998). They argue that a person who has experienced a significant loss in the early stages of her/his life, particularly if it also involves humiliation or helplessness, preserves this experience in a form of so-called *depressogenic emotional schemas*. If s/he later finds her/himself in a situation that is similar to the early traumatic experiences, her/his emotional reaction can activate these schemas. Such schemas represent a rigid fixed pattern that affects both perceiving and experiencing[19]. A person feels an absence of love, feels humiliated, trapped and powerless, and is not able to mobilise an alternative reaction.

[18] It is interesting that modern biological theories of depression talk about a deficit of neuroplasticity. The central nervous system loses the ability to react flexibly to the present situation. The brain then functions in a rigid and stereotypical way and shows characteristic changes in activity and neural transmission. This theory is actually describing a fixed Gestalt at the biological level. Scanning studies show that the use of antidepressants, and also psychotherapy, leads to unblocking of such a rigid state and to restitution of a flexible plasticity of connections between nerve cells (Gabbard, 1997).

[19] These hypothesis are consistent with contemporary infant research, see i.e. Tronick, 2008.

These schemas often include introjected negative evaluations such as: "*I am worthless*". Greenberg, Watson and Goldman (1998) describe this state as a *depressive organisation of self*. A depressed person is overwhelmed by feelings of fear, loneliness, insecurity and shame. S/he develops a negative conviction about her/himself and others.

The loss of creative adjustment manifests in a particular fixed way in the modification of contact process: there is a repeating pattern of an interruption in the contact sequence (Withdrawal → Awareness → Mobilisation → Action → Contact → Assimilation → Withdrawal). A depressed person usually reaches a good level of awareness. However, s/he stops at the transition point before entering the next phase of the contact sequence. As soon as s/he starts mobilising her/his energy, s/he stops her/himself before the action that could satisfy her/his present need in relation to the environment[20]. A depressed person has insufficient energy to go on, s/he lacks the self-support, will and motivation to proceed with the contact process. S/he stays isolated, can't see any future in front of her/him, becomes resigned. S/he is spinning around in a *vicious circle*. The more s/he lacks the energy from the vivid contact with the environment the more s/he is unable to mobilize energy enough to make a satisfactory contact.

A depressed person doesn't manifest her/his impulses and demands visibly but turns them back to her/himself, *retroflects* them. S/he doesn't express openly her/his needs concerning the environment and instead of that tortures her/himself by unattainable demands. That causes another frustration of her/his unsatisfied needs, another decline in self-confidence, will and motivation. The depressive organisation of self is strengthened by this kind of individual-environment interaction and subsequently the person is even more unable to make contact. *A depressed person stops her/himself by retroflection before the action that might lead to a contact.*

2.3.3. The Experience of the Therapist

The usual organisation of the relational field described above tends to repeat in the therapeutic situation too. The therapist becomes a part of the "depressive organisation" of the field.

The usual reaction of the patient's family or other nearest and dearest persons to her/his depressive state is polar. They first want to encourage her/him ("*Come on, it will be OK soon. Let's have some fun, It will help you to overcome this*"). Later, when this effort is not effective and they become exhausted, they try to protect themselves and withdraw from the depressed person (often with more or less hidden aggression).

[20] If s/he actually succeeds in mobilising energy, s/he might try to commit suicide.

The therapist finds her/himself in the same relation pattern and s/he feels impulses to repeat the described reactions to the depressive person. Thanks to her/his awareness the therapist has the chance to step out of this rigid relational pattern and respond differently to the depressed person – s/he remains available for contact, does not blame either her/himself or the patient, does not give up hope. Doing this, the therapist changes the usual rigid field organisation and opens a space for a change also for her/his patient.

Fear is a common initial reaction when dealing with a severely depressed patient. This may take the form of an undefined yet powerful sense of unease or of an intense fear for the patient. Sometimes the therapist may wish to get away from the patient, or to send him/her on to be dealt with by someone else. It is important to frame these experiences in their field context. All of these reactions reflect the therapist's perception of the lack of ground in the relational field. It is for this reason that the involvement of a third party provides a vital anchor (Francesetti and Gecele, 2009; 2010). This may take the form of pharmacological support, supervision, meetings with colleagues or further theoretical training (hopefully including reading this chapter).

Another aspect of countertransferance concerns the side effects of the therapist's placing him/herself in a depressive field. The depressive condition leaves the therapist teetering on the edge of a precipice, feeling a terrible weight pulling him/her down towards into the abyss, the vacuum, a state of solitude, fear and extreme impotence where all sense of direction is lacking. This can lead to feelings of anger, which may result in self-depreciation (*"I'm not up to working with this patient"*) or a loss of faith in one's training and profession (*"My chosen therapeutic approach doesn't equip me to deal with this patient"* or *"Psychotherapy's no use at all with this patient: (s)he just needs medication!"*).

The experiences of a therapist with a depressive patient can be described by an overall metaphor of "magnetic power of depression"[21]. The therapist feels drawn to the patient experience as to a magnet. S/he then either keeps a safe emotional distance by keeping a professional mask, keeping the depressive experience unfamiliar for her/himself and sometimes taking an inappropriate responsibility for the whole situation. Or, the therapist comes closer by sharing the patient's depressive experience to some extent. The therapist experiences falling off, loneliness, helplessness, shame, heaviness. In this case s/he might feel endangered by the risk of "depressive contagion", s/he experiences: *"It is too much for me!"* and reacts by self protection and/or aggression towards the patient: *"She's unbearable. She needs me and I'm here, holding out my hand but she just can't see it!"* or *"Nothing I do is of any use, so she can do as she likes and that's that!"*. The therapist may feel tempted to defy or challenge the patient: *"Ok then, let's see what's stronger: my commitment or your inertia!"*.

[21] Jan Roubal, oral communication, EAGT Conference, Berlin, Sept. 2010.

It is important for the therapist to be aware of her/his own experience and not to blame her/his patient or her/himself for it, because blaming is a distinct feature of a depressive field organization. The therapist can use the metaphor of "magnetic power of depression" and her/his experience would indicate how strong the "magnetic power" of depression is and what is the therapist's position towards it.

The therapist her/himself is endangered in the depressive field organisation. S/he might get "infected" by the patient's depression and get depressed too. There is a clinically observed phenomenon of spreading emotions associated with depression in interpersonal contacts. The "contagiousness of depression" is a theoretical concept that serves as a tool for better understanding and not for blaming the "carrier" of the depression. This concept has been substantiated by meta-analysis of 40 research projects (Joiner and Katz, 1999) which gives sufficient support to the statement: "depressive symptoms are contagious in close relationships"[22].

The therapist's task is to remain present, when it would be so easy to get lost, fall asleep or lose one's temper, without getting depressed, when it is so easy to lose hope. Such a situation represents one of the most arduous tasks faced by the psychotherapist: s/he places her/his own self at the patient's disposition, but in this situation his/her id function encounters an abyss. How can s/he inhabit such a cavity, such an abyss?

All the therapist's experiences should be brought into awareness, because they represent a way of being-with the other in the relational field. The field perspective provides support to the therapist on two counts: it enables him/her to make sense of his/her emotions at the same time as enabling him/her to act. By simply asking her/himself *"how are we depressing together now?"* the therapist brings the situation back into range.

[22] There are diffent hypothesis explaining the mechanisms, e.g. excessive searching for support; excessive self-disclosure; emotional transference; burden; assortative mating; attribution theory, common history; self-verification theory; imitation.

2.3.4. Suggested Therapeutic Approach[23]

Depressive experience is like a swamp for both the patient and the therapist. It is useless to jump in a swamp, to have ambitious therapeutic goals, to push for optimism. The more the therapist encourages the patient to jump, the more the patient sinks. Instead, slow, little movements that patiently look for minor sources of support are needed. The therapist does not force introspection of the patient, does not look for what is not working. This retroflective and self-critical pattern is already too strongly involved.

While working with depressed people the therapist has to emphasise security, structure, and learning. The principle of the therapist's approach is support and appreciation of the effort more than frustration, because depressed people frustrate themselves permanently (Roubal, 2007). During therapy patients first learn how to accept support from their surroundings and then they create a system of self-support by themselves. The work centres around a primary task of creating a safe environment, a safe relational field, in which the patient's self-healing powers can be activated.

The therapist accomodates to the actual capacity of the patient. If the patient is experiencing a severe depression, then the most important thing is just to be present and available with hope. The therapist supports the client to hold a distance from the actual experience, to articulate some thinking about it. Later, when the patient is not totally overwhelmed by the depressive experience, s/he might have the capacity to explore the meaning of the depressive experience within the context of his life and relationships.

Safeguarding the memory of the future is an important therapeutic task. The therapist must pay special attention to making sure that the therapeutic conversation always leaves open chinks through which future possibilities can cast light. If the patient says *"I can see no future – only blackness"* the therapist can reformulate the statement in order to imply a broader horizon in which the

[23] There is a lack of research studies in Gestalt therapy of depression. It seems that the effectiveness of Gestalt therapy is comparable with the other therapeutical methods, for example with Cognitive Behavioural therapy (Rosner *et al*., 1999; Beutler *et al*., 1991). The effect of a therapy based on a supportive therapeutic relationship may be increased by the use of specific interventions focused on emotions in ways that are used in Gestalt therapy (Greenberg, Watson and Goldman, 1998). Greenberg presents the evidence base for emotion-focused therapy (EFT), which he describes as an integration of Gestalt therapy and Person Centered approach. In three separate trials a manualized form of EFT for depression was found to be as effective, or more effective, than a purely relational empathic treatment and a cognitive-behavioural treatment. EFT was more effective in reducing interpersonal problems than both, and promoted more change in symptoms. EFT was also highly effective in preventing relapse (Greenberg and Watson, 2005). Other research indicates the Gestalt approach is especially effective in the therapies of internalizing patients who deal with depression in intrapunitive ways (Beutler *et al*., 1991).

future can be present (e.g. *"just now you can't see beyond the difficult phase you're going through"*). In the therapeutic relationship, the therapist is the guardian of hope but also, more radically, of time and space. This is true not only in the course of a single session, but also from session to session, inasmuch as the therapist holds together the threads which are gradually co-constructed as the therapeutic relationship progresses. Therapeutic time and space become *loci* in which the time and space of experience gradually begin to coagulate once more.

It is important to avoid amplification when describing depressive experiences. The therapist should be very careful in verbalising or reformulating patients' experiences. S/he should confine and limit them to a specific situational frame, since to exaggerate the phenomena would risk further intensifying the experience which already tends to overflow its boundaries. Inasmuch as depressive experiences appear completely cut off from the patient's life, the therapist's task is first and foremost to reconnect and thus to limit them to traceable experiences and events. For example, to the patient's complaint *"I have a terrible weight pressing down on my chest…"*, one might respond by asking: *"How does your breathing change? Are there moments when the pain seems diminished? Can you let me know how it varies over the course of our session?"*.

Alternatively, it might be useful to contextualise that which the patient presents in generalised terms, in order to restrict the experience to specific situations. Thus, for example, if the patient says, *"I feel empty and devoid of energy"* the therapist might ask the following questions: *"In which situations do you feel this emptiness more and in which less? When did you feel it most strongly this week? Who was with you and what were you doing?"*. In short, the therapist should not amplify the patient's interior experiences. S/he does not reinforce retroflection, which only intensify the patient's isolation, but rather brings the experience back to the contact boundary, to the site of reanimation and *inter-esse*.

In the therapy of depressed people the work with *retroflection* is very specific. The depressed patient turns against himself the feelings and tendencies which s/he would need to direct at his surroundings – for example anger or criticism. The therapist examines these relational patterns directly in her/his present relationship with the patient. And in this relationship s/he also experiments with new ways of behaving and relating. The therapist's task is to enable the patient, even in the most incremental way, to express the energy which he experiences within himself. It is important to find, highlight and appreciate even the briefest moments during which the patient mobilises her/his energy for an action which leads to interpersonal contact, for example when s/he directly looks into the other's eyes or expresses his own opinion. The therapist

points these moments out and then leads the patient to the awareness of the process. How has the patient mobilised her/his energy in that particular moment? What did s/he need to make that possible? The patient can come to an innovative experience: *"This little thing is something I coped with. I am not completely incapable of action"*. Slowly and gradually s/he finds his own way to confirm himself, to mobilise energy and move to action. S/he learns how to moderate expressions of her/his energy. However, working with retroflection the therapist must be cautious. The patient needs a sufficient self-support first to handle the retroflective impulses that might be released in therapy (e.g. anger).

The depressed person needs to learn how to protect her/himself in ways other than by isolating himself. S/he needs to learn how to direct her/his experience into contact with her/his environment. If we work with retroflection this way we can re-orientate the patient's rigid contact style in the opposite direction; we direct it outside. The contact sequence that was stuck before the action by the retroflection can now continue. In the safe relationship with the therapist the patient relearns the ability of flexible contacting and withdrawing. Later he gradually uses the support of the therapeutic relationship to try out these new abilities in other relationships as well. The goal is to restore the ability of self to creatively adjust according to the present needs of the organism and to establish the ability for fluent and flexible contacting and withdrawing.

The extreme fatigue which often plagues patients suffering from depression is the consequence, not of anything they have actively done, but rather of their detachment from every situation. It does not derive from commitment and effort – it rather takes their place. Depressive fatigue is a paradox. It is at its height in the morning and increases with the patient's inactivity, finding relief in physical effort. For this reason, to use one's physical energies, to move, to tire oneself physically, is a positive experience for individuals suffering from depression. In therapy, we should take every opportunity to spur the patient on from this point of view, also encouraging him/her to undertake physical activities. This body work can be done in different ways and with different frames. As we have already described, the therapist can seek simply to *get the patient moving.* S/he may seek to promote an awareness in the patient which will increase the sensory and motor possibilities of his/her body. The therapist supports the patient to make a step from mobilising energy to action. At this point, the patient's body will not just be more mobile and efficient, it will also be more alive, free and creative. Here, the focus will be on *the patient's feelings as (s)he moves.*

Then there is another approach, which is specific to the Gestalt approach and has as its final aim an exploration of contact phenomena (Frank, 2001). The focus here is on *the patient and therapist's feelings as the patient moves*

(or fails to move) *towards or away from the therapist.* Work on the patient's bodily experiences is geared towards supporting the journey across the space between patient and therapist. In this case, relational space does not correspond to Euclidean space: a few centimetres of physical distance may correspond to light years of relational distance. The overall effect of this work is not only to heighten the individual's awareness of his/her own body. It is also to bring the body into play in the field of contact, improving the individual's competence in encountering and being-with-the other. The end result is not a finely sculpted muscle tone so much as another kind of beauty: that profoundly real yet ephemeral beauty which springs from the moment at which the other is fully, truly encountered.

When memories about her father emerge, Ada is frozen, blocked in her petrified posture. I ask her to move towards me, but it is too much, no energy supports this movement. I ask which part of my body may attract her. After a while she says "your cheek". I propose she cross the space between us with her hand to reach my cheek. She tries, trembling and slowly she reaches my cheek and suddenly a scream breaks the frozen silence and she starts to cry. It is the first time she can free such a gesture towards a man: until that moment this was an unaccomplished and forgotten gesture cherished for her father.

It is important to highlight again that a Gestalt therapist doesn't see the depressed patient as an object which he researches and to which he applies the therapeutic procedures. The Gestalt therapist works with the relationship between the patient and the therapist. The therapist's task is to ask himself: *How do I co-operate in creating the present form of our relationship with the patient?* So in the case of the depressive patient the therapist asks: *How do I contribute to the fact that the patient who is sitting in front of me is retroflecting and stopping himself before action? How are we depressing together?* The therapist then investigates these patterns of relating in the here-and-now therapeutic relationship. Moreover, in this relationship he also experiments with new, unusual ways of behaving and relating.

Accepting the current emotional state of the patient can serve as an example. The therapist takes seriously all of the patient's complaints about low mood, inefficiency, and low self-confidence. But the therapist does not console and does not become resigned. He does not, as far as possible, repeat the reactions the patient has been familiar with in his environment and which again and again supported him in a fixed *Gestalt* of depression. The patient's family tries to console him: *"It's not as bad as you say. Don't worry, everything will be fine soon".* But when the depressed person continues retroflecting and withdrawing from the contact, his close ones resign and send him to a specialist. By doing this, they again strengthen his rigid depressive pattern.

The therapist avoids repeating these patterns. Of course, during the course

of therapy s/he will be seduced by the patient to console him or to become resigned. However, based on her/his awareness s/he can liberate her/himself from reacting automatically to the patient and s/he creates a free space with the potential for a different way of relating. That enables the patient to step out of the rigid depressive pattern.

The therapist is opening up the possibility of activity through an awareness that client and therapist are together co-creating events as they are unfolding. This having been achieved, the action taken may be something as simple as staying awake, as retaining the capacity to think, or of seeking the support of a third party as the therapist comes near to the depressive abyss. In this way, the therapist doesn't lose hope of eventually reaching the patient, and is able to remain at his/her disposition. This continued ability to hope and to be present (despite the abyssal absence of the other) is the very foundation of therapy when dealing with severe depression.

2.3.5. Clinical Case Example

Clara suffered from an episode of severe depression just before sitting her A' Levels. After a course of pharmaceuticals and a brief period of psychotherapy, the same symptoms recurred. This was when I[24] first met Clara and we began working together.

After two evaluation sessions, I ask her if she would be interested in beginning psychotherapy with me. She takes a pause, before answering, *"I don't know…"*. Her voice is a thin and desperately fragile thread, which only just cuts through the space between us. I crane forward as much as I can, in a bid to catch her words before they fall into nothing.

T: *"At our first meeting, I told you we'd get together three times before deciding whether we wanted to carry on working together. Do you think you need help at the moment?"*

C: *"...I don't know…"*

T: *"Do you feel there's been any difficulty between us so far?"*

C: *"...I couldn't say..".*

It is clear that my questions are arising from a neurotic dimension of experience, but that is not where we are at the moment. Before each *"I don't know"* a pause comes, in which Clara seems to go looking for clues in her own feelings, but to come away with nothing. Her self is unhinged from the id of the situation – it is without body. I find myself in doubt and come to a halt: Clara needs a therapeutic relationship, but is unable to formulate any questions. My mind, instead, is filled with a whole series of questions: *"Can I choose for her?*

[24] G. Francesetti.

Would that be therapeutic? Would it be ethical? Who am I to think I can help her in this situation?". I reach a decision.

T: *"Ok. Let me tell you what I think we could do. How about if we work together for the next six months and then weigh up whether or not it's worth going on?"*

C: *"Ok. Alright"*

Clara remains emotionless, nothing ever changes for her, as far as I can make out. Yet I feel a certain relief. Perhaps if I bring it into the field, we'll be able to move forwards. I don't want to breach the question of pharmaceuticals right away. I mentioned right at the beginning that we might need them (I use the pronoun "we" knowingly), and I know that at this moment this is a decision which I will have to make alone. I am worried about Clara, but I do not think she is a suicide risk. Everything has ground to a halt for her, and she has no intention of flight. I decide to wait. I feel a profound tenderness for Clara. Sometimes her pain and loneliness touches me so deeply that I could cry.

Three months later:

T: *"We'd left the issue of medication on hold. I think pharmaceuticals might give you a bit of relief. What do you think?"*

C: *"I've already tried that. They did help a bit for while… but then I got ill again. I'd rather wait…"*

I'm overjoyed by this answer. Although I would really prefer her to follow a course of medication, this is the first answer in several months which has shown any trace of her ego function and has been supported through recourse to memory. She succeded in making a minor, but such a desirable step in the contact sequence – an action toward a contact.

T: *"Ok. We can wait and see how it goes…"*

Much to my surprise and curiosity, Clara's eyes suddenly light up.

T: *"What's going on Clara? I noticed a glint in your eyes"*

C: *"I was surprised by your answer. I didn't think you'd agree"*

T: *"And how do you feel about me respecting your preferences?"*

C: *"It seems strange…"*

For the first time, her eyes are damp. The temperature between us rises, a shared warmth wells up from the depths of our togetherness. I breathe in. Each one moves the other while we move together. Clara gives me a fleeting smile.

3. Depressive Experiences in Subjects with a Dependent Relational Style

For a more thorough study of the various relational styles, we would refer

you to the other chapters in this book[25] (see also the introductive chapter 29 on personality styles). We have to keep in mind that a personality style is an expression of a field that has become fixed: the therapist, despite his deliberateness, is continuously attracted to co-create the field carried by the patient, even in its dysfunctional parts. And, at the same time, the easiest view on what is happening in the therapeutic relationship is to think that the responsibility of the contact dysfunctions is up to the patient. This way of thinking is not respectful of the process of co-creation and neither supportive for new creative adjustments. For the time being, we will limit ourselves to a consideration of the form which depressive experiences tend to assume in the presence of a dependent modality of relationship[26]. This relational modality arises from an experience of relationships where it has been impossible to express one's own vitality and energy spontaneously and in which one has been coerced into accepting an externally imposed set of rules as one's own. If it is chrystallised and repetitive in nature, a person develops a dependent or introjective personality style. We could even go so far as to refer to this modality as the *depressive modality*, considering how frequently it leads to depression[27].

These people have learned to allow only such experiential figures to emerge which are compatible with their introjections (Perls, Hefferline and Goodman, 1994; Polster and Polster, 1973), and are unaware of the extent to which they are suppressing their own feelings. In this way they lose sight of the creative potential of the present situation, losing energy, impetus, interests and vitality. They often experience problems with their sexuality, both because it is difficult for them to experience their own bodily excitement and because their lack of relational aggression makes it difficult for them to approach another's body. Low self-esteem is very common in these cases, and a great deal of work is often required to chew the introjections and to anchor their self-esteem in their feelings and critical faculties.

In these situations, depression becomes a norm. It is not acute, but it is long drawn-out[28]. It is often more evident to third parties than it is to the subject him/herself. It is a condition of reduced vitality that impedes the flow of aggressive spontaneity. Usually, the environment plays a role in sustaining this fixed adjustment, i.e. in the couple the partner always knows what is good and what is wrong for the depressed person and at the same time is complaining

[25] See also Francesetti and Gecele, 2011.

[26] We are here referring to dependent relational style, as opposed to addictive behaviours, such as those related to addictive substances or dysfunctional compulsions (betting, internet, sex etc.). These behaviours usually emerge in relational styles which are more frequently borderline or narcissistic than dependent.

[27] This might correspond to the new category which has been proposed for the next edition of the DSM: namely, *the depressive personality*.

[28] It could be classified as Dysthymia in the psychiatric diagnostic systems.

about the depression. In these situations, underdog/top-dog dynamics frequently arise (Amendt-Lyon, 1999; Polster and Polster, 1973). The subject cannot reach the other because s/he starts off from introjections which freeze out his/her original feelings rather than from the light and strength of his/her own appetite. In his/her history, the only way to reach the other involved adopting a regime which castrated his/her vitality to the point at which it was entirely forgotten.

Therapy should consist in sustaining feeling, awareness, desire and choice, in teaching the patient to differentiate that which is one's own from that which is not, that which is desired from that which is not. A focus on the id function of the self, in a non-psychotic dimension will soon reveal the patient's vitality and his/her anger at what has been forced on him/her. It is fundamental that the therapist sustain the patient's aggression[29].

Particular attention should be paid to two points. Firstly, aggression should be sustained by the body – should be made incarnate. Only through corporeal sensation can aggression be sustained and regulated in a relationship. Secondly, the therapist must avoid straying into an individualistic perspective. Undeniably, in these situations the subject is in need of emancipation, needs to feel him/herself live and autonomous, free and capable of self-determination. However, at the same time, we must not forget to sustain the individual's sense of him/herself as being ever in relation to the other, to his/her own history, to the situation. This is particularly important for more vulnerable patients, who may accept the therapist's advise uncritically, "freeing" themselves from relational ties prematurely or unnecessarily because, introjectively again, they believe this is the right thing to do. Whilst this might represent one way to free oneself of introjections, it is nonetheless a kind of introjection in itself and thus removed from feeling and from the authentic direction which the subject wishes to give to his/her own life. The therapist has to put a lot of attention to not become a new environment that, again, supports the same old dysfunctional style.

Comment

by Joe Melnick

I appreciate the thoroughness of this chapter and especially the authors' understanding of the complexity of the label depression*: how it ranges from the biological to the situational and how it can easily be confused with sadness,*

[29] To be understood as the impulse provided by contact intentionality rooted in one's own feelings and ability to deconstruct introjections. For a detailed consideration see Spagnuolo Lobb, 2011a; 2011b.

grief and mourning. (As an aside, it can also be confused with chronic exhaustion – a close cousin). Their insistence on viewing it as a description and as a label for an ongoing experience that consists of low energy and an inward focus is important. So, too, is their emphasis on the Gestalt concept of creative adjustment; these individuals are doing the best they can, given how they experience their world. A depressive way of living was originally an attempt to creatively solve a problem.

Of a more practical nature, I found their suggestions on how to work with individuals who relate depressively – how to create and maintain a therapeutic relationship – useful and often illuminating. So was their emphasis on therapist self-care; how to not "catch" the depression themselves.

They describe the depressive experience as one of detachment from self and others. Therefore, one of the therapist's first tasks is to create the conditions in which the patient cares "just enough" – not too little and not too much. At the same time, the therapist must also regulate his/her caring.

They suggest that therapists notice instances when patients are not "depressed". I would like to underscore this point. Even in the most depressed of us there are glimmers of light. It is important for the therapist to notice these times, bring them to the patient's awareness, and work with them. Even in the most fixed of gestalts*, there are unfixed, creative moments.*

They understand that an ongoing depressive experience is, at its core, a loss of appetite*: an inability to taste fully, to move towards another, to have resiliency, to bounce back and to mobilize. The work is to help the patient taste again, in the fullest sense of the word: to become interested and to care.*

There are three places where I differ slightly with the authors. First, all therapy – especially Gestalt – focuses on the management of energy: the patient's, the therapist's, and the "in-between" (the energy that is created and shaped between them). People whom we label as depressed have low energy throughout the contacting process. Their ability to move through the contacting cycle, to experience a range of sensations, to be aware, to mobilize, to act, to form a figure, to make meaning, and withdraw, is limited. Their energy is low, not just around the mobilization phase as the authors suggest, but at different "stages" throughout the cycle, depending on the individual patient's relational dynamics. Therefore, therapists can use the contacting process as a template, where they can map the patient's process. Therapists can then look for places in the patient's contacting process where the patient's energy is low and use it as a diagnostic indicator and a place to focus the therapeutic work.

Also, the authors say that the depressed person «usually reaches a good level of awareness» (p. 16). This statement puzzles me. Some patients do, but many don't. To become aware is, to some degree, to mobilize and generate energy.

More confusing is their insistence that much of a depressive experience is retroflective in nature. It sounds like a broadening of the old "depression is anger turned inward" chestnut. Of course this is true in some cases; especially those we call "agitated depression". However, retroflection takes energy. Although many depressive experiences involve a negative self-absorption, most involve a lack of energy, interest, and caring – about both self and others. I believe the therapist's job is to create conditions where the patient is supported in noticing his/her movement through the contacting process and to teach the patient how to focus his/her minimal energy on someone or something other than him/herself.

The most difficult situation that a depressive process creates is the potential for suicide. It is at these moments that many therapists wish that they had chosen another profession. I would like to end with a recent experience I had with a suicidal client that supports their description of the work.

He entered therapy because he was depressed. He had reason to be: a lost job, a failed relationship, and trouble with his adult children. Two months into treatment he revealed that he had been hospitalized three times previously for serious suicide attempts and he was seriously contemplating suicide.

I quickly became mobilized. We talked of hospitalization. He refused to go and said that if I tried to hospitalize him he would deny our conversation. I strongly suggested medications. He replied that he had tried them, that they had never worked, and that he would not try them again. I suggested exercise, a support group, spiritual direction, etc. He kept saying no. Soon I got it. No suggestions. They were more for me than for him.

I tried to get him to agree to call me or the emergency room if he was serious at the moment. He refused. I tried to get him to fantasize about how his two adult children would feel at his funeral; still to no avail. I felt trapped and powerless, much like him. I discussed how I would feel if he died. Finally, in desperation I explained to him that I could not continue working with him under these conditions; I would not take on his depression. I would need him to agree that if he were going to kill himself, he would have to terminate with me first and wait one month so that I would not feel responsible.

He seemed surprised and said that he needed time to think about my proposal. Two sessions later he agreed. I like to believe that I was finally able to get him a little interested in me. The story does have a happy ending, at least up to now. Although still out of work, he has reestablished contact with his children and is in a new relationship that he reports on with a mixture of joy and terror. I am not sure what shifted in him. I sometimes think of asking him if he would rather be terrified or depressed. I haven't yet.

Bipolar Experiences

by Michela Gecele

1. Introduction: Historical Considerations and the Complexity of Definitions

For many centuries, the word "mania" was used to mean madness in the widest sense of the term. In Ancient Greece the various forms of mania-madness were believed to be connected with the transcendental, with the more vital and complex aspects of human existence.

Kraepelin is considered the "father" of what today is called manic-depressive psychosis. In the 1800s though, these clinical profiles had been studied by many scholars, who identified their characteristics, frequency and patterns of progression in different ways (Haustgen and Akiskal, 2006). The clinical condition that would later be defined hypomania was first extrapolated in 1866 by Falret from the clinical profiles that Esquirol had called *monomanie raisonnante* (*ibidem*). At the beginning of the nineteenth century, Stark used the term "hyperthymia" for what Kraepelin proposed should be defined "constitutional excitement" (Angst and Mameros, 2001). Today, hyperthymic temperament is considered a trait, whereas hypomania is considered a state (Fritze, Ehrt and Brieger, 2002).

A continuum exists from "normal" to "pathological" mood states (Gamma *et al*., 2008). Episodes similar to hypomanic states, though without the pathological connotations, can occur in the lives of people who are high achievers professionally (Mansell and Pedley, 2008); while traits and behaviour patterns considered clinical symptoms of hypomania are widespread across the population without clinical problems (Wicki and Angst, 1991; Udachina and Mansell, 2007; Gamma *et al*., 2008). The DSM IV, however, defines hypomania as a pathological state very close to mania, distinguished solely by the degree of its symptoms. More recent publications (Jamison, 1994) use terms such as "hypomania", "hyperthymia", and "hyperthymic temperament" to define the energy and transformational drive that creativity and artistic inspiration can give. In doing so they evoke a connection with the inspired mania of Plato's Phaedrus.

Any choice of approach or terminology will necessarily involve preconception. To talk of mania and hypomania implies defining these experiences as pathological, despite the exceptions we have identified. To talk of well-being, euphoria or excitement, in contrast, poses the risk of neglecting the hazards that these same situations present. Here we will use the term "hypomania" arbitrarily to identify a range of experiences that allude to creative adjustments of varying functional effectiveness. Understood in this way, hypomanic states can be an experience of well-being, an expression of discomfort at the contact boundary, or a first step towards further, potential decline. The difference between hypomanic states – in a pathological sense – and the sense of well-being is given by a diminished or augmented presence at the contact boundary, by the presence or absence of adequate support. Soaring well-being can risk crashing if insufficient resources are found at the contact boundary to sustain such an expansive mood.

Manic episode, DSM criteria

A) A distinct period of abnormally and persistently elevated, expansive or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).

B) During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:

1. inflated self-esteem or grandiosity;
2. decreased need for sleep (e.g., feels rested after only 3 hours of sleep);
3. more talkative than usual or pressure to keep talking;
4. flight of ideas or subjective experience that thoughts are racing;
5. distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli);
6. increase in goal-directed activity (at work, at school, or sexually) or psychomotor agitation;
7. excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C) The symptoms do not meet criteria for a Mixed Episode.

D) The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

E) The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count towards a diagnosis of Bipolar I disorder.

2. Relational Intentionality in the Manic Experience

The impossibility of reaching the other (Francesetti and Gecele, 2009) offers a specific key to unlocking the vast territory formed by depression-related suffering.

If the dance that emerges at the contact boundary does not move to its own unique rhythm, bringing the movement of the various members of the field into sync, if a reciprocal synchrony is not established in a relationship, then intentionality will be frustrated.

When development is marked by a failure to achieve such synchrony, the very impulse to live is affected. Such an early, devastating experience of being unable to reach the other inhibits the experience of "us"[1] as a support propping up the narrative of self continuity, which can ultimately lead to a rupture between the mind and body, between the individual and the world.

Is manic experience simply a polar reaction to a depressive state, or does it imply an underlying relationship – in the past or in the present – that makes the elevation of energy and excitement possible? In this latter case, does the relationship provide true support, or is it a confluent us? The hypomanic sense of "excessive well-being" may be a compensatory reaction to the impossibility of reaching the other, or it could be tied to the presence of relationships that give and have given support. In this latter case, the manic experience is also impelled by a "drive towards", by an intentionality that does not, however, persist sufficiently to give direction. Excessive drive and too much energy without direction ultimately shatter experience. The movement becomes afinalistic. If, as happens in the most extreme cases, intentionality is frozen or becomes fragmented, figure and ground are lost, as are time and space, the world and its inhabitants. For relational intentionality determines the emergence of figures; but it is also the ground that gives each new figure time to emerge, and collectively time to create a pattern. In the manic's suffering, depressive "death" and freezing are avoided by "killing off" the relationship, in a superhuman effort of life beyond life itself. The relationship is killed off in the sense that it is emptied of its meaning and multiplied into a thousand hollow simulacra. The extreme effort, energy and drive of the manic experience are channelled into overcoming the fragility of relational intentionality, the dissolving of the contact boundary.

If the broad, gradual nature of the depressive experience is seen as a means of saving energy in fields where contact has become difficult, then mania is the failure of this creative adjustment. However, even increased drive, dispelled energy, and effort beyond hope can be seen as a functional creative adjustment within a field. For it is precisely by withdrawing that relational intentionality

[1] The experience of "us" (you and me together) opens up to relationality, to living and assimilating the possibilities at the contact boundary.

makes a last, extreme effort – though it is difficult to say with what support or due to what lack of support. It is as though the person having the serious, extreme manic experience brings into the field all the energy that was lacking in her repeated experiences of not reaching the other during development. In doing so, however, all that excess drive leads the person to overstep the temporal boundary of human experience.

3. Introjects and Mood Swings

Creative solutions to life are adopted at the contact boundary during development, when the relational field extends from the family circle to encompass the world. In this process, learning cultural models and social rules is important, as they help simplify reality and make it easier to deal with the world. Introjection is normally seen most of all as a drop in relational intentionality, as one of those losses of spontaneity that we call "interruption to contact" (Spagnuolo Lobb, 1990). There are, however, introjects whose acquisition is fundamental for development. They are functional to the need underlying the relational intentionality. In these cases, what bursts in from the outside does not do so in a constrictive way, blocking the experience underway and shaping its contents and meanings (Robine, 1977).

The id and personality functions of the self can also be "occupied", to different degrees and in different ways, by introjects. If these introjects dissolve away, the ego function is left with diminished support. Even the "impossibility of reaching the other" can be understood as an introject, as the crystallisation of an impossibility that then becomes the ground for subsequent introjection. These "foreign bodies", which life experience can modify but only partially and with great difficulty, can sometimes become figure, and by emerging they cancel out the rest, becoming, quite literally, master of the field. Where this happens, depression takes hold. On other occasions these foreign bodies can suddenly dissolve or be expelled, releasing into the field more energy than can be sustained. The heightening excitement that results may be channelled into afinalistic efforts, into movement without direction. At its most extreme, all introjects are dissolved in the manic experience – those relating to resignation and depression, those tied to custom and habit, and possibly even those connected with the structuring of time. At that point what would be left?

Especially if a large part of what constitutes the very makings of the functions of the self had been structured in relational fields that did not sustain assimilation. Instead they led to material being swallowed whole, over and over again.

Binswanger (1994), reporting the words of a patient in a manic phase, talks of how easy it all is when the "blindfold" falls away and the "grey-coloured

glasses" are shattered. He tells us of the void that opens before our human eyes when all the filters through which we understand and construct reality are taken away.

The effort needed to shake everything off, including those relationships that "kill", takes us to the boundaries of human experience, to a "brutal" potential of life. In this way the sediment that contributes significantly to defining the specific "character" of an individual is also swept away. Even Freud, in *Mourning and Melancholia* (1953), associated depression with an introjective sort of mechanism (Ferenczi, 1916), and the manic phase with the rapid release – and consequent sense of euphoria, elation and triumph – of energy and space formerly occupied by the *introject*. In depressive states, a part of the self is occupied by something fixed and rigid that comes from the outside. In early psychoanalysis, this was everything which was not intrapsychic. For Gestalt therapy instead, what is occupied is the field, the contact boundary.

Shifting perspective, the partial reduction of life into stages and roles that can be controlled, defined and introjected represents, in all social contexts, a defence mechanism against the complexity of life (Remotti, 1993; Gecele and Francesetti, 2005). Social success and confirmation, achieved by fulfilling roles, can bring euphoria, heightening energy, excitement and the sense of well-being. This may apparently contradict the theory of mania as a phase in which introjects are dissolved, but this is not the case. It is true that letting go or reducing our grip on social constructions can raise energy levels, but quite often, adjusting to external norms and values can be so reassuring that it dissolves introjects tied to self-definitions premised on limits and negativity, on feeling small and inadequate[2].

4. Time, Body and Vital Rhythms in Mania

Changes in the sleep-waking cycle are a key sign of the possible onset of mania (Wehr, Sack and Rosenthal, 1987; Jackson, Cavanagh and Scott, 2003), representing both a cause and effect (Feldman and Eidelman, 2007; Feldman, 2007; Armitage *et al*., 2009) of mood changes.

In hypomanic experiences, the next consists of multiple potentialities; with mania, however, these potentialities collapse – eliminating the intermediate space of expectation – into the here and now, fragmenting reality, relatedness and time. In the passage from hypomania to mania, time flattens into the *infinite succession of nows* that is characteristic, according to Heidegger (1953), of

[2] «As a whole, the self has been defeated, for its conflict has not been allowed to mature and become some new positive thing; but the identifying self can now say "I am the victor"» (Perls, Hefferline and Goodman, 1971, p. 380).

inauthentic experience. What is lost is the chronological succession of events, the boundary of non-simultaneity, and above all the full, shared experience of time (Binswanger, 1994). This in turn denies the sufferer the freedom to stop and experience contact, the now that comprises the past and opens up the future (*ibidem*). Expectation does not exist, absence is eliminated (Salonia, 2004b). What follows is flatness, sterile repetition, direction lost in the void. The continuous succession of stimuli that race through the manic experience creates the illusion of speed, which in reality vanishes into a fixed, false present. In this vortex of vacuous movement that brings to nothing, body and world are lost. The body ceases to include a history of past movement that stretches into the future (Merleau-Ponty, 2002), acquiring instead a sort of estranged life, outside the relatedness of shared space-time. Many of the parameters that define mania concern the relationship between the body and the world – changes in the sleep-waking cycle, in action, speech, sexuality and eating patterns. What unites them is a lack of pauses, of the sense of satiety, of limits.

Respiratory and digestive processes, hormonal balance, and circadian rhythms (Goodwin and Jamison, 1990; Leibenluft and Frank, 2000) are affected by the social context and relationships (Spagnuolo Lobb, 2001), during both development (Tu *et al*., 2007; Feldman and Eidelman, 2007; Feldman, 2007; Armitage *et al*., 2009), and adulthood (Ehlers, Frank and Kupfer, 1988; Malkoff-Schwartz *et al*., 2000). Scientific research into chronobiology intersects with phenomenology (Schneider, 1959; Scheler, 1973; Borgna, 2008b). In both disciplines, it is the mechanisms connecting us to the world, and the possible disconnections, that are studied and described. The underlying somatopsychic affective disposition is also driven by the degree to which various internal rhythms are synchronized with each other, and with external, natural and social rhythms (Kripke *et al*., 1978; Roenneberg, Wirz-Justice and Merrow, 2003; Wittmann *et al*., 2006; Grandin, Alloy and Abramson, 2006). These rhythms start to develop in the earliest months of infancy (Glotzbach *et al*., 1992; Recio *et al*., 1997; Rivkees, 2004), representing linkages with the environment and other human beings. They are the ground for relational intentionality itself. Minkowski (1933) uses the expression *contact affectivity* to describe «that ground that ties us to the world». Lifetime events can determine changes in both social and biological rhythms, promoting the onset of a first manic experience. Subsequent episodes then tend to become increasingly independent of events (Post, 1992; Malkoff-Schwartz *et al*.; 2000; Alloy and Abramson, 2006).

In the most "pathological" forms of mania, biological rhythms are lost altogether. Instead, in conditions of elevated well-being and hypomania, rhythms tend to readjust themselves, in much the same way as what physically happens

with the changing of the seasons[3]. Indeed the onset of hypomanic and manic states often begins in spring, when darkness starts to give way to light. People who suffer from seasonal patterns of depression (Westrin and Lam, 2007) react more strongly than average to seasonal changes, in a way that is much more similar to other mammals (Wehr *et al*., 2001). It is as though in these cases, natural synchronizers outweigh social rhythms, which are normally so important for humans (Ehlers, Frank and Kupfer, 1988; Grandin, Alloy and Abramson, 2006; Frank, Swartz and Boland, 2007). Hence it would appear that biological rhythms can go "haywire" if the springtime urge for renewal is not sustained, if life experiences that gravitate around the personality-function are not congruent with experiences connected with the id-function. In the absence of adequate support, the unity of experience is split into a bodily-biological part and hollow encasements of social roles, emptied of all presence at the contact boundary.

5. Figure and Ground and the Functions of the Self

In manic states there is no distinction between figure and ground, because stimuli are not selected or filtered. Figures do emerge, but the process is continuous and so quick that they cancel each other out. The uninterrupted movement from one figure to the next evades – in what is a sort of creative adjustment – the perception of the impossibility of reaching the other. Such avoidance, however, signifies a void at the contact boundary. For what is avoided is the perception not only of an absence, but also of the presence of the other.

If the impossibility of reaching the other is experienced during development, experiential skills and structures connected with the various stages of development will be introjected instead of being assimilated spontaneously at the contact boundary (Frank, 2001). This process places limitations on and impairs the potential of the id and personality functions. When these functions are overcome with introjects, they are less able to play their fulcral and supporting role for experience; the plasticity of action is lost as they stiffen and become structure. The creativity and spontaneity of the self is diminished. At the same time, introjects are crutches that the self has learnt to rely on to function, albeit in an impaired, less effective and less spontaneous way. The dissolution of introjected material and structures paves the way for both potential and risk. Risk heightens when introjects dissolve away together, or over a short amount of

[3] «The body has also seasonal or circannual rhythms. [...] Many of the body's chemicals, such as cortisol, testosterone, thyroxine, and serotonin, have yearly fluctuations. The adjustments of these and other chemicals to seasonal changes in light affect our health, mood, sleep, and sexuality» (Hyman, 1990, p. 16).

time. In such cases, the potential that floods into the field drowns the functions involved in creative adjustment, not only because it is excessive with respect to the support needed, but because it undermines their own work. A partial, even temporary, loss of the personality function means losing narrative and past, and hence direction. Any diminishment of the id function, on the other hand, will impair the ability to relate to the world through the body and chronobiological rhythms. Without the support of the id and personality functions, the ego function risks being lost. To simplify, three different situations can be identified:

- A predominance of the ego function of the self, supported by id and personality functions that have been structured primarily through assimilation. This is the case of what we have called hypomanic states or the sense of well-being, where the self has not lost its spontaneity at the contact boundary. Here, distress will be experienced only where imbalances arise between the functions of the self, the level of support available in the field, and the degree of risk and novelty faced.
- An imbalance between the ego function and the other functions of the self, which are lacking. Spontaneity is diminished and experience becomes hollow. Figures emerge continuously, only to dissolve into nothing, shattering the sense of orientation into myriad directions. The contact boundary is characterised by suffering.
- Imbalances at the contact boundary increase taking suffering up to a higher level, where the ego function is fragmented and dispersed. Figures are merely sketched out; spontaneity and effective action are inhibited. The contact boundary is marked by a void.

6. The Importance of the Social Context: Connections Between Mania and Personality Disorders

The diagnosis of personality disorders has become so pervasive in our society[4] that is worth considering areas of intersection between this type of suffering and manic experience. How can mania be distinguished from a personality disorder? And how can we constantly bear in mind the possibility of both occurring together?

More than in any other situation, family members, friends and colleagues tend to put down to the character of manic sufferers traits that we therapists

[4] In our narcissistic and fragmented society (Lasch, 1979; Salonia, 1999; 2005a), the rhythm of the contact cycle is often lost. The pivotal points around and through which we construct narratives, and from and to which we ferry ourselves around the world, are fragile. The result is a weak and fragmented personality-function.

recognise as pathognomonic symptoms of illness. Manic people would appear to be "just like that".

The definition of personality disorder covers specific types of experiences from our own social context as well as pathological profiles that in the past were understood in different ways.

We shall limit our analysis here to the latter – to "narcissism" and "borderline personality disorder" – due to the complexity of their historic and clinical implications, but also because of the way they intersect with mood disorders.

The manic experience of people who structure their relational fields in a predominantly narcissistic way is a model of reference that can also be used to consider other personality disorders. The feeling of not counting, of virtually not existing, when faced with a person in a manic state, as we spoke of earlier, takes us very close to a description of the relational field that covers the narcissistic experience. The impossibility of reaching the other, described repeatedly in this chapter, also leads us to this point. People who experience extreme mood swings fight back the shame of being "small and needy" in much the same way as those who structure experience in a narcissistic way, banishing the feeling of shame to the depressive phase, and bearing no memory of it in other phases. Manic phases can therefore be a period of lesser suffering, compared to a long phase of depression. In other cases, self-esteem built on the sacrifice of the spontaneity of the self (see note 1) is shattered, giving way to an awareness that leads to depression, but also to life.

In all personality disorders, though most specifically in narcissism, introjective processes appear during development, in which parts of the environment are used to fill in the empty gaps.

The impossibility of reaching the other is an experience shared by all personality disorders. The styles of contact that ensue take the structure of introjects, which often perpetuate and exacerbate the emptiness that they were meant to fill. The therapeutic relationship must necessarily focus on the ground (Salonia, 2001a; Spagnuolo Lobb, 2004b), on the long, frustrating work needed to modify the field, clearing it of the detritus built up from frustrating relational experiences. There is a fine line between relational support and the risk posed by the relationship – a line that is all too easy to cross.

Borderline experiences can be seen as halfway states between depression and mania (Smith, Muir and Blackwood, 2005), between the continued attempt to reach the other and giving up in resignation. Developmental experiences are shaped by the ongoing alternation or overlapping of the risk of abandonment and the risk of invasion by the other. Dysphoria – an intermediate experience between depression and mania – is a common mood state for people whose experience of relationships is mostly borderline. Experience is depressive, but there is energy at the contact boundary. Then again, the feeling, at certain

times, of being free from both the invasive other and the abandoning other can lead to bright, light-hearted, though sometimes fatuous, periods of hypomania.

7. The Therapeutic Relationship

In this section we will seek to use a dual polarity to guide us. The first polarity is that between the acute phase and the intercritical phase. The second is that between creativity and adjustment.

During the acute phase, on building the ground, and not the figure of contact. Hence it is "sufficient" to stay by the side of the other, with awareness, while facing the risk of emptiness and anxiety. "Being with" means weaving a narrative, instant after instant, and keeping memory and sense of time also for the other. The focus of therapy is on not being sucked into the void of totalising situations – those which absorb all the energy in the relational field, along with its meaning, direction and potential. Hence specific techniques are not required, and pharmacological treatment is fundamental. Feedback is not easy to grasp, to gauge whether the person experiencing a manic state has been reached by something or not. It is also difficult to understand to what extent thought, racing so fast that it risks blockage, can pause to grasp a word, or a gesture; or to what extent an action, incessant to the point of bustling futility, can be modified by a presence. It is worth persisting though, acting "as though" it can, as though our words and actions can reach the contact boundary and affect it. In certain moments contact is possible – it happens, we feel it. Then it seems to vanish without a trace. But does it? Sometimes this can be understood afterwards, during intercritical phases, by rebuilding together the possibility of memory. Other times the question remains buried beneath an experience that is unable to become narration or memory.

The most striking expressions of mania can lead to isolation from the social world. These are extreme, rare situations in which it is disorganisation and incoherence that principally emerges. The boundary here with other psychotic states is faint. Support therefore consists of very basic containment, focusing on biological and social rhythms, on bodily care (Ehlers, Frank and Kupfer, 1988; Biddle, 2000; Frank, Swartz and Boland, 2007), and on the environment. Such support is also fundamental in the event of hospitalisation, which can be necessary in the most serious cases. Think, for instance, of how falling asleep is the time of the day when anxiety gushes to the fore most insistently through the web of the expansive reaction.

Another aspect to be underscored is the importance of giving family members support. Very often family members need to be relieved of their sense of responsibility, so as to prevent their transformation from friends and relatives

into therapists or guardians. That risk grows all the more if adequate external support is lacking, and in the long term can even lead to the very opposite result: the abandonment of the sufferer.

During intercritical phases it is important to shift the focus onto the assimilation and integration of experiences, including the most painful and estranged, and on preventing the return of manic episodes. This means watching for early warning signs of relapse, such as less need for sleep, rising self-esteem, elevated energy and growing activity. That is, when well-being risks overflowing into excess energy (Frank, 2005; Frank, Swartz and Boland, 2007). The ability to catch and contain early signs of expansive changes in vitality and mood reduces the risk of overstepping the boundary between well-being and suffering. People who slow down the pace and limit their commitments manage better at preventing recurrence. Instead those who acritically embrace their sense of well-being and the possibility of raising their activity levels are more likely to overstep the boundary of psychopathological suffering (Lam and Wong, 1997; Lam, Wong and Sham, 2001, Morriss *et al*., 2007).

Assimilation interrupts and hinders what we described earlier as the continuous emergence and dissolution of introjects. During intercritical periods, it is important to build a relational support structure capable of containing the risks, fears, desires and potential connected with the possible return of manic episodes (Spagnuolo Lobb, 2008b). Building a relational ground is a prerequisite for sharing to become, when a crisis arrives, a support for the person in their effort to maintain the sleep-waking cycle and social rhythms, where necessary also with the help of pharmacological treatment. If no containing relationship is built, the effort needed to prevent the crisis might still be made, but it will entail giving up much more at the contact boundary. If fear predominates – the limiting aspect of adjustment – the price of preventing the crisis will be a loss of potential, of a part of the self. The risk is that during intercritical phases, performance – at the work, relational and social levels – will progressively decline, and a process of restriction and resignation will unfold, a pervasive and ongoing retroflection.

It is when the sufferer begins to remember, accept and integrate the manic experience that recovery begins. The lost parts of the self reappear at the contact boundary and possibilities once again bloom. The bipolarity of the mood swings, however, seems to pervade the way that manic experience is lived, perceived and remembered. On the one hand we have suffering, shame – for one's behaviour, for having lost control – and a desire to conceal one's limitations; on the other we have efforts to protect what is creative and vital. These two polarities exist side by side in intercritical phases, emerging together at the same time in the relationship, or in rapid succession. Often, when a manic episode is imminent, people experiencing well-being or hypomania are afraid of

being "pulled down" into the depths of depressive despair. This is why they might choose to avoid therapy and act without the caution that can help prevent the onset of symptoms or their aggravation. At other times, in contrast, the possibility of being welcomed into a relationship is a moment and encounter that they have long desired. A way is opened up of legitimating suffering and effort, of giving breathing space to a mode of being in the world (Baalen, 2010). The sufferer brings many relational experiences into the field, all trapped within the polarity of impotence and grandiosity.

These processes can be seen more clearly through the following case examples.

When we met, Laura was going through a manic phase. Through previous crises, the dynamics of her relationships had come to take on a consolidated, repetitive pattern. As soon as Laura's energy levels began to rise, together with her reactivity towards him, her husband would seek medical help. In this way his wife was labelled as ill and her behaviour, thoughts, and words were pigeonholed with reference to the illness. This pattern was reinforced every time Laura's husband's calls for treatment were endorsed. Then again, it was difficult to resist the voice of "normality", subsequently underscored by Laura herself as, once the manic phase was over, she would always return to her role in the family and to family dynamics. The effort made to support the patient in legitimising her thoughts, experiences, and behaviour immediately changed the field. Support in this case came not only through the therapeutic relationship, but also from the role of the therapist – as psychiatrist, working in a public service, and as, therefore, an institutional interface with the world. Her husband thus lost his privileged role, and the vicious circle was, in this way, interrupted. What emerged was the distress afflicting the marriage relationship, the suffering at the contact boundary.

It was a matter of creating space for possibility, for at least imagining change, to understand whether leaving her husband was ultimately the right thing to do. In this way, life projects could be expanded to encompass other roles – not only the role of wife, but also that of mother, daughter and teacher. Laura's feeling of being understood and accepted allowed her to sense her needs and give room to creativity and potential. The resources present also, and perhaps specifically, in that phase of acceleration were able to emerge. The strength and energy released by the dissolving of introjects had, however, to be contained within the therapeutic relationship. Laura also accepted taking medicine, whose objective was no longer to "pull her down", but to help organise her thoughts and keep her sense of direction. They were for her, not against her. Sharing her experiences turned what was once only hers, and hence at risk of not existing, into a narrative.

Then came the depressive phase, the loss of drive, strength and energy. She began to feel that the claims and positions from "before" were overly ambitious. But she remembered them – we remembered them together, and this was another novelty. We both knew that it was not about some far-off dream, but about her life, a shared narrative, a real experience. And in spite of the depressive introjects that had crystallized again, in spite of the blockage, we were able to keep the possibility open. Then the introjects began not to completely recrystallize during depressive phases; her anchors began to multiply during manic phases; the assimilation process started. Her presence at the contact boundary progressively increased, along with her ability to draw support from the field – the sympathy of friends, esteem and success at work.

Laura separated from her husband, but without a traumatic break-up, maintaining a good relationship and the possibility of giving and receiving support. With her children the process was less smooth, but it lead to the recognition of her role as mother, and hence the possibility of giving direction, containment and support.

For Marco, the first turnaround lay in understanding that he had an illness. That dangerous dysphoria, that feeling of being right beyond all reason, of having the right to defend and uphold his position against everyone – the expressions of his manic phase – were not grounded in a shared reality. Others could see things in a different way, and that divergence of views was caused by a state of distress.

Awareness of the manic episodes was achieved with great pain, not only by Mark, but also by his family members – and only after his being hospitalised twice. For although his bouts of depression had always been seen as periods of suffering, and at times even treated pharmacologically, his dysphoric episodes were believed to be tied to his character and to external situations. The recognition of illness led to greater caution and a focus on preventing forthcoming crises; but also to a certain rigidity. Drugs could help combat the symptoms, but the risk of assault by an invisible enemy always loomed large. This diminished possibility, freedom and spontaneity.

Giving a name to the problem opened up the potential for treatment. That treatment lay in drugs. Instead therapy was seen by Marco on the one hand as useless – against the invasion of a foreign enemy, and on the other as risky – given the presumption that the foreign enemy had conquered internal outposts in the most unexpected corners of the psyche. Only by becoming accustomed to his new condition of "being ill", by realizing that the limitations imposed by the condition were fewer than he expected, and by beginning to move and act without the "enemy" immediately coming to the fore, helped Marco to start taking therapy more seriously. The support given by pharmacological treat-

ment also proved fundamental, as did the support of relationships won and won back – first and foremost with his girlfriend, then with his psychiatrist and with family members. With regard to the aspect of risk and caution, of central importance was the emphasis placed on sleep and minimising stressors.

The second turnaround came with learning to live with the illness not as a foreign invader but as something to relate to dialectically. For Marco this meant claiming his past, including his clinical history, as his own, and beginning therapy with a psychologist at the same health service as his psychiatrist. By appropriating his symptoms, the possibility of having an effect on them grew. Still today, legitimate caution persists and gradual progress is being made with the therapist in opening up to a "normal" social and working life.

Two approaches to relationships can be identified from these accounts: the first is predominantly borderline, while the second is narcissistic. In Laura's story, as in other similar cases, the presence of the other as a support is necessary, even if it does not respond to her needs. On the one hand introjects are anchors, on the other they are refused. It is hard to escape the circularity of such a situation.

In the second example, the depressive introject, tied to the impossibility of reaching the other, to the experience of not being seen, dissolves in the manic phase, leading to a self-sufficiency that annihilates the relationship.

A crucial question that must be asked is whether therapy should focus more on social adjustment (which often has a depressive taint) or should respond and give support to the "challenge that lies ahead" (which can often lead to manic disengagement). Should it give greater support to creativity, to unique, personal styles of contact, or to reasonableness and reducing the risks for adjustment? Naturally the answer is both. The difficulty lies in gauging the need for different emphases and nuances in different moments. The dissolution of introjects can be a process of growth and maturity, but it can also be one of destructuration. Should priority be given to encouraging dissolution, or is it more important to erect containment walls first? Turning back to the case examples given earlier, we can say that in Laura's case, the priority was to encourage the dissolution of introjects. For Marco, establishing limits and containment were more important.

In any case, the point is to support creative adjustment (Spagnuolo Lobb 2007a) in experiences that can swing, in a very short amount of time, from one polarity to the other. The task of therapy is, quite literally, to walk the line between creativity and adaptation. As therapists we join the other in performing this balancing act.

Comment

by Daan van Baalen

I am grateful for the opportunity to comment on the excellent article about bipolar experiences by Michela Gecele.

Gecele's introduction gives a detailed overview of the history of the diagnosis of bipolar disorders since Kreapelin. She elegantly shows the range from normality towards pathology and the fact that many patients suffering from bipolar disorder present with a creative and artistic temperament. I miss in her historical perspective the work of Miklowitz et al. *(2003; 2007), who write about psycho-education. They maintain that psychosocial interventions should be part of a treatment package offered to most patients with bipolar disorder. Examples are teaching patients to identify early symptoms of relapse and if possible influence the symptoms, or offering group and/or family psycho-education in the prophylaxis of recurrences when there is remission.*

Gecele offers the reader a wonderful description of the manic state that is both poetic and theoretically sound. It is theoretically sound when she sees relational intentionality as a condition for figure formation, which is lacking in manic states. The detailed description of biological rhythms disturbances in bipolar disorder is important. My experience with clients suffering from bipolar disorder is that seasonal, daily menstrual and other hormonal rhythms influence the mood disorder.

In the paragraph about introjects and mood swings Gecele makes an important point. She sees that in the contact-form of introjection there is a possibility of understanding the bipolar situation. Constrictive and limiting introjection can lead to depressive moods on the one hand, and on the other hand lack of or little introjection where everything is possible can lead to manic moods. At the same time Gecele seems to omit the point that introjection as a contact-form is a figure/ground formation of a situation. She uses the word introject as if that is a thing in or of a person, as a substantive, which seems to neglect the figure/ground formation as a process. Wheeler (1991) offers a possibility to see contact-forms not as resistance, but as a figure formation and that every contact-form has a counter pole hidden in the ground. For example introjection and "looking at, experimenting and seeing anew" can represent a polar pair. Gecele's point suffers when seen from Wheeler's revision of contact-disturbances and resistances.

The bipolar situation can be carefully explored with "looking at, experimenting and seeing anew" as described in my article about Gestalt therapy and bipolar disorder (Baalen, 2010) where I show how Gestalt therapy can be a relevant psychotherapeutic modality from which clients with a bipolar disorder can bene-

fit. Using specific Gestalt interventions I try to raise awareness of the shared situation, where the client can learn to identify her moods. Having identified her moods she can next experiment in the therapy situation with ways to lift her mood when the mood is down and, when the mood is high, how to come down. With such procedures she can learn not to be the victim of her moods. This is an example of what I think Miklowitz called psycho-education. Such learning by experimenting can best be done during relative stable periods.

During more unstable, depressive and or hypo-manic periods where figure formation is more unpredictable, being together seems to be enough. The therapist is "mood challenged" in the bipolar situation and she needs to stabilize her moods so the client can start to learn not to panic while being together. Figure formation is co-creating which means being together and that can be too much for the client. Therefore just being there with a relaxed mood is enough, not an easy task.

When Gecele speaks about figure and ground and the functions of the self, I am not sure whether she means that the self and its part-functions are of the person or of the relationship or situation. In the therapeutic relationship the self is of the client and the therapist. As Yontef (2002) states: «Gestalt therapy is systematically relational in its underlying theory and methodology. A relational perspective is so central to the theory of Gestalt therapy that without it there is no coherence». Wollants (2007) in his book suggests speaking of the situation instead of the field. I guess that Gecele means the self of the relationship as later on the same page she writes with a clear relational perspective that: «The contact boundary is characterised by suffering».

Gecele's clinical examples are clearly supporting her theoretical stance. I miss a discussion about whether pharmacological treatment is needed in the non acute phases. From my point of view new episodes are not reduced by a pharmacological treatment as I describe in Baalen (2010). I think that psycho-education over time can reduce and or replace medication.

There is a possibility for confusion when the word self is used in the Gecele's text. When, for example, she says: "The id and personality functions of the self can also be "occupied", to different degrees and in different ways, by introjects", I can misunderstand the use of self as something of the individual here. I prefer to speak of the self-function and its part-functions of the situation. In my work with bipolar disorder clients I practise being part of the bipolar disorder situation and or the self-function. I also get high and/or low in mood working with them. Being aware of the moods in the situation of which I am a part, I can direct experiment, choose and influence the mood of the bipolar situation and later in post contact reflect together, with the client, on what we have learned from our experimenting; learning that the client can possibly use in other new situations.

Anxiety Within the Situation: Disturbances of Gestalt Construction

by Jean-Marie Robine

If we see psychology as the study of human experience, then psychopathology is the study of the dysfunctions of that experience. If we regard human experience as essentially unique since it includes all the contact operations that link human beings with their world, then the study of the dysfunctions of experience will show us some of the ways in which experience may cease to be unique, presenting instead a number of flections[1]. I have borrowed the concept of flections of experience from Binswanger (1947). This term, which has a range of meanings, refers to a kind of deformation. It seems to me more appropriate than the term "contact interruptions", or even "resistances" as a way of referring to alterations to the contact experience. These flections narrow the field of possibilities of experience and modify or interrupt the continuum of self-regulating contact and creative adjustment.

A psychotherapeutic approach adopted for its focus on the concept of experience can be linked to a psychopathological description of the flections of this experience, by using concepts designed to restructure this experience if and when it becomes stuck.

Gestalt therapy is rich in concepts for thinking about psychopathology: constitution of the field, identification/alienation, excitement, acute emergency, interruptions to the sequence of creative adjustment, disturbances and loss of self-functions, disturbances of contact-boundary, orientation/manipulation, lack or excess of deliberateness, repetition, fixation, unfinished situation, awareness, dominance, *Gestalt* formation or construction/destruction, premature conflict resolution, self-conquest and so on. Our task is to develop these concepts and to use them in clinical practice and in the theorising that flows from it.

[1] This term is also used in linguistics to refer to the modification of a word by elements which express certain grammatical relationships (inflections): declensions, conjugations, suffixes etc.

1. Anxiety in Gestalt Therapy

1.1. Anxiety and Excitement

The term "excitement" lies at the heart of the Gestalt Therapy approach, even featuring in the subtitle of the founding text *Gestalt Therapy: Excitement and Growth in the Human Personality* (Perls, Hefferline and Goodman, 1951). Excitement, defined as «evidence of reality» since «there is no indifferent, neutral reality», accompanies contact and figure/ground formation. It is born with the emergence of each figure and tends to be attached to the "object" which is contacted, so much so that it would be pointless to locate it in either the organism or in the environment. It is «the immediate evidence of the organism/environment field» (*ibidem*).

Excitement is maintained, increases and then diminishes during the entire contact sequence. However, this excitement may be inhibited or blocked, for various reasons, resulting in anxiety. This anxiety is the manifestation of blocked excitement due to interruption of the excitement of creative growth.

1.2. Anxiety and Support

Other theorisations can be found throughout Gestalt writing. In the present study, and complementing Perls and Goodman's approach, I shall take note of the perspective pioneered by Laura Perls (2001), which links anxiety to the absence of necessary support during the contact experience. When the necessary support is missing, anxiety occurs. Similarly, if an interruption occurs – meaning of course inadvertent and non-deliberate interruption! – in the context of inability to engage with the challenges of the current stage, or fear of moving on to the next, the result is anxiety. This prevents the subject from drawing the necessary supportive resources from within him/her self or from the environment. It is not the person who needs the therapist's support (as in what is sometimes called "supportive therapy") but the process of *Gestalt* formation. Within this formation, one of the most important tasks is to allow the blocked excitement producing the anxiety to become active excitement.

1.3. Can We Speak of Contact "Interruptions"?

Before outlining the vicissitudes of *Gestalt* construction, I need to clarify some of the major theoretical underpinnings of the concepts I shall be using. In fact the concepts of confluence, introjection, projection, retroflection and ego-

tism have a controversial history within Gestalt therapy. These modalities were long held to be forms of resistance (Perls, 1942; Polster and Polster, 1973) until this generic label came to be recognised, though perhaps not universally, as a theoretical error, and they were at the centre of a wide-ranging debate in the *Gestalt Journal* during the Nineteen Eighties which I will not recapitulate here. In the second, theoretical part of the founding text – *Gestalt Therapy* (1951) – these phenomena were addressed in the last chapter, *Loss of Ego-Functions*. Other Gestalt therapists followed suit in referring to these modalities as examples of the loss of ego functions. Although I cannot develop the argument here, I would maintain that in this chapter the authors show how these modalities of contact (introjection, projection etc.) may constitute a pathological experience when accompanied by a loss of ego-functioning. In my view these modalities of contact are neither healthy nor pathological in themselves: it is experience which may be inflected – or even considered pathological – when two factors operate concurrently: the loss of ego-function *and* the presence of one of these modalities.

A second point to make concerning these modalities is the widespread current use of the expression "contact interruptions" to describe them. It is important to remember that contact has a specialised technical meaning within the theory of Gestalt therapy: it refers to figure formation. It is perhaps not contact itself that is interrupted but the forms it takes when influenced by one of these flections of experience.

A final preliminary remark: Perls and his fellow authors (1951) saw these modalities as intervening during the sequence of *Gestalt* construction, but not at any random point during the process. Some of their successors contested this idea, arguing, for example, that introjection could occur at any point during the sequence. It seems to me that this disagreement arises from differences in how the concepts are defined, and in particular the confusion between the process and the result of the process. Introjection, like projection and retroflection, are actions, short-lived modalities which may emerge at a specific moment as ways of contact. For example, introjection may give rise to an introject, that is, a particular fixed sedimentation of previous introjections. Similarly, chronic muscular tension is not a retroflection in that the person is perhaps not in the process of retroflecting. But the tension itself could perhaps be thought of as a retroflect, that is, the result of previous retroflections which have become chronic, one with which the person is in confluence.

Hence when I use these concepts in the following pages I am referring to phenomena situated in time, within the logic of process, short-lived modalities of contact and action, rather than the possible fixed outcomes with which the person might be in confluence.

1.4. Anxiety in Gestalt *Construction*

1.4.1. Emergence of a Figure versus Confluence

During the first or fore-contact phase, the body and its primary and secondary physiological processes form the ground. Within the on-going situation, whether this is rest where nothing emerges as a figure, or activity that the subject is pursuing yet allows him or herself be distracted from, consciously or not, "something" emerges. This something, the "id of the situation", may take various forms: proprioception of a bodily sensation, perception of an environmental stimulus, need, desire, appetite, attraction, drive, an unfinished situation which intrudes into the present. The concept of the "id" refers precisely to this pressure, and to the awareness of pressure, shorn of any speculation as to its possible origin. The id-function is a modality of the self, often based on perceptions and bodily sensations and inseparable from awareness, which emerges from the figure and constitutes the "what-comes-next" of the situation.

There is no doubt that during this phase of the sequence the self is primarily a function of physiology and thus forms part of the organism, so to speak. At other times, as we shall see, the self appears much more clearly as a function of the field, or more precisely as «the way the field includes the organism» (Perls, Hefferline and Goodman, 1951, II, 12, 1). During this phase it is the appetite, or the environmental stimulus which awakens it, which is the figure.

1.4.2. Flections I

Nevertheless, the mere fact that a figure of contact has emerged, however vague and ill-defined it may be, may give rise to anxiety. The acknowledgment of an appetite or a desire, the awareness of a bodily sensation, indicative of some need, the sudden appearance of a theme, a memory, or an association, the forming of an initial representation, all phenomena which start to take on meaning produce excitement. Hence they may lead to anxiety which prevents the figure emerging. This interruption of the sequence, if we can call it an interruption given that, from a phenomenological point of view, it is more a failure to start, takes place through confluence. The emergence of a figure is a rupture in confluence. Refusing to allow the figure to emerge is tantamount to maintaining, or seeking, confluence (Lapeyronnie and Robine, 1996).

The available modalities for maintaining confluence are similar to repression, and the reader is urged to return to Goodman and Perls' important study of this issue in chapter XIV (1951). Premature shame concerning affects frequently lies at the origin of phenomena of this kind.

One of the functions of maintaining this confluence relates to anxiety about individuation and differentiation: becoming aware of one's desire means adopting the first person singular, becoming an "I". Confluence, that is, maintaining a lack of differentiation between the organism and the environment, removes this risk. Desensitisation enables one to be unaware of anything and to say nothing, to experience only fog and darkness, sometimes described as a feeling of emptiness.

When a figure emerges, it is bound to become a contact figure. The creation of a *Gestalt* also constitutes this delicate transition from the physiological to the psychological. But maintaining confluence makes it difficult to transform physiological into psychological experience, to pass from the body to contact, and thus it forces experience to stay at the physiological level of unawareness. The repressed excitement then remains exclusively physical, sensation cannot become affect and nor can affect become feeling or emotion. The pathology which may result tends to see the body as an object, since, metaphorically speaking, the figure/ground is located within the body and not in contact with the environment. It is during this phase that excitement may come to a halt and anxiety may become fixed within the body, in pathologies often described as psychosomatic conditions or hypochondria. To a lesser degree muscle stiffness, chronic tension, loss of feeling or local anaesthesia may occur.

Less severe disturbances linked to repeated interruption of this phase may also be manifested in various forms of immaturity – or regression – since a reduction or absence of contact with the environment deprives the organism of novelty and hence interrupts growth. I am inclined to hypothesise that the over-investment of the body in intensive and excessive practices, whether sporting, quasi-sporting (bodybuilding, different forms of gymnastics or martial arts etc.) or artistic (various body-arts, tattooing, body ornaments or fashionable adornment etc.) may occur with flections of this phase, or at best diverted into sublimation.

Gérard is reaching a sensitive stage in his therapy, but nothing is coming out. He comes to the sessions punctually only to say, with no apparent ill-feeling, that he has nothing to say. He makes himself comfortable; from the start he settles down on his side, half-lying down, leaning back on one arm of his armchair and resting his knees on the other, slumped and relaxed, and he maintains this position for several sessions. All my entreaties, invitations and focussing fall flat; he does not grasp anything, nothing arouses the slightest anxiety or the slightest excitement. He seems to be saying "Please leave me alone, don't make me aware of anything!". There is a demand for confluence, but he still comes to sessions regularly and he sometimes seems to be sending me brief furtive looks of appeal. Until the day when, at the beginning of the session, I suggest an experiment: that this time we will take the session sitting

on a different type of chair, and I bring forward two very upright chairs with no arms. Almost immediately, excitement and anxiety return: he has a lot to say, aggression comes back.

Michèle is about 23, nearly the same age as my daughter at that time, something she found out from another person. She spent her adolescence, alone with her father, in an incestuous relationship with him. She very quickly pours herself into our relationship, to such an extent that after a few sessions, and by way of telling me that she wants to enter into an amorous relationship with me, she says "I want to be more than your daughter to you". Thus, a confluence with her lived experience, to the point that the father-daughter relationship is seen as self-evidently the model for any amorous relationship.

1.4.3. Excitement of One's Own Desire versus Introjection

The emergence of a figure from the ground, carried and energised by elements of the ground which have formed as a background for the "id" of the situation, initiates a stage of the contact sequence where there is a dynamic relationship between figure and ground. «Excitement is the feeling of the forming of the figure/background formations in contact situations» (Perls, Hefferline and Goodman, 1951, II, X, 2), as we saw earlier. Of course, each moment of the sequence requires a specific excitement, but the particular feature of the excitement of this stage is that it brings the organism out of a state of "nothingness", rest and silence and into an awakening of desire. This is of course "my" desire, and this "my" opens the way to all the processes of identification found in the contacting phase: fully becoming one's desire, identifying with or alienating possibilities within the environment that can be contacted and turned into action, which can be highly anxiety-making.

This nascent growing appetite needs an "object". Literally, "ob-ject" means "thrown in front of", that is, some feature of the world to be contacted, to take up in order to meet, appropriate, and assimilate. Traditionally, and perhaps somewhat prematurely, Gestalt therapy subsumed all internalisation processes under the undifferentiated rubric of introjection, a concept both used and abused.

From his very first book, Perls (1942) used the term introjection to refer solely to a "pathological" process, the healthy equivalent being "assimilation". Today there is a tendency to apply the term introjection to the entire phenomenon, whether healthy or unhealthy, of grasping the world around us and appropriating it, which may lead either to assimilation (a healthy process), or construction of an introject (an unhealthy process). If the internalisation process is

interrupted and the object becomes fixated in the form of a "foreign body", we term this an introject.

"Healthy" introjection (I shall retain this concept for the moment, even if I attack it elsewhere) can only operate in the absence of any coercive context: social, cultural and linguistic conventions and rules and so forth. This appropriation, undertaken in these conditions with no loss of the ego mode of the self, may be «a spectacularly creative achievement» (Perls, Hefferline and Goodman, 1951, II, XV, 5).

1.4.4. Flections II

Since «coercion is incompatible with excitement», whenever any aspect of the environment begins to exercise coercion, preventing the self from functioning in ego mode in the contact underway, the excitement linked to the upsurge of desire becomes immobilised. The heightening of this excitement produces anxiety. The desire itself cannot be recognised, taken up and used. Introjection occurs when «the self [...] displaces its own potential desire or appetite with someone else's» (Perls, Hefferline and Goodman, 1951, II, XV, 5), as a substitute for creating its own appetite, desire, or meaning. Affect is then turned back before it can be recognised and thereby felt. Introjection thus formed can never become assimilation.

The child's adoption of the parent's desire is similar to the client's adoption of the therapist's desire. Any lack of vigilance on the therapist's part, including at the level of counter-transference, opens the way to possible introjection and blocks any restoration of an ego-function supported by the id.

Those flections of experience linked to the interruption of *Gestalt* formation by introjection may take various forms.

The one most frequently encountered in contemporary psychotherapy is found in patients who present narcissistic disturbances of experience. The constraint they are under in their early years to substitute the significant parent's desire for their own desire in order to survive emotionally forces them into the "habit" of ignoring their own desire, to the extent of sometimes confusing it with an absence of desire, and constantly seeking introjection: the patient's identity is replaced by introjects, and he or she continues to seek introjection in the course of contacts.

And of course we should pay particular attention to syndromes expressed through eating disorders. This physical equivalent of introjection certainly appears to be a prime modality of a being-in-the-world fixed in this mode.

Bruno has been coming to psychotherapy for several months. He regularly asks me to tell him what I think about various situations that he describes. Af-

ter some time has passed he realises that the reference points provided by his friends no longer seem reliable to him, given the changes he has undergone. Some time later, he becomes aware that he had been attempting to replace his parents with his friends, and then his friends by me, as people who would be able to show him how he should feel, think and act in any situation. “When I go to a party, for example, I act happy and sociable, because that’s what my friends do. But what do I feel? Nothing! What I think I feel doesn’t belong to me, it’s not mine, it’s not me... All I do is act the way people expect me to in the situation”. Once he has identified his anxiety over feeling and thinking by himself, he goes into a severe depressive state, linked to a feeling of emotional emptiness, and a first awareness and recognition of the affects that he will be able, little by little, to turn into feelings.

I was able to track changes in the way in which Julien introjected over the months through his attitudes to choice of car.

In the initial stage, during the first year or two of therapy, he repeats every session: “I think I’m going to change my car. The one I have now, it’s too showy. I only chose it to impress the people around me. But now, it doesn’t relate to who I am or what I want... but what sort of car do you drive, by the way?”.

Second stage, around six months later: “I’ve changed my car, a few months ago, for a Peugeot 205 diesel. It’s robust, it doesn’t make a statement, it’s reliable, hardy, straightforward; I imagine it’s the same sort of car that you have!... but what sort of car do you drive, by the way?”.

Third stage, a few months later: “I had a dream, I was at the garage I go to, and I saw at the back there my old golf GTI that he hadn’t sold, and I was overcome with a kind of nostalgia. You know, I miss it because the one I have now isn’t like me at all. I’m going to change it. What sort of car do you drive, by the way?”.

Final stage, a few months later on, he brings a dream to the session. Among other things, he tells me that he found himself driving through the streets of the town where I live and where he has the therapy (he lives more than a hundred miles away), caught up in traffic or stopped at a red light, and he realises that he is driving a little child’s pedal car. We find out in working on this dream that he has the feeling of starting to take responsibility for his own desire, as if he is taking up the construction where he left off, and metaphorically returning to his own first “car”.

1.4.5. Perception of the Environment versus Projection

If the excitement of desire has not been interrupted by a passive introjection

implying abandonment of the ego mode, desire can once again fade into the background and excite the ground as a resource for construction of the current *Gestalt*.

Particularly at this point in the sequence, figure formation requires an investment of energy from both poles of the field, the organism and the environment. The excitement of desire which formed the figure in the previous phase gives way to the object, or a series of possible objects. This is a particularly sensitive – and anxiety-creating – moment as the figure migrates from one pole of the field (the organism) to the other (the environment), moving out from the interior to the exterior.

"Moving out" immediately recalls the Latin equivalent: "ex-movere", from which "emotion" is derived. This moment is in fact the phase when emotion is most crucial. Gestalt therapy sees emotion as a kind of impact between the state of the organism and the state of the environment: «the integrating awareness of a relation between the organism and the environment. It is the foreground figure of various combinations of proprioceptions and perceptions. As such, it is a function of the field» (Perls, Hefferline and Goodman, 1951, II, XII, 6).

In other words, for emotion to exist, it is necessary to «accept the excitement and face up to the environment», meaning «relating appetite or other drive with a vaguely conceived object» (Perls, Hefferline and Goodman, 1951, II, XII, 5).

For the organism, confronting and adapting to the environment it is a process of trial and error involving successive adaptations which commonly use projection as a tool for orientation within the field.

This normal "hallucination" factor, comprising intuition, premonition, or simply the capacity to apply to current experience knowledge derived from previous experiences is part of projection in its broadest sense.

1.4.6. Flections III

However, extending and generalising the use of such a concept, as with many others, voids it of specificity and substance. If projection becomes synonymous with any kind of exteriorisation, or refers to the process through which a subject, through his or her own subjectivity, forms an idea of the field, another person or the environment, we would have to acknowledge that projection is permanent. Within the modern constructivist perspective it would be reduced to merely some "generalised principle of projection". So I think it would be useful to define this concept more stringently in order to retain its operational value.

In projection as defined in Gestalt therapy, it is more a question of an unwitting refusal (denial, impossibility…) to own one's own affect, emotion, and feelings and their accompanying representations. Through projection, the subject constructs a screen in relation to the field. Inappropriate and anxiety-producing affects are attributed to other people, and features of the environment fail to register because the environment is reduced to virtual images created by the subject him/herself.

Of course, paranoia and its whole range of sensitive or interpretative forms is one mode of contact in which persecutory projections figure prominently, but other psychopathological styles also make frequent use of projection. Any form of denial will entail projection, for example the denial of sexual difference in perversions; generalising stances (sexism, racism, homophobia, fascisms of all kinds), rigid certainties and the creation of phobic objects. It contributes to the elaboration of compulsive rituals and reaction formations, neurotic guilt, superstitions and beliefs, mythologies and mythomanias, jealousy, delirious states, and others. We might also venture to hypothesise that the process of hysterical conversion resembles projection rather more than retroflection, even if the subject turns him or herself into an "environment" in order to expel any affects.

Etienne and Sophie have had several sessions of couple therapy. They have started talking to each other again, and Sophie, who had been keeping very distant from Etienne to the point of thinking about leaving him (after some twenty years of life together), has discovered a renewed intimacy with him. Touched by this new closeness, Etienne confides something to her that he had kept secret, namely that as a child he had been sexually abused by his father. I shall not dwell on the power and control games surrounding this revelation, but the immediate result is that Sophie feels humiliated and begins to reconstruct their past married life with considerable violence: "You married a nurse", "You only chose me to get away from your family", "You never trusted me!", etc. There is a temporary interruption of contact.

1.4.7. Going Towards versus Retroflection

When one is able to perceive and create the environment, excitement may then truly engage with the situation: go towards and contact fully. Identifications and alienations progressively restrict the field of possibilities, but this going-towards may suscitate anxiety or dread, and this function «originally directed towards the world by the individual, changes direction and turns back on its originator» (Perls, 1942).

Going-towards, *ad-gredere* in Latin, corresponds to the Gestalt conception of aggression «as a beneficial, self-expressive, and creative human power to make something or to make something happen, to be willing to give oneself back to the world as well as to receive from the world» (Miller, 1994). This idea of aggression is thus «anything but the hostile warlike exercise of power over others that we generally think of as aggression nowadays» (*ibidem*).

At this stage, retroflection is the contacting modality which makes it possible to avoid the anxiety of aggression. The action is then turned back onto «the only available harmless objects in the field, his own body and personality» (Perls, Hefferline and Goodman, 1951, II, XV, 7). In the normal course of events, retroflection enables engagement to be slowed down, making it possible to readjust the emotion, correct the ground and hence reconsider the emotion. This is called self-control, and is linked to the exercise of will. Sometimes one's fears stimulate retroflection, and sometimes too these fears are the result of projection. The subject may find it appropriate to slow down or not engage in aggressive activity, considering the context and the adjustment it requires. A retroflection may then rightly be considered a creative adjustment.

Thinking (re-flecting) is a type of retroflection, talking to yourself. But are you the right person to talk to? People often say: "I ask myself"[2]. But are you the right person to ask? Thinking as a way of preparing to relate is not the same as thinking as a way of avoiding action.

1.4.8. Flections IV

As in the case of the phenomena I have discussed above, retroflection can intervene to interrupt the current *Gestalt* with or without the intervention of the ego function, with or without awareness, and this is what makes the difference. When one's aggression, in the sense discussed above, cannot be expressed it may turn into hostility or be turned back on oneself. The fear of destroying produces anxiety, so the destructiveness will then turn towards the only available objects: one's own body and personality. This retroflection will be manifested as self-destructive behaviour, from self-harming to masturbation, from obsessions to what are known as psychosomatic illnesses, from suicide to certain types of masochism, from the compulsion to fail to remorse, and from resignation to self-mastery.

Even in his very first writings Perls made a clear distinction between repression and retroflection: in the case of the latter «little material is lost [and it

[2] "I ask myself" is the literal translation of the common French expression "Je me demande", although a better English equivalent would be "I wonder". This particular therapeutic intervention appears to be language-specific (Translator's note).

is] only a reorientation as the conflicts which induced the retroflection are near the surface» (Perls, 1942, III, 8).

Generally the person who is the assumed recipient of contact is not completely excluded, and retroflection may affect him or her indirectly. For example, a person's suicide attempt will readily affect those around them whom they were unable to attack directly.

For some time Monique has been spending most of the session with her hand over her eyes. We work on this gesture in various ways but the theme which emerges from this remains focused on sight: what does she not want to "see", does she not want to see that she is looked at, etc.? Even though this brings different things to mind, the gesture remains, which suggests to me that she still needs it, and that nothing of what we have brought up around this gesture has really made sense to her. One day, after three or four sessions like this, something becomes clear to me: "What are your eyes doing, under your hand?", "They're closed". Of course! If I don't want to see, all I have to do is close my eyes! "Let's imagine: what you could do with your hand if you didn't have it in front of your eyes?". She removes her hand from her eyes (which she keeps closed) and replies "I don't see it!" (sic), all the while gently stroking her arm with the hand that is now free. Retroflected demand. From this point onwards the therapy enters a new phase, one in which demand, transfer and relation can be worked on directly.

1.4.9. Letting Go versus Egotism

The concept of egotism that Goodman (Perls, Hefferline and Goodman, 1951) introduced into Gestalt Therapy did not find favour among Gestalt therapists. It is ignored in most theoretical and clinical texts, or at best mentioned in passing, and to the best of my knowledge it has only been discussed seriously in two studies, one by Burnham (1982) and one by Davidove (1990).

In order to attain final contact, spontaneity must be able to supersede the deliberateness which often dominates in the contacting phase, through loosening control, letting-go, daring to finish the action undertaken, opening the barriers to the encounter with the object contacted, and allowing the I-Thou to become briefly a We. The problem with this control, which makes the barrier impermeable and closed to genuine full contact, is that it is not itself under control. There is certainly an excess of ego invested in this phase of the self, but the ego finds it impossible to choose not to exercise control. The controlling is out of control. An excess of ego goes hand in hand with a loss of ego function.

I would tend to see egotism as a specific form of retroflection inasmuch as

it corresponds exactly to one of Perls and Goodman's definitions of retroflection: «Any act of deliberate self-control during a difficult engagement is retroflection» (Perls, Hefferline and Goodman, 1951 II, XV, 7).

When the subject experiences only moderate anxiety at this stage of his/her experience, egotism is limited to slowing down, «to make sure that the ground possibilities have indeed been exhausted – there is no longer threat of danger or surprise – before he commits himself» (Perls, Hefferline and Goodman, 1951, II, XV, 8). Egotism manifests itself through diffidence, scepticism or slowness.

1.4.10. Flections V

However, in certain situations, the approach of final contact produces so much anxiety that egotism is used as a final brake to avoid it. This often occurs towards the end of therapy, when "introspection" has become second nature to the client. It is often found, and to a high degree, in individuals presenting with narcissistic disorders of experience. Rendered anxious when faced with letting go, anxious about loss of control, anxious about opening up to the other, anxious about being swallowed up by the We of the encounter, or anxious about being subsequently abandoned, they cut themselves off from the environment and reduce it to a stock of knowledge they can use to increase their power and control.

Isadore From emphasized that using any form of "we", even at the purely verbal level may arouse anxiety in personalities who present with serious disturbances of their narcissistic experience. Not only could Philippe not use "We" when he talked about himself as part of a couple, not only could he not talk about "MY wife" or "MY partner" when he referred to her, but he would actually use paraphrases such as "the woman I live with at the moment", "Bernadette, the woman I married ten years ago".

Luce, in all her relationships including with me, quite obviously switches off before final contact: during the session, that is when everything starts to get muddled, when she starts thinking about something else etc. In her love affairs, which are numerous and doomed to failure, she starts to daydream during sexual encounters about all the men she would like to seduce.

2. Conclusion: Psychotherapy as an Emergency Situation

When the organism finds itself in a new situation of disequilibrium, danger,

threat, survival, a situation that the creators of the holistic approach describe generically as an emergency, it formulates a global adaptive response: global, because it brings into play perceptions, proprioceptions, representations and thought, motor activity and so on; adaptive because the possibility emerging at the contact boundary allows the event to be managed in a spontaneous and creative way. All the capacities for orientation and manipulation within the field can unfold fully and prevent the field from becoming disorganised.

But through repeated failures to re-establish equilibrium or taking «refuge in repression or hallucination» (Perls, Hefferline and Goodman, 1951, II, III, 9), the disequilibrium of the adaptive *Gestalt* may become chronic at a low-key level. Hence a double tension arises, danger and frustration, which mutually reinforce each other to the point of neurosis. This, what Perls and Goodman term «a chronic low-grade emergency», is one definition of neurosis.

1. In this situation, the contact boundary tends to simplify the field thanks to the two emergency functions which come into play: deliberate blotting-out and non-deliberate hyperactivity. «In a reaction which is different from that in the acute emergency, the attention is turned away from the proprioceptive demands and the sense of the body-as-part of the self is diminished. The reason for this is that the proprioceptive excitations are the more controllable threat in the mutually aggravating troubles. […] the proprioceptive has been diminished. […] If the process is long continued, the state of deliberate alertness to danger becomes rather a state of muscular readiness than of sensory readiness. […] With all this again goes a habitual readiness to take flight, but without actually taking flight and releasing the muscular tension. […] We have here the typical picture of neurosis; under-aware proprioception and finally perception, and hypertonus of deliberateness and muscularity» (ibidem).

This disturbance also corresponds to what the authors term elsewhere a disturbance of "orientation" (perception and proprioception), which brings with it a disturbance of "manipulation" (psychomotor activity).

«If the neurotic state is the response to a non-existent chronic low-grade emergency, with medium tonus and dull and fixed alertness instead of either relaxation or galvanic tone and sharp flexible alertness, then the aim is to concentrate on an existing high-grade emergency with which the patient can actually cope and thereby grow» (Perls, Hefferline and Goodman, 1951, II, IV, 12).

It is here we find the full meaning of the concept of experiment which lies at the heart of Gestalt method, in using the actual emergency, or even creating a high-intensity experimental emergency *in situ*. The gestaltist experiment, used intelligently, is not just a behavioural exercise; it is a symbol or metonym of the subject's experience, just as the experimental high-grade emergency is linked metonymically with the chronic low-grade emergency: they have the same structure, the same *Gestalt*, the same function. «But the point is for the

patient to feel the behaviour in its very emergency use and at the same time to feel that he is safe because he can cope with the situation» (*ibidem*).

Gestalt therapy, like other psychotherapeutic approaches, cannot dissociate the tools used in diagnosis from those used in intervention, any more than diagnosis itself can be considered in isolation from the particular therapeutic relationship and the field in general[3].

Comment

by Myriam Muñoz Polit

The description of what is dysfunctional instead of what is pathological is more appropriate from the point of view of Gestalt Therapy. However, we gestaltists should definitively abandon the use of the concept of "psychopathological". We must avoid any notion that takes us back to the idea that the person with inflections, or interruptions in the creative adjustment sequence, is "sick". I consider the Gestalt focus is based on an educational model and not on a medical model.

The medical model has set its sights on curing, discovering what doesn't work adequately, to then intervene and try to remedy whatever is considered a disease. On the other hand, the educational model emphasizes the development of potentialities, of watching human beings from their healthy functioning.

Under the medical model, when the person is seen as sick, required to have specialists in that ailment who can, in the first place, adequately diagnose it to then define the most adequate form to cure it; more than sick people, we have diseases. In contrast, under the educational model the only expert on him or herself is the person, who is not sick, but rather has an issue he or she must see to, facilitating the self regulation process to recover his or her well-being. Based on this point of view, the expert on him or herself is whoever has the problem, and the therapist is a "specialist" in viewpoints and methods to facilitate the person's recovery of his or her well-being and improve its quality. There are no abstract problems, but rather concrete persons who have problems.

This is the vision of Gestalt Therapy: human beings are constructive by nature and require support from their environment for their development.

When the text says: «If we regard human experience as essentially unique… the study of dysfunctions of experience will show us some of the ways in which

[3] An earlier version of this chapter appeared in Robine J.-M., *Gestalt-thérapie, la construction du soi*, L'Harmattan, 1998, to be published as Unfolding Self, Gestalt Press, forthcoming.

experiences may cease to be unique», it offers one of the clearest and most appropriate descriptions I know of the meaning of dysfunctionality.

The section where the author mentions the relationship and distinction between anxiety and excitement, deals with descriptions of the sensations that may be involved in the process of contact and figure/ground formation. I would like to add that their equivalent, in terms of feelings, would be anxiety and enthusiasm. Although in the contact process feelings emerge at a point after sensations, I consider it is important to continue to pay attention so that enthusiasm does not become anxiety in that latter stage.

My hypothesis is that all of us human beings share from birth basic emotions that take the form of feelings as we relate to our environment (Muñoz, 2011); these feelings are fear, affection, sadness, anger, and happiness, from which the feelings we have are derived, which become more sophisticated and complex. In other words, there are five "families" from which all emotional experiences are born, sometimes directly; for example, throughout a person's development, affection may become tenderness, compassion and love. When these "families" are combined, even more complex feelings arise; shame, for example, which seems to include elements of sadness and anger.

To put it in more concrete terms: anxiety, which is a sensation, and anguish, its corresponding feeling, belong to the family of fear, where the spontaneous reaction is to seek protection and withdraw from any threats. Similarly excitement, which is a sensation, and enthusiasm, its corresponding feeling, stem from the combination of two families, fear and happiness, where the spontaneous reaction is ambivalent, with threat coexisting alongside an attraction to novelty.

The passage where the author states that when inflections occur contact is not interrupted, but rather that it is influenced by them, generating what might be an impoverished or diminished contact, is enormously relevant.

In broad terms, I believe all of the author's ideas about inflections and how they take place in the contact process are not only very clear, but also beautifully described; besides, with the examples from real life, the understanding of the concept becomes sharper. There are sentences that leave no room for doubt, such as "coercion is incompatible with excitement", or "I would tend to see egotism as a specific form of retroflection", or "egotism manifests itself through diffidence, skepticism or slowness" and many more such statements that further clarify the concept.

In the end, the mention of "diagnosis" attracts my attention again to the use of terms from the medical model and, even, the psychoanalytical model. Wouldn't it be better to talk about a "working hypotheses".

I can state that it is a text which describe the process of how natural excitement, enthusiasm and vitality decrease and become anxiety, anguish or fear

and, when occurring continuously in time, they become chronic patterns that arrest the development of potential and the possibility of an adequate satisfaction of needs with the resulting chronic dissatisfaction, which may reach the point of the loss of the sense of vitality.

In summary, I believe it is a highly useful text on how to achieve clarity about inflections in the contact process; I recommend it to my colleagues and students. I also found it personally instructive.

Gestalt Therapy Perspective on Panic Attacks

by Gianni Francesetti

Panic Disorder is on the rise, and presents a particular challenge to the psychotherapist for various reasons. Firstly, it manifests itself through physical symptoms which do not initially appear to be connected with psychological or existential problems. Secondly, it can drastically affect the life of the patient, preventing him or her from fulfilling responsibilities to family and society. Then, it strikes in moments when the therapist cannot be present or support the patient. Finally, it constitutes an acute loss of autonomy for individuals who are often fiercely independent. In the present chapter, I intend to present a reading of panic disorder from the theoretical and clinical perspective of Gestalt therapy. For further reading, please see the phenomenological and clinical observations already published in Francesetti (2007). According to DSM IV, a panic attack is a precise period of intense fear or discomfort, accompanied by specific somatic or cognitive symptoms[1]. The attack begins suddenly, reaches its climax rapidly, and is often accompanied by a sense of impending doom or catastrophe and a sense of urgent need to distance oneself. Panic attacks can occur in various situations, but Panic Disorder is only diagnosed when, at least in the early stages of the condition, attacks occur unexpectedly.

1. Panic Attacks and the Figure/Ground Dynamic

The differences between anxiety and panic attacks are not only quantitative but also qualitative, and their recognition can further our understanding not only of panic disorder but also of its treatment. In contrast to more generalised

[1] At least four of the following symptoms should present themselves: palpitations, pounding heart or accelerated heart rate, sweating, trembling or shaking, sensations of shortness of breath or smothering, feeling of choking, chest pain or discomfort, nausea or abdominal distress, feeling dizzy, unsteady, lightheaded or faint, derealization (feelings of unreality) or depersonalization (being detached from oneself), fear of losing control or going mad, fear of dying, paresthesias (numbness or tingling sensations) (APA, 2000).

states of anxiety, panic attacks strike suddenly, catching patients unawares. When a panic attack occurs, the patient's habitual psycho-physical and emotional landscape is abruptly and alarmingly turned on its head. Panic attacks are perceived as episodes of discontinuity within the normal continuum of experience, as can be precisely delimited temporally. Patients' accounts of panic attacks typically follow a standard format: "I was going about my normal business… when suddenly catastrophe struck…"[2]. They all share a common rhythm, whereby the normal continuum of experience undergoes an abrupt and violent fracture. What essentially happens, and what is unique to panic attacks, is a sudden falling away from beneath our feet of the "ground" upon which we assume we can "go about the normal business" of our lives. A panic attack consists in the sudden collapse of all that which sustains us, of that which is common, taken for granted, familiar, unproblematic and non-reflexive – in a word, of the ground. This ground is made up of the id and personality functions of the self (Spagnuolo Lobb, 2001a; 2001b). If every individual experience is to be understood as a figure emerging against a ground, during a panic attack the ground shatters and the figure disintegrates. A figure, as a creative synthesis of the self, can only form if a set of contacts make up and maintain the ground for long enough for the contact sequence to be completed as excitement grows until the organism withdraws. After the first panic attack, patients begin to lose faith in contacts which they usually take for granted: *"Can I trust in my body? In my sense of direction? In gravity? In the people around me? In the brakes of my car?"*. The fear of further panic attacks sets in, and patients seek to steer clear of the situations in which previous attacks took place. After the first panic attack, the patient's fear of the ground subsiding means that the acquired and taken for granted contacts which normally form the ground become figure: "*Am I breathing properly? Can I see all my points of reference? Are there any familiar faces around? Will my legs still be able to carry me? Will my heart keep beating? Am I reasoning properly? Will I be able to find my way home?"*. «The real world exists only in the constantly renewed assumption of the constitutional continuity of experience» (Husserl quoted in Binswanger, 1960, p. 22 it. trans. 2006). The momentary collapse of this "constantly renewed assumption" is the key factor in panic attacks. It is immediately restored, but the abyss which has momentarily opened up is so terrible that the fear of its return blights the patient's life. «The patient undergoes an authentic

[2] For example: "I was driving to work and stopped to queue at a traffic light. Everything seemed normal, when I was suddenly struck by a terrible sense of anxiety. I felt bottled-up, imprisoned. I had a sudden hot flush which seemed to grab me by the throat. I felt like I was suffocating and was terrified that I was going to die". Similarly: "I was chatting away quite happily with some friends when something suddenly clicked inside me and I felt locked outside the situation, as if I was experiencing it from the outside looking in. I felt lost, vertiginous and terrified".

and terrifying experience of being thrown out into the world unprotected (of what Heidegger calls *Geworfenheit*)» (Salonia, 2007)[3].

2. Panic Disorder and Contact Interruption

The reduction of presence through contact interruption is a key factor in the Gestalt reading of psychopathology. The habitual form of contact interruption comes to represent not only a limit to personal growth but also the very ground which supports the patient. If this form of contact interruption suddenly becomes impossible, therefore, the patient is all at once bereft of a fundamental part of the ground which generates his or her normal, safe and (neurotically) stereotypical way of getting through everyday experience. This is exactly what happens when a panic attack strikes: panic attacks occur when the habitual modalities of contact interruption are suddenly found to be lacking and when there is insufficient support in the field. Panic, therefore, is also a form of laceration, an opening out towards a new kind of contact with the environment which can not yet be sustained because the exposure to that which is new is too much for the individual to deal with, rubs too much salt into the wound of his or her personal history. From another point of view, then, we can see the fissure which opens up during a panic attack as an escape route from the stereotypical world in which the patient is living. As such, it necessitates a new form of creative adjustment.

Of the various modalities of contact interruption, we will here limit ourselves to describing one example of a patient who tended towards the retroflective style. Rossella is a 24 year old, only child, who has been suffering from panic attacks for about six months. She is a physiotherapist, who left her family home about a year ago for work reasons, but travels back to see her parents at weekends. She has been in a steady relationship for five years. "*My life's going absolutely fine. I don't understand why this terrible thing has happened to me, why it's turning everything upside down. Now I'm suddenly afraid to sleep alone, to drive on the motorway. I wouldn't even dream of going out of town to follow a course"*. What strikes Rossella most of all is the change in herself: *"I've always been really independent. I remember how, as a child, the night before we had to go away on a school trip, all my schoolmates would be crying whereas I'd be absolutely fine… I'd be the one comforting them. I've always managed everything by myself, but now I suddenly need my boyfriend to hold my hand before I can go anywhere. It's unbelievable!"*. Rossella had her first

[3] As in psychotic disorders, panic attacks are experiences without ground, but in this case there is a temporary collapse of a consistent ground, while in psychosis there is a permanent lack or fragility of the ground.

attack when, home alone, she began to feel unwell. *"In fact it was nothing",* she recalls, *"but if it had turned out to be something serious, what would I have done? I didn't think of it at the time, but it started to worry me afterwards. At the time, I just felt my heartbeat going crazy and thought I was dying".* From the work go, our sessions reveal that Rossella is living against a rapidly changing, evolving and traumatic existential ground. Just before her first attack, she had left her family home, changed jobs and been involved in a serious road accident in which one of her best friends, of whom she subsequently took care, had risked losing her life. Yet this situation alone does not explain the onset of panic disorder. The key factor in Rossella's story is that her independent personal growth cannot proceed in accordance with the model of self-sufficiency which she had learnt from her family. *"I now realise that in my family it has never been possible for me to give expression to my own pain and anxiety. My mother would have panicked and my father would have ended up comforting her instead of me. I've never talked about my problems. I've always been a perfect daughter. Even now, they don't know anything about my panic attacks or my therapy. The relationship Marco (my boyfriend) and I have built up together is great because we're both really free and independent, but I'm coming to realise that I often feel lonely".*

In Rossella's life the possibility of needing someone else and of exposing her own fragility led to a crisis of the retroflective contact modality. Rossella had learnt to suppress her own needs, since her environment was unresponsive to them. She had founded her own sense of security on her ability to control her environment. Her crisis stemmed from an experience which revealed the uncontrollable nature of her own body which, as a consequence of her retroflective tendencies, had come to represent an external environment: "*And if I were ill? What would happen? How would I cope on my own?".* Rossella at this moment undergoes a terrifying realisation of her own frailty and need for others. At the point where control and self-sufficiency cease to be possible, she enters into a new and uncertain terrain, where she may find herself in need of the support of others. This is the terrain of which Rossella has always been taught to steer clear. Yet now she finds herself thrust here, she must find new techniques which will enable her to traverse this new territory: new ways of being with her own needs in the company of others, new ways of belonging which do not centre on self-sufficiency alone. It will be a therapeutic experience for Rossella to feel whole, even when she is feeling needy and small, without being abandoned, rejected or humiliated Rossella will gradually come to restructure her personal relationships, learning to incorporate into them her own vulnerability and to accept support when she needs it. Her experience of panic attacks has taught her that there can be no autonomy without belonging, no liberty without interpersonal ties.

3. From *Oikos* to *Polis*: Panic Attacks and the Life Phases

From an epidemiological point of view, the peak period for individuals to have their first panic attack is between late adolescence and the age of thirty-five (APA, 2000). Nowadays, this is the period of the life cycle during which subjects normally break away from their birth families and acquire an increased level of independence. At present, this transition is more precarious than ever, since both the individual's roots in his or her own family and the new networks of relationships he or she is seeking to establish, are increasingly uncertain and tenuous. For this separation to take place, the birth family needs to constitute a ground which is at once stable and flexible. The new environment, "outside" the birth family, should offer points of reference to which the individual can relate. There should be new, consistent and open networks of belonging, which the subject can identify with or differentiate him or herself from. The passage from "*oikos*" (from the Greek: a space belonging to the few, to the home, to intimate friendship) to "*polis*"(from the Greek: a space belonging to the many, to the city, opening out into the world) would seem to be a key factor in the onset of panic disorder. This crucial passage involves a profound restructuring of the subject's affiliations and ground, exposing him or her to solitude and vulnerability. The new context in which the subject finds him or herself makes new and unprecedented demands, which the modalities of contact interruption learnt in the *oikos* may be insufficient to meet. Belonging is a significant element in the "ground" in which the individual puts down his or her roots, which provides sustenance and security at the most basic, fundamental level (Perls, Hefferline and Goodman, 1994). When the subject breaks away from his or her family, this ground has to be broken down and re-constructed. Its instability exposes the organism to the risk of its sudden collapse, and this leads to panic attacks. Patients suffering from panic attacks are suspended between past networks of belonging, which no longer offer any support, and future belongings which have yet to become supportive.

The post-modern difficulty in finding support in the polis is therefore particularly connected to and particularly evident during those stages of life during which individuals are in the process of abandoning their existing networks of belonging and increasing their autonomy. It appears likely that panic attacks strike at the very moment when the subject's autonomy increases in disproportion to the support provided by his or her networks of belonging or, to put it otherwise, when the individual's movement away from the *oikos* receives insufficient support from the *polis*.

This significant alteration to the subject's networks of belonging usually take place for one of two reasons: they may either result from a loss which is independent of the subject's intentionality, or the subject may grow apart from

his or her acquired networks of belonging. In the first of these two cases, it may result from a dramatic change of context (in the case of one patient, moving to another region) or from the loss of a significant affective connection (for one patient, the loss of a parent; for another, the end of a relationship). In the second case, panic attacks are a symptom of a rapid (indeed, over-rapid) evolution underway. The patient may be thrown in the face of a sudden loss of autonomy at exactly the moment when he or she was striking out for a greater degree of autonomy: "*What's happening to me? I thought I was making all the right decisions, but now all at once I feel terrible. I'm walking on egg-shells and it's terrifying"*. Indeed, the onset of panic disorder very often brings with it a sudden loss of independence which the patient may see as a frustrating "regression". "*It's as if something suddenly snapped and made me regress. I can no longer do things which I used to take for granted"*. The apparent contradiction between the pull of autonomy and the need implied in seeking therapy may also be a source of confusion. We often come across introjections (typical of what Lasch (1978) describes as the "Narcissistic society" who strive for self-sufficiency): *"You've got to make it on your own", "The most important thing is to be well in yourself", "You mustn't count on anyone else"*.

At this stage, it is important that the therapist remembers that our aim in helping these patients to become more autonomous is not that they become absolutely independent[4]. Instead, we wish to help them find a way to deconstruct existing networks of belonging in order to build up new ones. To push a patient towards autonomy prematurely (e.g. by encouraging them to move around unaccompanied) is to collaborate with a narcissistic trait which often exacerbates their problems. Whilst for the patient, the figure is his/her loss of autonomy and efforts to regain it, the therapist's figure should be the fragility of the patient's networks of belongings (i.e. his/her ground). While the patient may worry about the new affiliation s/he is developing with the therapist, the therapist, who sees the ground as well as the figure, can be confident that autonomy will result spontaneously from the construction of a healthy, consistent and flexible form of belonging. Autonomy feeds on belonging. The two should not be seen as being in any way opposed. Indeed, where autonomy is the figure, belonging is the ground. When dealing with patients suffering from panic attacks, it is therefore important to work on the dismantling and reconstruction of their networks of belonging before pushing them towards independence[5].

[4] From Latin, *ab-solutus* means untied from every bond and reference point.

[5] In another historical context the required specific support might be very different. For example, in a context characterised by secure, clear and rigid networks of belonging, it might be more important to sustain the deconstruction of affiliations and to encourage autonomy right from the beginning, without worrying about sustaining the ground of present and future belonging networks. The spirit of the "new" schools of psychotherapy in the

This consideration of the movement towards autonomy brings us to one of the key issues in patients suffering from panic attacks: solitude. The fragmentation of networks of belonging, the process of differentiation and leaving the *oikos,* all leave the individual at risk of a solitude which is not only painful but also unsustainable and terrifying. A brief clinical example may prove useful at this juncture. At a certain point in the course of her therapy, a patient called Clara began to suffer from an intense sense of anxiety and ill-being which only struck in the evenings and which sometimes led into a full-scale panic attack during which Clara was afraid she was about to die of a heart attack. In a moment of profound insight, Clara captured the central feature of this new disorder: *"I'm terrified of dying… No, that's not it… In fact, I think what I'm really terrified of is dying alone".* Clara's therapy was now geared towards dealing with her fear of death on two fronts. Firstly, she was afraid of losing people dear to her. In particular, she was very much surprised to realise that she was suffering as a result of her fear of losing her parents. This anxiety was a sign of a new elaboration of her sense of belonging to her family. Secondly, she discovered that her panic in the evenings was linked to a sense of distance from her husband, in a period of solitude and little intimacy between the couple. *"I'm not afraid of suffering a stroke at work, even if the idea comes to mind or I deliberately try to think of it. I'm scared of dying in my bedroom".* She gradually realised that her fear was transforming itself: *"I'm increasingly less afraid that I have heart disease. Instead, I feel as if my heart is swollen from crying".* Clara made a further important breakthrough in reaching an acute and overwhelming awareness of the solitude in which she had spent her life. At this point Clara was able to sense and articulate her fear: *"I'm so alone I'm going to die".* From this point on the fear of death was replaced as figure by the pain of solitude, and a figure thus emerged which we were able to access and elaborate upon in the course of the therapeutic relationship. Her fear was incomprehensible, devoid of history and reason, suspended like a figure with no ground. Her pain, instead, was rooted in the experiences which she was gradually recalling. Solitude and isolation are often the ground against which the fear of dying emerges so devastatingly during panic attacks. Marco, another patient suffering from panic disorder, hit the nail right on the head with the following illuminating synthesis: *"A panic attack is basically an attack of acute loneliness".*

1950s, with their strong emphasis on the independence and self-sufficiency of the subject, can be understood from this point of view (Salonia, 1999; Francesetti, 2007).

4. Specific Support: Building up the Ground

Therapy for patients suffering from panic disorder can be divided into four distinct stages, which mark four significant moments of therapeutic passage for the patient:

1. From physical symptom to fear: the patient becomes aware that the panic attack does not represent any genuine risk of madness or death, but comes to fear the attacks in themselves;
2. From fear to solitude: solitude emerges as ground and fear is replaced by pain;
3. From solitude to belonging: the reconstruction of networks of belonging (above all through the therapeutic relationship) helps the patient to lay down new roots;
4. From belonging to separation: the patient learns to carry his/her ties of belonging within him/herself and to function separately without being alone.

These four stages do not necessarily occur in a rigid sequence. They should rather be seen as a set of recurrent and interlacing thematic strands, such as we would expect to emerge during any growth process. Let us now therefore focus our attention on some important points which the therapist should keep in mind when dealing with patients suffering from this disorder.

4.1. The Therapist's Ground

In order to cope with the impact of panic disorder, the therapist must be able to maintain his or her calm, feeling him or herself to be supported by a ground which makes it possible to deal with a relationship so strongly characterised by anxiety and the lack of support. On the one hand, he or she must be able to rely on the support provided by his or her own breathing, from the body's rootedness and comfort (we might say that, for a certain period of the therapeutic relationship, at least, the therapist has to breathe for both him/herself and for the patient). On the other, s/he must have faith in his/her own knowledge of the phenomenon and in his/her own skills and therapeutic experience. The first of these forms of support derives from the id function of the self, the second from the personality function. It is also important that the therapist receives supervision and support from a third party (Francesetti and Gecele, 2009). Another telling point, to which significant attention is rarely paid, is that the therapist is participating in the same field as his or her patient (i.e. is in the same world during the same historical period). The therapist too encounters fragmentation, uncertainty and fear, sharing some of the patient's difficulties in building up a secure ground and secure networks of belonging. It is important for the therapist to be aware of the problematic nature of his or her

own ground, firstly because this awareness enables him or her to "meet" the patient on common ground and, secondly, because it aids him or her in seeking out contextual support and relational networks which will help him or her to put down stable roots and deal with uncertainty.

4.2. Words as Ground

Patients suffering from panic attacks experience a sense of acute disorientation as a consequence of the apparently incomprehensible nature of what is happening to them. Therefore, they need support in applying a verbal definition to their experience. Sometimes, patients refer to their own symptoms as "panic attacks" right from the word go. In these cases, it is important not to automatically accept this label. The patient's hasty self-diagnosis reflects his or her need to escape from the anxiety which stems from that which is unknown and indefinite. The specific support provided by the therapeutic relationship in contexts such as these consists in dwelling on and "chewing over" the indefinite, elaborating on it together in order to reach a shared understanding based on the description and the phenomenology of the experience. Otherwise, there is a risk that the patient will once again remain isolated in the process of recognising and defining his or her own experience.

4.3. History as Ground: Recovering the Continuum of Experience

Every panic attack has a "before" and an "after", which often come to be omitted from patients' accounts because the intensity of the attack itself has dwarfed everything else. Recovering this sequence enables the patient, on one hand, to delimit and confine the experience temporally and, on the other, to recover the continuum within which this experience, often perceived as a schism, as something "other", is actually situated. Thanks to this preliminary work, which is sometimes slow and difficult, the causes which trigger the episodes gradually emerge. This, in turn, builds up the patient's faith that the panic attack is not a completely unpredictable flash of lightening against a clear sky. It comes rather to be seen as the result of experiential circumstances which formulate a pathway to panic. The recovery of the patient's awareness of the other emotions which accompanied the terror of panic is an important step forward. The emotions will be perceived more clearly as this awareness becomes more sustainable. Often, indeed, terror is accompanied by pain, but this latter emotion will only emerge when the therapeutic relationship is mature enough to sustain the patient's anxiety and support him or her solitude.

4.4. History as Ground: Recovering the Sense of Terror

The panic experience which the patient brings with him/her into therapy is an incomprehensible event with no background. When the therapist begins to understand the patient's personal history and to meaningfully locate the disorder within that context, he or she will identify the direction in which the therapeutic process should tend and build up a ground of perceptible support for the therapeutic relationship.

The life phase of the patient and his/her changing networks of belonging provide us with a precious key for reading the symptoms in connection with the patient's life. We can thus gradually locate panic within the subject's biography, so that it becomes a figure which emerges naturally, even obviously, from his or her life experiences. A turning point in therapy is when the patient exclaims, "Now I understand that it isn't so strange that I'm suffering from panic attacks!". At this moment, panic is no longer a suspended figure, without meaning. It is instead recognised as an expression of the individual's personal history and life experience. The patient will now finally be able to recognise the symptoms of panic as representing an expression of ill-being in his/her own life, as opposed to a crisis of physical health.

4.5. The Functions of the Self: the Id and Personality Functions as Ground

Panic attacks result in the partial loss of the support provided by these two functions of the self. Part of the therapist's job consists in restoring this form of support and helping the patient to become aware of it. Panic disorder often leads to the onset of a corporeal numbness and a loss of fluidity in bodily gestures and rhythms. Sometimes the body seems to be suspended in space or trapped instead of resting on a chair. The resulting impression is that the organism feels unable to rely on any resting place, that the body is braced against the sudden collapse of its support and therefore stands guard, cautious and vigilant.

It is necessary to pay particular attention to the patient's breathing, as this is one of the fundamental bases of the organism's self-support. The breathing of patients suffering from panic attacks is lacking in fluidity, continuity, rhythm and harmony. Specific support in such cases should consist in helping the patient to achieve awareness of the way in which he or she interrupts the spontaneous flow of breathing, of feeling, and ultimately of the emotions which accompany this interruption. The therapist, especially in the first stages of therapy, has to help the patient to manage the crisis, teaching her/him how to deal with the acute anxiety. Two techniques can be helpful: first, the patient can

learn how to relax when s/he is out of the psychotherapeutic room: how to breath, to maintain the grounding, to relax muscles, etc. Secondly, the therapist can suggest that the patient keep a little notebook where s/he writes all phenomena when the anxiety grows: this not only supports the patient in maintaining the connection with her/his therapist but also offers a distraction from, and therefore an interruption, in the process of increasing anxiety. Reading these notes together in the successive session offers much support to the patient and information to the therapist. In this way, the therapist takes some responsibility in the process of dealing with anxiety and this leaves the patient feeling less alone when s/he is not with her/him.

Coming now to the personality function of the self, specific support should here consist in sustaining the assimilation of experiences, and especially of those experiences which are connected to belonging and losses. In this way, the patient's life story gradually acquires meaning and continuity. It becomes a narrative which belongs, at a deep level, to the subject, a story which comes to be revitalised and inhabited. During the life phase's most crucial moments of transition, the subject's notion of "who I am" undergoes some major restructuring, moving between "who I was", "who I'm becoming" and "who I will be".

4.6. The "Next" as Ground: the Unfolding of Intentionality

The ground is made up not only of the past, but also of the future. As a perceived horizon, the future, too, provides roots and supports. The figure created in the present acquires direction not only from moving in response to stimuli and needs, but also by moving towards the creation of a form or shape – a *Gestalt*. The "next" is the point towards which the organism's intentionality moves. The unfolding of intentionality and new projects forms part of the ground in the present, to which imagination, prediction, hope, desire, expectation, possibility and dreams all contribute. The subject's personal horizon emerges as a figure against the ground formed by the perception of the future which is shared on a social level. Representations of the future have taken on previously unheard-of contours over the last decades. As several authors have noted, we have passed from a vision of "future-promise" to one of a "future-threat" (Benasayag and Schmidt, 2006). Once again, we come up against the sum of two kinds of vulnerability: in his/her uncertainty as to the horizons of his/her own biography, characteristic of certain stages of life, the subject is afforded no support by the profound and disturbing collective scenarios prevalent at a social level. Panic can indeed be overcome, in part, through a construction or reconstruction of the future horizon and, in particular, of the future plans and

networks of belonging towards which the individual is moving and which have yet to be defined, acquired or consolidated.

5. Therapeutic Belonging

The cultivation of therapeutic belonging is crucial to the treatment of panic disorder. Indeed, if we bear in mind that, as we have observed, panic disorder is the expression of an inconsistency in networks of belonging and, thus, of an insupportable solitude which is gradually revealing itself, it grows clear that an authentically and emotionally therapeutic relationship should constitute a specific remedy for this condition. Patients suffering from panic attacks undergo significant improvements if they feel that they are able to, in some sense, *keep the therapist with them*, between sessions. In order for this to happen, the patient needs to experience contact with the therapist and to assimilate this novelty. There are no short-cuts here. It would be useless (indeed, it would be downright foolish) to dilate the boundaries of therapy, passing beyond its limits. Neither is it possible to keep a safe distance without getting personally and authentically involved. It is necessary, instead, to respect, support and get across the protective mechanisms which the patient has built up in the course of his/her lifetime (modalities of contact interruption), which impede him or her from risking a new involvement. Notwithstanding this, such considerations should be particularly present when dealing with patients suffering from panic attacks: *"How do we two belong to each other? Will you take me with you? What impedes you from doing this? In what way is this place present from one meeting to another? How do you lose me? What are your feelings for me? Do you think that you disappear to me when you walk out of the door? Do I disappear to you?"*. Where there was panic, therapeutic belonging will gradually emerge, weaving together a network strong enough to provide a persistent ground upon which the patient's experiences can be founded. At this point, separation should become possible. The patient will find him/herself able to sustain presence in absence, to be alone without feeling alone.

Comment

by Nancy Amendt-Lyon

With clarity and profundity, Francesetti presents a concise description of the genesis, onset and manifestation of panic disorders according to Gestalt therapy theory. His description of four "significant moments of passage"

which may occur during the therapeutic process as well as the specific supports that the practitioner must keep in mind when dealing with a patient suffering from panic disorders offer excellent orientation in this difficult field. The case vignettes chosen to bridge theory and practice are succinct and afford the reader insights into the course of the disorder.

Francesetti's contribution to Gestalt therapy theory is to be highly commended and I indeed support his perspective. Nonetheless, this review intends to initiate a discourse by highlighting and questioning certain aspects and by revisiting sections of Francesetti's chapter that were not perfectly clear to me.

In the section entitled "Panic Disorder and Contact Interruption", the author emphasizes an important supposed contradiction: «The reduction of presence through contact interruption is a key factor in the Gestalt reading of psychopathology. The habitual form of contact comes to represent not only a limit to personal growth, but also the very ground which supports the patient». Francesetti speaks of contact interruptions whereas I would prefer the term contact styles, describing the specific patterns which human beings tend to create in dealing with the exigencies of their life. Although a person's contact style reduces his or her presence, i.e. limits personal growth, this individual, habitual way of behaving with others and dealing with life's demands has become part of the very foundation which enables contact. When the individual's habitual modalities are suddenly insufficient and the field fails to provide adequate support, panic attacks ensue. This perspective is convincing, yet when Francesetti writes that a young female patient is «living against a rapidly changing, evolving and traumatic existential ground», I am unsure what "living against" implies. I wonder if she is struggling to keep up with the tempo of a world that is too hurried for her, feeling out of synch, or is she reluctant to accept certain contents of her surroundings. My tendency is to focus on the developmental crisis in the patient's life, and how she appears to very suddenly find her habitual patterns of retroflecting needs and feelings to be inadequate and inhibiting. Her new life situation virtually forces her to realize that she has outgrown the style that suited her as a child and adolescent. The developmental crisis of a young adult leaving home to live somewhere else for the first time differs markedly from the developmental crisis that, for example, a recently widowed elderly man faces when he picks up the pieces of his life without his spouse, or a single, middle-aged woman in a demanding managerial position during times of financial duress, even if, phenomenologically speaking, they exhibit very similar symptoms.

The section entitled "From Oikos to Polis: Panic Attacks and the Life Cycle" clarifies many questions referring to developmental issues, the life cycle, and the onset of panic disorders. My concern here is that several crucial aspects of the transition from Oikos to Polis have not been thoroughly addressed,

possibly because this would have gone beyond the scope of a book chapter. Reference to gender differences would have enhanced the reader's understanding of the manifold influences on the genesis, manifestation and course of this disorder. Similarly, exploring the ways that various social strata and the ethnic and religious affiliations affect panic disorders would make for fascinating future research.

Francesetti's tenet that there can be no autonomy without belonging emphasizes field theoretical, relational aspects of modern Gestalt therapy. Despite the fact that Perls, Hefferline and Goodman (1951) equated the definition of the organism with the definition of an organism/environment field, what remains in most readers' minds is Fritz Perls' dictum about moving from social support to self-support as a goal in life. Subsequent generations of Gestalt therapists introjected this aim of autarky, often taken to the point of being extremely narcissistic and self-referential, while relationships fell by the wayside. I fully embrace Francesetti's view that contemporary Gestalt therapy neither considers autonomy and belonging to be a matter of separate states of being, nor does it prefer one state to another. The concept of contact and support that Laura Perls so gracefully taught helped me to realize that the relationship, connectedness and mutuality enable growth, that the most solid psychotherapeutic work is done in small, experimental steps that can be well assimilated, and that the field must always be taken into consideration.

The section entitled "The functions of the self: the id functions and personality functions as ground" was quite illustrative in describing the id functions. To enhance the personality function of the self, I followed Francesetti's suggestion and asked a patient suffering from panic attacks to carry a notebook with her and describe situations that either enhanced or diminished feelings of panic. After many months of note-taking, she told me that she also drew little self-portraits when she jotted down what enhanced or diminished her feelings of panic. This process resulted in what we named her "illustrated panic autobiography".

In his final section, entitled "Therapeutic belonging", Francesetti zeroes in on making the therapeutic relationship and the issue of belonging therein explicit. He does this with admirable authenticity and grace. Theoretically, he convinces me that separation should become possible if belonging has been experienced and there remains a noticeable connection with the other despite his or her absence. Once again I felt that a case example would have been illustrative here, since many therapists have been faced with the difficult situations in which it is a struggle to establish appropriate boundaries. As Gestalt practitioners know from experience, there will be patients who either despair at not presently being able to establish a sense of belonging with others outside the therapeutic context or who tend to misread the growing therapeutic contact

to be an offer of "real" contact, relationship or partnership with the therapist beyond the therapeutic setting. The latter was the case with a young woman with whom I worked for about three years. About six months after we terminated psychotherapy, she called to inform me that she was doing well and carefully asked if we could meet for coffee, just to chat. Beyond informing her of the formal regulation that prohibits any social contact with former patients for at least several years, I attempted to pick up the thread of our therapeutic bond. I told her that I often thought of her and was glad that she let me know how she is, because a therapeutic relationship is such an intimate one and once it has been terminated, we therapists are left to our own imagination about our former patients. In this way I tried to convey that despite the affection that I developed for her, my social life does not voluntarily include contact with patients. This "personal space" is necessary for me to work professionally.

Gestalt Therapy with the Phobic-Obsessive-Compulsive Relational Styles

by Giovanni Salonia

His mummy gives him a big warm hug.
"Now I'm not alone", thinks Ben
"Now I'm not alone".
And so his mother explains the reason why
hugs were invented: to unite solitudes.
David Grossman (2010)

1. Gestalt Therapy and Psychopathology

Gestalt Therapy[1] reads phobias, obsessions and compulsions as dysfunctional relational styles that reveal a serious difficulty of the organism in entering into a nourishing contact[2] (Salonia, 2001b) with the environment[3]. In the hermeneutic of Gestalt Therapy, in fact, every psychic disturbance reveals and derives from an interruption of the process of approach between organism and environment, which occurs at different moments of the temporal relational path.

Missing the contact with the environment stops the growth and produces symptoms: for example, after talking to a friend, I become more aware (Salonia, 1986) of it when I'm concentrating whether the contact with him has been full or not by checking the following questions: "Did I say *what* I wanted to say? Did I say *everything* I wanted to say? Did I interact as I wanted to?". If the answers are affirmative, the contact was full and nourished the friendship; but if the answers are negative, the contact was unsuccessful in whole or in part. We speak of relational competence when a person is habitually capable of full contacts with the environment.

Another central point of the Gestalt Therapy psychopathology, in my opin-

[1] For an introduction to Gestalt Therapy: Perls, Hefferline and Goodman (1951); Polster and Polster (1973); Spagnuolo Lobb (2001c).

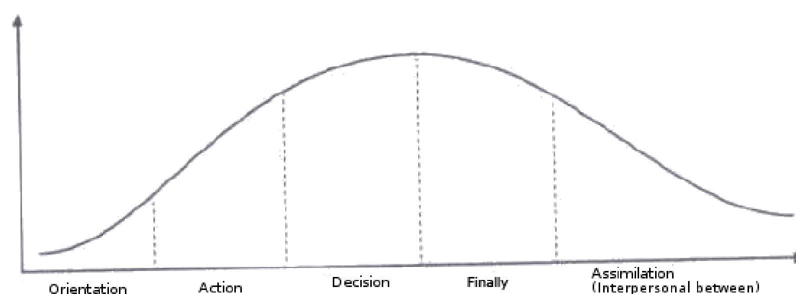
[2] "Nourishing contact" in the language of Gestalt Therapy is a valid, functional encounter with the environment.

[3] The environment for Gestalt Therapy is the otherness in its variety (animate and inanimate).

ion, is given by the analysis of the precise moment in which the interruptions occur along the course of the contact; it runs from the need of the organism to its concrete realisation which is the encounter with the environment (Salonia, 1989c). In the Gestalt Therapy theory of contact, this pathway is articulated in precise stages – or phases – follow one another epigenetically (in each, the organism assimilates the preceding one and prepares for the next): the first is to orient oneself, knowing where one wants to go; the second happens when energy emerges and the organism moves towards the environment; the third is the moment at which the organism, by now close to the environment, decides to surrender; finally, the encounter occurs (the contact, at last!): in the last phase, the organism assimilates and grows because of the completed contact (Tab. 1).

Table 1.

Commento [AG4]: Figg. impastata e storta
Rinviare originale in migliore risoluzione



Each passage from one phase to the other would generate desire and fears. At a developmental level (Salonia, 1989b) the child learns the relational competence (Salonia, 1997) if in these passages s/he receives the specific developmental support from the parental figures. If the parental figure, instead of containing the child's natural anxieties, becomes frightened in her/his turn, the child will also be burdened with the adult's fear and her/his anxiety will become anguish and terror: s/he will lose spontaneity in the experience of the organism and, instead of going ahead towards the full contact, will produce a symptom. In other words, in Gestalt Therapy the symptom refers to the interruption of a progress towards the contact and would be "*instead of*" the step that the organism has blocked because it was overcome by anguishes. It is useful to specify that the interruption of the contact about which we are speaking is not to be read in behavioral terms, but at the level of corporeal and relational experiences. For instance, if two partners are engaged in a telephone conversation and suddenly the line goes dead there is an interruption of contact which is

only a behavioral one, because it does not concern the processes of contact. If, on the other hand, while they are talking one of the them feels offended and does not make this explicit but goes on talking, slowly but surely reducing her/his interest in the interaction, in this case an interruption of the relational and "corporeality experiences" (her/his body too becomes closed) occurs, although the verbal interactions continue.

Going back to the developmental phase, support or lack of support in the developmental relationship also passes through *corporeality* before through the contents: the parental introjections ("Don't do this or that!") block the child's spontaneity not so much because of the content as because of the corporeality tensions, the tone of voice with which the parent unconsciously acts on the child's body[4].

To conclude, the interruptions of contact (which, according to the phase in which they occur, take on differing forms of disturbance) (Salonia, 1989c) are learned in the primary relationship, are manifested in the various relationships, that the organism attempts to set up with the environment and will be able to find a solution and a cure in a relationship which is therapeutic[5].

2. What Specific Interruption for the Phobic, Obsessive and Compulsive Relational Styles?

In the paradigm of Gestalt Therapy – as already mentioned – disorders differ according to the different moment at which the organism's progress towards the fullness of the encounter is interrupted.

I think that phobias, obsessions and *compulsions* are disorders which reveal interruptions of the cycle of contact (Salonia, 2010b) at the specific moment (second phase of the development) when the organism, after being oriented towards the new direction, begins to be aware of excitation and energy to move towards the environment (action/manipulation phase)[6] (Tab. 2).The rising excitement (increase of amplitude of breathing and energy, the body activation) is, in fact, a necessary preparation to carry on the intention to reach the environment (Salonia, 2010c).

The aggressive energy[7], whose aim is to come to terms with the environment before encountering it, is developed in two stages with two quite different

[4] On the concept of *intercorporeality* see G. Salonia, *Edipo dopo Freud. Gestalt Therapy e teorie evolutive*, Il Pozzo di Giacobbe, Trapani, in press.

[5] On this topic, even if with different perspectives, see also: Gaffney (2010a; 2010b) Jacobs and Hycner (2009).

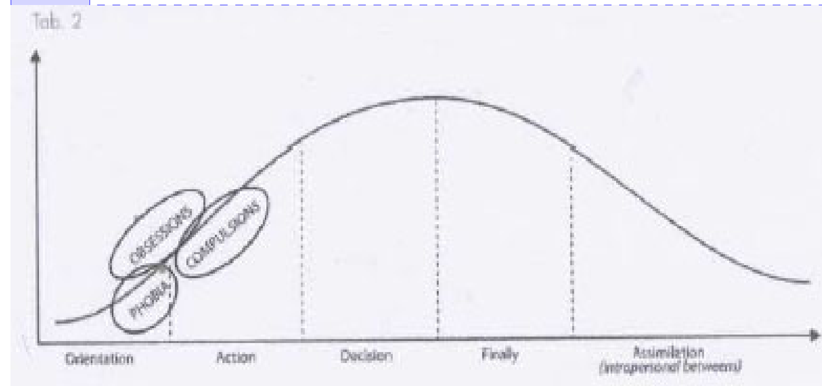
[6] See Mascarello (2008).

[7] Aggressiveness has a positive valency in Gestalt Therapy, in that it indicates the strength to fulfill oneself. See Spagnuolo Lobb, Salonia and Sichera (2001), pp. 180-190.

forms: in the dentition phase and in the anal phase. The Perls (husband-and-wife team) (Perls, 1995) discovered that, with the arrival of teeth and chewing, a form of aggressiveness necessary for biting, seizing, deconstructing and assimilating the environment is developed.

Table 2.

Commento [AG5]: idem



Stress on this discovery (which, contrary to what is usually maintained, is not the advance of the time of aggressiveness, but the discovery of another kind of aggressiveness)[8] leads to a radical change in the paradigm of learning and hence of psychotherapy too, replacing the "passive" introjection theorized by Freud with deconstruction and assimilation. A significant moment in this change of relational paradigm is the moment when the baby "bites the breast": with this gesture, s/he closes the interactive but calm modality of sucking and introduces, in being-with[9] the mother's body, the novelty of the power of the teeth. There are several ways the mother's body can offer to the early bites to her nipple: she may withdraw, become annoyed, punish, smile, surrender and much more. There is an interesting rite in the *Utku* tribe, in which after the first bites, the mother smiles and says in a kind of "mantra": "S/he has no brain" (i.e., "s/he's not doing it on purpose") (Briggs, 2009).This is a delicate moment: the response of the mother's body (confirmation, recognition, discredit, punishment, abandonment) marks the experience of aggressiveness in the body

[8]A common thesis in the world of Gestalt Therapy; see, for example, From and Miller (1997), pp. 8-23; Salonia (2011c).

[9]Differently from Stern – see Stern (1995) – I prefer to speak of patterns of "being-there-with" (and not so much of "being-with") as to recall the phenomenological tradition.

of the baby[10]. If the new power the baby is expressing receives negative bodily feedback, it is blocked producing specters of terror, destructiveness or nastiness[11].

The aggressiveness of this phase has a distinctive feature due to the fact that it is connected with hunger and survival; for these reasons (this is why) interruptions are so serious and so intense as to be configured in some cases as psychotic[12].

Subsequently, attention (*libido*) is developed in the body of the child towards the anal sphincter (Freud, 1989).The child realizes that, as well as receiving food from the environment (which s/he chews and deconstructs in order to assimilate it, or rejects by spitting it out) s/he has a power now that is all her/his own: s/he can "withhold" or "let go" the excrement from her/his body. Recognition of this power brings about an epistemological change of perception of the self and of the other. The child would learn another relational paradigm (Salonia, in press): in fact, by controlling the anal sphincter (every sphincter is a frontier between inside and outside) s/he experiences a power that regards not only her/his own body but the parental body too, which – as the child realizes at once – is waiting for the products of her/his decision.

The marked difference between the two types of aggressiveness, which are developed at different times, also explains the variety of different symptoms and experiences in the various pathologies depending on the moment at which the interruption occurs. Interruption in the teething phase (transition from receiving to manipulating) will lead to symptoms of phobic-obsessive-compulsive disorders, whereas in the anal phase it will produce symptoms on the projective side (attribution to the environment of the paternity of one's experiences).

Within this developmental picture, phobias, obsessions and compulsions fall into the same clinical area, because they have in common terror (unsupported fear) as a response in the body of the child to the fact that the parental body does not support the emergence of experiences of excitation and energy. In particular, in the phobic style the blocking of energy would come about precisely at the moment when this appears in the body, in the obsessive and compulsive-containing style at the moment when one attempts to control the energy on experiencing its first sensations, in the compulsive-expulsive style when the experiences of excitation have already been felt, but have been evaluated as

[10]This is also true for bottle feeding, when the child begins to bite the teat on the bottle and the irritated mother tries to shaking it to make suck the baby again or to "play along".

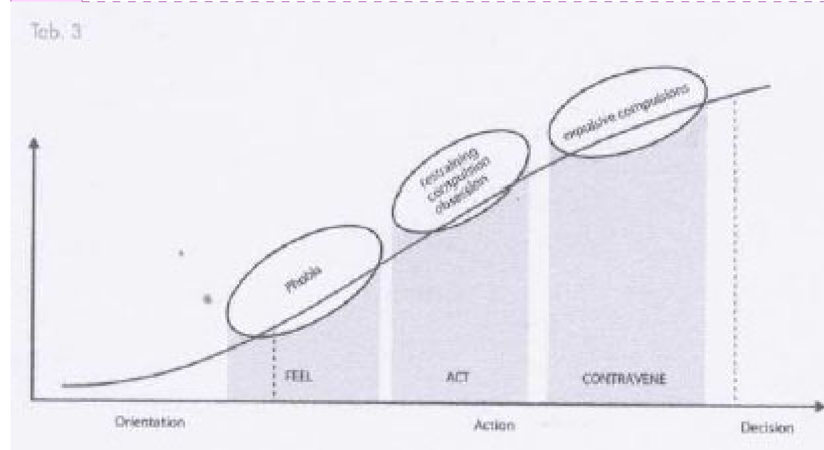
[11]Many primary anguishes spoken of in the literature and in child clinical treatment – D.W. Winnicott (1970), *Sviluppo affettivo e ambiente*, Armando, Roma – should be read in this context of adults who exacerbate children's fears instead of contain them.

[12]I am grateful to the psychiatrist Dr. Paola Argentino for this clinical clarification.

destructive of the parental body and hence there is a desperate attempt to expel them (Tab. 3).

Table 3.

Commento [MRC6]: è necessaria una figura migliore



3. Phobic Relational Style[13]

Phobia is described as unmotivated, intense fear of an object or a space unrealistically perceived as dangerous. As we shall see, the subject is not afraid of the object itself (not really afraid that it will harm her/him) but has a phobia of the sensations that it provokes in her/him. Hence, the phobia fundamentally concerns the anguish of feeling certain emotions which the body evaluates as insupportable.

3.1. Descriptive Level

In the phobic relational style the patient feels constrained to avoid contact with specific objects (animate or inanimate) or with precise environmental conditions (large spaces/agoraphobia or restricted spaces/claustrophobia) in order not to feel unpleasant, unbearable sensations. As we were saying, although the term "phobia" recalls fear, the subject does not really fear a concrete danger (if, for example, s/he has a phobia about grasshoppers s/he is certainly not

[13] Anthropologically, phobia refers to the anxiety of feeling, see Salonia (2010c).

afraid that s/he will be devoured), but feels that the sensations that the proximity of grasshoppers provokes in her/his body are unbearable. These sensations are also perceived as looming in their fixity (like an unmoving figure that does not evolve in the background), so that the subject needs to exert thorough control over every new environment in order to make sure that the phobic object is not present (and cannot become present) in her/his perceptive field. As we have seen, this terror has been learned in a relationship in which the patient has not been supported in the emerging of the excitation of her/his body. Without a hand to contain them, the sensations that should lead to contact become dangerous and block the progress of the relational intentionality. At this point, the child connects the unbearable internal sensation with an external object which is easier to control. Thus there comes about a circular, interdependent entanglement between the constriction of the outside world (from which the phobic objects are excluded) and the constriction of the subject's bodily pattern and pattern of relationships. This constriction becomes particularly rigid because it has the dreadful task of controlling the drive to go into the world, where one might encounter the phobic objects that inhabit it.

I believe that to understand the world of the phobic patient it is necessary to bear in mind that s/he is contextually attracted and terrorized by the phobic object: the sensations s/he wants not to feel – by means of phobic avoidance – attract her/him irresistibly, in that they belong to her/his identity and are a challenge to her/his fullness and to her/his relationships.

The seriousness of the phobic disorder is connected to the partial or total impairment of the relational, professional and social life. Phobias are presented in various forms and at various levels of seriousness (neurosis and psychosis) (Salonia, 2001a)[14]: phobias of contagion, diffusive invalidating phobias, monothematic phobias and posttraumatic phobias.

One particularly serious phobia is the fear of *contagion*: fear that the external object may enter inside the body; whereas, when the phobia regards an object, the danger seems to be circumscribed and can be kept out, in the contagion phobia the object is imperceptible (dust, grime, fragments of glass or of dirt) and difficult to control even at visual level. Knowing that the toxic material is present even if it cannot be seen becomes the patient's nightmare, and s/he feels constrained to avoid any place where s/he has even the slightest possibility of being infected. The basic phobia is that of an emotion perceived as dangerous may pass through the skin and into the body without the subject's realizing it and being able to stop it. That is a more ancient fear than the others, located in the first phase in which one moves from introjection to energy/action. This fear is often learned in a primary relationship in which the pa-

[14] Theoretical and clinical aspects of serious disorders will be dealt with in a future paper.

rental figure is physically intrusive. One woman patient reminded me of the explosive irritation that her mother's body excited in her: when she started to hug her, the body-to-body contact gradually became suffocating and even painful because of little bites which were supposed to be affectionate but which hurt her and made her violently angry. When she tried to withdraw, she was accused of being cold and unloving. If the person grows up with the feeling that even her/his bodily boundaries are not clearly and controllably outlined and that the environment can break through them in many ways, a contagion phobia will readily develop. The lack of skin, as a perimeter that protects, recalls the lack of the boundaries of the Ego. This is because, often, contagion phobias become so pervasive that they cancel out the patient's social life. In the acute phases, it even becomes difficult to live at home so that contacts with the external world are avoided as far as possible and time and energy are consumed in the exhausting (for the patient and for others) control and cleansing of possible contaminations/penetrations of "toxic material".

If the phobia regards precise objects which increase like wildfire (you start with one object and then continually add others to it), we speak of *diffusive phobia*. Since the emotions one is seeking to avoid press on the body to be recognized, avoidance of one object will not be enough and it will be necessary to keep adding others, under the illusion that it is possible to control the internal world by means of controlling the external world. When this type of phobia becomes increasingly pervasive, the subject will progressively avoid all those objects which enter her/his perceptive field, to the point of shutting her/himself up in the house in an increasingly serious regression. In fact – as we have said – the human being cannot become adult without experiencing and living through the emotions necessary to the development and wholeness of the person.

In addition to this category of diffusive phobias, there are circumscribed (*monothematic*) phobias which only block the subject's sense of fullness. This is the case of subjects who have a good sense of wholeness and of relational, professional and social life, but are unable to overcome phobias of precise objects or situations (e.g. the phobia of airplanes and such) which go back to some slight block of growth. Since the object is always the same and is not habitually present in the subject's existence, by way of tactical expedients s/he is able to avoid them without particular inconvenience. At the moment, when the subject is attracted by a new developmental task (at affective or professional level), which will constrain her/him to come to terms with the phobic object, s/he will take into consideration the concrete possibility of turning to psychotherapy to overcome this limitation.

In conclusion, *post-traumatic* phobias. We speak of trauma when the subject suffers an unforeseen and unforeseeable violence. Being taken unawares

without being ready, and thus in a situation of impotence, makes the experience dramatically negative. It is known that when the subject cannot actively express her/himself in the interaction with the environment, s/he has an unpleasant sensation which takes on valencies and intensity according to the significance of the experience. It is necessary to develop the whole complexity of the trauma (and of the many experiences provoked by it) in order to reestablish the destroyed spontaneity of the organism. In post-traumatic phobias the fulcrum of the disorder is constituted by questions and doubts that are seeking answers: the organism first asks itself why ever it has happened; secondly, how to avoid it happening again and being vulnerable; lastly, why ever no one was there to protect it[15].

4. Obsessive Relational Style

Obsessions are thoughts, impulses or images of an invasive, repetitive kind which are presented to the mind unwished for, irrational and uncontrollable by the individual. Their function appears to be to control the energy and the sensations the body begins to be aware of and is afraid of because it feels them to be irrepressible drives to destructive actions. It is the risk of asking that the individual wants to control: the action, in fact, is risky because you may make a mistake, you may (be) hurt and action makes you personally responsible. Action[16] is, in the last analysis, the place where the uniqueness of the person is expressed in irreversible way, becomes visible to the whole world and traces the lines of identity (Saraceno, 2007).

4.1. Clinical Level

We start from the awareness that through obsessive thoughts the patient now, dysfunctionally and painfully, cares for her/himself. The excessive control s/he exercises would be due to the excessive lack of care on the part of the parental figures.

Since in the absence of the spontaneous developmental control by the parental figures s/he has not learned intimate spontaneous control, the patient attempts in every way by means of obsessive thoughts to keep under control those emotional energies that s/he considers dangerous. For Fritz Perls obses-

[15] It may happen that a trauma brings up to the surface certain problematic aspects of the subject, so that the subject may pass from post-traumatic phobias to phobias of contagion.

[16] The obsessive relational style is referred to the anguish of acting, see Salonia (2010c).

sive thoughts represent a pacifier[17]: a way of attaching oneself in order not to act, not to risk provoking a change in the relationships. The obsessive relational style, in fact, is developed in a more advanced developmental phase than is the case with phobic modalities. Fear – which, being unsupported, has become terror – emerges in the child's body when the motions begin to be felt and drive towards action. It is as though the child had received the first support in feeling experiences, but then had lacked a support in letting her/himself go in the flow of emotions. Now the child's body feels energy, but does not trust it and desperately tries to keep it under control.

While the body (the bodily pattern) of the phobic is, as it were, made smaller, the obsessive's body is very tense, since s/he is constantly, dramatically engaged in the appalling task of controlling the energies s/he feels.

Obsessive thoughts, although they take various forms, have in common the indecision which expresses (almost makes visible) the interior-relational drama: "Shall I let myself go or not to the emotions in the relationship?". The indecisions regard certain fundamental topics: security/insecurity ("I turned off/didn't turn off the gas", "I closed/didn't close the door"), health ("I have cancer/I don't have cancer"), guilt ("I am/am not responsible") and perfection ("I'm wrong/I'm not wrong"). This indecision clearly revives the process of the organism which is opened or closed with regard to the emotion that attracts or terrifies it, in a suffocating teeter-totter. Nor is the energy that is consumed in indecision and in the torture of obsessive thoughts calmed, since, in effect, it does not achieve its aim.

Obsessive thoughts are distinguished in *syntonic egos*, when the subject understands the reasons for them, feels that they are her/his own (s/he must know whether s/he has turned off the gas, s/he must decide whether to mail the letter s/he has written); or *dystonic egos*, felt as extraneous, coming from outside (for example: undesired blasphemy, images of aggressiveness, swear words and much more). These last often go back to a furious anger, because they are connected to oral aggressiveness in its terrible ambivalent declension: feeling anger at the person on whom one depends and for that very reason being unable to express it. A brilliant solution to this ambivalence was invented by Letizia, the seven-years-old daughter of a former patient with obsessive relational style: "Mummy" – she says furiously – "you have to die, but not immediately... in five minutes". If the child is not supported and does not find a solution, s/he will be overcome by an anguish of death: her/his own death, but also the deaths

[17]«The dummy allows the discharge of a certain amount of aggressiveness but, apart from that, it does not produce any change in the child, that is, it does not feed him». «There is anything that cannot serve as a dummy, as long as it helps to avoid changes in reality. Take for instance the obsessive thoughts, which can go on for hours and hours, keeping the patient busy without leading to a decision or conclusion» (Perls, 1947, pp. 135-136).

of the much-loved people who are indispensable to her/him. From backgrounds of this kind, thoughts – sometimes fantasies – emerge: dystonic egos which have subjects and images, often intense, of violence (obsessive thoughts of actions against loved ones, seeing heads rolling, and images of this kind).

As indicated, the background fear would be of being separated, of having one's own emotions: becoming unique as the risk of death. It is, in this sense, interesting to note how the disorder actually attacks thought, which is the location and the beginning of separation and differentiation. In this case too we are faced with a – wise, paradoxical – harmony of organismic and relational self-regulation: the thought is born, but as it cannot lead to differentiation it is blocked in regressive attachment to the other.

5. Compulsive Relational Style

Compulsive actions are actions that the patient feels forced to carry out under the drive of an irresistible internal duress in order to calm the excessive tension (if s/he does not carry out that particular action s/he will plunge into terror and something terrible may happen). Restraining compulsions should be distinguished from expulsive compulsions (which we shall see in due course) and which specifically concern gestures of purification which in contrast have no aim of restraint. The frequency of a compulsive action varies: from a periodic rhythm (which creates some difficulties) to one which is so intense that it makes social and personal life impossible.

5.1. Restraining Compulsive Actions - Clinical Level

In restraining compulsions, the person carries out gestures which serve to calm the tension resulting from the sensation that the energy felt is unbearable. In contrast with what happens in obsessive thoughts – which attempt to control the emotions and which, together with thoughts, avoid action – restraining gestures have the precise aim of calming the tension which has become unbearable.

We start with an example. A patient was terribly afraid that she would throw out valuable things together with the trash. So she never threw out the trash, but piled it up in a room, knowing that she would check it: thus she had a mental picture of the trash not thrown away, but checked in the expectation of finding some valuable objects. This gesture – it subsequently became clear – had the sense of controlling her fear that, if she let herself go to aggressiveness, she would lose things (bonds) that were important to her.

Within the same phenomenological field (restraining those emotions felt to be uncontrollable) but with different nuances, I think, we may collocate rituals, tics and stammering.

Rituals – as we have said – are repetitions of a single codified gesture (e.g., if I don't count up to three I can't close the door) directed to control an emotion that is felt to be dangerous and uncontrollable. Always repeated in the same way, they thus become a kind of structure which restrains energy and are supported by a magical thought: "If I carry out this gesture I will succeed in controlling my impulses, i.e. nothing bad will happen". It is the opposite of trust in the spontaneity of the organism. These are idiographic gestures, perceived as obligatory ("anankastic" rituals). A young girl could not sleep unless she first arranged her shoes with one facing the door and one facing the bed: in this way she calmed her desire to run away from home, and her fear of doing so. These are different from *stereotypies* – idiographic-relational gestures – which serve to create a safety belt in the psychotic experience of the relationship.

Tics – when they have no organic basis – are reflex behaviors characterized by repetitiveness, and are a kind of bodily discharge of a tension that becomes unbearable at bodily level. A background element often found in tics is the impossibility of expressing disagreement in the family environment. Although they perceived as something timeless and spaceless, careful attention (microanalysis) reveals that they are connected to a sharp rise of emotional tension in the family climate. In a family session, parents spoke of their son's tics – in his presence! – which they could not understand. It was interesting to note that the tics emerged each (every) time they repeated a particular word about their son.

Tics have a creative form too which tells about the relational frame from which they emerge of. Avoiding (rapid, imposed) interpretations, it becomes interesting – always accompanied by the person's consent and verification – to work back from the tic to the story which it summarizes in poetic form.

In *stammering* there is terror of expressing a different or aggressive thought towards some family member of whom the stammer is afraid. The person feels the drive to express her/himself, but also powerfully feels the block. From the bodily point of view, the short circuit of stammering would be caused by the fact that on the one hand the body is frightened and blocked in a chronic inhalation, on the other, in order to speak it must exhale: stammering would be the result of the dogged attempt to exhale, breaking the spasm of inhalation (a compromise between saying and not saying). That it is a case of a block in the expression of the subject's uniqueness (in terms of having thoughts of one's own or anger of one's own) is apparent from the fact that the stammer can sing well in a choir or even alone, because in this s/he is not expressing her/his uniqueness but returns to a confluence with a "we" from which s/he has not differentiated her/himself.

5.2. Compulsive "Expulsive" Actions[18] *- Clinical Level*

In expulsive compulsion, as we have seen, gestures are performed which seem to answer a precise purpose (washing teeth, hands etc.) but which in reality are carried out in order to calm anguish. While the ritual is precise and calming (washing the hands three times), expulsive compulsion does not have time and numbers as perimeter and may be prolonged until the subject is exhausted.

I think that the aim of the compulsive expulsive gesture is the wish to expel from one's body an experience that has become unbearable, an aggressive or sexual bodily sensation that the body ahs felt with interest but which has provoked a disruption in the bodies of the parents. The subject is afraid s/he will be punished or abandoned because s/he has felt excitation and, in order not to be "thrown out" of the relationship, s/he begins the vain attempt to "throw out" of her/his body the experience and the need. S/he does so with a gesture which s/he would like to be able to expel, but has no success because the paths of awareness are different. This is a more disturbing drama than Macbeth's: the guilt in question may be taken on and subsequently forgiven or expiated, but the neurotic feeling of guilt leaves no way out. The outcome is the tragically fruitless gesture of persisting in purifying the hands on the part of the individual who, having committed no crime, nevertheless feels entirely guilty.

But every symptom has its own painful logic. As the energy cannot be expelled, the compulsive gesture, paradoxically and indirectly, obtains what it denies wishing to obtain: it keeps the others (from whom it is not separated) bound to itself, but perversely irritating them. Maria, when she starts washing her teeth, prolongs this gesture for half an hour, sometimes longer. If her family have to go out with her, she need only say "Excuse me, I must wash my teeth first" to cancel out any family project. In fact, the symptom may become invalidating at both personal and family level. The almost violent strength with which the subject performs the expulsive gesture also expresses the anger s/he feels at having to deny her/himself of a part of her/himself (stated to be unbearable for the relationship, and hence for her/his body).

6. The Work of Therapy with Phobic-Obsessive-Compulsive Relational Styles

The first step at the therapeutic level – as we know – is to collocate the request for help within the personal or family Life Cycle (Salonia, 1986; 1987).

[18] See Salonia (2010c).

Even when the malaise lasts for years, attention should be devoted to the moment at which the subject asks for help because that is when the disorder, which has been borne for a long time, has become unbearable because of the impending of a new developmental task. The "direction in which" the organism is going (the "where to go" at developmental level) is always the guideline of a work of therapy[19].

In my opinion what proves very useful (to the patient and to the therapist) is starting with two or three family sessions (Salonia, 2009) before personal work, so that both therapist and patient can go into the background against which the phobic-obsessive-compulsive relational style has been formed. Even if – understandably – the members of the family will always try to bring the subject of the conversation back to the DP's (designated patient's) disturbance, during the session the relational modalities of the family and, specifically, those of the parental couple towards the offspring and particularly towards the subject who suffers from the phobic-obsessive-compulsive disorder will become visible. Deciding whether to continue with family sessions or to work with the patient and see the family again after some time is a delicate choice, which must take into account the risk of stigmatizing as designated patient the subject who is suffering from the phobic-obsessive-compulsive disorder. When possible, it is very useful to suggest to the parental couple that they undertake a parallel therapeutic path, in order not to hinder – unawares – the child's path.

If, instead, it is a parent who is ill, the current family should be convened. During the session the therapist will have a circular view of how the symptom involves not only the partner (who often becomes a care giver) but also the offspring. Clearly, the therapeutic work will be continued either individually with the sufferer, or with the couple. Particular attention – when it is a parent who has the symptom – should be paid to the possible disorder of the personality function: a person who has a phobic-obsessive-compulsive symptom tends to give up the parental function, creating a considerable relational disturbance for the offspring who may become marginal (sometimes even for the couple), in view of the intensity and pervasiveness of the symptom. It is counterproductive to treat the phobic-obsessive-compulsive suffering of a parent without working on the parental function – not so much (obviously) to increase responsibilities, but rather as a resource for the therapy and with a view to taking care of the offspring. The long-term objective of the therapy is the recovery of the energy by which the subject is terrified, in order in this way to reach the other, realizing full, nourishing contacts[20]. It is said that phobic-obsessive-compulsive patients put the therapist's patience to the test. In fact phobias, obsessions and

[19] For another vision of this topic, especially talking about Gestalt Therapy, see: Bar and Levine (2012); Miller (2011); Feder and Ronall (2011); Staemmler (2009).

[20] On this topic see also: Zinker (1977).

compulsions are very resistant, repetitive symptoms, so therapy is no simple matter. The patient "hangs on" to the symptom, whatever it may be (phobia, obsessions, compulsions), with the same persistent, inflexible strength of one who, in order not to fall into the ravine, hangs on to the rope that saves her/him. Asking a phobic-obsessive-compulsive patient to trust the reassuring words that you say to her/him, is like saying: "Drop the rope!" to someone who has a gorge below her/him. The symptom, we know, replaces the lack of the parental figures, so that the patient has said to her/himself: "If I don't look after myself, nobody will care". "How can I trust you", a woman patient says to me, "if my parents, though they love me, have made mistakes? How can I be sure that you won't make mistakes with me?".

The therapist's task is to create an atmosphere of trust, in which s/he stays with the patient's torment and gradually becomes visible to the patient (at first, in fact, the therapist is only a prosthesis for the patient: a person who is hanging on to a rope does not see anyone). In any case, in all three relational styles, it will take a long time to create this atmosphere of trust, given the terrible experience the patient has lived through. I believe that what assists the therapist's work is the certainty that the patient is not only afraid of, but also attracted by that emotion which, by means of the phobic object, the obsessive thoughts and the compulsions, s/he is trying to keep under control. In fact, the terror covers experiences that belong to the patient and which s/he needs in order to feel her/his own wholeness and fullness (now could the fullness of human beings be experienced and lived through without aggressiveness and uniqueness, without sexuality and interdependent bonds?).Throughout the sessions (and afterwards), the patients will try to talk about their phobias and obsessions. It may be said, simply, that the improvement of these patients can also be measured by how long, in therapy, they talk about other subjects. I recall a patient who, who was on the road to recovery and was talking about other subjects in his life, asked me with a conniving smile: "Before we finish, can we talk for five minutes about my thoughts?". Brecht said that even once we have recovered we go on looking with affection and a little nostalgia at the crutch that helped us walk at another time.

Aware – as Perls and Goodman remind us – that neurotic «has lost the contact with the ground of personality and he remains aware only of the symptom» (Perls, Hefferline and Goodman, 1997, p. 359) the therapist will try to re-establish in the patient the recovery of the background, the relational tissue that the symptom encloses. In this direction, it is efficacious to invite the patient to collocate the symptom in a context, beginning to draft a sort of "hierarchy" of intensity in the course of the day: s/he thus passes from the perception of the disorder as an timeless and "spaceless" event ("It happens to me" to the awareness that the symptom is linked to situations of tension at relational level

("Now I think about it, I'm worse when s/he says…", "When I'm on my own…"). Little by little, in this way, the interruption of contact on to which the symptom has been grafted will emerge. During the session, the patient keeps asking: "Are we sure I locked the car?". The question seems to be going round in circles and to be repeated at random, but, on close attention (microanalysis), the therapist realises that it comes up more insistently precisely when the patient is talking to the therapist about a topic of particular difficulty. In the task of restoring relational background to the symptom, certain questions become enlightening, such as: "How would your relationships with significant individuals (with me, your therapist!) change if you no longer had your phobia, obsessive thoughts, feelings of guilt, the need to carry out compulsive gestures?".

In all three of these pathologies, as we have said, the bodily relational experience would be terror: terror of feeling energy activated in the body, of action that leads to emotion, of detaching oneself and transgressing. Terror is an experience that paralyzes the body and, in this case, freezes the patient creating rigid bodily patterns: the phobic's body is "contracted" (it welcomes no emotions), the obsessive's body is tense and specifically has the sphincters contracted, the compulsive's body is agitated. Work on the body will always be within the awareness of the intercorporeality between the patient's and therapist's bodies.

6.1. The Phobic Relational Style

Phobias of contagion go back to an archaic situation in which the child was restrained by the obtrusiveness of the parental figure from having her/his skin as the contact boundary in such a way as to mark the frontier between her/his own world and the external world.

The phobia of being infected concerns impalpable elements which are hardly controllable (dust, grime). In these cases the family session makes it possible to identify which areas of the organism have been mainly invaded. The therapist's task is to help the person to understand what specific emotions s/he has difficulty in feeling in her/his skin and not to experience them as infected by the environment.

The work of therapy would revolve around two aspects: the definition of the boundaries of the skin, and the recognition of the feared emotions. In order to identify those experiences that create phobia, it may be useful to explore the catastrophic fantasies ("What happens if you come into contact with this dust that you're afraid may infect you?", "How do you know it infects?", "What were you doing when you became aware of the dust for the first time?"). At the same time, if supported by growing trust in the therapist, there will be an at-

tempt to give support to the patient's body in progressively facing the feared experiences. Work with the body of the contagion phobic will aim at rediscovering her/his bodily boundaries as her/his own and impassable.

Diffusive and monothematic phobias refer – as has been suggested – to two different levels of growth: wholeness and fullness. The former have to do with wholeness, whereas the latter refer to fullness. Diffusive phobias are serious because they interfere with social life, while monothematic phobias are marginal in the subject's life and only slightly reduce her/his freedom in going about in the world.

From the methodological point of view, approaching the phobic object (even in imagination) to the patient has the aim, in Gestalt Therapy, of making her/him become aware of the bodily and relational experience that the object evokes. For example, in the case of a patient who has a phobia of mice, s/he is asked on the one hand to imagine the presence of a mouse and, on the other, to feel what happens in her/his body. The passage from the phobic object to the experience allows the patient's body – supported by the body and relationship of the therapist – to become aware of and succeed in containing excitation and the energy which s/he is avoiding.

What proves to be particularly useful are the questions that allow the patient to have a more detailed perception of the closures and tensions of her/his body (id-function of the self): "What changes in your body on seeing the object? What parts do you feel are closing? If you feel my closeness and my support, what part of your body relaxes and opens up?".

Other questions open up the relational dimension: "How would you be different in your life if you didn't have a phobia? And how and what would you change in your relationships at home, at work, with me your therapist?". The question "What would happen if you could not avoid the encounter with the phobic object?" serves to explore the fantasies of catastrophe, but also to make the patient make contact with potentialities which normally remain in the background.

Here are some Gestalt techniques and experiments. With young people (and not only with them) something which proves very useful is the metaphor of approaching the phobic object with a "magic wand", in that I hand over to the strength and power that the organism has difficulty in experiencing. In the last analysis, it is a case of re-establishing in the patient faith in her/himself through her/his trusting the therapist. For example, it may be useful for animal phobias to ask the person to identify with the animal and to perform gestures typical of the animal that is object of the phobia: the phobia is a phobia of what I do not do and I do not express. Often, it is precisely in the description of the phobic object ("intrusive, disgusting, slimy") that the patient expresses the experiences s/he is afraid of. Working on the phobias allows the organism to feel the emo-

tions that drive it to encounter the other and to experience the spontaneity and fullness of the encounter and of her/his own world. The dialogue with the phobic object also proves useful (especially in working with monothematic phobias). The story of Fritz Perls is famous in the history of Gestalt Therapy: working with a person who has an airplane phobia, he asked the subject in question to imagine that he was talking to the pilot, thus making him aware of the terror he had of entrusting himself to someone.

Lucia has a phobia about mice. After asking her to give a long description of the mouse she has the phobia about (its size, features etc.), I ask her to concentrate in order to feel which emotions this description excite in her. Her fear is due to the fact that mice – so she says – can squeeze in everywhere. Having by this time achieved a good awareness, at a certain point she remembers an episode when she was little: she was two years old and was in a room with various family members, when all at once everyone became excited, their voices became tense and shrill because they had discovered that her diaper had been nibbled by mice. There were shouts – "We've got mice!" – and a frantic, agitated research began. Lucia felt (even now as she told the story) a shiver of cold and a sensation of terror. When I tell her to stay within the scene of her memory, but with a magic wand and choosing someone to stay close to her, she finds – in the room in her memory – none of those present who can give her warmth. I tell her to have recourse to someone who is present in her life today but she feels a great struggle because she is terribly afraid of letting herself go to the feeling of receiving warmth. When she accepts it, the shiver of cold dissolves and she gradually begins to feel warmth; she answers that she felt the powerful, liberating feeling that her pelvis was beginning to open up. I tell her to relish these feelings. When I see that her body is calm, I ask her how she is and she answers: "I feel that my body's warm, in some parts as if it were the first time. And now so many situations in my current emotional life are clear". Phobia is indeed a closed door but when one succeeds in opening it s/he enters a world (or rather a body) of warmth and strength which gives (or restores) the sense of wholeness and fullness.

6.2. The Obsessive Relational Style

In the work of therapy with patients who have obsessive thoughts, it is necessary, in my opinion, to bear in mind certain preconditions already mentioned:

a) obsessive thoughts replace the parental figures and are a way in which the subject, in exaggerated fashion, tries to look after her/himself;
b) the excess of control on the part of patients is an attempt to compensate for a serious lack of parental support;

c) obsessive thoughts express the subject's indecisiveness: on the one hand s/he feels attraction towards certain experiences and on the other is terrified by them;
d) the interruption of contact which brings obsessive thoughts happens in the phase in which the Organism feels emotions that drive towards action;
e) the (active) emotions that drive towards action are basically aggressiveness and sexuality, because the lead the subject to move towards the other.

The therapeutic intervention would above all facilitate bodily awareness (id-function of the self) asking: "What do you feel?". We are working on the personality-function of the self when we face the topics of entrusting oneself (not an easy experience for those who have not been supported) and risking one's own uniqueness. It is important, however, as we have said, to create an atmosphere of trust in the therapeutic relationship and to connect the symptom first with current, concrete situations of life and then, very especially, with the therapeutic relationship. A specific line of work for the obsessive style concerns bringing to the contact boundary the emotions of which the subject is terrified precisely because these are interruptions of action. It is a matter of proposing physical exercises which make the subject feel the bodily energy rising, reaching a peak and descending. Perls (1995, p. 126) states: «If a person suppressed aggression as in cases of obsessive neurosis, if he bottles up his rage, we have to find a way out. We have to give him an opportunity of letting off steam. Punching a ball, chopping wood or any kind of aggressive sport, such us football, will sometimes work prodigies: if a person suppresses aggression (which is thus not at his disposal) as in cases obsessive neurosis, if he bottles up his rage, we have to find an outlet. We have to give him an opportunity of letting off steam. Punching a ball, chopping wood, or any kind of aggressive sport, such as football, will sometimes work wonders». In reality, the patient has not suppressed aggressiveness but has avoided feeling it out of fear, so that in suggesting these exercises it is necessary to be very careful not to give the patient the picture of a person to be struck (this would increase the terror and the symptomatology) and, especially in the first stages, to give the patient bodily support. Something else which proves useful is emitting a sound which comes from the depths and gradually reaches its peak. Helping the patient to build a scream as an expression of wholeness and fullness – in the sense of martial arts or Janov's primary therapy (Janov, 1970) – is a way of supporting her/his energy. By means of these exercises the patient's body gradually learns to entrust itself to the energy and to risk expressing it. It is important that in all physical exercises there be progress in the form of crescendo, peak, plateau: in fact, it is a matter of the metaphor of the path that leads to the fullness of contact.

While for the depressed patient, physical exercise is designed to make

her/him feel her/his body through genuine tiredness, for the obsessive exercise serves to relax the body and make trial contact by training the body. After a complete exercise, the patient is pleasantly surprised at the degree of relaxation experienced and at how the obsessive thoughts have gone (at least for a while).

A delicate moment is reached when the patient asks the therapist for *unbearable* certainties: “Can you guarantee that… the roof won’t fall down, I won’t get sick, it’s not my fault, I won’t have an accident?”. Obviously exact replies cannot be given: how can the therapist guarantee that the roof won’t fall down, when s/he is not even sure that s/he will be able to complete the sentence s/he has begun? How, then, should s/he answer? It is clearly not a cognitive problem. The therapist must bear in mind that it is only from the certainty of a parental relationship that one learns to tolerate the inevitable uncertainties of life, so s/he has recourse to the reassuring style that the parental figures use with the child’s fears. For each patient, the therapist must find (invent) a sentence that is reassuring at a “parental” level of certainty (neither false nor technical), keeping in mind that it has no value in itself but serves to build a reassuring relationship of support and trust. Making lengthy speeches, trying to convince the patient of the illogical nature of the obsessive thoughts or the compulsive behaviors is not much use, indeed is counterproductive because it provokes further irritations, in that the patient will always find in the therapist’s many words a contradiction, a perplexity which will make it still more difficult to put her/his trust in the therapist. I think that it is important to find the phrase that artistically gives certainty and to use it always, in such a way that the patient slowly assimilates it.

6.3. The Compulsive Relational Style

6.3.1. Compulsions of Restraint

Compulsions of restraint, as has been said, reveal that as emotions become more intense, the patient is increasingly afraid that s/he will be unable to control them. The compulsive action does not express the spontaneity of the organism, but serves to increase control so that emotions perceived as destructive will not emerge from hiding. For example, checking over and over again that the gas has been turned off is a relational gesture, both insofar as it expresses the uneasiness of someone who has been assigned a responsibility greater than her/his possibilities, and when it expresses the fear that a negative emotion may come out of her/him. When I ask Lucio to make the gesture of turning off the gas several times in front of me, it is often apparent from the tome of his voice, the gestures of his hands and the expression on his face if there is anger present

in him at having had to assume a responsibility that should have been someone else's (when he repeated the gesture for me, I noticed in Lucio's eyes a flash which he later told me was directed at his mother) or the fear that a negative emotion might emerge (Mary stood there checking that the door really was closed, almost ensuring that her whole internal world had been fenced in). The difference in the meaning of these two gestures, which seem to be the same, recalls the principle that Gestalt Therapy works not on behaviors but on relational experiences.

6.3.2. Expulsive Compulsions

In expulsive compulsions the work of therapy is devoted in prevalence to the personality-function of the self: how does the subject experience feeling a particular emotion? How does s/he assimilate it? "Who" does s/he become after experiencing this emotion?

In expulsive obsessions the patient would feel constrained to carry out certain gestures whose aim is to expel the experiences the body has felt. While in rituals or gestures of restraint the subject has the (even if momentary) feeling of being calmed, in expulsive compulsions her/his anguish is not calmed but on the contrary seems to be increased little by little as the gesture is repeated and ends only because the subject is exhausted. Hence, the therapeutic intervention would not so much aim at increasing the experience of the emotions (which are present in any case) in the patient's body, but rather at restructuring the bodily and cognitive evaluation of those emotions. The body of the compulsive expulsive should be calmed because it experiences agitation, the need to throw out something that makes it feel endangered, as the basic experience. For these people it is very efficacious to begin to distinguish the various levels of experience: how s/he feels (name and meaning of the emotion); how the emotion is perceived by her/his organism (pleasant or unpleasant, interesting or uninteresting) and finally how s/he evaluates the experience and on the basis of what criterion. The interruption happened when the organism received from the environment a definitely negative evaluation of the experience in question ("How could you say that? How could you feel these emotions?" etc.). One theme, therefore, which will certainly emerge will be the feeling of guilt, regarding which it will be necessary to explore both the bodily correlative (what part of the body feels tense when s/he feels guilty) and the cognitive pattern of feeling guilty (what model of being-there-with s/he has learnt).

The involvement of other people in the symptom should also be explored (who witnesses the compulsive expulsive gesture? Who stayed close to the patient because of this gesture? etc.) because – as we have mentioned – in the

sense of guilt there is also both the drive to separate oneself off and its negation. Moreover the compulsive behaviour is reinforced precisely by the fact that it obtains the situation of remaining with the others not in developmental terms but in terms that are regressive both for the individual and for the others.

Trust in the therapist will allow the patient to go through the anguish of separating her/himself in gratitude but also in pain, discovering an unexplored faith in her/himself and in the person being left.

7. Towards the Fullness and Uniqueness of the Encounter

We have seen how phobias, obsessions and compulsions are disorders that arise exactly at the moment when the organism is preparing to become unique in feeling the energetic excitation of the emotions. Otto Rank[21] speaks of the two phobias that run through the life of the human being: the phobia of belonging typical of the narcissist and of those who have developed their own identity on the one hand, and the phobia of separation on the part of those who feel frightened by the emergence from the confluence of the "we" (and so are afraid of living). I believe that in the phobic, obsessive and compulsive relational styles, phobias seem to be present: becoming unique in bodily excitation provokes first fear of death and then fear of life. Not having experienced the specific support of the "we" creates the terror of separation and that of affirming oneself: the patients, in their indecision, fluctuate between the fear of death and the fear of life in the search for a support, a body that will welcome them and let them go. The poet is right: «What do you say? If I hug you tightly, shell I have a better chance of escaping death?» (Marcoaldi, 2008, p. 61).

It may be added, thinking about phobic, obsessive and compulsive patients, that only someone who is (has been) given a big warm hug can feel and handle her/his own uniqueness! And s/he can hug the other… because s/he is not afraid of dying and of living.

Comment

by Hans Peter Dreitzel

The author of this article seems to be a psychoanalyst disguised as a Gestalt therapist. Or is it vice versa? Whatever the case maybe, here are some points in which he seems to confuse both approaches in his contribution: 1. the problem of the contact boundary; 2. the problem of the contact phases; 3. the

[21] See the stimulating presentation of the theories of Rank in E. Becker (1982).

problem of the developmental phases and 4. the problem of the conceptualization of phobias.

1. Salonia starts with the notion of contact, which is, of course, the most basic of Gestalt concepts. "Disturbances" or "dysfunctional relational styles" are to be understood as difficulties of "entering into a nourishing contact". Yes. These disturbances occur at the "contact boundary" which is identified in the case of phobias as the mother's nipples when the sibling grows its first teeth, and in the case of compulsive disturbances in the sphincter during the time of potty-training. Well, it is rare that the contact boundary as the psychological field in which we experience our world, is identical with our skin (here: nipples and sphincter), but it happens, for instance in pain – and maybe in the cases mentioned by Salonia. But we don't know – because it happened during a time which remains in the darkness of childhood amnesia: we do not remember.

2. The author claims that psychological disturbances occur at typical moments in the 4 phases of the contact process. I do not believe that this can be generalized. Take, for instance, the case of depression: the interruption may occur in the fore-contact: the person feels disinterested, not hungry, not driven by any goal (1st phase). Or the aggressive emotions are suppressed, there is no initiative and little movement (2nd phase). Or, even if all this is experienced suddenly the energy drops and all vitality is lost when it comes to giving up control in full contact (3rd phase). Or, finally, the person is flooded by a sense of meaninglessness and resignation in final contact (4th phase) as in post coitum omne animal triste.

3. Strangely the author does not apply his own claim with regard to the importance of the stages of the contact process. Instead he relies on Freud's oral and anal stages of childhood development. He does not give any reason for this selection from other notable theories of the stages of childhood development; to my knowledge psychological research has not been able to find any support for this psychoanalytical theory. In any case this choice would make it impossible for Salonia to work with his patients in the here and now of their experience, which is, of course, basic to the methodology of Gestalt therapy. Yet that is exactly how he describes how he is working, and without any reference to his Freudian phases.

4. Usually in clinical psychology phobias are considered to be special cases of anxiety neuroses. So it was astonishing to me and comes as another surprise to see them categorized as belonging in the same basket as the compulsive disturbances. This makes sense only within the orthodox Freudian conceptual framework the author prefers. But even within these premises the choice of the word "terror" for the emotion the child experiences when the mother feels uncomfortable seems to me somewhat exaggerated. Here, of course, we encoun-

ter the problem of causality: can we really explain severe psychological disturbances by such comparatively simple causes? I doubt it, there are no one-dimensional causes in psychopathology.

What I do not doubt is that Giovanni Salonia is doing wonderful therapeutic work with difficult patients. What makes this article worthwhile reading are the fine descriptions of how one would have to approach patients with such disturbances and how they are to be distinguished from one another. In this respect this is a valuable contribution from which I have learned much. His theory as given in this paper is, however, not Gestalt Therapy as I understand it.

In conclusion I should like to point out very briefly an alternative way of seeing things from my own Gestalt therapy point of view:

a) *Phobias are special cases of the anxiety neurotic process, which should be treated as such. The basic introject which governs anxiety neurosis is that being aggressive (critical) to the mother is to lose her love and appreciation. Since this anxiety is strong but its reason unknown (unaware), a creative solution would be to focus this fear on some known object the nature of which has biographical but not psychological relevance. "The fire is not where the smoke is", as H.S. Sullivan said about compulsive acts and thoughts (according to an oral communication by Isador From).*
b) *The compulsive-obsessive neurotic experiences a neurotic style of experience, whose basis is the introjected (hence unaware) idea that there is a single correct or right procedure for every act in life. Since this introject denies the ambiguities and the spontaneity of life, it is a failure program which leads to constant fear of doing something wrong, resulting in guilt feelings.*
c) *In contrast compulsive behavior and compulsive thoughts are what Perls, Hefferline and Goodman (1951) called reaction formations, i.e. actions and thoughts the psychological function of which is to repress anxiety of excitement from awareness. Concentration on these behaviors will lead to knowing (awareness) instead of speculating about what the excitement is or was about.*

Anorexic, Bulimic and Hyperphagic Existences: Dramatic Forms of Female Creativity[*]

by Elisabetta Conte and Maria Mione

1. A Look at the Ground: Body, Gender Identity and Adolescence in the Post-Modern Age

Forms of existence which manifest themselves in the world as eating disorders do not represent a perturbation of the present socio-cultural system. They are, rather, a characteristic expression of it. Contemporary society today is seen as an age of great transformation, and hence as an age of transition, bringing with it consequences of great complexity under many aspects. For some, this represents an opportunity to develop «interesting approaches to creativity and maturity, for others (especially the weakest) [they are] harmful or self-harmful existential failures» (Salonia, 2000a, p. 105). Though the word "failures" is used here, in Gestalt Therapy even eating disorders are considered an expression of a person's intentionality to grow, for some the best creative adjustment (Bloom, 2003; it. trans. 2007) possible to the complexity of post-modern society, to changes in family relationships, and so on. Such a dramatic creative adjustment would appear to be a paradoxical developmental response that lies in the intersection between three fields of experience at great risk today – three escape routes which, by adding one source of fragility to another, can create a relational field in which a mode of existence with an eating disorder appears to be the only chance for growth and contact with one's world. These three fields of experience concern the body and its manifestation as eating function; the construction of female gender identity; and adolescent contact processes.

[*] We speak of female creativity because such disorders are considered in much of the literature as predominantly gender disorders (Borgna, 2007; Bonino, Cattelino and Ciairano, 2007; Riva, 2007; Gabbard, 1994, it. trans. 1995). Moreover, although such disorders are becoming more widespread among males, in our own clinical experience, from which we have chosen to draw to create a model that is as phenomenological as possible, we have found ourselves predominantly faced with women patients. We hope, in the future, to give a picture of the masculine face of eating disorders.

1.1. The Body and Its Manifestation as Eating Function

The body represents the first and foremost means of conveying self-image. It bears witness to identity (Kepner, 1993, it. trans. 1994; Fabbrini and Melucci, 2000) and coincides with the very presence of the person. However, one cannot speak of the body in and of itself, because «there is no "body" as such, but a concrete instance of experiences that can only pass through the flesh, the senses, movement and action» (Fabbrini and Melucci, 2000, p. 44). In today's world, two critical issues, among others, are problematic for this embodied presence: the emergence of a new paradigm, the paradigm of flexibility, which is affecting all aspects of experience, and hence bodily processes as well; and the partial "dematerialization" of primary relationships in today's age – an age in which "body to body" encounter is no longer such an obvious event.

1.1.1. The Flexible Body

Post-modern society is characterized by the mass communication of diets, cosmetics, fitness regimes and cosmetic surgery. Artistically this has taken on forms such as "carnal art", where artists modify their bodies permanently, for instance by inserting an artificial body part. Every single person thus appears to be ever more directly responsible for their own appearance, with the body practically transformed into a malleable, flexible object, an object that the individual "possesses" and is entitled to modify, to turn it into a faithful mirror of one's own identity and lifestyle choices. In past eras, the body was shaped to express or reinforce social bonds. Today the aim seems more to exalt or manifest our own uniqueness, our own personal life projects (Borgna, 2005). Moreover, the body, as shaped by biomedical technologies or "post-biological art", has extended its senses and capacities beyond traditional limits, breaking free of the natural fetters of the body. This being a body as a project through which to reassert one's subjectivity makes the task of delimiting the boundary marked out by the body an ongoing torment, creating fertile terrain for a multitude of anxieties.

1.1.2. The Dematerialization of Primary Relationships

The relationship between bodies is an intimate foundational relationship for children. Today, the presence of parents in primary relationships has been reduced in part, and often the bodily separation of the child from its parents occurs precociously. «Being with the body of the child, holding it in your arms,

listening and responding to its breath are all things which one often has little time for today. [...] The break in the relationship between bodies, between spontaneous physiologies, can occur very early today in the development of the child, sometimes too early [...]» (Spagnuolo Lobb, 2002b, p. 3). In this way, the body of the parent no longer represents a safe haven for the physiological needs of the child and the excitement associated with those needs – an excitement that the child of today is required to deal with much more on its own than in the past. As a result for the child, learning all the psychophysical information and bodily micro-behaviours that shape the self-confidence underpinning experience becomes all the more difficult, creating a relationship with physiological needs that is troubled, and a ground that is only barely traced out. All of this influences the eating function. Food conveys primary communication and represents a «bridge with life» (Parsi and Toro, 2006, p. 33). A positive relationship with food teaches children the act of receiving, exploring and desiring. There is, therefore, a close bond between food and intimacy, «between the smell of food and the fragrance of not being alone. For all of us, eating does not just mean feeding, but coming into contact» (Parsi and Toro, 2006, p. 35). A hug at a time of need (hunger) helps the child perceive the boundary of its own body and feel the warmth of nearness, which makes it feel safe and protected. Through eating, the experience of pleasure and displeasure is organized, and the basis is laid for internal confidence (Jeammet, 2006). Today, the eating function has become problematic. Meals are often no longer an occasion for sharing, but a moment of solitary consumption, or an act overloaded with importance due to the anxiety with which it is experienced, especially in the parent-child relationship. Thus the eating function becomes a privileged arena for conflicts to crystallize, and the child's physiological resistance, which is necessary for it to begin controlling the world and learn how to oppose invasion, becomes exasperated or paralyzed.

1.2. The Construction of Female Gender Identity

A loss of certitude can also be observed in the field of gender identity (Wheeler, 1998, it. trans. 2000), the second core issue in the contemporary world for our topic of concern. Today, even sexual identity is a subjective construct. Manifested in a human model combining both masculine and feminine traits, the complexity of that model has made the process of constructing gender identity, especially female gender identity, non-linear and troublesome. In today's world, female suffering has become widespread. Young women are compelled by social norms (which are much more severe in judging the adequacy of physical development in girls) to seek a perfection that appears to re-

quire the traditionally feminine traits of sensuality and elegance to be combined with the traditionally masculine characteristics of strength and determination, while excluding any symbolic reference to maternity and its signifiers (Riva, 2007). Young, post-modern women, at grips with the construction of their own femininity, tend to reject all those aspects of their bodies that refer back to maternal identity, in favor of a model of the independent, competitive woman, conforming more to the values of efficiency than to those of care, containment and relationship-building. This partial foreclosure of maternal values (Riva, 2007) in the construction of female gender identity still occurs in a conflictual way, setting female "productive" roles against female "reproductive" roles. This battle is etched in the bodies of girls today, a battle made all the more troublesome by the fact that the reconstruction of bodily identity, especially in adolescence, is much harder for women. Several factors make girls more prone to such complexity, including the greater importance placed on body image in the process of constructing female gender identity, their early development, conflicting social demands, and so on (Riva, 2007).

1.3. Adolescent Contact Processes

To observe how the previous two escape routes intertwine with the age of adolescence, it must first be remembered that adolescence is the age of the body (Fabbrini and Melucci, 2000). Adolescents speak the language of the body, and it is through the body that they express their identity and sense of belonging, tastes, values and sense of self. All of that is already in itself quite a complex task. The intensity of the sensations that adolescents experience can leave them feeling threatened, driving them to distance themselves from their bodies and, as a consequence, perceive it as something foreign to them. Their bodies are not yet theirs in a profound sense (Fabbrini and Melucci, 2000). Integrating that new body, a body with overwhelmingly sexual connotations, is the key task of this developmental stage, which will bring to the reconstruction of the self. This age of deconstruction entails the loss, for adolescents, of their perception of the unitary nature of the self. It is hard to answer the question "Who am I?" at a time when one needs to «re-plot the co-ordinates of one's identity along the "same as/different from" axis, integrating both masculine and feminine qualities, behavioural codes, and the different emotional values associated with them» (Fabbrini and Melucci, 2000).

Adolescents today arrive at this stage of life in a fragile state, due to the little self-confidence developed during childhood with regard to their bodily ground, which is unable to provide full support for their present uncertainty. At a time of overflowing energy, the perception for adolescents is that of having a

body not entirely adequate to contain that energy. Not feeling rooted in their bodies, they are frightened by their own urges, which still today cannot be lived within a solid framework of relationships with adults. Indeed, their fears are often amplified by the anxiety with which adults experience the relationship with their own bodies and the bodies of their children (Spagnuolo Lobb, 2003c). Besides not feeling they have the necessary support to have the courage needed to cross such an uncertain period of space-time, adolescents are then often overloaded with the excessive expectations of society and of their families. The climate in families today is more emotional than normative (Galimberti, 2007), where the ideal of the "good" person has been replaced by the ideal of the "attractive" person, tied to the idea of happiness and success. Under this mode of contact, greater importance is given to gratifying needs and to the emotional bond between parents and children. Exposed to idealizing expectations, in the event of failure, adolescents are no longer "protected" by prohibitions ("I can't because it's not allowed"), which would otherwise help them maintain their sense of self whole, and will feel ashamed and afraid of disappointing – a fear that will be stronger than the desire to rebel in the name of self-affirmation. All this is a factor raising the risk of developmental paralysis. Adolescents in our society are very developed intellectually, but they have little experience from a bodily and relational point of view, which pushes them to one of two extremes: desperate acting out, which brings high levels of aggression, towards both themselves and others; or acting in, where an excess of words and thoughts unduly occupies the space needed to act on the world (Fabbrini and Melucci, 2000). To conclude, faced with the specific developmental tasks of a twofold nature of individuation (independence and responsibility) and gender identification, adolescents today can find themselves in a particularly vulnerable position, running the risk of facing a highly problematic process of subjectification, due to the poor construction of their ground, to excessive expectations, and to the unclear generational divide, which is no longer marked out by well-defined limits and differences. For those adolescents who are, for varying reasons, more exposed to these problematics, the only way to continue existing is by adopting risky behaviours, such as, for instance, an eating disorder.

Leaving in the background the literature available on this issue (Lavanchy, 1994) in the fields of psychoanalysis, cognitive-behavioural psychology, systemic therapy, social-psychology, and Gestalt Therapy (see Table 1) to let our clinical experiences emerge, our aim here is to present an approach to understanding existences with eating disorders.

Table 1. The Main Psychotherapy Approaches to Eating Disorders.

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Psychoanalysis

In the work of **S. Freud**, as in that of **H. Deutsch**, eating disorders are interpreted on the basis of an impulse model, whereby they are a defensive regression during puberty to earlier stages before the development of the libido, involving a shift from the genital stage to the oral stage. This gives rise to the unconscious fantasy of oral impregnation, which causes young anorexic women to refuse to eat (Riva, 2004).

E. Kestemberg, a more recent classical psychoanalyst, says that it is a secret megalomania that lies at the basis of anorexia, caused by a regression to a primitive emotional stage, to when the child was six months old, in which the pleasure of functioning autonomously is accompanied by fantasies of self-sufficiency and immortality. The megalomaniac fantasy is not manifested in the form of delirium however, but as a perversion in which the body is fetishized and impulsive needs are split apart, controlled and manipulated to the point that a sort of perverse pleasure is attained, called a "hunger orgasm" (Lavanchy, 1994; Riva, 2004). In classical psychoanalysis, bulimia and hyperfagia are also caused by the anxiety that young women feel about their own Oedipal urges, though the substitute satisfactions sought are easier to understand than with anorexia, as instead of erotic pleasures, it is the pleasure of eating that is sought. Anorexic women deny themselves even this sort of substitute satisfaction.

According to **I. L. Mintz**, bulimia and anorexia are two sides of the same coin. Neither the bulimic woman nor the anorexic woman is able to deal with relationships in an adequate way, and so they shift their relational conflicts onto food. However, while the anorexic woman has a stronger ego and a much more controlling superego, the bulimic woman is unable to put off the surge of impulsion due to an ego and a superego that are weak (Gabbard, 1994, it. trans. 1995).

Cognitive-Behavioural Psychology

H. Bruch, whose essentially cognitive-behavioural approach also takes on psychodynamic elements, began her work on obesity by constructing a theory called "learning hunger". Bruch stresses that "obese young people are defective in their awareness of being self-directed, separate individuals with the ability of identifying and controlling their body urges, and of defin-

ing their needs and presenting them in a way that they can find appropriate and satisfying responses […]. This self-regulation appears grossly disturbed in obese adolescents [...] on account of a learning deficit […]" (Bruch, 1973, it. trans. 1993, pp. 154, 156). In her later studies of anorexia nervosa, Bruch identifies a triad of specific symptoms: 1) a delirious perception of body image; 2) interoceptive perceptual disturbances; 3) a sense of impotence, of inefficiency, and of dependency on the will of others, in particular of the mother. According to Bruch, anorexia nervosa emerges as an attempt to take care of oneself, so as to achieve autonomy, a sense of existence and a sense of interpersonal effectiveness by controlling the body (Bruch, 1973, it. trans. 1993).

P. Aimez and J. Ravar posit a "bulimic universe" centered on eating habits quite similar to drug addiction. They describe bulimic people as impulsive, with an all-or-nothing mentality. According to these authors, the two aspects that are most significant in female bulimic patients are their lack of self-esteem and their perfectionism, which results, as a consequence, in rigid, unattainable ideals. The smallest deviation from those ideals is felt to be a complete and utter failure, thus a single prohibited morsel opens the flood gates to bingeing. Like anorexic women, female bulimic patients have an extraneous relationship with their body, which they loathe at the same time. The sense of bodily emptiness that follows and that sparks their crises reflects these women's conviction that they are empty – if they did not feel that emptiness, they would run the risk of perceiving the emptiness of their very existence (Lavanchy, 1994).

B. Bauer believes that female patients with eating disorders suffer from a diminished capacity to manage information. Loss of control in people accustomed to having everything planned for them by others is a manifestation of the chaos of thoughts and feelings inside them, which these women need to sedate. These young women, bombarded by excessive stimuli, seek to comply with social models at the price of drastically stunting their own emotional lives. The exasperated focus they place on eating is a form of protection against information overload (Lavanchy, 1994).

Systemic Therapy

M. Selvini Palazzoli, in her early work, analyses anorexia from a psychoanalytic point of view. For this thinker, due to the infant experience of being provided food without restriction, but also without love, eating is a source of anxiety for anorexic women, provoking a sense of degradation and defeat. Food provided by the mother in such a climate of detachment

thus becomes a symbol of the "evil mother", for which the body that accepts such food also becomes evil, or is blameworthy. This in turn provokes a schism between the body and the subject, between the embodied ego and a central, disembodied ego, which ultimately does not identify with the mother. (Selvini Palazzoli, 1963). In her later studies, Selvini Palazzoli shifted her attention to a family approach, stressing how female anorexic patients were unable to separate themselves psychologically from their mothers, due to the frequency of discrediting communication. Refusing food thus reflects the way the family interacts. At the same time, in line with the paradox theory, Selvini Palazzoli considers anorexia to be a strategy by the designated patient to oblige parents to stay together. (Lavanchy, 1994).

As concerns the family system, **S. Minuchin,** in his structural approach, describes a tangled web of relationships in the families of female anorexic patients, in which there is often a lack of generational and personal boundaries. Each member of the family is overly-involved in the life of other family members, to the point that nobody sees themselves as having a separate identity (Gabbard, 1994, it. trans. 1995).

Gestalt Therapy

Within the Gestalt framework, **G. Cannella and P. Cavaleri** take the foundational work of **F. Perls** (1942, it. trans. 1995) as their starting point, by stressing that «food in Gestalt therapy is a metaphor for the Other and for the relationship with the Other […]. By binge eating or vomiting or saying no to food, subjects with disorders in the anorexic-bulimic cycle reject the Other, as ever since the earliest years of their lives, they have always had insufficient confidence in that relationship and in all that which "comes" from outside […]. Such subjects manifest themselves in the world as though they were distressed by an unreliable (and invasive) environment, which they want to distance themselves from so as to gain autonomy» (Cannella and Cavaleri, 2002, pp. 26-27).

M. Spagnuolo Lobb stresses how today, «human suffering is increasingly expressed through troublesome ways of nourishment. The need for hunger, whether self-regulated or spontaneous, has brought a distress that concerns all of society […]. When a disorder in physiology becomes epidemiological, we need to think about what primary, existential and bodily support is lacking in our present social life.[…] The relationship with food challenges the lack of a relationship, the solipsistic habit of doing everything yourself […]. In the case of eating disorders, the reaction is to shut oneself off proudly, in an attempt to demonstrate one's adequacy and capac-

ity, or open oneself to the world in a collapsed or angry way» (Spagnuolo Lobb, 2008a).

For **G. Salonia**, «Nourishment is a decisive experience for survival, which is why it is one of the most intimate aspects of the human condition. Food stands between life and death […]. It is a form of human imprinting, whereby feeding is learned as a relational experience that connects the body of the eater (personal dimension), the body of the feeder (relational dimension) and time (the food of now was prepared before and prepares for after). […] Those who have no self-confidence, and do not know their own strength, swallow food without "chewing it", without making it their own, and are thus compelled to regurgitate it on their own, in an obsessive, haphazard and torturous pattern. Those who do not trust the other and their own growth will shut the gates to food (the enemy from without) […]. Those who feel an insatiable emptiness inside them, because they are unable to reach and be reached by the other, will seek to fill their souls with food» (Salonia, 2011b, pp. 23, 24, 25).

2. The Situation of Vulnerability to Experiences Tied to Eating Disorders

Vulnerability is an experience intrinsic to human nature. It can be associated with that particular feeling of being exposed, of having one's relational wounds laid bare to an environment perceived to be discrediting, threatening, confusing, harmful or invasive. Vulnerability can manifest itself to varying degrees as the impossibility of being at the contact boundary fully and spontaneously. «In Gestalt therapy, we can call the emergence of this particular kind of interaction a "figure of vulnerable contact", whereby vulnerability is defined as an attribute of contact and not as an existential dimension of the individual. It is not the individual but the relationship which is vulnerable» (Mione and Conte, 2011, p. 253). If a figure of vulnerable contact forms in the presence of significant fragility in the relational ground, that is in the functions that support the contact process (self-support functions and the resources provided by the environment), the vulnerability dimension will take on a much graver value. Adolescence is one of those stages in life that brings, in and of itself, the need to reconstruct the ground (hence its momentary fragility), due to the great changes that this stage entails. Indeed, «in the creative process of this becoming, what is taken apart and pieced back together again are the foundational elements that make up human experience – being male or female, being an adult or a child, the combination of dependence and independence, the development of new, creative ways of being-in-the-world» (Conte, 2011, pp. 254-255). The

development process of adolescence unfolds over three foundational steps for human contact: the sense of self (perceiving oneself as an individual, as a clearly-defined "I" opposite a "you"); the desire for the other (the intentionality for contact, which could also be called a "hunger for contact"); and the capacity to draw nourishment from the other (the ability to take from the environment what we need to grow, while remaining aware of our autonomy – "*I can draw nourishment from you without losing the sense of myself*"). The process of dealing with these three aspects represents the situation of physiological vulnerability for the adolescent. It is this process that will bring out as figure the present possibility for the environment to support adolescent development, as well as archaic relational wounds inflicted on these dimensions.

To build a sense of self, legitimate the desire for the other, and explore the possibility of drawing nourishment (from food and, through food, from relationships), the body, in particular as experienced in connection with the eating function and with the construction of gender identity, can be considered a privileged locus of experience for children. At the same time, the body is also the main place in which the ability to refuse the nourishment that the world offers can be exercised spontaneously – by shutting one's mouth, holding or speeding up one's breath, pushing away, etc. (Frank, 2001, it. trans. 2005). During childhood, the bodily processes tied to the eating function and to the construction of gender identity, especially female gender identity (as we shall see in the following section), can be affected by relational wounds. If, during adolescence, when kids are thrown back into the search for a new equilibrium and new harmony, the adolescent encounters an environment which repeatedly neglects those wounds, at both the family and social levels, a vulnerable contact figure will form which is specific to these girls' experiences of eating disorders.

3. Co-construction of the Eating Disorder Experience

This girl, therefore, finds herself at the contact boundary of her environment, having to deal with the specific developmental tasks of this age of life, while bearing in her ground the creative adjustment (manifested in relation to her sense of self, hunger for contact, and capacity to draw nourishment) tied to her wounds, at the basis of which is what we might call a deficiency in the construction of the ground and in holding[1]. Parents today find it difficult to be a presence for holding their children's excitement, and to feel confident about their primary physiological processes (construction of the ground), that is the

[1] For Winnicott, "holding" signifies the capacity of the "good-enough mother" to act as an empathic container for her child's anxieties.

child's organismic self-regulation (Spagnuolo Lobb, 2002b). In the absence of adequate bodily support from an adult for the excitement tied to the emergence of her physiological needs (an excitement that would bring the child to spontaneously deconstruct her environment), this can result in the girl becoming anxious about what is happening in her body – a body she no longer feels "at home with" (Spagnuolo Lobb, 2007e), as she has never learned to contain herself or support herself in an adequate way.

In short, the girl may find it difficult to adjust the energy needed to satisfy her needs, determine whether that energy is hers or the environment's, and give it an authentic name (hunger, need for affection, etc.). As concerns the eating function, the deficiency in the construction of the ground and in holding is expressed as a loss of spontaneity in the relationship with food and eating. The girl eats anxiously, without relishing her food, and does not know whether she is full or not, so she finds it difficult to say no to food when it is too much, or to refuse food that is not good for her. She does not distinguish hunger for actual food from hunger for contact, nor does she know whether to call what she feels "hunger", but learns to call it "hunger" even when it is actually something else, because that is what the environment defines it to be.

As concerns the construction of gender identity, it should be pointed out that the process cannot be construed in individualistic terms, but must be considered a relational act, as the roots of perceiving oneself as a sexual, embodied self lie in "being with". «Male and female cannot be defined *a priori*, in an archetypal way, but only within the gender dialogue» (Negretti, 2004, p. 44). That dialogue, as various authors have underscored (Salonia, 2004a; Riva, 2007), is much more complex for women, as «the construction of subjectivity for the woman implies that she comes out of an exclusive relation with the same as herself, the mother, and that she discovers the relation with a different other, while remaining herself» (Irigaray, 2004, it. trans. 2006, p. 68). If such complexity is experienced by the entire relational field (especially between parents and daughters) when there is a deficiency in the ground and in holding, spontaneity may be lost with regard to the feelings and experiences of the body in relation to sensuality and sexuality (the id-function), as well as to self-image and roles tied to gender identity (the personality-function), and to all the connected differentiation processes. Thus, what can happen is that the young girl, in reaching out to make contact with the world and draw nourishment from it, becomes frightened or confused when a sensation of a sexual kind emerges, leading her to become ashamed of her own body and of the curiosity she might have about it and about others', to not know whether the excitement tied to sexuality belongs to her or to the environment, and to identify with the image of femininity that her parents project onto her, even if it is different to what she spontaneously would feel to be her own.

All the modes of contact described here in relation to both eating and gender identity can be considered the creative adjustment that young girls make in such a difficult relational field. The passage to adolescence physiologically requires a transformation in the creative adaptations of childhood and in parenting skills, which entails a review of the ground of the adolescent field, so as to take in new information concerning the id-function and the personality-function. For the adolescent, that means a new embodied self, a new understanding of the self, and new spaces for independence and individuation. For the environment, it means the capacity «[…] to recognize the strength and beauty of the kids» (Spagnuolo Lobb, 2004a, p. 219) and their urge to grow even in the hardest of moments, and to grasp their needs moment by moment, on the belonging-autonomy continuum. All this brings with it new opportunities to heal old wounds, providing that the relational anxiety tied to them finds at the contact boundary new capacities in the ground and in holding that are functional for the processes of adolescent contact. If that does not happen, the difficulties inherent to the separation and individuation process will become more marked, for which feeling a desire for the other, encountering it and drawing nourishment from it, while remaining individuated, will become so problematic that developing an eating disorder is the only creative adjustment possible in attempting to reach, and be reached by, the other, without repudiating oneself. Thus bringing us face to face with the full-blown manifestation of anorexic, bulimic and hyperphagic[2] existences.

4. The Dilemma: Having Form and Encountering the Other

For these existences, food and the body are a language for shouting out to the world one's intentionality for contact and the impossibility to reject being an individuated presence, in particular an individuated "female" presence, for the other. The eating symptom structures the relational field in an attempt to create and protect the contact boundary, the boundary between what lies inside and outside the skin, adjusting physiological needs, desires, and anxieties, as well as the relational distance with parents and the environment in general. Indeed, eating behaviour becomes a fixed contact figure (a fixed *Gestalt*), enabling the girl to take care of herself and her own energies by clutching at the possibility of a hyperfunctioning ego (Spagnuolo Lobb, 2005e), and hence of controlling the experience. Where it is no longer possible for self-regulation to rely on a spontaneous, full and fluid self, the adolescent will make extreme use of the decision-making and control functions of the ego over the id- and per-

[2] The DSM IV does not differentiate between bulimia and hyperphagia. We consider them separately because in our clinical experience they belong to two different existences.

sonality-functions. The ego will exploit physiological need, hunger and sexual desire (id-function) so as to construct a vague outline of the self, of the desire for the other, and of the attempt to draw nourishment from it, with which it can dramatically thrust onto the world the original uniqueness of one's identity as an adolescent and as a woman (personality-function).

4.1. Anorexic Existence

"*I will never let you inside me to nourish me*" (Spagnuolo Lobb, 2008a). This statement encapsulates the proud swelling of the anorexic girl's hyper-functioning ego, against a deceiving, invasive environment, on the borderline of incestuous, as she is forced to choose between satisfying the physiological need of hunger and taking on the identity of a young woman on the one hand, and on the other the survival of her sense of self, of the possibility of desiring the other and encountering it, albeit in an extreme way. These are girls who were cheated by their environment as children (Miller, 2005). All the times the environment offered (and still offers) nutrition, it was never "pure", because together with "good food", it inevitably, though secretly, conveys pieces of the other's experience, which the ego, in a spontaneous contact process, wants to alienate from itself, but it cannot exercise its powers of discernment without refusing the food itself. That is exactly the price that these girls choose to pay as adolescents in an effort to save their own integrity, their vague outline of a self (Spagnuolo Lobb, 2003c). This is their creative adjustment: to keep out everything, seeing as they cannot choose what to let into their bodies, and into their definition of self. «For food to be nourishing, says W. Black, it has to be eaten "without a safety net and without deceit". There can be no nourishment if food is experienced like a prison, or feared like a poison» (Salonia, 2011b, p. 24). Such deceit also touches the sphere of sexual experience. Often for these young girls, the emotional proximity of the parent of the opposite sex is excessive and, with sexual development, becomes flushed with erotic shades, as «the adult has gone beyond the most intimate boundary of the body» (Spagnuolo Lobb, 2005e).

On the other hand, emotional proximity with the parent of the same sex brings with it an all-absorbing demand for female identification ("*you are just like me*", "*you have to be the way I want you to be*"), which does not admit other ways of being a woman which are, at least partially, alternative to the mother's way, while the mother herself offers a model of femininity that is explicitly or implicitly discrediting.

In the desperate attempt to have clear emotional relationships, while not betraying themselves by accepting the impossibility of choosing that model of

womanhood, in order to maintain their own intentionality for contact with the other, these adolescent girls kill off their own sensuality and reject full female identification by disembodying their own body, which is the source.

4.2. Bulimic Existence

"*I throw you out of me so as to try and take you back the way I want*". This statement expresses the desperate, obstinate and inexhaustible attempt of the adolescent living the bulimic experience not to give up on the possibility of desiring the other and drawing nourishment from it in a gratifying way, and at the same time the renewed impossibility of achieving that. In the bulimic experience, when the desire for the other becomes figure, it is not anchored in a ground made up of good assimilation processes, a well-structured ground built on clear forms of one's feelings, roles and bodily experiences. As children, these girls grew up in a fragmented and confusing relational environment, in which the taste of food and the taste of intimacy are steeped in each other, and the hunger for food is confused with the desire for contact. This environment exudes affection, but it is lived in an explosive, incoherent and unstable way, which is not governed by clear generational roles. Life is never empty, but always full. Such limitless affection, always on call, is not truly nourishing because it does not respond to the real need of the child (which is proximity, not food). It does not allow emotional nourishment to be experienced in a well-defined way, nor does it allow the child to identify her own intentionality for contact clearly, or to understand to whom the intentionality for contact belongs – "*Is it you who wants to enter or do I want to bring you inside?*", "*What food is 'right' for me?*", "*How much 'food' do I need to satisfy my hunger?*", "*Am I full, or do I still need you?*".

All of this also involves the construction of gender identity, for cast into that emotional magma are experiences tied to sexuality and the gender model. In the form proposed by the parents, that gender model is based on polarities that cannot be integrated, as although one is the negation of the other, they coexist, one explicitly, the other hidden away, implicitly. Female qualities thus appear one way, but they imply their opposite at the same time. The mother figure, for example, is apparently strong but in reality submissive, apparently omnipresent but in reality not forthcoming, or vice versa. The father figure, for example, may present women as desirable but, at the same time, implicitly disdain them. All this makes the gender model impossible to assimilate, leaving the only chance for female identification in that of an "alternate" identity, which swings inescapably between two polarities. Once faced with the new developmental demands of adolescence, these young girls cannot rely on the

experience of the body as a clear boundary between "in" and "out", nor on a unitary gender model, while their environment persists in all its ambiguity – food/proximity, strength/fragility, desirability/disdain. The price they pay is that of desperately chasing after such integration through the bulimic contact process. Faced with this magma steeped in ambiguity, the bulimic adolescent attempts to exercise, through a hyperfunctioning ego, the possibility of making a choice between needs, and between polarities, by trying to control them in a severe way ("*I'll only eat one biscuit*", "*I'll only let them touch me a bit*"). That exasperated search for the unequivocal, for the discernment and the assumption of a single need, a single polarity, causes anxiety, as what makes it all so hard is the fact that in the ground of experience and the present relational field, everything is intertwined in a confusing and ambiguous way. The ego, impotent as it is, lays down its arms. It is no longer guided by a clear intentionality for contact, but throws itself into the environment (food and sexual intimacy), seizing on everything indiscriminately, desperately, voraciously, without limits, becoming itself ambiguous. "*All the biscuits in the world won't do me*", "*I'll give into your seductions so you can fulfill all my needs*". In this way, these girls violate the contact boundary by abusing food, sexuality, and the self. The moment in which they realize that they have betrayed their search for the unequivocal, that they have let themselves go without control into the confusing, ambiguous magma of food and proximity, that they have submitted to the other (both food and men), they are overcome by feelings of guilt, shame (Gillie, 2000; Robine, 1977, it. trans. 2006a) and humiliation. "*I disgust myself. I've failed once again*". The step to vomiting becomes a creative adjustment that enables a partial outline of the self to be restored and, as a result, the perception of a contact boundary ("*I'm still beautiful, with my feminine figure. I have power over food, and hence over relationships*"). Vomiting takes the experience back to the underlying ground, to the initial condition of possibility – the renewed hope that the contact process can, sooner or later, start over again from a whole sense of self and from an unequivocal intentionality for contact, to achieve real, nourishing contact. "*I'll finally be able to draw my fill of nourishment from you and feel unequivocally whole*". Hope is «focused […] *not* on what is not there, but rather on what is not there *yet*» (Borgna, 2008, p. 65).

4.3. Hyperphagic Existence

"*Now it's my turn, and I won't hold back. I'll eat as much as I possibly can*". These words express the core of the hyperphagic experience, the extreme, unfulfillable need to transform the energy trapped at the contact boundary into action that is finally for *oneself*; action that is entirely focused on *one's*

own desire for the other; action that is free, unharnessed by the need to please the environment. To do this, the hyperphagic adolescent is compelled to exercise her decision-making capacities in an extreme way (hyperfunctioning of the ego). Thus binge eating becomes a cry of angry self-assertion, a challenge to the world in affirming one's self-determination – "*Now it's my turn, and I won't control myself anymore*". Moreover, binge eating fulfils a protective function at the contact boundary, by lightening its load. For the boundary is weighed down intolerably (Perls, Hefferline and Goodman, 1952, it. trans. 1971) by the frustration, accumulated at length, tied to always being at the service of the other, and never of one's own, healthy aggressiveness. As a child, this adolescent grew up in a familial relational field characterized by an inability to manage energy, in terms of the good manipulation of the environment. The parents of the young girl do not appreciate her need to grow in terms of self-realization, and hence do not support her in her relative intentionality for contact, leading her instead to take on the function of being "at the service of". The child takes it upon herself to release the energy moving within the family field, becoming a master in grasping the intentionality for contact in others, while putting aside her own. The possibility of "taking the other for oneself" thus retreats into the ground, leaving space for the figure of "being driven" by the needs of the other. Thus the child cannot identify with that part of her energies tied to her own self-affirmation, because it is not legitimated within the environment. Her sense of self thus remains "obstructed" by the presence of the other.

This devaluation of self-determination involves, first and foremost, the eating function. It is the parents that determine eating rhythms (the time between one morsel and the next, between one meal and the next, the timing of breathing), and when the child's excitement should be called "hunger". Since they find it difficult to cope with moments of contact when energy levels are highest (conflicts, for instance), they will call any need or emotion expressed by the child in those occasions "hunger". "*Don't get upset… Doesn't this pudding taste great?*"; "*Stop playing up… Come and have afternoon tea instead*". Thus food becomes something "in the place of" – food-proximity, food-consolation, food-containment, and so on. In this way the child learns to adjust to the other by calling any excitement not legitimated by her environment "hunger". This same mode of contact is also adopted in the construction of gender identity. As from the disapproval, by both the mother and the father, of any show of self-determination manifested by the child, a model of womanhood is proposed that incorporates the aspects of being on call and welcoming, but which excludes everything tied to the active exploration of one's own femininity in the desire for the other and drawing nourishment from it. When they arise, even these needs are labeled "hunger": "*Stop admiring yourself in the mirror… come and*

have an ice-cream instead". During adolescence, when the primary developmental task is that of «becoming the owner of one's own individual, independent destiny» (Conte, 2011, p. 255), this child will not be able to draw on a ground of positive experiences that can support the process of independence, at a time when her energy for self-individuation is at its peak. If the environment once again does not let that energy make the contact boundary vibrate, the adolescent will deal with the situation in the only way she knows how: by using food "in the place of". Food in the place of the noes she does not say, in the place of the sensuality she cannot express, in the place of the anger that does not act, in the place of the intimacy she cannot pursue, in the place of the blossoming female body she cannot enjoy. While on the one hand, this process reflects the usual relational pattern, on the other it expresses a new creative adjustment. By binge eating, the adolescent reclaims her capacity to choose and does not renounce feeling the energy inside her and exercising her power to attack the environment, taking something for herself. «What do I care? I'm in command. I can eat as much as I want» (Spagnuolo Lobb, 2010a, p. 62). The drama of that creative adjustment is connected to the fact that these powers of the ego are exercised in solitude. The adolescent is unable to do the same within a relationship; she does not know how to take things for herself when she is with the other. Thus binge eating brings with it a reawakening of her energy for self-affirmation, but also the price to be paid for it – a harrowing solitude which excludes the risk of making contact with the other.

5. Resolving the Dilemma Through Therapeutic Encounter

> […] one needs to break out from the "we" to become an "I", but then immediately move on, leaving behind the "I" to build a "we" (Salonia, 2011b, p. 101).

As regards specific support (Spagnuolo Lobb, 1990), in co-creating a new relational experience in the therapeutic field, the primary objective will be that of fostering the construction of new ground (self-support) and self-holding (self-containment) capacities at the contact boundary. For the female patient this means anchoring herself in her body; reshaping her perception of hunger, of fullness, and of body limits; learning an emotional language; building a sense of self that is broad enough to contain sexual feelings and manage her energy with confidence; and renewing her capacity for choice with regard to modes of nourishment and of being a woman. This objective can be accomplished through therapy, indicatively by going through the stages described below.

5.1. Heeding the Cry

If an existence with an eating disorder is the only way for adolescents to cry out to the world to express a uniqueness that seeks to reach out to the other, then the therapeutic encounter must, first and foremost, be a place where that cry is heard and embraced by the strong, respectful arms of the therapist. So as not to be frightened, ensnared or swept away by the painful intensity of that cry, the therapist needs to anchor herself in her own ground (Zinker, 1997, it. trans. 2002), in the confidence of her own sense of self, and draw abundantly on a ground nourished by her own id-function and personality-function. That means standing at the contact boundary with the full presence of her body and the depth of her breath, guided clearly by her own therapeutic intentionality (her own knowledge, ethics, professional background, and so on), and rooted in well-integrated gender experiences. All this is the humus thanks to which the therapist can look beyond the inherent destructiveness of the eating disorder and remain steadfast in her confidence, almost like an act of faith, that the patient "will pull through", will manage to find nourishment spontaneously and reach out to the other, and let herself be reached, without losing herself. It is thanks to that confidence that the therapist can co-construct with the patient the fundamental moment of contact in this stage – permitting her subjectivity to emerge, by accepting the only identity that she has ever managed to construct (her anorexic, bulimic or hyperphagic existence) and appreciating its uniqueness and the great effort made to create it, thereby legitimating that identity and giving it dignity. This means that the therapist takes on the role of "empathic witness". She hears out the emotions of the patient without correcting them. She is involved, but not invasive or judgmental in defining experiences. She does not suggest what the patient should do (if, when and what to eat) or how the patient should be (which femininity to embody). In this way the therapist metacommunicates with the patient, who comes to recognize the intentionality for contact inherent in her creative adjustment (the eating behaviour) and to reassert that she can achieve it just the way she is, without having to become something else. Finally, the patient can live the experience of feeling capable of making contact with the other without renouncing herself and, having fulfilled its purpose, the ego can relax its decision-making capacities and stop hyperfunctioning. Thus the ego is given the chance to shift its powers away from the eating disorder and start imagining new scenarios of existence. This unconditioned recognition of the patient's desire to reach the therapist is the first authentic nourishment of her sense of self – a nourishment which she can accept and make her own, without expelling it or devouring it. When this happens, it is like relishing the experience of a small miracle occurring. A habitual pattern of contact is broken and the seeds are sown of a new ground, in which subsequent therapy can lay down roots.

5.2. "My Nourishing You and Your Hunger"

It is precisely by resting on the assimilation of this first important relational breakthrough that the step can be taken onto the next stage of the therapeutic process. This will be the time in which to create the relational ground from which the experience can emerge for the patient of finally being able to combine the construction of a fuller and freer subjectivity *and* the possibility of a bond. To do this means bringing out, at the contact boundary between the therapist and the patient, the relational anxiety that lies at the heart of these troubles and touching the wound tied to the vulnerable contact figure, which always lays itself open whenever attention is shifted from the patient's habitual modes of existence. The contact boundary, in that moment, is like a knife-edge – between the risk of dependency and the risk of rejection; between the fear of being sucked in and the anguish of solitude; between the distress of eating and the fear of going hungry; between the fear of one's own femininity and the pain for the woman that one is.

Hence, the difficult art of therapy will be focused, at this stage, on the precise and constantly renewed search and experience of good relational distance. Changing from moment to moment, good relational distance is the distance that makes it possible not only to give expression to experiences tied to these dual possibilities, but also to take the first steps towards an intimate relationship, towards an "us" in which the "I" is fully entitled to exist. Doing this allows anxiety to be transformed into desire for the other, and action can begin to be taken to reach the other. The creation of good relational distance, in providing specific support for an existence with an eating disorder, will be tied to the therapist moving from the role of "empathic witness" to coming into play at the contact boundary, subtly calibrating her movement "to" and withdrawal "from", by "staying in one's place" and by making one's involvement felt, leaving room for the patient and not abandoning her, giving reassurance and not asking anything in return. Obviously, experiencing good relational distance cannot be achieved without the encounter of the therapist's and the patient's bodies and the experiences tied to that encounter; however, it will take time before work can be done directly and explicitly with the body, as it would cause too much anxiety. For these existences, the body *is* the relational wound. It *is* the profound pain that for a lifetime has been sought to be silenced. It *is* the solitude of the last belonging possible – one's own body.

In order to give explicit voice to the body, a "root-bond" must first be built, on the basis of which body-experience can then be developed with a "you" that is respectful and able to support and contain. That bond will be home to the body, to femininity, to autonomy and to desires. It is thanks to that bond, and to the bodily experience made possible by it, that another small miracle will

occur – the passage, for these existences, from the power exercised *over* the body to the power *of* the body, in all its potential.

5.3. The Long Road of Courage

In the previous stages, the female patient's sense of self was broadened, her desire for the other was "fleshed out", and the ground was created to begin transforming her energy into new, original action. All these new elements are now present at the contact boundary, but they have yet to be completely assimilated and hence may still exist side by side with the old relational mode (the eating behaviour). The road of courage – the having taken on the risk of approaching life with a new femininity and a new relationship with food – undertaken through therapeutic contact can now branch out increasingly towards the rest of the world. It will be a time of further efforts, of audacious advances and fearful withdrawals, of possible discouragement or even momentary lapses, of unexpected conquests. A time of perceiving the freedom of the body in getting close to a guy and pulling back out of the fear of "going too far"; of fully feeling one's energy in eating, then taking fright and retreating again into the eating disorder, and so on and so forth down the long road of courage, until finally feeling satisfied, at one with the world, and free (Spagnuolo Lobb, 2010a).

Faced with all of this, the therapist's approach will be that of "guarantor" of the journey, the person who never wavers in her attention and carefully gathers both the beauty of the new, emerging femininity and the moments of difficulty and fear in experiencing it; the person who supports courage in those moments of greatest risk, when perceiving one's energy for nourishment can become a dangerous enterprise. In this stage, therefore, the therapist is a very self-conscious presence alongside the patient, as she learns to dance in the world with the new sense of self, the desire for the other, and the capacity to draw sustenance from it that she has co-constructed with the therapist. At this point, the therapist must be watchful, to ensure that all the energy that was formerly channeled into the eating disorder once again becomes vitality for a sensitive body, and transforms itself into full contact. All this will happen in the archaic time of bodies, thus requiring patience and unwavering confidence in the power of the spontaneous act of nourishment and the freedom of being a woman.

6. A Clinical Experience: Resolving the Anorexic Dilemma[3]

A small delicate face, big blue eyes, light brown hair, baggy, warm clothes. Marcella was nineteen years old, and for a long time a great, anorexic suffering had been a part of her life.

6.1. Heeding the Cry

It is this being recognized in a relationship that dissolves away anxiety and lets the patient relax. She finally feels seen by the other, and can let go of her breath (Spagnuolo Lobb, 2011a, p. 44).

At the start of therapy, Marcella seemed very determined to talk about her life to me. I had the feeling she wanted to "test" me, to see if I would be a valid interlocutor for her or if she should "discard" me immediately. I could feel her pride and strong will, as though laying me down a challenge, in an effort to gauge implicitly whether I would be on her side, even while the rest of the world was against her. I breathed deeply, knowing that I had to be there with full awareness, especially as I could sense that behind that wall of determination there was something beautiful, but yet to be explored. I accepted her view of herself, of her rights and of what she wanted, unconditionally. I could feel her "drawing me into the relationship", but by her own rules and on her own terms – she knew it and kept drawing me in closer, and in that way really managed to touch me. After a few months of therapy, Marcella introduced her own original "rite" to the session. As she lived in another city, she had to catch the train to come and see me. She arrived one day at my practice and, during the session, took off her cold, wet socks and laid them on the radiator. Then she put on a pair of dry socks and a shawl, pulled out from her bag a thermos full of hot water and some tea and herbal tea bags, and prepared a hot drink for herself at first, and for both of us later on. Naturally she had no sugar or solid food. Marcella weighed, at that time, thirty-four kilograms. She joked that at that weight she was always cold, and I perceived her profound, silent despair. I gave her a gentle look, from which she understood that I had caught what the joke was meant indirectly to convey. For the rest of the winter, we would warm our bodies by drinking the tea she would bring. Marcella had fine taste in the objects she used, and I appreciated the care with which she offered me things. We would warm ourselves up, breathing together as we drank. I accepted all

[3] The clinical case study presented is analyzed along the theoretical lines proposed in this paper. We greatly thank Marcella, a patient of one of the authors, for having kindly consented to its publication.

this as her way of letting me into the topic of food, but also as a way of beginning to tell me who she was. I gathered her intentionality to let me know that her body was there, and that her almost transparent body needed to be cared for, heated, and not left to get sick. We would drink our tea, looking at each other as we spoke, and in that look we would warm ourselves even more. That look we gave each other was special for both of us, and I sought not to lose it as I felt that the construction of our work could anchor itself to that look. This enabled me to look on her existing creative adjustment with confidence, legitimate it and give it dignity. I stressed it to her that I saw her gestures as a way of taking care of her body, and that I found it fascinating that despite all those train trips in the dead of winter, at thirty-four kilos, she never had so much as a sniffle. I told her that hers was a body that really deserved confidence, because as pain-stricken as it was, it had its own health, its own capacity for self-regulation; despite everything it was a body that wanted to exist. She was surprised that I should think so. For years and years, everybody had always considered her body quite simply as sick; it was something very new to her that I should see anything positive in it. "You don't know how reassuring it is to hear somebody say that my body is okay, that I can be confident in the fact that it is basically healthy, and that I have to learn to listen to it. Everybody tells me that my body is defective". For her it was finally an experience of a holding environment, which had confidence in her, which accepted her, and respected her the way she was without telling her how she ought to be. She would later write me a letter: "Dear Doctor, the confidence you have shown in me is like a heartening stroke on the cheek, a massage to a knotted stomach, an encouragement to hang in there". At that point I knew something new had happened. She had accepted my acknowledgements as a first source of nourishment that she could accept into her body. We had made contact and were beginning to lay down roots (ground).

6.2. "My Nourishing You and Your Hunger"

Therapy time flowed. Fresh new shoots were emerging from the roots nourished by the ground that we had, in the meantime, consolidated. Marcella was making progress in claiming back her bodily presence, in listening to its needs, and in finding new ways of relating to me which she found nourishing. "I have traced out a map of my needs as a woman […]. I know myself better now. I know I can rely on myself, on my feeling a bond from a distance, like a naked embrace, intense and unique".

She had even taken stronger root in her own body, now that she weighed forty-four kilograms. But her relationship with her femininity still frightened

her, as though the ground in that field was still shaky. “If I am thin then I keep all the sensations connected with sensuality, transgression, all those strong female urges calm and flat”. I figured that Marcella needed to experience taking back the possession of her body, of the needs, sensations, desires and delights tied specifically to her being a woman.

It was essential that Marcella experienced her feminine side with me, feeling that I was present but at the same time knew how to stay in my place, without invading her with desires, models and forms that were not her own, feeling that I would leave her the space she needed without, however, abandoning her. In that way, Marcella could find her own way, accompanied by my concerned, though serene gaze. She could ask for reassurances about the “beauty” of her womanhood and on the possibility of expressing it in the world. For me all that meant focusing very carefully, and for a long time, on how to adjust the relational distance between us, and between our femininities, especially when such an adjustment would reopen, in her hesitancy, the wound of vulnerable contact.

“Dear Doctor, it hurts me when you said that I am not ready yet to have a man. Knowing that there is sunshine outside is not enough; you have to enjoy it sometimes. I deserve it”. It was a crucial moment. I became more active at the contact boundary, though in a very vigilant way, conscious of having to be very careful in this delicate equilibrium. An important episode happened at that point. During a session in which she was particularly upset, Marcella asked me to hug her. It had not happened for quite a while. I was astonished and surprised to feel her bosom against mine – I realized that she now actually *had* a bosom. The realization warmed me and made me proud of her, of her courage in embracing life once again through her body as a girl. I told her that it was wonderful to be there bosom to bosom with her, in an intimate encounter between women, the body of one woman encountering the body of another woman. It was a moment of great significance, not only as an acknowledgement that reassured her of her original female form, but also as a sign of confidence in the fact that this new-found femininity could find space for itself in our relationship. A healthy, playful, strong and respectful feminine bond grew between us.

The experience was so significant that I could feel it was beginning to let both of us take root in our bond (root-bond), through which new powers in her body began to emerge for Marcella. “My body expresses health now and bubbles with joy […]. Once again I can feel the pleasure of fatigue running through my body without it consuming me. It is reassuring to know that I can eat when I am hungry, because my body tells me so and I listen to it”.

6.3. The Long Road of Courage

Marcella came to feel she had a solid base beneath her, created by the therapeutic relationship, from which she could reach out increasingly into the world. "Doctor, you have taught me to be with the other. I always carry you inside me because of that. It helped that you never pushed me, but followed me gently. Now I know what I want, and I want love, so I want my bosom back. Bosom to bosom, Marcella".

At this point in therapy, another important episode occurred. Marcella arrived for her session with a picnic basket, telling me she had brought everything we needed to eat together. After her first year of therapy, she had told me that the day would come when, during her therapy hour, we would have broken bread together – not in my practice but in the midst of nature, in the sunshine surrounded by greenery. I felt I was fully confident with her decision, in the creativity expressed by Marcella in that proposal of hers, and also that it was important, at this stage of therapy, to go with her into the world and share the fragrance of food. Together we went to a park near my practice, and sat down on a bench. Marcella pulled out of her basket a loaf of fennel seed bread, flavorsome olive oil, and Coca Cola. At the contact boundary I could feel both our excitement and our complicity ("Doctor, we have gone through so much together!"). It was a joyous picnic, where we ate and laughed a lot. I realized later, when thinking back, that our being there together had come so spontaneously and naturally that I did not at all feel the need to check how much Marcella actually ate. I profoundly feel that we both ate the "right" amount, which is something that moves me intensely. After that episode, Marcella began to put on weight at a regular pace, but we did not speak of food anymore. The issue now was taking her new femininity and sensuality out into the world. Marcella was beginning to show her femininity in increasingly more evident ways, even allowing herself to be seductive and letting her womanly body become visible to others. "I tried on a figure-hugging dress for the summer – I was a knockout! The shop assistant asked me 'What have you done, Marcella? You glow with a new light now'". Another important victory for Marcella's femininity came at this stage of therapy. "Dear Doctor, your listening to my intimate self has unleashed my most feminine side – I've got my period! Thank you, you always receive me with such great respect". Furthermore, Marcella increasingly was expressing her creativity and originality in the world, interacting with it through her remarkable artistic talent, and through her numerous travels, which were a further source of growth and expansion towards the other for her. "Travelling, diving into the rich variety of the world is an elixir of life for me". Opening up to the world was not always without its pain. When that happened, I strongly felt the importance of not diminishing or brushing aside

Marcella's difficulties, and the impasse they brought to our work (respect for the "archaic time of bodies"). I summoned up my solid presence at the contact boundary (reminding myself of the firmness of our ground, the strength of our root-bond, and the results achieved together) and my vigilant, unwavering confidence in Marcella's strengths and the courage that I knew lay within her.

In one of those moments of discouragement, Marcella arrived at the session and told me all about her pain at feeling discredited by her parents in her attempts to stay in the world fully and autonomously. It was a moment that took her back to the harrowing solitude that she had felt in the past, and the fear of not making it through. "You won't abandon me, will you? Thank you for not having done it so far". I answered her decisively: "I wouldn't dream of it! The thought has never even crossed my mind". The strength of my determination emerged spontaneously through those few words, conveying the absolute certainty that I was and would continue to be there for her, the importance that she had for me, the esteem I felt for her, and the affection that we shared. "Thank you, Doctor. This doesn't normally happen to me. I was scared that you might abandon me […]. For you I am your work; for me you are still my anchor of salvation. In icon painting, the board that you paint on is called a *zattera* (life raft), because symbolically it takes you towards salvation. I put in the colors, you the backing. I put in the ideas, you the support". It is precisely by going through moments like these, sustained by the confidence I have in Marcella's creativity (which is so indissolubly and intimately tied to her being) and my strong and safe roots – the ground that is still indispensable for her to stay in the world – that Marcella can live the experience of feeling both nourished by the other *and* free.

Comment

by Irina Lopatukhina

I've experienced great personal and professional pleasure in reading this chapter by Conte and Mione. They tell us how eating disorders become a dramatic creative adjustment to «create a relational field in which a mode of existence with an eating disorder appears to be the only chance for growth and contact with one's world». It is very interesting to accompany the authors as they explore the recent changes in the understanding of these disorders: what is the human body in social and relationship contexts; how the function of eating, the most direct and easiest way to moderate the appearance of the body, becomes an instrument of self-image; how it influences the construction of female gender identity and the adolescent contact processes.

To present the current understanding of eating disorders the authors review the theoretical approaches in psychoanalysis, cognitive-behavioral psychology, systemic therapy, social-psychology and Gestalt Therapy. They show us how food and the body becomes «a language for shouting out to the world one's intentionality for contact and the impossibility to reject being an individuated presence». I particularly appreciate the step-by-step pacing of work proposed by the authors at the contact boundary with this category of clients.

*The clinical case-study of an anorexic client is very interesting. It illustrates clearly the importance of the therapist's flexibility in a therapeutic setting and how validation of the client's experience could help the patient find new creative adjustments. In addition to their contribution, I would like to offer the possibility of understanding the contact phenomena of clients with bulimic symptoms, grounded in my clinical experience. I would propose a further investigation of how bulimic contact with food is rooted in child development. Let's look at the following quote from the authors from a different point of view: "*I throw you out of me so as to try and take you back the way I want*".*

During child development food is a fundamental part of the contact boundary adjustment between mother and child. Bulimic patients complain that in hyperphagic attacks they lose the ability to stop the process. In the contact with specific food, which I call "mother's", they try to find mother's love and care. They project their childish mode of contact with their mothers on the process of eating this specific food and in this frame the food becomes "mother", and becomes "aggressive" and "non-stop", in the same way their mothers gave them support and care in their childhood and adolescence. The need for food – of good quality, tasty, satisfying, digestible without excessive energy waste and with no unpleasant after-taste – is connected to the necessity of the other. An other who feeds us with his presence and attitude, and whom we feed with our presence in the contact. The relationship with the mother is at the same time a contact with food and love. Since childhood, hunger and love are regulated at the mother's breast, so it is easy to transform the desire of mother-care and love into hunger – the desire for food. During the bulimic attack the desire to contact the food implies the loss of even the minimal ability to regulate this contact by intensity –density – volume. There is a "mother food" (taste, smell, consistency) which fits well with the desire for the mother's contact. It's commonly something sweet, dairy, thick, warm, dense.

The patient confuses love and food, and is looking for food when he needs love. Food then, as the projection of the mother's response at a difficult time, "breaks in" inside the client, sweeping away any attempts to rehabilitate any boundary, to say "no" to any of her requests.

Instead of meeting at the contact boundary there is total and unscrupulous "acceptance" of everything with the loss of sensitivity to one's own needs, lim-

its and resources. Afterwards there is the same total and unscrupulous rejection in the separation. Through the attack of vomiting release is achieved. There is no meeting. Time after time the symptom, as an early childhood model of child-parent relations, wins back – the absolute mother's power in which a child has a very passive role.

During the attack the client, who in today's reality has real power over the food, embodies his childhood helplessness faced with the excessiveness and "impossibility" of resisting. Following the attack, the client totally rejects the "imposed" by intentionally provoking vomiting.

These patients are very vulnerable to any pressing or "hyper-care" from the therapist and rely greatly on their own ability to control the contact even when they are asking for care and support. In my opinion, the process of therapy, especially in the beginning, must be very flexible to allow them to appropriate their own power and ability to dictate the intensity of relationship with the other, and the risk of leaving their habitual frame "all or nothing". The authors demonstrate this flexibility when they describe the case with their anorexic client.

From my clinical experience I would like to add some more examples that illustrate ways of working with clients' emotions, "packed" into the symptom.

In a bulimic attack the client contacts food in an unconcontrolled, agressive way – destroying, for example – winning back his agressive impulses that are retroflected in contact with the others; the more he restrains his energy in his relationships with people, the fiercer the attack would be. Therefore, the ability to differentiate emotions before the attack is a great step forward in recognizing which emotions were re-addressed from the contact with the other to the food.

Food diaries are a great help in revealing retroflection when the client "uncovers" the emergence of an emotion or state at the beginning of an attack. They clarify how maintaining real contact with the other or with his own environment is projected into an overexcited appetite. This appetite as a transformation of the desire for contact was impossible to present to the world.

The attacks imply a mystery and solitude. If contact with a living person could be added to that solitude or the client has the opportunity to call or write to somebody before the attack, to tell of the heavy burden or of immersion – then the projection may be partially revealed. Then the experience of disclosing the distressing emotional state in contact with the other will gradually form an inner reality. Even if this does not yet happen with the one who provoked that situation but in the "story about..". it is also very helpful. The therapist may also be a source of support. By agreement the client could for example write a letter before, or send a message to the therapist. The therapist then takes responsibility for reacting quickly or according to his availability. This could be part of the therapeutic contract.

As the authors have already remarkably well stated, the difficulties of contact are perfectly recreated in the contact with a living other, allowing the possibilities of being accepted at the boundaries with the desire for sometimes being close or sometimes being apart. Then the therapy work happens exactly at the contact boundary. This interaction, among other things, helps to "unpack" inner phenomenology, projections and "packed-in" symptoms and helps to restore in the client the freedom for new creative adjustments in his on-going reality.

Gestalt Approach to Psychosomatic Disorders

by Oleg Nemirinskiy

Let us begin with mentioning that Fritz Perls and other pioneers of Gestalt therapy had no comprehesive theory to describe the origin of psychosomatic disorders and the specifics of therapeutic dealings with them. Nevertheless, F. Perls did describe, first as an outline in *Ego, Hunger and Aggression* (1947/1992) and then, more coherently, in *Gestalt Therapy* (Perls, Hefferline and Goodman, 1951), his understanding of psychopathology. To my mind, that concept is not only a pearl of psychological science related to the person but also remains largely underestimated even today.

What is the basis for such an opinion?

Most psychotherapists, including many of those belonging to the Gestalt community, perceive a psychopathology theory as mainly medical diagnostics and a description of "personality types". In addition, they quite naturally adopt the logic of psychoanalysis, simply because the logic of Gestalt theory is trans-typological, that is to say, it reflects the common patterns of creative adjustment on the neurotic level and is *dialectic* throughout, which means that it is built up of contradictions and paradoxes, which is not always easy to comprehend for people in general and even for therapists in particular.

1. A General View of Symptoms

The most general theoretical basis for understanding any symptom in Gestalt therapy is the concept of *the double nature of the symptom*.

A symptom is a contradiction, a paradox, because it is an expression of vitality and at the same time a defense against vitality; a manifestation of "a problem" and, at the same time, a means of solving it. A symptom is an attack on the free flow of excitement and, at the same time, an indirect, a compromised means of satisfying a need – indeed, the very same need whose existence creates the excitement that is being "repressed". Also, a symptom is a means of fighting anxiety and, at the same time, of chronically maintaining it.

This is why the Gestalt therapist perceives a symptom not only as a cause of suffering but also as a potential source of excitement, a source of unused vital energy. The fact that the Gestalt therapist's subject matter is contact in the organism/environment field does not mean any lack of attention to specific pathological symptomatic; symptoms are a treasure of unused human capacities.

While the notion of the double nature of the symptom reflects the adoption by Perls of some important aspects of psychoanalysis, the other construct, namely, "resistance against resistance", expresses his deviation from the psychoanalytical theory.

The revision of psychoanalysis by Perls began with *a change in the understanding of resistance*. Back then, psychoanalysis studied mainly the anal resistance, considering it in the context of the conflict between individual needs and social norms, in particular, of the child's protesting reactions against toilet training. While studying eating behaviour F. Perls noticed that what controls it is an internal pair of opposite forces – appetite and aversion. Food aversion is a natural resistance to appetite. In *Ego, Hunger and Aggression* he writes that appetite and aversion are two sides of one regulatory process. While appetite marks what the person lacks in his/her environment, aversion fulfills the important function of rejecting what the organism does not need. The phenomenon of losing one's appetite is connected to repression of food aversion. Such repression may only be actualized by way of reducing sensitivity, which is why it causes loss of appetite. It is also worth recalling what an important role in the development of phobic symptomatic is played by fear of fear and by other cases of resistance against the experience of rejection (in the broad sense, which includes not only rejection of the environment but also a manifested and experienced rejection of one's own activities).

Based on the idea that the phenomenon of "resistance against resistance" forms a basis of pathological process Perls later developed one of the most important tactical principles of Gestalt therapy. Since resistance to something is always backed by another need, it is necessary to let that resistance manifest itself, fulfill and exhaust itself, after which it should give way to the opposite trend (Perls, 1969).

If we adopt this standpoint then the model of a healthy personality appears to be a balance of possibilities. A healthy person might be tough or gentle, fast or slow, intellectualizing or emotionally sensitive, seducing or chaste. They might be this and that, depending on the situation and their own choices. A person must be described, not as a complex of traits and features but as freedom of movements on the continua of opposite possibilities.

This dialectical self-regulation by means of pairs of opposite tendencies is, therefore, a sign, not of pathological, but, on the contrary, of healthy develop-

ment. From the standpoint of the Gestalt theory of neurosis (Perls, Hefferline and Goodman, 1951) it is precisely the attempts to avoid the contradictory character of development that lead to neurotic development. It is not conflict per se that forms the basis for neurotic development but, quite the contrary, *a premature pacification of a conflict.*

A healthy response to a conflict situation is this; that the most urgent need (or figure) of the moment comes to the fore, which brings about action, or, more precisely, a *deed*. In the last analysis, it is precisely the deed that leads either to an internal approval of the choice made or to a re-evaluation and, then, to the doing of another deed.

Another possible response to the situation is this; that instead of developing an external confrontation a person remains within the framework of his/her internal struggle. While trying to make preliminary calculations and warrant success for oneself, one becomes unable to make a choice and thus becomes suspended between the two directions. Being thus "suspended in one's internal world" one begins to avoid real relationships and loses the ability to feel adequate satisfaction, because the energy in the framework of the internal struggle is always directed retroflectively at oneself and cannot be fully discharged. Since the neurotic choice consists of avoiding any possibilities of conflict, the acute tension of the opposite forces turns into a *chronic low-grade tension*. Thus the neurotic person, while striving for comfort, always ends up in the state of endurable discomfort.

2. Psychosomatic Symptoms and Contact

For a long time I have thought of Gestalt therapy as if especially created for dealing successfully with the area of psychosomatic symptoms. But when I tried to find some literature on the Gestalt approach to psychosomatics I was surprised if not shocked. There was almost no literature in English! I found the well-known book *Body Process* by James Kepner (1987) and the translation of the article by Giuseppe Iaculo (1997) where the author describes the important role of retroflections in the genesis of psychosomatic disturbances. I know of more articles on this topic in Russian, particularly by those authors who have been my students and who are now trainers at the Moscow Institute for Gestalt Therapy and Consulting (Lasaya, 2005; Serov, 2006; 2009; Shevchenko, 2009, and others). I am not going to discuss here the possible reasons for this situation; I will just try to touch on some difficulties Gestalt therapists might have when they deal with psychosomatic symptoms and to present my therapeutic approach.

When dealing with a psychosomatic symptom the therapist faces one tradi-

tional difficulty. Psychotherapy does not deal with the human body per se but with contact in the organism/environment field. F. Perls and P. Goodman stated:

> Experience occurs at the boundary between the organism and its environment [...] Experience is the function of this boundary, and psychologically what is real are the "whole" configurations of this functioning, some meaning being achieved, some action completed. The wholes of experience does not include "everything", but they are definite unified structures; and psychologically everything else, including the very notions of an organism or an environment, is an abstraction or a possible construction or a potentiality occuring in this experience as a hint of some other experience. We speak of the organism contacting the environment, but it is the contact that is the simplest and first reality...» (Perls, Hefferline and Goodman, 1951, p. 227).

Gestalt therapists often emphasize this point by claiming that "we work with contact rather than the symptom". The assumption here is that if we deal with the pathology of contact, we shall thus exert influence upon the symptom. Such a vision of therapeutic process means that we largely deal with the symptom in a haphazard and blindfolded way. But could it possibly be otherwise? Is it not true that a psychosomatic symptom belongs to the body and not to the contact in the organism/environment field. In other words, it is not an experience.

That is what it is. The psychosomatic symptom is "non-experiencing", it is "non-contact". Or rather, it is a retroflected form of contact. And if we venture to break out of the bonds of overly opposing symptom and contact, we shall come close to the proposition that *the psychosomatic symptom is a retroflected form of contact with the world* (Nemirinskiy, 1997).

In addition, when considering a symptom, we encounter not only retroflection but also projection of the patient's needs and experiences onto a certain organ (*ibidem*). Eventually, as the disorder progresses, that organ becomes alienated from the holistic interaction of the body with its environment.

Allow me to dwell briefly on some more simple and basic aspects of symptom genesis.

The universal means of overcoming a critical situation is to experience it (Vasilyuk, 1984). A refusal to experience is a trigger for a pathogenic process. The central position here belongs to the emotional component of the experience, to a feeling which serves as an immediate and holistic indicator of the person's relationship with the world and with his/her own life. Feelings, however, are known to be unpleasant, while man, "King of Nature", possesses well-developed capabilities to ignore his own feelings. What is to be done in order not to be aware of a feeling? The term "repression", inherited from psychoanalysis, suggests that an unacceptable feeling is being exiled into a kind of

special “reservoir” of the unconscious. In reality, however, it is a specific *body process* that takes place here. In order not to be aware of a feeling, it is necessary to become unaware of body sensations that signal that feeling. For example, in order to avoid awareness of fear, it is necessary to “freeze” low-amplitude movements of epigastria muscles (we must make a reservation here that this is only an example, because fear can be related to something other than epigastria). In addition, in order to stop that muscle activity it “would help” also to decrease the respiratory amplitude. So, we must infringe upon our body activities (muscular, respiratory or other) in the place where the corresponding feelings are located. Such infringement leads to the development of physical pain (Mindell, 1985). This is the first stage of somatization, a transition *from a feeling to intermittent pain*.

But pain is an alarm, an urgent call to an immediate reaction. It is very difficult to endure pain for long. Hence the second knot of the matter. There is either understanding of the pain’s function and listening to or a continuing alienation. In order for the latter to be fulfilled, it is necessary to create «chronic low-grade tension» (Perls, Hefferline and Goodman, 1951) in the area of the potential pain. Such muscular tension (accompanied by corresponding tension in psychological structures) is supposed to serve as a means of leading the person away from feeling the pain, but in order for that tension to be chronic it must be of low intensity. (An increase in tension will lead to more pain and therefore will require either a change in the situation or, again, a decrease in tension). This is the second stage of somatization, a transition *from pain to chronic tension*. (On the other hand, the boundary between the first and the second phases might be fuzzy, and in some cases a person leaps through the pain symptomatic quickly).

Chronic tension has a number of physiological implications, such as metabolism distortions in the corresponding part of the body, increase in secretion of some hormones and decrease in others, and various other processes well known to physicians. All these processes create an accumulating background for development of disease. Generally speaking, the third phase of somatization might be said to constitute a path *from chronic low-grade tension to a manifestation of disease.*

What happens on that path? Here it is important to understand what the attack of disease is in relation to the background of chronic tension.

Sergey Serov, analyzing the structure of asthmatic attacks, writes:

> What is the bronchial constriction physiologically necessary for? Without bronchospasm (or bronchostenosis) it is impossible to sob; it would be just deep breathing. Sobbing requires a resistance to exhalation. Try to strain your stomach and at the same time to force an exhalation, and you will produce sobbing sounds. But that is not yet a

symptom […] Deep breathing is a result of the diaphragm's movement. But the point is that the diaphragm is quite inactive […] An asthmatic attack is an attempt to sob, in the form of a bronchospasm, and at the same time an interruption of the sobbing, in the form of inactivity of the diaphragm (diaphragm spasm, a fact confirmed by radiologic research) (Serov, 2006, pp. 79-80).

Serov goes on to claim that what we consider an attack of disease is, from the standpoint of the release of experience, quite the contrary, an attempt to recovery. On the other hand, «actual manifestations of disease will be such symptoms as cough, asthenia, short breath, etc. (*ivi*, p. 82).

The onset of an attack of disease, then, is an escalation of tension, a breaking through of experience, and a desperate attempt to not let the experience go.

Now let us consider what the above-mentioned somatization stages are when viewed as a process of retroflecting a contact. We will easily and from the outset observe the most important role that the retroflection mechanism plays, but the point here is not just retroflection as a dynamic moment of an interruption of contact. With stable retroflection there forms a body area of alienated experience, which manifests itself in the phenomena of desensitization and "subtle" projection as described by J. Kepner (1987). (In the latter case a person senses the body part but does not fully identify with the body processes that take place). It may be argued whether or not it is legitimate in this case to speak of "projection", applying the term to any alienation from the self, but here we speak of a form of retroflection with which a person in a sense "perceives" his/her own body as part of the environment.

A symptom, then, is a form of contact which, having undergone a kind of evolution, has lost the features of contact. In order, therefore, for a symptom to be drawn into therapeutic workspace it must appear *at the contact boundary*. Only then might it begin to change (Nemirinskiy, 1997). I would like to explain the point by the following example.

A member of a therapy group suffers from episodes of acute anxiety: he is afraid of finding himself far away from a restroom, that is, he is afraid that he might have a fit of indigestion but would be unable to reach a restroom soon enough and would be terribly disgraced in front of everyone. When actually finding himself in such a situation (e.g. on a street of an unfamiliar city on a business trip) he does indeed feels a strong urge to defecate.

One day, during a group session, he found himself at the epicenter of sharp collisions. Soon after the situation unfolded, he rose from his chair and announced his desire to step out for five minutes. I asked him what the matter was, and he pointed at his stomach. I told him, "Let us make a deal. The restroom is but a few steps away. If it becomes unbearable you will leap out. In

the meantime, let us try and figure out what it is that happens to you in the group that brings out those symptomatic feelings even though the restroom is nearby".

That moment proved a breakthrough and a turning point in therapy. The reason it happened that way was because the symptom happened to be right on the boundary of his contact with the other group members. The symptom came to life during a particular type of interaction with the world, and now if we unfold the contact, "de-retroflect" it, the symptom might start moving, disappearing and appearing again, and changing its intensity.

We can give many more examples of the ways in which a therapeutic situation reproduces an acute life situation, when a symptom "revives" and starts moving. Perhaps the most important practical issue here is the understanding of the *relational context* in which such a "revival" takes place. In this regard, I may offer an efficient practical solution. During one of our seminars, the participants dubbed the method "tensionmeter technique". The name took root and has established itself in our community as a technical term.

A frequent example is the headache. If a headache occurs during a group therapy session it gives us a remarkable opportunity to bring that symptom out at the contact boundary. Sometimes it is sufficient enough to ask the patient just to register variations in intensity of his/her headache while staring at one group member after another. When the patient is looking at one person – the headache subsides, looking at another – it intensifies, at yet another – it becomes splitting… The next step is to find out what kind of relationships the person has with those "upon whom" the headache worsens or abates. Thus we may create, by way, not of *a priori* theorizing but of practical experimentation, a "map" of connections between the symptom and the character of the interpersonal interaction.

It is important to notice that "the tensionmeter" can work in one of two modes: actual (as in the above-mentioned example) or virtual. In other words, the symptom does not necessarily "react" to someone actually present in the therapeutic situation. In many cases (more often in individual therapy than in a group) it is advisable to ask the client who is experiencing symptomatic sensations to visualize, one by one, relevant persons and try to register the intensity of symptomatic sensations. However, it is necessary to make yet another stipulation in the "tensionmeter user's manual". "The device must be plugged in", that is to say, the client must be excited to a degree. Otherwise, in the state of alienation or confluence, the client will not be able to differentiate his/her reactions to objects in the surrounding world.

The Gestalt therapist's task, then, is, generally speaking, to help the client to gradually return to the original form of contact.

However, symptoms do not always make appearances on the therapeutic stage in a sort of "magic" way. Quite often it exists *over there*, in the client's life, but is absent *over here*, in the therapist's office. In this case, we can use the special techniques of "calling the author to the stage". (Of course, dealing with the symptom at the contact boundary is, as a rule, more efficient. Yet at the initial period of therapy, an unexpected occurrence of a symptom can frighten the client and might have an adverse effect in the situation where the client has a low level of self-support and does not yet adequately rely on the therapist at the stage when the therapeutic relationship is only beginning to establish itself).

The reader can find one such technique in the method by which Fritz Perls dealt with dreams. He called it the method of identification with a projection (Perls, 1969).

According to his concept, every element of a dream is a part of the self which has been alienated and projected into the dream (a virtual external world). That is why in order to re-establish lost integrity it is first of all necessary to transform partial projection into a total one by way of identification with the image presented in a dream, which is what Perls did using the "empty chair technique". Based on Perls's ideas pertaining to the technique of dealing with dreams, as well as on the aforesaid concept of the symptom as a transformation of contact, it is possible to develop a certain sequence in dealing with a symptom.

In a way similar to dealing with dreams, the first step here is a transformation of partial projection into a total one by way of identification with the diseased organ. This is accompanied by experiencing the qualities, desires, and feelings that are being projected.

It is important to make the point that when F. Perls discusses dream images as projections it is not the same as the conventional notion of projection as "translocation" of experience into the external world. Within consciousness, a person does not attribute his/her experiences to a dream image. By the same token, a person does not consciously think that his/her hand feels anger against someone or that his/her genitalia feel sexual desire. Yet, if one succeeds in achieving at least virtual identification with a certain body part, those experiences begin to come back. This is why we might in a sense regard the alienation area that we discussed earlier as a domain of the existence of projections. It is necessary, however, to make at least two reservations. Firstly, it is not a combination of retroflection and projection but rather coherence of the two mechanisms. Projection in this context exists, as it were, within the retroflective world. Secondly, it is often difficult to delineate such an alienation area anatomically, since psychosomatic diseases are illnesses of a whole human being, not of a certain organ, and involve many systems of the organism. Thus,

for example, arterial hypertension is, of course, not about "a projection upon blood vessels"; rather, it impels us to draw attention to alienation of vivacious muscular activity among hypertonic patients.

The second phase is a reconstruction of the personal context of relationships (reversal of retroflection). How does that work? At some point the therapist intuitively apprehends either the "script" character of a statement or an emotional arousal, and asks the patient, "To whom are these feelings addressed?". At this point, some figure from the patient's life might emerge. This is an important matter in understanding the interpersonal character of a symptom.

The decisive phase is the third one, that of projection assimilation. In essence, it consists of taking responsibility for experiencing those desires or feelings that had been attributed to a body part and/or another person. This stage is a turning point. It is at this stage that the original experience is restored after it had been blocked by the symptom and at the same time had manifested itself, though in a distorted form, by means of the same symptom.

The fourth phase is that of complete reversal of retroflection. Technically speaking, this process usually has to do with testing the stability of the newly acquired responsibility (e.g. in actual interactions with other group members, in the case of group work).

Thus, tactically speaking, this technique comprises an alternation of actions aimed at assimilation of alienated experience (projection assimilation) and those aimed at reversal of retroflection. Various techniques for dealing with psychosomatic symptoms in group therapy might also be constructed according to this tactical principal. Still, let me make a reservation again, such techniques are mostly auxiliary ones; they cannot replace the work at the contact boundary. What is the most important for me is that in this case, too, the general direction of the work is from the symptom as a retroflected form of contact to reestablishing the fullness of contact with the world.

3. Linear and Dialectic Models of Therapy

So far we have dealt with the interconnection between the symptom and contact as well as with the way the therapist can understand to what kinds of relationships the emergence/revival of a symptom is related. Now let us see what therapy itself consists of and by what means the client can get rid of a troublesome psychosomatic symptom.

In this respect it is important to realize first of all that it is impossible to "cure" a symptom in the traditional medical sense, because *a symptom is a means of self-regulation*. It must not be considered an external infection which

is to be driven out of the body. We can only help the client to find another means of self-regulation that would enable him/her to meet his/her needs more fully. But then arises the question of *how* self-regulation actualizes.

Most therapists will tell you that symptoms emerge as a result of a blocking experience. According to this standpoint it would be enough to make a certain experience free or to overcome the lack of a certain ability, and the symptoms will disappear. This point of view is explicitly or implicitly based upon the notion of *resource*. The therapist thinks that the client lacks something; basing his approach on this idea the therapist tries to create conditions for obtaining that "resource".

However, we often see that though the therapist believes that the release of a specific experience must cure the symptom, such a recovery does not happen. Moreover it is easy, when relying on the ideology of "search for resource", to inadvertently slip into fighting the symptom; as a consequence the client is most likely either to walk away, taking along his/her symptom with pride (resentment, irritation), or to "surrender" the symptom and create another one in its place. In the warfare between the therapist and the organism the latter usually acts more cunningly, if only for the reason that it fights on its own territory.

That is why the psychotherapist who deals with psychosomatic (or any other) pathology must learn to respect the symptomatic creativity of the organism and, figuratively speaking, to know how to talk to the client's organism. It is not so simple, yet neither is it as complicated as it might sometimes seem.

The thing is, a symptom is not only a riddle, not only a nuisance or a challenging puzzle but also a hint for the therapist, a cue to what the client's organism occupies itself with. Having once observed a neurotic or psychosomatic symptom the therapist need no longer guess what contradiction in the client's life is the most relevant for his/her development and at the same time the most threatening for his/her integrity.

From the Gestalt standpoint, the symptom is a frozen mode of existence of a contradiction, a prematurely reconciled conflict of two opposite tendencies, needs, aspirations. This thesis is only one step away from the following idea, that *the most relevant contradiction for the client's development is precisely that which is "frozen" in the actual symptomatic* (Nemirinskiy, 2006).

(Apparently, it makes sense to differentiate a chronic symptomatic, the one that is related to the client's "chronic" problems, from an actual one, which is related to the current period in his/her life).

This thesis creates a basis for a different, non-linear view of therapeutic dealing with the symptom. The point of the matter is not that a client lacks something that would promote a more full and healthy life. Essentially, that is true, but only a part of the truth. The important point is that the basis of the symptom is a frozen conflict of opposites, and the therapist who does not hold

this dialectic view of the client can easily slip into promoting the trend in one or the other of the directions and eventually will be confronted by "resistance" from the opposite one.

In the previous part of the paper we have tried to explain how one can figure out which specific contradiction is responsible for the symptom. When a symptom appears at the contact boundary we find, at least approximately, an answer which is related, not to some theoretical constructs but to empiric evidence of the ongoing interaction of the client with the environment.

Now what are we to do with that newly found contradiction? What should the therapy itself be like for the symptom as a frozen contradiction? This is where, in my view, the divide lies between psychotherapy per se and counselling. The natural way for the counsellor is an appeal to the client's reason, something to the effect of "look here, you contradict yourself". The psychotherapist can, of course, work on the counselling level (sometimes the initial period of work with the client does not even allow for anything else), but he knows that the appeal to reason does not as a rule lead to resolving the contradiction. As a matter of fact such a resolution is only possible by way of living the contradiction through. What follows from this is a most important principle of the psychotherapist's work: *the psychotherapist supports both of the contradictory tendencies*.

I remember a client from a long time ago who experienced chronic backaches. It must be mentioned that at the beginning of our work it was not about psychosomatic problems at all. The beginning of the therapy was a constant struggle. She confronted any remark of mine with mistrust. I couldn't offer her any experiment without her ironic reply to the effect that "Yes, I know, this is what Gestalt therapists do". After a while she decided to quit. I guess both of us felt somewhat relieved.

Half a year later she unexpectedly asked me to resume therapy. Was it she who had changed (I thought so) or I who had become wiser? But we started making progress. I was grateful to her for the fact that there was now much less struggle, and not only did I come to think that she was overly prone to counter-dependent behaviour (behaviour driven by avoiding intimacy out of fear of dependency) but also came to agree with her more often that her autonomy is very valuable for her.

At one point we concentrated on her backache. What turned out to be the focus of our work was the dilemma, should she rely on others or on herself*? Indeed, she was trying to control everyone around her, including the therapist, but at the same time she sincerely grieved the "impossibility of full trust" and longed for intimacy. She was equally unable to joyfully mistrust (her mistrust was accompanied by bitter emotions) and to lightheartedly trust (the very pos-*

sibility of trust frightened and repulsed her). In the course of therapy she was slowly loosening control. At one point she expressed the desire to be able to physically lean on me in such a way as to be able to FULLY relax, but immediately voiced the fear of becoming amorphous, losing ground and breaking apart. I supported both of her aspirations – to rely on me and to rely on herself. It was obvious to me that both abilities enforce each other. What was going on in the therapy could be called the swinging of a pendulum. It was work related to the improvement of spinal flexibility, both on physical and psychological levels.

There are two possible situations where the principle of supporting both of the opposing tendencies actualizes differently from the technical point of view. One of the situations is where the client demonstrates now this of the opposing tendencies, now that. The therapist's concern here is to help both of the tendencies to express themselves as fully as possible. For example, during one period of work the client might concentrate on the tendency toward rejection and autonomy while during another, toward belonging and closeness. It is important for the therapist to make it possible for the client to *live through* both. The other situation is where the client behaves paradoxically, trying to achieve both ends simultaneously. The therapist's task here is to encourage and even amplify that contradiction. (Strictly speaking, the differentiation of the two situations is somewhat relative. If it is all about an actual and dominating contradiction related to a symptom then, in that context of being, the client is always contradictory). Assuming that the symptom is a paradox and a frozen contradiction, the therapist's task (at least in the case of manifested symptomatic) always includes the swing of the pendulum of contradictions and, speaking broadly, the improvement of spinal flexibility.

Here I would like to make a reservation. Such work is by no means possible as a set of techniques; it only actualizes in the framework of therapeutic relationships. To come back to the question of means by which recovery takes effect, we must mention yet another context in the answer, and a very important one at that. This context is nothing new for the Gestalt therapist: *in relationships with the therapist* the client can actualize both of the opposite tendencies and obtain, as was the case above, on the one hand, freedom and ability to rely on, and trust another and, on the other hand, freedom and ability to rely on, and trust herself and become self-dependent.

Speaking from a different perspective, at the level of organismic processes proper we can also observe the same dialectic structure of self-regulation. In general, psychosomatic pathology takes place when a human organism acts in two opposite directions simultaneously. One part of it reacts as if something

disturbing is happening, while another part, as if there is nothing of the sort[1]. Which means that even at the level of the human body we observe the same "non-experiencing" as a universal mechanism that triggers pathological processes and the same disturbance of the dialectic structure of self-regulation which, at the level of neurotic behavior, was brilliantly described by F. Perls within his concept of "premature pacification of conflict".

4. The Counter-Symptom Hypothesis

The dialectic view of the client is not restricted to considering a single symptom as a frozen contradiction. A person suffering from an illness is compelled to adjust to different living conditions, and this adjustment takes place at both the levels of relationships and of organismic processes.

To my mind, we must take into consideration the phenomenon that we

[1] Human body, at the level of nervous and endocrine systems and at the biochemical level, is built up in such a way that each substance has an antagonist substance (as well as a synergist one). Alexander Lowen (1988) offers the following description of psychophysiological processes that lead to the hardening of blood vessels and an increased probability of myocardial infarction (heart attack).

When under stress, the adrenal glands produce "fight hormones" (catecholamines), adrenaline and noradrenaline, that stimulate cardiac performance, increase arterial pressure and lead to a spasm of collateral vessels. As a result, the brain, heart and muscles receive more oxygen and nutrients. In an urgent situation the metabolic processes intensify, which is easy to understand in the context of adaptation. At the same time, "fight hormones" influence the secretion of lipoproteins, which can produce hemoliths (sediment on vascular walls) and thus increase the risk of a heart attack. This "side effect" of adaptation, according to Lowen, takes effect when the human organism, while being mobilized to either fight or flight, is at the same time ceased by fear. As a result its activity becomes "frozen", which causes excessive lipoprotein sedimentation on the vascular walls. In other words, the system makes ready for action and at the same time blocks action, and such co-existence of opposite activities creates the ground for a pathological process.

In addition, Lowen points out yet another very important mechanism, namely, the antagonistic activities of thromboxane and prostacyclin. Thromboxane causes agglutination of blood corpuscles (if a vascular wall gets damaged then during the accompanying spasm a clot is formed, which prevents bleeding), but at the same time serves as a cause of vasospasm. Prostacyclin slows agglutination down and dilates blood vessels. When the secretion of catecholamines ("fight hormones") intensifies the level of thromboxane increases. This is one part of the stress reaction. But if prostacyclin gets secreted at the same time, it removes the danger caused by the increased level of thromboxane. Prostacyclin, as it were, follows thromboxane's footprints and removes the side effect. And that is the second part of the stress reaction. It is in the absence of the second part that danger appears. The reason for this is that prostacyclin secretion is closely related to lung activity. If the respiratory system acts in such a way as to "ignore" stress, then the prostacyclin secretion does not compensate the effects of thromboxane.

might call "counter-symptom". *Counter-symptom is a body process making it possible to avoid acute manifestations of the symptom and to keep it in a more or less stable state* (Nemirinskiy, 1997).

The idea of a body counter-symptom occurred to me while working with a sub-depressive patient. She suffered from melancholy and a specific sensation in her chest – constriction – which is characteristic of depression. At one point I proposed an experiment, one typical in Gestalt therapy. I asked her to follow those sensations and change the posture of different body parts just the way "they themselves like it". She leaned slightly forward and bowed her head. Constriction in her chest disappeared, replaced by tension in her neck. At the same time, her emotional state altered too. Now she was experiencing something akin to humiliation. And when I asked her to keep moving in such a way that would help her to avoid the feeling of humiliation, she gradually came to her initial posture and felt melancholy again.

One could, therefore, discern two alternating patterns in the patient – melancholy and constriction in her chest, on the one hand, and humiliation and tension in her neck, on the other. Thus one could observe how the interchange of two sensations corresponds to the interchange of two emotional states.

Once we have ascertained those two alternating positions on the body level, it becomes much easier to correlate them with the corresponding positions in the patient's relationships with other people. The therapist usually can make a more or less sophisticated guess about these relationships, investigating his/her own contact with the patient. Having, then, some information about the body alternatives we obtain an observable criterion of truth for our conjectures. If our suppositions concerning the major alternatives in the quality of the patient's contact with the world are true, they should correlate (in the patient's actual experience!) precisely with those sensations that are characteristics of the symptom and counter-symptom. In the case described above, the patient experienced a chronic longing for intimacy but avoided any of it in panic fear of humiliation.

Allow me to propose yet another example. One of the group members suffers from biliary dyskinesia (although her motivation for participating in the group was related to educational reasons rather than medical ones). While working with the group she encounters a situation where she is afraid of getting close to people while at the same time feeling specific pain that is characteristic of her symptom. Having lived through that "acute" situation she experiences a great relief and warmth in her relationships with other group members. Her pain is also gone. But the next day she gets hit with a series of diarrhea fits, her anxiety increases, and she feels urges to drink alcohol.

What had happened?

The client was a recovering alcoholic. Even though by that time she had

had a significant period of sobriety, we must keep in mind that the life of a recovering alcoholic is largely related to the necessity of abstaining from spontaneous impulses. Perhaps her biliary dyskinesia was part of a retroflective and egotistic dam. When the dam collapsed all her anxiety and restrained impulses began to flow in a torrent.

That case set me wondering whether a rapid disappearance of a symptom can always be regarded as an unquestionable therapeutic success. I am not trying to say that we should avoid exacerbation of the symptom. When doing therapy we inevitably provoke change. When the symptom appears at the contact boundary it ceases to be static and starts changing. However, I think it necessary to understand the dialectic structure of personality and the symptomatic and to be aware of the possible dynamics of the symptoms at culmination points of the therapeutic process.

In this part of the paper, then, two hypotheses have been asserted.

1. On the level of body processes, there usually exists a counter-symptom which makes it possible to avoid manifestations of the symptom and to keep the latter in a more or less rigid state.
2. The opposition of the symptom and the counter-symptom might be brought into direct correlation with the corresponding psychological opposition that is with the type of interaction with the world that triggers the symptom.

5. On the Strategy of the Therapy

How are the techniques described above to be integrated into the holistic process of therapy? The optimal way seems to lie in combining thorough individual work with group therapy. I prefer to start in the individual setting, and it seems important at this stage to ascertain the polar structure of symptoms and perhaps to decrease the rigidity of the symptom by way of dealing with the dynamic pair "symptom-counter-symptom" (often a tactful physician's control is needed at that time) and correlation of body alternatives with psychological (relational) ones.

At the time a therapy group is being formed, another sort of work becomes more appropriate. The group dynamics in a group of psychosomatic patients might be developing more slowly than usual. At the initial stages of work with such a group (after, of course, the issue of basic trust has been more or less worked through), the technique of identification with the diseased organ becomes quite appropriate as a means of an individual focusing in group therapy. Along with that, the therapist encourages interactive processes within the group and thus facilitates the group dynamics. What is characteristic of therapy with a psychosomatic group is the fact that group dynamics lean not only upon the

communicational level of interaction but also upon the experience of bodywork in the group. That's why the group members gradually become aware of the connections between their own sensations and the content of their interaction within the group. Under these conditions it becomes easier to use the third method, the one described in the beginning of this paper, namely, the method of bringing the symptom out into the context of the currently important contact with the other group members. This could be called work at the contact boundary; it is that kind of work which, to my mind, is the most crucial in therapy. In such cases we may to a certain extent say that while dealing with contact we by the same token deal with the symptom. However, if the symptom comes out at the contact boundary in the interpersonal interaction at the beginning of therapy, it is not always strategically favorable. This is why it is important to gradually support the client on his/her way from symptoms to the fullness of healthy relations with the world.

Comment

by Giuseppe Iaculo

In his approach to psychosomatic disorders, Oleg Nemirinskiy, focusses on some interesting and prominent aspects. The first one is the theorical reading of the symptom itself, seen as an expression of vitality and, at the same time, as a defence against vitality. Talking about the psychosomatic symptom, the author points out how it belongs to the body and not to the contact in the organism/environment field, so as not to be considered either experience or contact. The psychosomatic symptom, in Nemirinskiy's reading, even if partially considered as an expression of vitality, is further on defined as "non-experiencing", "non-contact" because it is a retroflected form of contact with the world. The lack of bodily sensation awareness, seen as the basis of the feelings and its transformation into physical pain are identified, in a persuasive and successful way, as fundamental moments in the onset of somatisation. For this reason I ask myself: could the lack of awareness and the parallel creative adjustment of the psychosomatic symptom, as a transition from pain to chronic tension, be identified as a "non-contact"? Shouldn't the psychosomatic symptom, like any dysfunctional expression in human beings, be considered as an attempt, even though distorted, to get in touch with the environment and the other? The expression of an impulse that has been previously damaged and then stuck in the present but still alive (as the author remembers) and as an appeal to the relationship? When the author is pointing out the essentially relational nature of Gestalt theory and practice, it seems he uses an intrapsychic

reading of the psychological suffering. He talks about the symptom as a frozen mode of existence, the result of an untimely reconciliation between contradictory tendencies present in the patient. Whilst appreciating the care the author uses to describe the clinical work enacted by the therapist in his relationship with the patient, so that both contradictory tendencies can be fulfilled, I would once again highlight the relational dimension of the symptom, considering its function as a message for the other and for the therapist. When a patient explains his symptoms, the therapeutic approach is aimed towards a phenomenological and relational meaning, rather than an explanation concerning its contents. At the first level of psychosomatic distress, some retroflections may be noticed. Through the corporal retroflection *procedure, the action and the movements chronically blocked cause stress and somatic inhibition, leading to a subsequent onset of psychosomatic symptoms (Kepner, 1987). But the psychosomatic symptom is not necessarily connected to the retroflective relational style (Iaculo, 2007). A decrease in superficial spontaneity (corporal retroflection) may stratify on other different forms of distortions of spontaneity. It's not sufficient to describe only the retroflective functioning, deriving from the unawareness of corporal feelings and sensations and the projective one, at the basis of conflict of individual contradictory tendencies. They can be found, for example, in patients who show an inclination for a "do it by yourself" relationship with the environment and don't trust others, but also in people particularly reliant on the environment and, for this reason, unable to trust in their own capabilities of self-support. A psychosomatic symptom is a wide and complex communication system, supplied by the patient to the therapist who is willing to listen to him (Schnake, 1995). The information, which refers to the past history, the personal style, old wounds and previous creative adjustments, should be considered a relational rather than an absolute truth.*

I offer a clinical example to show how a symptom can become a message: Paolo, 33, suffering from gastrointestinal problems. He already knows the meaning of his doubling up in pain. He is aware it's the only weakness he is "compelled" to give in to. In one session, observing Paolo I notice both his facial expression and his posture and I get the feeling he may be sad. Paolo confirms he is sad and also adds that in the morning he felt lonesome. I perceive a light sense of disturbance and I ask Paolo who he has perceived as particularly distant these days and he refers to some events connected to his relationship with his wife. As I feel a decrease in energy, I resolve to put myself to the test, asking Paolo to think about our previous sessions and when he may have felt me distant. After a few minutes of silence, he recalls the time when I seemed to be too rational and descriptive. Aware of my unease and of the fact that he can criticise me without being either harsh or disparaging, he weighs up my suggestion to look at me and tell me how he sees me. He cries for a while stopping

immediately after. I ask him the reason for holding back his tears, even though he recognises my willingness to receive them. He says he is thinking about his mother and her difficulties, when he was a child, to give him the warmth he needed because she was occupied with controlling her husband, who was really jealous of him. Paolo becomes aware of his slowly learning how to hide his need for warmth in order not to appear too weak. There lies the reason for his detachment, contraction and his obsession with his stomach. At this stage I could choose different interventions but I resolve to follow a relational perspective: I take the risk again and ask: "Would you consider the possibility of showing me your weakness helpful and enriching?" Paolo feels like crying again and I invite him to breathe and stay longer within his emotion with me. He feels a relaxation in his stomach and chest while looking at me and breathing. He looks at me again and our feelings come into contact. He sighs. He enjoys my presence but, at the same time, feels anxious about it. I communicate my understanding with a nod and a smile, without words. We are in a full contact and it's the contact itself that develops into figure between us, both involved in contacting each other with a spontaneous act. When the session ends, saying goodbye to Paolo I not only shake his hands, as I usually do, but I also touch his shoulder. I am aware of this action just after having performed it.

Relational Sexual Issues: Love and Lust in Context

by Nancy Amendt-Lyon

> *Love aims at proximity, that is, the closest contact possible while the other persists undestroyed. The contact of love occurs in seeing, speech, presence, etc. But the archetypal moment of contact is sexual embracing.*
> (Perls, Hefferline and Goodman, 1951, p. 419)

1. The Phenomenology of Relational Sexual Difficulties

Having chosen to explore relational sexual issues from a Gestalt therapy perspective, sensations of excitement, mixed with feelings of awe, rush through me as I consider the scope of this topic. The field is enormous! Realizing however that I have chosen a topic that is very close to my heart, I feel sufficiently energized and supported to address this huge field, knowing full well that merely a fraction of it can be dealt with within this text. Sexual difficulties between human beings comprise phenomena that emerge as they engage with one another within the field of their mutual experiences in their interactions and attempts to reach and affect one another. From a field theoretical Gestalt perspective, sexual difficulties are relational, even if only one of the partners subjectively feels sexually unsatisfied, inadequate, unable to experience pleasure, unaware of his or her own needs, confused regarding his or her choice of partner, or anxious or depressed in the course of coming to terms with his or her sexual orientation. This refers to the experiences of heterosexual, homosexual and bisexual partners, and it may be noted that one's sexual orientation alone is not considered to be a disorder.

1.1. Diagnostic Approaches

1.1.1. Nosological Diagnoses

With this in mind, consulting the World Health Organization's International Classification of Diseases, Chapter V (F): Mental and Behavioural Disorders (including disorders of psychological development), better known as the ICD-

10 (2007), I found four general categories of sexual difficulties: Sexual dysfunction, not caused by organic disorder or disease; gender identity disorders; disorders of sexual preference; and psychological and behavioural disorders associated with sexual development and orientation. All of them are described in terms of individual suffering and symptoms[1].

In sum, relational sexual issues reflect difficulties in allowing sensation and arousal to occur, being open to mounting sexual tension, sustaining contact while sexual excitement peaks and surrendering to orgasm, as well as being able to linger and savor the afterglow of satisfaction. Discomfort or confusion about one's own gender may result in the desire to experience life as a member of the opposite sex, either in the clothes of the opposite sex or with the desire to change one's anatomy surgically and hormonally. Those suffering from disorders of sexual preference, including paraphilias, experience strong, sexually arousing fantasies, intense sexual drives or behavioural episodes that involve children, non-consenting individuals, or nonhuman objects or beings. Moreover, disorders of sexual preference may involve humiliating one's partner or oneself, or causing their physical or emotional suffering.

[1] In the World Health Organization's ICD-10 (2007), the first of the categories encompasses those sexual dysfunctions which are not due to organic disorder or disease (F52). These include the lack or loss of sexual desire (F52.0), sexual aversion and lack of sexual enjoyment ((F52.1), failure of genital response (F52.2), orgasmic dysfunction (F52.3), premature ejaculation (F52.4), non-organic vaginismus (F52.5), nonorganic dyspareunia (F52.6), excessive sexual drive (F52.7), other sexual dysfunction, not caused by organic disorder or disease (F52.8) and unspecified sexual dysfunction, not caused by organic disorder or disease (F52.9). The second category comprises gender identity disorders (F64), including transsexualism (F64.0), dual-role transvestism (F64.1), gender identity disorder of childhood (F64.2), other gender identity disorders (F64.8), and gender identity disorder, unspecified (F64.9). Disorders of sexual preference (F65.0) follow as the third category, including fetishism (F65.0), fetishistic transvestism (F64.1), exhibitionism (F65.2), voyeurism (F65.3), paedophilia (F65.4), sadomasochism (F65.5), multiple disorders of sexual preference (F 65.6), other disorders of sexual preference (F65.8), and disorder of sexual preference, unspecified (F65.9). Finally, psychological and behavioural disorders associated with sexual development and orientation (F66) denote the fourth category, listing sexual maturation disorder (F66.0), egodystonic sexual orientation (F66.1), sexual relationship disorder (F66.2), other psychosexual development disorders (F66.8), and psychosexual development disorder, unspecified (F66.9). In particular, the diagnosis of gender identity disorder of childhood (F64.2) and all the diagnoses in the category of psychological and behavioural disorders associated with sexual development and orientation pertain to phenomena occurring during the phases of childhood and adolescence or young adulthood. The remaining diagnoses generally refer to phenomena experienced after the onset of sexual maturity (Chapter V, Mental and Behavioural Disorders (F50-F99) can be found under http://apps.who.int/classifications/apps/icd/icd10online/ October 31st, 2010.

1.1.2. Process-oriented Diagnosis

The theoretical foundations of Gestalt therapy – phenomenology, dialogue, experiment and field theory – imply a relational approach to human emotional suffering and disorders. As such, using the term "relational Gestalt therapy" may appear to be a pleonasm, but only at first sight. The aforementioned basic concepts of Gestalt therapy theory are oftenmisconstrued or overlooked. Similarly, the practice of Gestalt therapy is not always consistent with the original relational perspective, resulting in an individualistic approach, inattention to what is happening in the field, insufficient engagement in dialogue and presence on the part of the therapist, interpretation of the patient's behaviour from a supposedly objective and external standpoint, to name a few inconsistencies (see Yontef, 2002; Wheeler, 2000a; Hycner and Jacobs, 1995; Robine, 2003; Wollants, 2007).

As a worst-case scenario, a practitioner may "localize" loss of sexual desire or psychogenic impotence in a patient, ignoring, for example, the fact that he has been unemployed for over a year and is consumed by worries about failing to support his family. Further, the practitioner might decline to engage in dialogue about how powerless and inadequate he or she feels during the sessions, reacting instead with annoyance at the patient's "manipulation" and "not being a man". If the patient mentioned that his parents slept in separate beds after he was born, to follow the temptation to deal with his failing genital response as part of a transgenerational plumbline of erectile disorders would make the therapist an onlooker, exempt from mutually experiencing and reflecting the co-created, impotent therapeutic situation and particularly how the therapist sustains it (see Roubal, 2007).

1.1.3. The Co-Created Situation

When fathoming sexual concerns in psychotherapy, as practitioners and theorists we must be prepared to direct our attention to the substantiality of sexual attraction, sensuality, and moments of intimacy that are experienced within the therapeutic situation. An essential aspect of addressing ourselves to these realities is how we manage our own gender identity and sexuality. Thus, my reflections are those of a heterosexual woman in a long-term intimate relationship, now middle-aged and the mother of two adults. How I perceive and relate to my patients reflects this reality, and vice versa. This reality has not prevented me from working effectively with patients who do not share the same sexual orientation, including gay and lesbian, bisexual, hermaphrodite,

and transsexual patients. (Every form of sexuality runs the risk of feeling anxious or hostile toward, or discriminating against those – be they in the majority or minority – who practice unfamiliar forms of sexuality). Our ability to feel, contain, deal with and appropriately express our sexuality within the context of a therapeutic relationship is a valuable skill. Having sensual feelings in a therapeutic setting does not in itself constitute malpractice. What therapists need to learn is the ability to manage and convey these feelings in a fitting way, one that is beneficial to the therapeutic process, not to the satisfaction of the therapists' needs (see O'Shea, 2000).

When a successful career woman began therapy with me many years ago, I regularly noticed a scent that I associate with sex. She was very seductive towards men and I soon was confused by feelings of sexual arousal while working with her. She had been sexually abused as a child by her brother, as a young adolescent by her neighbour, and later by her former (male) therapist. When she described these instances of sexual abuse and her delight in sexual conquests, I had fantasies of her in the bloom of adolescence, testing her charms on much older men, and I felt slightly sick to my stomach. Her sexual "scent", which overwhelmed me in a therapeutic situation, now made sense to me. This sensory information allowed me to understand how the sexually charged background of her suffering became figural in the atmosphere of our co-created sessions. Her "creative adjustment" was to sexualize many of her contacts, including our therapeutic encounters. Contextualizing her "fragrance" in terms of her abuse episodes made sense to us both, smelling became figural in our work, and soon I no longer smelled "sex" when she arrived.

1.1.4. The Emergent Field

By taking a decidedly relational stance in Gestalt therapy, our attention is directed at the situation in which difficulties emerge. Dealing with sexual issues in Gestalt therapy must consider the broader societal field in which the therapy takes place, including values and norms, social class, ethnicity and religion, all of which have a direct influence on the development of gender identities. The field of the patient who seeks us out for psychotherapy includes not only his or her past and present relationships, socioeconomic or work-related problems and the like, but also the very special field we co-create in the psychotherapeutic encounter and of which we as therapists are an essential component. Our own relational patterns and life experiences contribute to each unique field that we produce with each patient. When dealing with relational sexual issues in therapy, both the patient and the therapist contribute jointly to

the development of this special "between" with their personal past love and lust experiences, their present needs and resources, and their anticipations and expectations for the future. Our joys and woes, our highs and lows, play a role that is not to be underestimated. The transferential patterns and needs of our patients in sexual issues are met by our own counter-transferential sexual concerns, co-creating an inimitable shared space which characterizes each therapeutic relationship.

A female patient in dire need of information and orientation about basic sexual acts evoked my motherly behaviour, which allowed me to offer her the frank discussions she lacked as an adolescent and young adult. While taking notes after one of these sessions, I not only became aware of my own need for such a mother figure during my youth, but also of my present age. What will sexuality in advanced age will be like, I wondered?

I do not practice sex therapy as a method separate from Gestalt therapy. As with all other relational issues, I deal with sexual ones in their context, convinced that sexuality flows through almost every difficulty or joy which emerges in therapy. Bringing the role that sexuality plays in our society into awareness appears to be one of our therapeutic tasks. How do we talk about sex in our broader cultural field, or avoid doing just that? One reason for sexual issues not being broached in therapy is that, on the one hand, they are shameful to the patient (for example, a woman in her thirties is ashamed that she is still a virgin; a man is embarrassed about his dependence on "kinky sex"), and, on the other hand, the therapist is uncomfortable with a certain issue and conveys this unawares. Another reason relates to the cultural backgrounds of both involved: in certain cultures the field forces lay a heavy taboo on sexual topics. Breaking this taboo would mean pulling the patient (or possibly the therapist!) out of this field, into one in which extraordinary and perhaps frightening things happen. From my experience in training groups in Austria, and I imagine it is similar in Germany, two strong taboos are National Socialism and sex. In many cases, avoiding the entire subject of sexual fantasies and desires in the therapeutic encounter becomes a way of denying that they exist.

My own sexuality is not a topic for discussion with patients, except for the fact that I am married and have children. I never encountered the normative debate about what is "perverse" or not when accepting someone in therapy, because patients don't present themselves with a label – they present their complaints. Once therapy is underway, I become privy to sexual practices about which they are ambivalent: dysfunctional solutions to difficult situations. Just as in other realms of my work, I occasionally experience repulsion, alienation,

disgust or discomfort when confronted with the details of certain sexual practices. These feelings are no reason to discontinue therapy. If they can't be dealt with adequately, supervision should be sought.

2. Gestalt Therapy's Approach to Sexual Issues

To date, Gestalt therapy publications on sexual issues in theory and practice have focused mainly on gender issues, sexual matters between therapist and patient, contextual issues of therapy with gays and lesbians, the victims of sexual abuse, and various approaches to couples' therapy. Rarely has specific sexual suffering been addressed and research literature on the subject of sexual difficulties from a strictly Gestalt therapeutic perspective is scant[2].

In their foundational text, Perls, Hefferline and Goodman (1951) discussed such sexual issues as masochism, sadism, and compulsive lovemaking as fixations of the healthy aggressive functions of good contact. They indicate that when a desire is repressed and constantly kept out of awareness, then «the self is exercising a fixed hostility against itself» (p. 345). From a perspective that tends to neglect the social other as part of the co-created field, they consider frigidity to be «curable by correct concentration» (p. 178); "neurotic" masturbation, accompanied by guilt-producing fantasies and performed with a lack of proper pelvic activity, is seen as a person's attempt to deal with non-sexual suffering, such as loneliness, depression or annoyance (p. 179). Sexually promiscuous persons, they claim, demand «immediate terminal satisfaction, without preliminary contact and development of the relationship» (p. 194). Among other factors, their extreme tactile deficits drive them to be greedy and impatient in attaining tactile closeness. Masochism, a disorder of sexual preference, is defined by Perls, Hefferline and Goodman as «holding in the maximum excitement and wanting to be released from the pain of it by being forced, forced because the self is afraid to "die"…» (p. 422). Here they see the self striving dysfunctionally for perpetuation, not for completion, denying its own transient nature. Since contemporary Gestalt theory views suffering as arising from both sides of the contact boundary, information about the interpersonal and social situation in which these disorders occur would put them into proper context.

[2] Research exists on exercises stemming from the Gestalt tradition which were used to enhance sexual awareness (Shahid, 1979) or as interventions to heighten sensory awareness in behavioural or eclectic approaches to sexual dysfunction (Beck, 1995; Tugrul, 1993). Yalom *et al*. (1977) compared the impact on individual therapy of persons after a weekend workshop either in a Gestalt therapy group, "affect arousing" group, or tai-chi meditation. Approximately half of the subjects suffered from sexual dysfunctions and/or the inability to commit to an intimate relationship.

Sexual abuse and violence were topics addressed, from the perspective of developmental processes, by J. Kepner (1995), who offered Gestalt therapists an exemplary model for working with adults who have been abused as children. Wolf (1998) reported on working with victims of sexual violence, Laschinsky (1996) depicted the ways in which sexual abuse may enter the therapeutic dialogue, and Layne (1990) presented his work with father-daughter-incest families, particularly with men who chose therapy under the threat of criminal prosecution. Sexual abuse is the violation of a person's boundaries by one or more others, usually in an asymmetrical relationship (power, status, age, physical strength etc.), involving sexual acts which are not mutually consensual.

Focusing on specific sexual disturbances, Valentin (1996) described the phenomenon of vaginismus in a case illustration and, noting current social developments in the field of sexuality in a further article (Valentin, 1999), presented the case history of a "sex addict"; working with sexual compulsivity was depicted in an article by Friedman (1999) as was practicing Gestalt therapy with sexually impotent males portrayed by Harman (1979, 1989) (sexual dysfunctions). Sexual deviance was described by Reichmann (1992) in her therapeutic work with a pedophile man in an Austrian jail (disorder of sexual preference).

Relational sexual issues have been widely addressed in publications on gender: in a book on the gendered field[3], editors Ullman and Wheeler (1998) gave numerous authors the opportunity to describe the pivotal role that gender differences and gender identity play in shaping the context of our experiences. In this anthology, Becker (1998) made an appeal to Gestalt therapists to dialogically recognize and appreciate sexual differences and identity, focusing on the mother-daughter relationship, whereas Wheeler and Jones (1996) explore the father-son bond ("a male-male *Gestalt*"), the male experiential field, and male/female self-processes.

The field of practicing Gestalt therapy with gays and lesbians has been addressed by many Gestalt therapists, emphasizing the need to attend to the specific issues faced by same-sex couples, particularly shame-binds, marginalization, and stigmatization[4]. Gay and lesbian issues were also addressed personal-

[3] The term "gendered field" refers to the concept that all our experiences are influenced by the dynamics of gender identities and take place within a field that is shaped by gender differences.

[4] Singer (1994) states: «Growing up and ultimately identifying oneself as gay means growing up within a complex field of negating beliefs and attitudes, unavoidably introjected

ly and therapeutically by Rosenblatt (1998), Jacques (1998), Curtis (1998), Huckabay (1998), Singer (1994, 1996, 1998), Brockmon (2004), Iaculo (2004), focusing rather on contextual matters than on specific sexual difficulties. Petermann (1992) delved profoundly into the dynamics of homosexuality, narcissism and ideality.

Using case examples to illustrate the implicit influence of gender differences and sexual issues within the therapeutic encounter, Eidenschink and Eidenschink (1996) and the present author (Amendt-Lyon, 2008) addressed sexually charged or intimate moments and the challenge of adjusting to appropriate proximity. In particular, they focused on how gender constellations play a role in the choice of a therapist, the course of therapy, and appropriate interventions. Latner's (1998) opinion piece on the intimate possibilities of the therapeutic alliance explored issues of trust, concern, involvement, sexual attraction and affection. O'Shea (2000) aptly addressed the discussion (or lack thereof) of sexuality within the context of therapeutic practice and therapy training[5].

Resnick's model for couple's therapy (2004) targets the sexual aspects. Her somatic-experiential model is founded on a body-centered, phenomenological Gestalt approach that promotes the use of playful experimentation and affirms the pleasures of sexuality and sexual intimacy[6]. Jessee and Guerney (1981) compared Gestalt-specific and relationship enhancement approaches to treating married couples.

or internalized in the course of development. As therapists, failing to understand this complex field would be a serious error in appreciating the potential tensions and conflicts embodied in the Gestalt notion of "polarities" in a given gay couple» (p. 169).

[5] Beginning with a view to our wider culture, psychotherapy in general, and Gestalt therapy's history, O'Shea (2000) then described how our own experiences and ways of expressing sexuality influence our work – appropriately and inappropriately. She laments the fact that sexuality is so rarely a topic of publications or an explicit part of training curricula, resulting in an attitude that sexuality and related issues are something to be considered separately from our developmental, interpersonal and social fields. It is inspiring to read how O'Shea (2003; 2004) directly addresses the challenge of dealing with the subjects of eros, intimacy, sexuality and vulnerability within the therapeutic relationship.

[6] The interested reader is referred to Resnick's convincing description of three somatic substrates which comprise risk factors in long-term intimate relationships: the connection between infant attachment and adult intimacy; the overgeneralization of the incest taboo, termed "incest transfer"; and pleasure-resistance, or the anxiety associated with impending sexual stimulation (see pp. 52-54).

2.1. Case Examples: Clarifying a Possible Gestalt Therapy Perspective

On the huge spectrum of relational sexual difficulties, self-functions may be impaired in infinite ways. Certain aspects of the following case examples are emphasized in order to illustrate possibly impaired self-functions which are described here separately, but they are always of the whole.

Generally speaking, id functions are figural during the fore-contact and orientation phase of contact. Impaired id functions of the self can be found in a person's inability to perceive sensations, experience needs, and feel incipient stimulations. Moreover, inchoate feelings and sensations may be easily disrupted (i.e. lack or loss of sexual desire or sexual enjoyment). Stimulation that implies injury may be deflected; the sensation of one's needs and emotions may remain unaware lest they trigger anxiety (i.e. sexual aversion, failure of genital response). In contrast to the deflection of sensation, raised attention to one's bodily sensations, often found in conjunction with nonsexual needs as compensation for real or subjectively experienced failures, may result in excessive sexual drives that smack of addictive behaviour.

Usually, ego functions are figural during the contacting and full contact phases. Disturbed ego functions may be manifested when the fore-contact and orientation phases of contact are skipped. Sexually promiscuous persons (excessive sexual drive), for example, tend to seek immediate satisfaction of their lust and to neglect the preliminaries of foreplay and the "dance" of getting to know one another physically and emotionally. The deficits from which they suffer on the tactile level fire their impatience in achieving unimpeded physical intimacy. For example, those caught in the sexual bondage of a sadomasochistic relationship (disorder of sexual preference) may rush blindly into action, failing to orient themselves adequately in a new situation. They throw themselves into the phase of final contact, yet have difficulty allowing themselves to let go and savor the pleasure. Further, introjected beliefs of being stupid and unworthy of respect may prevent individuals from deciding what is appropriate to fulfill their needs, what should be rejected, what belongs to them, what is foreign. When faced with altercations or arguments, they appear unable to express a determined "yes" or a resolute "no". Gender identity disorders, for instance, also reflect difficulties in making comfortable, clear identifications with one's own sex.

Personality functions tend to be most figural during the full contact and post-contact phases. Ailing personality functions in relational sexual disturbances may reveal themselves as the inability to see oneself appropriately as a

sexual being. These individuals have neither an adequate voice nor a narrative for the accurate description of the person who they now are. They are lacking the social resonance and support that would help them to describe their present competencies and talents, as is often the case with individuals who have wrestled with gender identity disorders, particularly dual-role transvestism, or those who are coming to terms with who they have become after abusive sexual practices.

The interplay of figure and background issues is another Gestalt concept guiding our practice when working psychotherapeutically with relational sexual disturbances. More often than not, patients' presenting problems (figure) will not be sexual ones, but rather panic attacks, depression, sleep disorders or compulsive behaviour, yet hearing the narrative of their developmental and sexual history (background) points to relational sexual issues as the crux of their suffering. Shame-binds (see Robine in this volume) tend to push sexual issues into the background, allowing less threatening topics to dominate the foreground.

For example, a woman in her mid-thirties presented a range of drastic symptoms and disorders, each of which we dealt with in cooperation with her attending physicians. I felt overwhelmed by the gravity and number of physical illnesses, wondering if my decision to begin psychotherapy with her was indicated. Only after these somatic issues were addressed and we developed a trusting relationship did she confront me with the fact that she was still a virgin, panic-stricken at the thought of sexual intercourse. This revelation allowed me to revise my approach to her presenting problems and address issues of intimacy in a developmentally more appropriate way.

If the interplay of figure and background freezes, then patterns reflected in fixed gestalten offer us useful information. For instance, a woman involved in a sadomasochistic relationship was frozen on the dominance-submission polarity on the pole of extremely submissive behaviourial patterns. She was convinced that, despite her admirers, she's never good enough for a man, others will always overpower her and she must please her significant others. She wanted to attain her parents' love by embodying the stereotypical female virtues they appreciated: passivity, submission, concern for others, chasteness. Needless to say, when she related to the men in her life in this fashion, they embodied the complementary part of this fixed relational *Gestalt*. They were active, dominant, inconsiderate, appetent, and unfaithful to her. When the course of such a relational issue is taken to an extreme, then a view not only to the immediate, but also to the sociopolitical field is advisable. Polarized social

norms of gender stereotypes appear to generate such disorders of sexual preference. A social order that supports rigidly dichotomous gender roles squelches the human need for ambivalence in psychosexual development and all the intermediate degrees of gender mixture.

Those suffering from relational sexual disturbances exhibit diverse contact styles and contact functions. Brief vignettes will help me to illustrate several of the innumerable possibilities.

A thirty-year-old woman complained of conflicts with her boss and doubted whether her choice of career was wise. Although the reason for starting therapy appeared to be career related, this patient spoke as if she were much older, which prompted me to explore her family background and relational history. I felt irritated by my impression that she was so full of parental introjects, that there was no room for her own feelings and thoughts. During anamnestic interview she revealed that the sexual aspects of her seven-year relationship were beginning to trouble her. "I never had an orgasm", she said (orgasmic dysfunction), and began to cry profusely, excusing herself for this emotional outburst. At this point she became a young woman to me again. I engaged with her like a motherly friend, encouraging her to discuss sex with me. "Let's take the time to look at this part of your relationship in detail. You can ask me whatever you'd like about sex. Tell me whatever is bothering you", I offered. "I don't know how to talk about sex. My boyfriend refuses, he just wants to do it and is annoyed if I say I need some foreplay. I never could speak to my mother about sex, never had a boyfriend in high school, and when I began to date in college, my father called me a whore!", she replied. Her boyfriend was uncomfortable discussing their sexuality and attending to her sexual needs, reinforcing the anti-sex atmosphere exuded by her parents. She felt that she had a physical anomaly, claiming that her clitoris was overly sensitive and refusing to let her boyfriend touch it directly. The thought of presenting her naked body in an active sexual role was "offensively aggressive", intercourse often painful (nonorganic dyspareunia). In the course of therapy, her compulsive tendencies became obvious. As an only child, she had been forced into the role of her mother's confidante, united with mother in battles against father. The patient shared a bed with her mother until she finished her studies and moved out, never having been "allowed" to experience puberty. Instead, her creative adjustment was to direct her energy into her studies and job. In sexual encounters, she particularly suffered from the loss of her ego-functions towards the end of the contact phase, when she denied her own desires and aggressive feelings, instead of identifying with them. As a result, guilt feelings dominated the foreground, redirecting the aggressive impulses of power struggles inwards.

The presenting problem of a woman in her late thirties was her infertility. She cried readily and profusely through most of our initial sessions, suffering from the fact that most of her friends and cousins had children, only she had trouble conceiving. She spoke rapidly and without interruption until I became aware of my own impatience and irritation. "I feel that you are galloping away from me" I told her, "and I feel left out of our conversation". Again she sobbed, "That's just what my husband says to me! He says I'm so impatient and speedy, that he doesn't feel that I want him when I want sex, but that I'm pressuring him to sleep with me on certain days of the month so I might conceive". For a while he complied, but lately he had been reacting to her pressure with impotence. Her predominantly histrionic relational style was met with psychogenic impotence by her husband, a sign of his withdrawal from her sexual advances that didn't adequately consider his desires. This patient's ego-functions especially suffered losses during the middle phase of contact, when she felt anxious about impending conflict. She tried to compensate for this loss by speeding up her interactions and rapidly establishing confluence with others. At first, I went along with her speed, imagining that she'd slow down when we approached meaningful aspects of her difficulties. Eventually, though, I felt uneasy about just brushing over very germane topics, and caught myself breathing slowly, as a counterweight to her increasing speed. I used this awareness about my own breathing pattern to inquire about her breathing, which was shallow and rapid. Our co-created acceleration and deceleration became figural, and we were then able to take our time and delve into what was troubling her.

Difficulty in feeling comfortable with her sexual orientation and gender identity were the presenting problems of a woman who revealed in our intake interview that she is intersexual. After several operations and hormone treatments, she was grappling with her gender identity as a woman, having had phases of sexuality with men, then women. "Have you ever worked with intersexuals?" she asked me during our first session. "No, but I am interested in what you'd like to work on and will do my best", I replied truthfully, feeling ill-equipped for an imagined competition with "experts". She later revealed that my answer made her feel that I perceived her the way she'd like to be seen, that she was safe with me. "The other therapists I consulted treated me like a freak, like a curiosity", she said. Her same-sex relationship of ten years was crumbling; mutual sexual desire was lost soon after the relationship began. Recently she began affairs with men, enjoying orgasmic pleasure. "Can you imagine having a long-term relationship with a man?" I ventured. "But I'm a lesbian!" she answered, dumbfounded. This exchange triggered a long journey into her gender identity difficulties. Secrecy about the details of her corrective geni-

tal surgery and the history of her sexuality had become an obsession, complicated by feeling depressed about her plight. Her impaired ego functions prevented her from contactfully orienting herself and acting in a manner appropriate to her situation. Firm convictions (introjects) became hurdles to appropriate actions, resulting in retroflection in the form of inhibited anger and depression.

2.2. Psychotherapeutic Supports

Anamnestic tasks: when we work with relational sexual difficulties, it is necessary to thoroughly explore the presenting problem(s) and history of disturbances, with special attention to the sexual history of our patients. The respective context of the difficulties is especially meaningful, since human beings respond differently to partners and situations. Another task is to locate the relational sexual issues within the context of the patient's entire life sphere. Noteworthy attachment issues (affectional bonds in early childhood, losses) and developmental experiences (toilet training, beginning kindergarten or school, menstruation, nocturnal emissions, masturbation etc.) should also be discussed, as well as transgenerational gender patterns in the family, cultural and religious background, particularly shame binds (traditional sex roles and expectations in the family, ethnic group, religious community). Since sexual issues are often taboo, it is helpful to note hints at sexual malaise that a patient may drop, and return to them when the therapeutic relationship has matured enough to support addressing them.

Unspecific supports: as always in therapeutic work, the skillful use of contact and support to build a functioning relationship is the starting point. Attention must also be given to perceiving the emergent situation by attending to the patient's and our own bodily awareness, movements, and breathing; expressing what we perceive and giving selective feedback contribute to the co-creation of the situation. These are among the therapist's instruments for meaning-making. Recognizing our patient's unique contact modes and respecting how distance and proximity are dealt with in our emergent situation enable us to establish a safe space in which potentially shaming issues may be raised. The sensitive timing and pacing of interventions demand our patience and flexibility. This may alternatively require us to listen, ask questions, confirm the other verbally or with a nod, share immediate emotional reactions, offer a fantasy, suggest a metaphor, create an experiment, move our chair to our patient's side, articulate what we imagine they are feeling. Moreover, it may be wise to ask if what has emerged is too much to bear, if we should continue to explore it in this particular session, or postpone further exploration. Putting the patient's suffering into

a relational context is another important support, as is explaining that they are creatively adjusting to a difficult situation in a unique way. Orientation, or offering alternative ways of dealing with their suffering by creating custom-made experiments and rehearsing innovative solutions, supports the patients in gaining insights into their situation and in developing viable choices.

Specific supports: practicing inclusion and emphasizing context are important, since sexual difficulties rarely emerge unconnected to other life issues. To support awareness and assimilation processes, one specific support lies in appreciating differences in male and female sexual desire und behaviour, which is not only a matter of one's own experience. It also involves having sufficient knowledge of the psychological, cultural and somatic influences on sexual disturbances, being familiar with sexuality guidebooks, being nonjudgmental and prepared to broach, articulate and be confronted with shame-bound issues and information that may go beyond our wildest dreams. We may find ourselves in the role of a translator, finding words for images and experiences that our patients cannot express. Another specific support entails reflecting on the present gender constellation (therapist-patient) and our own immediate reactions, as a sexual being, to the field we are co-creating with this patient. Openly discussing sexual fantasies and wishes is best in an atmosphere in which a female patient may be recognized and appreciated as a woman, or a male patient as a man, by either a male or female therapist who is aware of and comfortable with his or her gender identity and needs. This is only possible if the patient can feel absolutely safe that the therapist will not act on his or her own feelings of sexual attraction or be shamed for what is revealed. If patients reveal desire for their therapists, then the latter must feel up to the role of the man or a woman from whom the patient needs confirmation as a sexual being. This task is equivalent to good mothering or fathering.

Reflecting on one's own psychosexual experiences in connection with the therapist's self-regulation of proximity is also a specific support. There are risks in becoming too confluent with patients and blurring the contact boundary (e.g. the therapist has experienced transgressive sexual acts and now overly identifies with a sexually abused patient), as well in isolating oneself from patients, creating an impermeable boundary (overwhelmed by the brutality of sadomasochistic practice, the therapist deflects his or her emotional memories and reacts coldly or with contempt for a masochistic patient).

2.3. Interventions

Helpful interventions include assisting patients to give form to their rela-

tional sexual disorders, such as in a drawing or painting, with modeling clay, hand-puppets, collages, an array of photos, or enactments, which enables them to find their own voice and develop their narrative.

One woman brought in all the photos she had from the duration of a sado-masochistic relationship and for several sessions described what she had endured according to the individual photos. I complemented her narration with my own emotional reactions, which nearly always triggered an emotional response in her if she had fallen into the pattern of talking "about" her traumas. Moreover it was testimony to our shared experience of her traumas, since I often voiced aspects that she had pushed out of awareness. Then I began to highlight the relational patterns she was accustomed to in childhood and adolescence, relating these foundations to her patterns with men and in pursuing her career. Afterwards, she burnt the photos, as if performing a ritual, and felt increasingly released from these haunting memories.

Especially with women bound to the passive female stereotype, finding their voice as sexual beings with desire and lust presents a challenge, as well as immediately expressing rejection of what violates or infringes on their boundaries. All interventions which support patients in gaining awareness of their sexual experience, learning to dialogically regulate exchanges at the contact boundary, deliberately saying "yes" or "no", attaining agency over their aggressive actions are supportive. Role-playing difficult situations with a partner or enacting an impending scenario proves effective in opening up the field to new possibilities. When patients are very inhibited or perplexed, I sometimes join them in role-playing, either playing the part they are accustomed to or trying out a new, even audacious approach, to offer impulses. Directing attention to future (short and long-term) goals (What is the best/worst-case scenario if you try this? Where will you be in five years if you continue this way?) enables us to rethink how priorities are set and energy invested in unsatisfying patterns.

Providing patients with information about human sexual responses and practices, or suggesting sex education or popular science guides, is a support, since many, despite post-modernity, are inexperienced or poorly informed, which impairs the ability to engage with others in a mutually satisfying way. With a patient who had "skipped puberty" and slowly became curious about foreplay, masturbation and talking about sex with her partner, I found myself in the role of "Dr. Ruth"[7], encouraging questions and offering information and

[7] Dr. Ruth Westheimer is a German-American sex therapist and author who first became famous in the U.S.A. in the 1980s for her radio show, "Sexually Speaking", during which she gave advice about "good sex".

orientation (i.e. foreplay and kissing add to pleasure, being on a time schedule detracts from sexual enjoyment, it's fine to experiment with oral and manual sex, it's unwise to allow parents to enter your apartment unheralded with keys of their own), and welcoming fantasies about what she could try out with her partner when the time is right.

Writing is the best way for me to connect my practical experiences with the existing body of Gestalt theory, to reassess how contemporary theory and practice inform each other. Writing also enables me to share what I have learned with my patients. Sexual issues are hardly ever isolated from other life issues, yet only when there is sufficient trust will patients be willing to broach complicated sexual matter in the therapeutic context. For their trust and the privilege of having been able to work so deeply I thank them all.

Comment

by Marta Helliesen

I applaud Amendt-Lyon on her relational approach to sexual difficulties, as self and thus sex exists only in relation to the other (Staemmler, 2010). It is true that sexual symptoms frequently manifest in only one of the partners, and yet, this manifestation is a field event that must be treated as such. However, I find a field approach to sexual obstacles to be in discord with a diagnostic approach like ICD-10, as mental diagnoses unfortunately tend to be permanent while any field event is a fluid, ever-changing process. Sexually this means that a person's psychogenic sexual obstacles (erectile problems, vaginal dryness, rapid ejaculation, anorgasmia etc.) can manifest with one partner and be absent with another partner, as the sexual symptom (aka "dysfunction") is a function of an interruption of contact in the erotic field. The use of a diagnostic manual for sexual "disorders" is a strongly controversial point. I support the effort of some authors to redefine and de-pathologize sexual problems. This view is underscored by major revisions in the upcoming DSM-V[8] and by removing several diagnoses from the Scandinavia's version of the ICD-10[9] (F65.0 Fetishism, F65.1 Fetishistic transvestism, F65.5 Sadomasochism, F65.6 Multiple disorder of sexual preference, and F64.1 Dual-role transvestism), meaning that these diagnoses are no longer recognized as dysfunctions or ill-

[8] http://www.dsm5.org/Pages/Default.aspx
http://www.dsm5.org/ProposedRevision/Pages/SexualDysfunctions.aspx
[9] http://www.revisef65.org/friskmelding_eng.html

nesses in these countries[10]*. I therefore welcome that after mentioning the medical diagnoses the author advocates a relational stance and proposes a process-oriented diagnosis.*

Amendt-Lyon eloquently stresses the importance of the therapist seeing the sexual symptom in light of the client's bio-psychosocial field, and of the therapist's sexuality being available when meeting the client in the field. She describes how she proceeds phenomenologically, how her joint explorations with patients describe what is, not what should be. I would stress more explicitly the importance of bracketing our sexual attitude in the meeting with our clients (Crocker, 2009). While total bracketing is idealistic, it is something the therapist needs to strive to cultivate as a means to contact the emergent sexual field regardless of gender, sexual orientation and cultural background of either client or therapist.

Another important point in the context of field and sexuality I want to emphasize more explicitly is the power-dynamic. The existing, and always oscillating, power-dynamic between the co-creators of the field is an essential part of the contact in a therapeutic field of sexuality. No erotic event can take place unless there is a polarity between the partners involved (Morin, 1995). This can range from subtle as in gentle, mutual lovemaking between people of any gender, or it can be pronounced as in a consensual dominant/submission event. In all scenarios, if the partners are embodied and fully present to the immediate moment, the power-dynamic will never be static, and thus the sex will never be boring (Helliesen, 2010). The sexually integrated therapist who is attuned to the field emergent power-dynamic can use this as a therapeutic vehicle. S/he can support the clients' process of contacting and expanding their erotic spectrum in a safe place where feelings and desires can be expressed and supported without resulting in action. This will help the clients understand, accept and integrate their sexuality, and promote freedom from the bondage of shame, guilt, desperation or compulsion.

I appreciate Amendt-Lyon emphasizing certain aspects of sexual problems to illustrate possibly impaired self-functions and mentioning at the same time they might be impaired in infinite ways and are always of the whole. I believe simply linking sexual problems to impaired self-functions would give a limited view, tending toward pathologizing. In a sexual interaction the various phases of contact can happen at any stage in a non-linear fashion and it is dangerous to tie certain sexual behaviours to fixed stages of contact. A promiscuous person can have many moments of contact along the whole spectrum from arousal to orgasm. Similarly, people engaged in a sadomasochistic dynamic can have intimate erotic events, including all phases of contact.

I would like to stress more that sadistic and masochistic desires are another

[10] Denmark,1995; Sweden, 2009; Norway, 2010.

facet of human sexuality that can be expressed in loving and intimate ways, and are not disorders (unless practiced in unsafe and non-consensual ways). Furthermore, a consensual sadomasochistic relationship does not imply a submissive female and a dominant male. Any gender can hold any power position, as it is a fluid interpersonal process with no link to the gender hierarchy in the society at large. It is essential for a therapist to know the difference between acting out introjects in an abusive relationship and engaging in a healthy, healing, consensual relationship with an agreed upon, mutually desired power-dynamic.

It is true that a client's presenting problem is often of a non-sexual nature, covering up an underlying shame-laden sexual suffering. Therefore much responsibility is placed in the hands of the therapist to bring the sexual issue into figure by inviting the client to talk about sex and be fully available to hear the client. There is a lack of support for expressing sexual desires or problems in the larger socio-political field, and thus it is essential that the therapist create a sex positive, safe environment for the clients to explore their sexuality and heal their sexual wounds.

Introduction to Personality Disturbances. Diagnostic and social remarks[1]

by Michela Gecele

This brief chapter is an introduction to later chapters addressing specific personality disturbances. Its aim is to underline the connections between the social context we live in and the label of personality disturbance, this definition being pervasive inside our daily clinical practice and our theorization.

1. The Social Dimension of a Diagnosis

DSM(s) divide the mental disturbances into different axes. As a consequence, on one side we find symptom clusters – often with neither source nor history – and on the other "ways of being". In clinical practice these ways of being often become a fixed entity, possibly even more than intended by the Manual's authors themselves (Barron, 1998).

Making diagnoses, we always run the risk of taking part in causing and maintaining pathology, particularly when faced not with illnesses but with ways of being. The definition of personality disturbances is a useful tool as long as their pictures are not fixed but ever changing with contexts and situations, which is not current tendency. More and more these ways of understanding experience turn into labels defining clusters of people. These diagnostic schemes have become part of our pattern of thought, both as professionals and as citizens, representing our society's overall view. Difficulties partially due to fragmentation in social background become a ground in our clinical practice. It is an inspiring paradox. The definition of personality disturbances is often used to describe and label not only pathological experiences but also ways of feeling, thinking and behaving.

Usually, around every psychopathological picture we can observe a sort of

[1] This brief chapter introduces the section on personality disorders, thus being something of an advanced comment on the following chapters, which, in turn offer a fuller explanation of the introduction.

"halo effect", which not only involves pathological phenomena but also experiences where the contact boundary is not suffering. Furthermore the social and cultural background of a given context largely contributes to shaping its own "pathological" figure. We can use Devereux's (1970)[2] words and say that personality disturbances are the ethnic disturbances of our time. Each society defines and codifies forms of relational and psychological suffering, reading some ways of behaving, thinking and feeling and relational habits as pathological (Benedict, 2006). Moreover the social context infects the individual with its own difficulties and unease. Even though in the last centuries many illustrious precursors were already puzzled by the intriguing connections between "temper", "personality" and "pathology", personality disturbances are an expression of our "western" social context, crystallizing some of its difficulties and risks.

The division into axis of DSM(s) sets larger stability in the manifestations of personality disturbances than in Axis I pathologies, together with earlier appearance, poor insight, reduced treatment response. Such a given pattern is an oversimplification (Krueger, 2005). Carrying these pictures to the extreme and crystallizing them into their more pathological versions – those bringing in the field more gaps than creative adjustment – we lose connection with life stories. We overlook all the intermediate steps of relational and social suffering (Ronningstam, 2005) which can develop into symptoms. These "intermediate pictures" are the various modalities of creative adjustment – part of the "halo effect" – we sometimes refer to when speaking of personality disturbances.

Modalities of creative adjustment can be useful paths to follow in difficult fields but can also bring about a failure[3]. "Holes"[4] in personality function cre-

[2] George Devereux is one of the main authors in the ethno-psychiatrist area of expertise. He proposes to the division of conflicts (in the psychoanalytic meaning) leading to psychopathological disturbances into ethnic and idiosyncratic ones. According to Devereux the conflict causing ethnic psychosis or neurosis is different from the idiosyncratic one in not being connected to the uniqueness of the individual. On the contrary, the patient is more conformist than most of the people, abiding by the cultural dictates of what is allowed and not allowed. Cultural dictates cause conflicts in all individuals, but mostly to the patient. Even symptoms are not a unique creation by the patient, but are provided by the context; they are "wrapped beforehand". Somehow the cultural context gives him the double message – not to be mad and to be mad in a conformist and reasonable way. Following this theory, we can consider the patient on the fringes and in the centre of society at the same time.

[3] See Spagnuolo Lobb (2011a).

[4] We use the word "holes" starting from theories concerning difficulties in assimilation processes in our present western context (Salonia, 1999; Gecele and Francesetti, 2005). As we know, difficulties in assimilation are connected with limits in contact processes and in being fully aware at the contact boundary.

Starting from these theories, we can assume that personality function can suffer from discontinuities in narration and role-taking. These discontinuities, which can be filled by introjects, are somehow holes (Gecele, 2011).

ate – both metaphorically and positively – the social fragmentation characterizing our present western context[5] (Salonia, 1999, 2000; Gecele and Francesetti, 2005).

When both people and society lack a shared narration, the flow of life is diminished, as is the capability to make memories. Social background itself becomes fragmented. Background fragmentation in turn is one of the crucial areas where society plays a role in building individual pathology. A dual relationship and society constantly refer to each other (Spagnuolo Lobb, 2007a). It is a circular process which causes impairments in personal and social growth, that is to say in assimilation. Impairment in assimilation is present both in personality disturbances and in our social context at large.

In "extreme situations" the personality-function cannot exert its capability of connecting and supporting, which results in impaired construction of roles and narrations. At the contact boundary we find absence and void that do not allow families, groups, societies to grow and relationships to develop.

2. Focusing More on Personality Disturbances

In experiences defined as personality disturbances a chaotic and fragmented social background contributes to setting a sensitive point connected with particular motifs in the developmental relational fields. When something – however small – in a present relational field recalls that very sensitive moment, this part becomes figure and provokes a reaction. The field polarizes and crystallizes around the resulting figure.

In order to give support, the therapist has to be aware of this process, to catch which fragment has become the dominant figure, and help restore it within the therapeutic relationship. This might be a useful key reading the following chapters.

The therapist has to keep on trying to respond to all fragments forming the

[5] «In the wake of Giovanni Salonia's lucid reading of our contemporary context (Salonia, 1999), we can identify social fragmentation and the complexity of reality as two constituent elements of our time. Faith in a deterministic and definitive form of knowledge has been replaced by an awareness of its irreducible complexity and subjectivity. This has opened the way for fresh explorations of uncertainty and possibilities which accept chaos and unpredictability as constituent elements in knowledge and action (Bocchi and Ceruti, 1985; Fogelman Soulié, 1991; Waldrop, 1992). The loss of these points of reference has rendered elusive any kind of unifying, essential, clear, and steadfast center – any stable point from which one might look upon the world, understanding it and orienting oneself within it. This leads to the experience of being "off-center", which a number of authors have associated with the postmodern condition (Vattimo, 1984; 1992)» (Gecele and Francesetti, 2005, p. 176).

field, even those in the dark, roughly sketched. The effort is not to repeat those relational paths that the patient knows, induces and suffers from. The therapeutic relationship provides the balance in giving support to all pieces of experience present in the field, without legitimating the role usually played in relationships by the patient. Legitimating this role would mean denying the potential suffering it causes other people and would further inhibit other relational possibilities.

The voids which are created by the fragmentation of the social ground let idiographic fragments through. Inner and private relational elements become confused with the social and public sphere, letting tears of developmental relational issues become figure. In dealing with these phenomena it is useful to refer both to gestaltic developmental theories (see chapter 11 in this book) and to what is described by the attachment theories as they deal with mirroring and tuning modalities, symbolization, and meta cognizance[6] (Stern, 1985; Fonagy and Target, 1997; Beebe and Lachmann 1998; Trevarthen 1998). The fact that the limits met by these processes during the developmental age may easily turn into figure is also a psychopathological expression of the lack of clear boundaries between oikos and polis (peculiar in our space-time). We are considering the fall of one of the two spheres into the other, or the invasion of both by some external images, products, and codes (Gecele and Francesetti, 2005). In the wide range of personality disturbance experiences the under-developed social background comes to the surface. As a result, fragments of difficult and confused relationships (Patrick *et al*., 1994; Leigh *et al*., 1996) prevail over the assimilation and the construction of a self-narration.

The social background is the fundamental ground for the evolutionary and the socializing processes, both within and outside the family circle. The fabric of community is fundamental in order to socialize emotions and thoughts, thus supporting and giving utterance to them.

"It's the way I am" is a statement as deadly as it is pervasive nowadays, in our here and now. The more it is socially approved the more it feeds the shaping of individuals as opposed to persons in a circular way (Maritain, 1947; Perls, Hefferline and Goodman, 1994)[7]. Anything is legitimate, equivalent,

[6] We are referring to intersubjectivity theory.

[7] We are hazarding to compare the Personalist perspective and the Gestalt one. Their match point comes out when we think how "here and now" experiences are supported by assimilation of past experiences, by a fluid integrity of personality function. And so is life and spontaneity at the contact boundary. «Thus personality is the responsible structure of the self. To give what is not so much an analogy as an example: a poet, recognizing the kind of situation and the kind of attitude of communication required, may contract to write a sonnet, and he responsibly fills out this metric form; but he creates the imaginary, the emotional rhythm, the meaning as he more and more closely contacts the speech» (Perls, Hefferline and Goodman, 1994, p. 161).

thus vain, valid in a here and now which reproduces oneself without the insight of a presence. Personality disturbances entirely express and embody these variations in dynamics.

Working at the therapeutic field involves building a frame to give support, space, breath and coherence – not rigidity – to the person and his history, as a whole.

Through the loose meshes of the fragmented society, we are back to the problematic developmental routes, and to the way "sensitive moments" are built. These sensitive moments seem to be at the same time void space and filled by introjects. Overlapping introjective processes may occur during the developmental age (Robine, 1977; Gecele 2011). Portions of the environment might be used to fulfill some voids at the contact boundary. These introjects often maintain and amplify the very void they should cover and if the introjected environment is fragmented as well, the process will become circular.

3. Biographic and Social Dimensions

How is the social context responsible for the structuring of the relational fields we are dealing with? How much is the evolutionary individual history responsible? The emotional dynamics, in relationships and families, and the consequent building of resources and limitations are influenced by the social context. Furthermore, within the various steps of life, the social context moulds ways of suffering and creative adjustment. The thesis this paper proposes is that there are different levels of narcissistic, borderline, and hysteric functioning – the personality disturbances dealt with in this text – more or less connected with developmental experiences and other life events.

There is a difference, for instance, in that narcissistic experience which derives from precocious difficulties in mirroring and attachment – due to that unattainability of the other which structures introjects and causes retroflections – from the one arising in working and social backgrounds marked by competition, or connected with widespread social consent around the inconvenience in experiencing strong feelings, and committing to the relationship.

Every personality disturbance somehow corresponds to some modalities enhanced by our society, at least as a sort of unavoidable and familiar shadow side. Think about mistrusting, manipulating relationships and situations, magnifying or repressing reactions, the firm belief in having to be self-sufficient.

The broad-spectrum of each personality disturbance in a sense corresponds to the different degrees and life phases in which the community contributes to giving that particular relational mark to the individual's moulding. Let's give an example: does the narcissist's need to be self-sufficient originate from a re-

lationship with parents who have strongly introjected this social "rule" and, consequently, pass on the same behavior to their child – perhaps through an unsympathetic and insufficiently relational style? Does it originate from the mothers' or fathers' more articulate and complex difficulty? From the couple mother-father? Inside the triad parents-child? Or does it arise among groups of peers, in which "using" the others becomes a sort of rule ("I-It" relationship, to use Buber's (1923) terms), so as to avoid risking too much in sentimental ties? Does it derive from relationships with the opposite sex? Or arise within the working field? Or within the totality of all these human contexts? Obviously, according to the most involved stage in the life cycle, the level of seriousness differs.

We are dealing with concerns whose origin and effect intersect social life in a complex way. So, it is important to work towards building relational backgrounds and to restore complexity to real-life both in the professional practice and in activities of a broader social and political sense. (Perls, Hefferline and Goodman, 1994; Salonia, 1999; 2000; Gecele and Francesetti, 2005).

4. Therapeutic Directions

How do we work at the background? Looking for words to tell it? Gathering contradictions and polarities and allowing them to permeate? Rebuilding "a third" (Francesetti and Gecele, 2009) and community starting from the therapeutic relationship? When working at background without passing by the contact figure (see chapter 22 on bipolar experiences), the path toward awareness and assimilation is long and uneven. Where relational suffering is higher, the boundary is almost lost between relational support and relational danger. So it is easy to cross it. Even the therapist is not exempt from the same potential suffering. In a relational field where borders and protection are lacking, the therapist can feel his own wounds and sensitive points, which increases the risk of undoing field complexity. The therapist takes part in an integrative process. He has to face fragments from his own experiences and history that do not correspond to his personality function's narration.

The therapeutic relationship works at restoring failures of attunement and mirroring in early development. It is aimed at building, step by step, what intersubjectivity theory calls meta-cognitive skills. It collects and contains partial, confused, intense, unstable, scary fragments coming from previous relationships. Above all it is supposed to enable spontaneity, potentiality and presence at the contact boundary (Perls, Hefferline and Goodman,1994).

The therapist is even more than usual the sensitive needle to all that is moving in the relational field, mainly to the elements that can "drive mad", posing

pathological dynamics again. The therapeutic relationship cannot be apart from the awareness of being inside society, a micro-context which refers to the macro-context. The therapist particularly needs this awareness of being part of a larger society in order to stay within such a difficult therapeutic field.

Every dual therapeutic relationship, disconnected from the awareness of being part of a larger field, runs the risk of causing further suffering.

Borderline. The Wound of the Boundary

by Margherita Spagnuolo Lobb

Patient: "The moon's made of cheese".
Therapist: "Yes, they're both yellow!"
Isadore From

1. Borderline Personality Disturbance and Society

Borderline disorder came to the attention of scholars in the period when Gestalt therapy was at its peak, namely in the period 1970-1990. Yet our approach in those years developed without paying much heed to this type of suffering, which remained an ambit of study for those experts engaged in psychiatric structures.

Gestalt therapy, widespread in the United States, basically in the bourgeois "fringes" of intellectuals curious about the new cultural movements, was occupied with supporting the autonomy and expansion of the self in neurotic personalities[1]. As part of the movement of Humanistic Psychotherapies (the so-called Third Force), Gestalt therapy was developing interest in supporting the autonomy and creativity of those individuals, who in that period felt the need to free themselves from bonds perceived as suffocating.

On the basis of its existential matrix, this approach cultivated trust in autonomy from affective bonds. The value it brought to the world of psychotherapy and of society related to the importance of uttering one's emotion, whatever that might be: this was, then, the *must* of Gestalt psychotherapeutic practice.

Borderline personality disorder faces a human drama that is much more complex than that of the repression of the emotions and consequent lack of autonomy. It pertains to a more delicate experiential field, in which uttering one's emotions leads to an expansion of the self which is always dramatically conflictual: a profound sense of split leads the sufferer to desire and at the same time loathe contact with the other.

The wound experienced by these persons has to do precisely with the contact-boundary: the difficulty of defining oneself solidly and of defining the

[1] Yontef (1993, p. 423) relates that Fritz Perls was well aware that he could not use Gestalt techniques with seriously disturbed individuals whom he encountered in his workshops at Esalen.

movement of the self in relation to the environment, the I in relation to the You.

From a social point of view, borderline disorder came to scholars' attention as a product of the narcissistic society, which had characterized the preceding years.

Busy parents, each in her/his personal fulfillment, blindly trusting in the child's autonomy which they were firmly intentioned to grant her/him (since they had had to fight so hard to obtain it from their own parents), intolerant of familial and institutional bonds (hence abandoners in the family), incapable of tolerating their children's mistakes or clumsiness (a god's child makes no mistakes), related to their children expecting the most of them and not able to bear their mistakes, only to be scandalized or to abandon them affectively as soon as they showed their weakness (by becoming asocial, drug-addicted, hobos etc.). While parents, successful professionals, thought that their children would blossom marvelously one day, the children went on collecting social (e.g. scholastic) and relational (incapable of sustaining relationships) failures, and turning to artificial paradises, in which they could be virtually the gods their parents were expecting, but without having to commit themselves with difficulty in life (experienced anxiously and hence avoided, in that they had not been supported in their mistakes).

Thus while on the one hand Gestalt therapy upheld the values of the creativity of the ego and of the self-regulation of the emotions expressed, as required by the needs of the narcissistic society, society was producing a new disorder, generated certainly by predisposing biological (serotoninergic) factors but also by social conditions brought about by narcissistic feeling. The strong boundary, in which "I am I and you are you", is the soul of Gestalt therapy but it is also the most delicate point for the borderline experience. The patient suffering from a borderline disorder is an expert on boundaries: her/his attention is often drawn to them in order to protect her/his self from the threats of destabilization that s/he continually feels when the contact-boundary is stimulated. As we shall see, this fully enables her/him to dismantle the therapist's narcissism (whether Gestalt or not), bringing her/him back to the humility necessary when faced with a wound of the boundary.

The interest of Gestalt therapy in the borderline disorder is relatively recent. We owe to Yontef (1993, p. 456 ff.) the first significant study. Affirming the need to leave behind the humanistic, anti-diagnostic pattern to which Gestalt therapy seemed firmly attached, Yontef (1993, p. 116 ff.) finally clarifies the differing styles of personality and provides a description of the borderline disorder in terms of style of contact in day-to-day relations and with the therapist. Moreover, he compares the borderline style with the narcissistic style, provid-

ing psychotherapists with an invaluable clinical tool. Yontef's openness to diagnosis and to psychopathology marks the beginning of a series of studies (of which more in due course) that lead us to the present book. However, notwithstanding the undoubted interest of clinicians in this disorder, the Gestalt soul, even in the years 1990-2010 – judging from the "emerging" topics dealt with at conferences, in the journals and in the literature of those years – was still centered on aspects that were more epistemological than clinical (such as the dialogic view, the perspective of contact versus the intrapsychic perspective, etc.), in that the need we all had was to define a clear epistemology rather than to deal with clinical specificities. From the beginning of the 21st century, the changes in social feeling and the clinical evidence with which all psychotherapy had to reckon, led Gestalt therapy too to face the subject of psychopathology.

What emerges, in my view, is that, despite the mentioned lack of historical synchrony, Gestalt therapy is able to create a model that is profoundly valid for the treatment of the borderline disorder, precisely because it is occupied crucially with what is unanimously defined as the heart of this disorder, namely the suffering in the here and now of the therapeutic contact.

1.1. BPD in Post-Modern Society

Going back to the generation that grew up between 1970 and 1990, on the one hand they nourished the illusion (brought on by parents from the narcissistic society) that they were exceptional; on the other they concealed the sense that they were a bluff. Unable to grow up in the concreteness of their mistakes, they developed a borderline relational modality: ambivalent, dissatisfied, incapable of separating themselves in order to affirm their value. The flight of the young into "artificial paradises", their anger with their parents who had borne values remote from their humanity, was facilitated by the spread of drugs, and also by significant group experiences. It was not by chance that even in psychotherapy there was in those twenty years special interest in groups: the group was perceived as one (at times, the only) source of treatment. There was a search for the self outside intimate bonds, an attempt to solve the difficulty of being-with by means of drugs or work. In the 1990s, only ten years later, the search for the self was transformed into a need to feel oneself in solitude: "I want to feel my self, find myself. At times I'm forced to fast in order to feel my self through hunger. Everybody wants something from me and I can't find out who I am".

In the first years of the new century, up to the present day, this need to feel oneself in solitude through the body has been transformed into a still more rad-

ical search, almost a cry provoked in the body as a sign of nonexistence, of non-relationship. We may say that, in some respects, today cutting has taken the place of drugs: a form of self-harming more inherent in the body, in the flesh[2]. No longer is it the group as container of shared anxieties that offers "stuff" as a possibility of overcoming (if only artificially) a relational problem, nor the stubborn anorexic closing-off towards the world-that-nourishes, but the demand to one's own body, to one's own self, that it produce relational pleasure. A young woman patient told me of the pleasure she felt in scratching her skin inflamed by mosquito bites to the point where a trickle of blood emerged. Then she collected the blood in a teaspoon and drank it. She liked to feel the warmth of the blood as she was drinking it. I felt very sorry for this 15-year-old, whose parents were very successful, busy doctors, who had brought their daughter to me to be treated for "strange" behavior. The girl did other things too: risky underwater dives, irregular meals, riding her motor scooter when drunk.

The two components of the social experience that I identified in Chapter 1.1 on the "Foundations", the globalization of communications and the desensitization of the body, have influenced and caused to develop the borderline disorder, in which the "liquidity" of social feeling and the absence of a primary relationship are declined as *angry demand for concreteness*, for *bodily containment*, where in the past decades it was the ambivalence of the primary relationships that emerged in a request for clarity.

1.2. Problems Inherent in the Therapist's World and in the World of the Patient with BPD

The various studies on BPD have considered not only the development of the disorder and its origins in the primary systems of attachment, but also the crucial importance of the here-and-now in the therapeutic relationship[3].

This peculiarity of the diagnosis and treatment of the BPD patient is also linked to the development of the social feeling. If the narcissistic generation gave life to the borderline generation, a situation is created in which the therapist contains in her/his relational style exactly what gave rise to the borderline suffering: the ambivalence between idealization of and disappointment in one's

[2] For specific studies on cutting, see Favazza, 1996; Zanarini *et al*., 2006; Favaro *et al*., 2007; Gratz, Conrad and Roemer, 2002; Muehlenkamp and Gutierrez, 2004.

[3] Gunderson (2008) gives a good summary of the most significant studies, and the fundamental contribution of Kernberg to diagnosis and treatment. See also the stance of relational psychoanalysts (for instance Stolorow *et al*., 1999), who consider experiences generated in the analytical field as crucial in treatment, against the classical intrapsychic perspective of Kernberg.

own creature. The patient's anxiety and awkwardness lead the therapist to reckon with her/his own limitations – what the narcissist experiences as a wound. Two wounds come face to face, as we can see in the following example.

The therapist is ten minutes late. As soon as he is seated in the armchair, the patient says: "You're late, you shouldn't be, I can't rely on you!". The therapist should simply answer: "You're right"; but instead, wounded in her/his narcissism, s/he says: "I do such a lot for you; you could understand me for once!".

The therapists' narcissistic wound at the failure of the significant other to recognize her/his good intentions is reactivated in the presence of the borderline patient, who requires precision in definition.

One of the consequences of the emotional reactions this patient induces in the therapist is the difficulty of diagnosis of BPD. Kernberg (1987, p. 93 ff.) shows how in fact the patients taken into consideration in the various studies were very different from one another, and Vaillant (1992) actually maintains that this diagnosis is substantially adopted by the clinicians in order to label the patients they do not like. This reflection not only alerts us to the risks of not questioning ourselves about ourselves in the case of unpleasant reactions (and on the importance of doing supervision), but also makes us understand how the ambivalent sensitivity "at the boundary", inherent in this kind of disorder, is what – apart from other symptomatic manifestations – guides its diagnosis.

2. The Diagnosis of BPD

The diagnostic definition of the borderline personality disorder appeared in 1980, with the DSM III (APA 1980). In 1992, it was inserted in the International Statistical Classification of Disease (ICD-10). Finally, in 1994, it was perfected, on the basis of an extensive series of descriptive studies (cf. Gunderson *et al*., 1996), with only modest changes as compared with the original version of the DSM III.

Between the late 1970s and the mid-1990s there was an enormous increase in the number of publications on borderline disorder. The psychodynamic texts in particular peaked in 1974.

Referring to the vast number and variety of clinical cases that come under the heading of borderline, Kernberg (cf. Clarkin *et al*., 2000, p. 5 ff.) speaks of "borderline personality organization" (BPO) (distinguishing it from true borderline "disorder"), which includes various types of experience and relational manifestations, all with certain experiences in common, and of which borderline disorder is one example. He distinguishes three macro-types of personality organization: borderline organization, psychotic organization and neurotic or-

ganization of personality (cf. also Yontef, 1993, p. 423 ff.). This distinction is especially useful for us Gestalt therapists, because it considers the patient's experience (rather than simply the behavioural manifestation) as a cluster that includes both the inner representations of the primary relationships (aspects of interaction with the affective environment) and the specific character (hence genetic/biological aspects), the socio-environmental conditions (culture, socio-economic influence and social educational agencies, such as school, friendships etc.), as well as the relational patterns the patient puts into effect.

The structure of the borderline experience is characterized, according to Kernberg, by three features (cf. Clarkin *et al*., 2000, pp. 5-6): 1) the syndrome of diffusion of identity; 2) primitive defense mechanisms centered on the split; 3) continuity of the examination of reality.

In contrast, the structure of the neurotic experience is characterized by: 1) solid identity of the ego; 2) defense mechanisms centered on removal; 3) excellent examination of reality.

Finally, the structure of the psychotic experience is characterized by an examination of reality that is constantly disturbed.

We now come to an examination of the experiential clusters that distinguish the borderline experience:

1) By *syndrome of the diffusion of identity* Kernberg (Clarkin *et al*., 2000, p. 6) means the lack, in the patient's experience, of an integrated concept of the self and of an integrated concept of the significant others. The patient's reflective ability is damaged (the experiences of relationships are not "reflected" in the self in an integrated, adapted manner). In other words, what is missing in these patients is the ability to integrate the satisfactory with the frustrating experiences, maintaining an experiential continuity between the good and the bad. We can all be sometimes bad and sometimes good, but for the borderline patient it is impossible to forgive the bad other or to consider that the good other may have moments of badness. In Gestalt therapy we may say that s/he lacks the ability to overcome the pain caused by irreconcilable aspects by using the integrating (i.e., Gestalt) function.

2) The *primitive defenses*, according to Melanie Klein (1957), are split and projective identification. For the psychoanalyst, in the pre-Oedipal development, the child's experiences of satisfaction and frustration are linked to the caregiver: when this person is able and willing to satisfy the need, s/he nourishes a bond of love, when at other times this willingness is absent, the frustration of the need generates anger and hatred in the infant. The gratifying other and the frustrating other are experienced as separate and distinct, often the interiorization of the one is functional to the constant presence of the other, solving

feelings of guilt for the annihilation of one or the other aspect of the self (paranoid position). The borderline patient may pass from the feeling of omnipotence and omnipotent control and of idealization of the other, to her/his devaluation and painful rejection. The later development, which according to Klein leads the child to a neurotic condition, implies the courage to live through the struggle for the loss of the ideal primitive supplier (the depressive position functional to growth described by Klein, 1957) and the passage to a more complex interiorization of the other, who may sometimes gratify and sometimes frustrate.

3) The *examination of reality* is maintained in both the borderline and the neurotic structure, but, whereas the neurotic is capable of empathy, delicacy and discretion, the borderline (though s/he may sometimes surprise us with profoundly empathetic statements) is often impulsive, chaotic, affectively unstable, and in stressful conditions experiences relationships in paranoid manner. This lack of perceptive stability, united with impulsiveness, may lead to the risk of suicidal behaviors, or of serious eating disorders, predisposition to abuse, addiction to drugs and/or alcohol and antisocial behavior. The presence of these risky behaviors, together with the lack of a stable affective relationship, is a sign of negative prognosis.

In addition to these three experiential clusters, Kernberg (Clarkin *et al*., 2000, p. 6), places the various possibilities of borderline experience along two relational dimensions, which allows mitigation of the categorizing approach of DSM IV: the borderline patient may relate to others in a more or less *introverted* manner (paranoid, sadomasochistic and narcissistic disorders are on the side of introversion, whereas histrionic and narcissistic disorders are on the side of extroversion) and to a greater or lesser degree damaged by the *infusion of aggressiveness*: histrionic, cyclothymic and schizoid disorders involve fewer problems of intimacy as compared with narcissistic, sadomasochistic, borderline, paranoid, antisocial disorders, which instead involve serious problems of intimacy (see Clarkin *et al*., 2000, p. 6).

3. The Contribution of Gestalt Therapy to the BPD Construct and its Treatment: the Reading of Isadore From

In the twenty years in which the studies of borderline personality underwent their greatest development (1970-1990), there were no particular Gestalt studies on BPD[4], excepting the oral teaching of Isadore From, precise and well defined

[4] Yontef's book was published in 1993, and Elinor Greenberg's studies in 1999.

even today. In parallel with psychodynamic studies, he read borderline suffering in the key of the primary relationships, but framed by Gestalt epistemology.

Isadore said that the borderline's primary intentionality in contact is to preserve a laboriously constructed sketch of the self. This simple observation illuminates us on the behavior of borderline patients and their "now-for-next". Isadore brought out the borderline patient's tension towards an anxiety developed in the primary relationships, when faced by the adult's attempt to define it in intrusive/abusing terms ("I'm sick, do something for me"; "you should keep me company"; "it's your fault if", etc.). In order to define her/himself against the invasion of the adult in her/his (fragile) boundaries ("it has to be me that says what I want"), Isadore says that the person develops an incomprehensible language. The sentence in the epigraph, "The moon is made of cheese", is the example he gave in his teaching, from which it emerges that the language of the person with borderline suffering is not remote from reality, it is only misleading for the adult. The moon is, in fact, yellow, like cheese. It is the therapist (or the caregiver) who must read the misleading language of the borderline with such profound interest, free from evaluations that would objectivize (and so cool) the vitality that animates it, and with such lucidity of the boundary that he will be able not to feel attacked in his turn by borderline language. This therapeutic operation can give the patient with BPD the experience s/he desires of the "I am I and you are you". The therapist is not made nervous by the attempts to evade capture, which are legitimate for the borderline, and focuses her/his empathy and intelligence on the patient's esthetic movement, designed to preserve the sketch of the self.

Here is an example I often use (Spagnuolo Lobb 2011a, p. 152). Faced with the patient who – angry with the therapist because she did not answer when he called her several times in the middle of the night, after a session that had been particularly full of human closeness – says to the therapist: "I'll never trust you again"; the therapist – more attentive to the way he says this than to *what* he says, and bearing in mind the patient's attempt to maintain a sketch of the self – answers: "I'm touched by the dignity with which you say that".

In the face of the readings of the object-relation theoreticians, to which we have referred, Isadore From provides a phenomenological reading of contact, centered on the intentionality of borderline behavior and on the esthetic of the contact set in motion by patient and therapist. From's Gestalt definition brings out two fundamental aspects of the borderline experience: the sense of having built up a *sketch of the self*, obviously to be maintained (as instinct for survival) and the *dignity*, the beauty, the harmony with which the person maintains this sketch of the self.

The readings of the object-relation theoreticians link borderline behavior to failures of the process of attachment (consequence both of genetic predisposi-

tions and of adverse environmental conditions), and to the impossibility of introjecting secure relationships and figures of reliable nurturing. The result is the lack of a self perceived as trustworthy, confusion as to whom the experiences belong to (they might belong to someone else too), anger at what one has not had, recourse to primitive defenses such as split (in order not to feel the anxiety of the loss of the other) and anger, the alternation of opposing states of mind, relational ambivalence, momentary distortion of reality (yet without ever losing the sense of reality, as happens in psychosis). If these readings permit a suitable orientation of borderline behavior in the setting and therapeutic relationship, and also of transference and counter-transference, From's Gestalt reading makes it possible to remain in contact with the borderline patient *supporting her/his intentionality*.

As Gestalt therapists, we find ourselves perfectly in line with the reading of the object-relation theoreticians[5], since we too work on the suffering relational patterns that the patient brings to the session and that are reactivated dramatically in the psychotherapeutic setting. Gestalt therapy, however, adds a further value, to both the reading and the treatment of the borderline experience. The intentionality to maintain a sketch of the self (an emphasis that belongs to the phenomenological register) enables the therapist to focus attention on the *next* of the borderline experience, on what her/his request for therapy, and also her/his atavistic desire for contact, tends towards.

This Gestalt perspective, with the relative therapeutic strategy, makes it possible to fulfill the processes of individuation needed by the borderline patient in order to emerge from the painful mechanisms of split, of insecurity and ambivalence, much earlier and more lightly[6]. Moreover, the esthetic glance with which the Gestalt therapist is trained to be in the therapeutic relationship enables a presence and a therapeutic action that includes not only the bodily processes, but also the way in which they are integrated in the expression of a self-in-contact that is always harmonious.

In other words, Gestalt training allows the therapist to see beauty in the pain of the borderline experience (Francesetti, 2012), which is to say the harmony and dignity with which the patient – nonetheless – attempts to fulfill the contact with the other while maintaining her/himself.

It is clear that Gestalt training gives the therapist, who must also be well trained in the dynamics of the primary relationships, that "something more":

[5] In particular, TFP (Transference Focused Psychotherapy) by Kernberg (Clarkin *et al*., 2000) allows us to read both the borderline patient's suffering and the therapist's experience, in the context of reference of the primary relationships.

[6] See in chapter 1 the definition of positive anthropology which characterizes the procedural and esthetic viewpoint of Gestalt therapy.

the *gaze on the future* desired by that patient[7] and the *esthetic glance* on the patient's pain and on the beauty implicit in it. All that happens in the therapeutic setting, from the ambivalent behavior of the borderline patient to the therapist's feeling of anger, is to be read in this frame: *the whole being is intent on safeguarding that sketch of the self and this is done with harmony and dignity.*

4. The Synopsis Between DSM IV and Gestalt Therapy. The Nine Criteria of DSM IV in the Gestalt Therapy View of Contact

DSM IV, the diagnostic handbook based on statistical criteria of revelation of symptoms according to category, is criticized by psychodynamic and experiential clinicians because it does not respond to the need to go through the dimensions of the patient's experiences (as though the patient could be x-rayed statically within the whole of her/his behaviors and experiences reported). Yet the DSM categorization, being of a descriptive nature, comes very close to the phenomenological perspective. What DSM does not do justice to is the patient's experience of contact, her/his being-in-relationship-with the therapist, and also the interaction of the patient's experience with that of the therapist, and the elucidation of the intentionality of contact that is implicit in every behavioral criterion listed in DSM. It is precisely the attention to this intentionality of contact that makes it possible for us to design the therapeutic operation precisely and effectively.

Furthermore, DSM has become a shared language, by means of which to certify the diagnosis of those patients who are treated not only in psychotherapy offices but also in mental health centers, in that they need a diagnosis in order to have social benefits of various kinds. It is precisely because of this need for comparison with the DSM diagnostic system that I shall now consider the nine criteria of DSM IV for the diagnosis of BPD and reread them in the light of Gestalt therapy. In particular, after a brief description of each criterion (taken from Gunderson, 2008, it. trans. 2010, p. 10 ff.), I shall refer to the patient's experience, to the therapist's experience in the face of the manifestation of that criterion in the patient, and to the therapeutic intentionality shared by both when the phenomenological therapeutic field is dominated by the manifestation of that criterion. I shall accompany each of these descriptions with brief examples of clinical dialogs.

In this way Gestalt psychotherapists will be able to find in the present work a map for reading and intervene in the many forms in which the borderline pathology can be expressed.

[7] I am speaking not of the general wish of the borderline patient to feel more secure and "united", but of the concrete wish of this patient to fulfill self-security in a specific way.

5. Disorders in Relationships

5.1. Unstable, Intense Relationships

Diagnostic criterion – Interpersonal relationships are unstable and intense, and the significant others (the sources of attention and protection) are hyper-idealized, when they gratify, or undervalued when they frustrate.

Patient's experience – In Gestalt therapy we may define relational instability as an inability of the patient to integrate polar aspects of her/his feeling. What is lacking is the constancy of the object. The consequence is a being in relationships, including the therapeutic relationship, with a never assuaged suspicion, which rapidly gets the upper hand at the least stimulus that the patient codifies as threatening to her/his integrity. The following text message was sent by a female BPD patient in the phase of idealization of the therapist: "You are the loveliest and truest person I know. I am very fond of you. I don't know if this is a swindle, it doesn't matter; I feel something strong and true. I can't be mistaken about what I feel for you. I am fond of you, I want to feel myself: my voice, my body, my emotions, my thoughts". And here is another text message sent by the same patient in the phase of devaluation: "I feel squashed, reached, devastated, exhausted by the others. What's the use of this fucking therapy if I'm so ill? I feel something biting in my stomach. I hate you, get lost. Even you don't help me, you only think about yourself. I'm sick of therapy that has opened up things in me and hasn't helped me to close them".

Shared intentionality – The patient's intense, unstable reaction brings into the phenomenological therapeutic field her/his intention to reveal her/himself to the therapist. The patient is like a child who shows adoration when s/he wants to draw near and then furious anger when s/he cannot have what s/he wants. She seeks solid containment in the therapeutic field: sharing of the furious mourning for the loss of what s/he cannot have and constant presence of the therapist. The shared intentionality is to create a space of containment of griefs and joys, without evaluations and without "shoulds", a permission to live the spontaneity that still dwells in the feelings of split. For the therapist to be in line with this shared intentionality, s/he must not be distracted by personal narcissistic involvements, which make her/him feel the patient's anger as a wound (not being seen in her/his attempt to help).

5.2. Fears of Abandonment

Diagnostic criterion – This criterion summarizes Masterson's contribution (1972; Masterson and Rinsley, 1975) to the borderline construct. He associated

these fears, typical of borderline experience, to the Mahlerian developmental sub-phase of reconciliation/rapprochement (16-24 months). The frustration and disorientation that the child feels in no longer finding the mother where s/he had left her (with a natural emotion that attributes no blame), when s/he drew away to explore the world, are at the basis of the borderline's (not always conscious) fear of being abandoned and of the consequent acting-out[8].

Patient's experience – This criterion was defined as "intolerance of solitude" by Gunderson, Singer (1975) and by Adler, Buie (1979), and as a symptom of precocious insecure attachment by Fonagy (1991). The following message, sent to the therapist by a female BPD patient, illustrates this: "Listen: if I speak to you, tell me it's all right. I feel you're far off; I'm closed in my fear, solitude, incomprehension, inability to pick myself up, to feel free. I need to free myself from fear, from my chains. I don't know how to tell you, I'd so love to rediscover myself. Do you think it's possible? Do you like me a little bit?".

Therapist's experience – Since what emerges in the phenomenal field of psychotherapy is acting out, in other words the anger with which the patient manages her/his fear of abandonment, the therapist's reaction is often a consequence of this manifestation rather than of the feeling at its basis. The background against which the therapist reads the behavior shown by the patient is crucial for the therapeutic strategy. If the therapist attributes to the patient the relational independence of a neurotic experiential structure, her/his reaction will aim to bring the patient back into the shared rules. If the therapist considers fragility constitutive of borderline experience and the attempt to rediscover the sketch of the self so effortfully constructed by defending it with anger against whoever fails to protect her/him (what is described in the psychodynamic theories as primitive defense of the split), her/his reaction will be to ally her/himself with the patient's defense of the self.

For instance, the patient says: "I don't trust you anymore, because you made me wait 10 minutes in the waiting room while you were on the telephone". The therapist answers: "I apologize to you for making you wait; I understand that you must have been afraid that the people I was speaking with in those 10 minutes are more important than you. We can start the session now, I'm curious to know how things have been going in the past few days". If the therapist presupposes a relational independence, her/his answer will be along the following lines: "You're right, I made you wait, but I'd like you to be more understanding sometimes about me, the way I am with you".

[8] Mahler herself (Mahler and Kaplan, 1977) rejects this reading by Masterson with an empirical study that brought out an unimportant correlation between the problems of rapprochement and the manifestation of these fears in adulthood, or, in contrast, between these adulthood fears and problems of rapprochement in childhood.

Shared intentionality – Shared intentionality in the case of fear of abandonment is not abandoning/being abandoned. The therapist would like to be recognized in her/his attempts to be with the patient, and the patient in her/his need not to be abandoned.

5.3. Sense of Emptiness

Diagnostic criterion – This is a gut feeling, located in the abdomen or the chest, not to be confused with boredom (which rather pertains to narcissistic experiences) or with existential anguish or non-existence (which rather pertains to depressive experience). If distinguished in this way, the sense of emptiness may be a fundamental criterion for the diagnosis of borderline experience.

Patient's experience – Abraham (1975) and Freud (1908 or. ed., 1959) linked this feeling to failure in the oral phase of development, which predispose to depression and dependency, and to an angry object bond in adulthood. The object-relation theoreticians (Klein, 1932, 1946) subsequently specified this concept with the impossibility of introjecting a reassuring other (the failure of the oral phase results in the inability to represent oneself to oneself as a protected, nurtured being), with the result that one is incapable of self-consolation or of self-reference to images of reassuring others.

In Gestalt therapy we may speak of the phobia of introjecting, so that the person feels anxiety – where the spontaneous movement would be to introject – and becomes hypercritical and dissatisfied. This is a criticism without content, but focused on the process of avoidance of introjecting.

Therapist's experience – Faced with the sense of emptiness, the therapist feels failure in having been unable to reach the patient. At times the emptiness the patient feels is so different from the therapist's emotion that s/he separates her/himself from the patient's experience, considers it foreign to the phenomenological field and is detached from the patient's reality: that emotion is "crazy", out of context, does not pertain to her/him.

Shared intentionality – The shared intentionality seems to be isolation: the patient avoids feeling the real closeness of the therapist, the therapist does not recognize her/himself in the patient's isolation and in her/his turn becomes isolated. Both are isolated in feelings of emptiness. Perhaps the only intentionality we may speak of is that of being in the cradle of emptiness, having her/himself rocked by nothing as a state of abandonment to the environment.

A patient says: "This week I've felt a great sense of emptiness. It gets me in the stomach like a whirlpool". Therapist: "I imagine being with you in this whirlpool, I feel like we're in a bubble separated from the world, where no one can reach us". Patient: "So you feel the emptiness too, with me?".

5.4. Affective Instability

Diagnostic criterion – The borderline experience includes sudden affective changes and intense emotions[9]. In contrast with mood disorder, these emotions are less lasting in the borderline patient and more dependent on the behavior of the other. These two aspects are useful in order to differentiate the borderline experience from the depressive experience and from bipolar disorder, which, as they have in common with BPD intense emotions, might be confused with it.

Patient's experience – The patient is aware of being unstable, to the point where s/he wonders (and asks the therapist) if s/he is mad. S/he perceives this instability as independent of her/his will, and passes from feeling guilt, to confusion, to the denial of this aspect of her/his experience. This criterion is in fact defined, above all by certain cognitive behavioral therapies, as "affective dysregulation": the idea is that the nucleus of the borderline disorder consists in the failure, based on a biological condition, of emotional regulation, which interacts with a socially pervasive, invalidating environment[10].

The therapist's experience faced with this criterion may result in actual small traumas, which damage the therapeutic relationship. The affective instability of borderline patients alerts the therapist. It is well known that the therapist can never relax before a borderline patient, that precisely when it seems that the session has gone well and that there has been an improvement, the patient will act out, or worsen[11]. Let us imagine what the therapist may feel on hearing these words: "Today I feel a sense of wellbeing from time to time. I've been wanting to build my life since a while; this is the right moment. You'll help me, I'll help myself. All this will pass. I want to live without caring about anything or anybody. The fact is, I thought I don't care about others; I don't care about you either. I want to make my own way". Clearly the therapist feels disoriented, and wonders whether s/he has made some mistake, asks for supervision. The lack of anchorage in the concreteness of the relationship on the patient's part reproduces in the therapeutic setting the confusion experienced in the primary relationships.

Shared intentionality – This reaction, common to borderline patients, may be traced back to the phobia they have of warmth and closeness. Precisely be-

[9] Zanarini *et al*. (1998), in a study entitled "The Pain of Being Borderline", report that all the patients diagnosed with BPD feel betrayed, abandoned, bad, out of control, as if they were small children, as if they were hurting themselves, for much longer and much more intensely than other patients who were diagnosed differently or simply neurotic.

[10] Marsha Lineham (1987), for example, created a model of "dialectic behavioural therapy" which involves an intensive outpatient program focused on the disadjusted behavioural symptoms (impulsive or inappropriate expressions of emotions).

[11] In some cases there may also be suicides or suicide attempts after a moment of closeness experienced in therapy or in an important relationship.

cause they are aware of the risk of being lost in the therapeutic warmth, they need to close themselves off and "become unlovable" (if not destructive), to take their distance again, in such a way as to preserve that sketch of the self that they have built with such difficulty. If the origin of BPD lies in solitude experienced in childhood, whereas the origin of the narcissistic disorder is in the cold attention, charged with an egoistic pretension, that insecure adults poured out on the child that was forced to be "exceptional", in both cases the person experiences that the emotion at the boundary is excessive. In the case of the narcissistic disorder it is excessive because the other is perceived as unsuitable (small or confused or demanding) to welcome and recognize her/him. In the case of BPD it is excessive because the person perceives her/himself as fragile and ambivalent: "I am on the boundary not bearing to love and hate at the same time: hoping you will see my desire and hating you every time you don't see me".

The shared intentionality is therefore to preserve oneself: the therapist preserves her/his own therapeutic love, guards it against the aberrations caused by the apparently unforeseeable mood swings, and the patient preserves her/his fragile self against the therapist's "incursions".

Here is an example. Patient: "I feel a wish to free myself in my stomach: past anger at the passivity I was forced to live with, the fear, the lack of affection. I'd like to see you every day. I feel confused; tell me I can manage to recover myself. I want to talk with myself. Why don't you ever answer me? It's disgusting. I'm not coming to therapy anymore. I'm angry. I could say a lot to you. Go fuck yourself; I don't want to be hurt by you as well. Goodbye". Therapist: "You feel that with me you can let yourself go as you like, opening up to the point that you feel between us that security you need to rediscover yourself. When I don't answer your call you get very angry, and you're afraid that I'm different from the way you had thought".

5.5. Anger

Diagnostic criterion – Many borderline patients are aware that they often feel angry, quite apart from the fact of expressing this feeling or not. Sometimes acting-out serves the patient to not realize her/his anger, so that in fact when the acting-out comes to an end the patients can make contact with anger.

Patient's experience – This criterion was considered by Kernberg (1967) to be the origin of the borderline disorder, which may be the consequence of a temperamental excess and/or a very strong environmental frustration in a very small child. The environmental or the genetic cause both determines extreme anger, which in its turn causes a feeling of split and of self-destructive behav-

iors. It is anger, then, that generates in the patient the experience of split, the inability to integrate the lacks of the significant other in the positive image s/he feels the need of.

The therapist's feeling in the face of this anger may be disappointment, anger, or detachment. As in the case of fears of abandonment and the sense of emptiness, the therapist may be detached from the patient's pathos precisely to defend her/himself against the frustration of not seeing that the efforts s/he makes for that patient are recognized. This increases the patient's anger. In the event of a therapist with a narcissistic style of personality, the patient's anger may cause the emergence of the fears of abandonment and the humiliation of not being recognized. At this point the therapist too may have an acting out and grow angry with the patient, stressing for instance that s/he is the one to make the rules, or in other ways imposing her/his authority. Apart from these extreme cases, the patient's anger may give rise to reactions from the therapist that prove traumatic for the patient, in other words a repetition of the consolidated, painful relational patterns from which the patient is asking to emerge (by means of therapy). This may result in the interruption of the therapy by the patient, with anger expressed outside therapy against the therapist.

The shared intentionality in this criterion is the blind defense of the self. It is a matter of a confluent movement, which precisely for that reason does not include a clear intentionality of contact in the subjects involved. Neither the patient's anger nor the therapist's defenses lead into therapeutic places. It is necessary to emerge from the confluence, detach oneself from the anger in order to take up the thread of therapy once again.

I feel it is important to alert the Gestalt therapist to a potential danger in encouraging expression of the borderline patient's anger. The humanistic trust in supporting the full expression of feelings, in the cathartic ability to exteriorize and dramatize the repressed emotions, is not advisable in the case of serious disorders**.** The Gestalt therapist is trained to be whole before the patient and to have faith in the expression of the self (her/his own and the patient's). Yet, when a BPD patient grows angry, the worst thing a Gestalt therapist can do is lead her/him to express that anger, to amplify it, in the expectation that it will be discharged. Borderline anger is not subject to discharge; on the contrary, the more the patient expresses it, the less s/he feels contained and the more the anger increases, it may reach levels of personal and social risk.

The operation recommended in the event of the borderline patient's expressing anger is in a phenomenological-relational key. For example: "You're angry with me, you'd like me at least to understand what your mother didn't understand about you". This verbalization contains the anger in the frame of the relationship (it does not make it become a destructive weapon for the patient) and also verbalizes the now-for-next, the intentionality.

5.6. Impulsiveness

Diagnostic criterion – The impulsive behaviors of borderline patients have been regarded as a basic temperamental disposition. The use of these behaviors also characterizes patients with maniacal (or hypo-maniacal) experiences and anti-social patients. In the case of borderline disorder, however, these behaviors are of a self-harming nature. This specification enables us to distinguish the borderline disorder from other disorders (such as bulimia or substance abuse) in which self-harming is not of an impulsive character. Furthermore, the subject with borderline disorder frequently uses the pattern of impulsive self-harming with various symptoms: s/he moves from cutting to taking drugs or purgatives.

Patient's experience – It is difficult to foresee in the patient's experience an impulsive act (often, in fact, self-harming). What the patients say sometimes regards solitude ("I was alone all day, everything seemed valueless to me, it happened in a flash"), sometimes it betrays an accusation ("Anyway I knew you couldn't have come because you were away"), sometimes neither ("I don't know what came over me"). After the impulsive act, the patient seems calmer, not interested in understanding the logical connections of what s/he has done.

The therapist's experience – as for the other similar criteria (affective instability, anger), the therapist feels an interruption of contact: the patient's impulsive behavior seems to pertain to a register different from the therapeutic relationship. The therapist attempts to re-locate the behavior within the frame of the therapeutic relationship, integrating the "other" situation that s/he thinks the behavior refers to. For example: "Suddenly you close yourself off with me just as you did with your father. Can you look at me and tell me what you feel with me, who am different from your father?".

Shared intentionality – Impulsivity plays on the channels of confluence, so that it is difficult to think of a shared intentionality, apart from the more general one of the therapeutic situation, in which the patient needs to be helped to protect the sketch of the self that she has built up with difficulty, and the therapist agrees to help her/him in this. It is as though the patient thought s/he could resolve an unbearable anxiety by emerging from the relationship and bringing to an end an imagined solution. As in the case of anger, it is necessary to emerge from the confluence, detach oneself from the impulsive feeling in order to take up the therapeutic thread once more.

5.7. Suicidal or Self-Mutilating Behaviors

Diagnostic criterion – The diagnosis of BPD is, so to speak, obligatory eve-

ry time the person has repeated recourse to self-destructive behaviors, such as attempts, acts or threats of suicide and self-mutilation.

Patient's experience – If we refer to the person's experience, it would seem that we can expect (and prevent) these serious manifestations when the patient is particularly depressed or discouraged. It sometimes seems that the self-harming gesture "keeps the person company", or becomes almost an addiction, a ritual that defines her/his being in the world. These recurrent behaviors are in fact accompanied or preceded by complaints about other people's behavior, about feeling lonely, about not being interesting for anyone. At times it seems that the patient is deaf to all positive novelties and clings to perceptions that make old prophecies come true ("I'll always be alone", "None of the family cares about me", etc.). There is an evident perceptive rigidity as regards the present.

Therapist's experience – The therapist's emotion in the face of the patient's self-harming may be distress, failure or frustration, or of enlightening awareness, but also of impotent anger and wish for detachment. This reaction is also linked to the intentionality that motivates the self-harming gesture.

Shared intentionality – Patients with BPD may be driven to these behaviors by a request for help, or by cutting themselves off from the world. It is necessary, therefore, to distinguish a depressive borderline disorder, in which these behaviors rather express a determination to interrupt any attempt to live, from a disorder based on the ambivalence towards the significant other, in which the suicide attempt is both a way to punish her/him (a retroflection of anger) and a way to ask for help. Both cases are in some way a seduction for the therapist, a call to repeat a pattern of intrusive contact, in which the invader is also invaded. The therapist is invaded by the violence of her/his patient's suicide and invades by running to her/his side; the patient is invaded by the possibility of melting in the warmth of the therapist (drawing near to the therapist) and invades with the manipulative appeal to her/his own suffering.

The type of therapeutic operation in both cases, despite the specific difference between them, requires a non-intrusive respect for the other's boundary. In other words, the therapist must give support suitable for creating an opportunity of "clean" attachment for the patient.

Beyond the feeling of anguish which both these possibilities may give the therapist, they oblige her/him to reckon with her/his impotence in the face of individual liberty.

5.8. Identity Disorder

Diagnostic criterion – This criterion concerns the distortions of the body

image and the sense of being influenced and dominated in their values, habits and attitudes by anyone who is with them. It is a more serious symptom than those we have already considered, and denotes a greater fragility of the self. It should be distinguished from the generic problems of identity typical of (above all adolescent) development.

Patient's experience – In Gestalt language, we say that the sketch of the self constructed with difficulty is perceived as fleeting and constitutionally endangered. There is no perception of a clear contact-boundary, and the experiential background is confused with the figure. The emotions visible in the other could be one's own and the other's thoughts could enter ones' own head. The distortion of the body image is the sign of a perception of the self that is not contained by clear boundaries. Here is an example in the words of a patient: "I'm exhausted, I can't relax, I can't feel that I'm myself. I've somatized my fear, if I can put it that way. I have no dialogue and contact with myself. I feel/sense my brain, it echoes with the voices of other people. I wish they'd go away. When I was little everybody invaded me, even physically. I can't take these things anymore. I feel the same fear in my body as when I was a little girl. The same difficulty in being in reality. I feel awful being like this. Please tell everything and everybody that they are hurting me, they have to go away. I feel small, please do something. Help me, do something. Don't leave me, say something to me".

Therapist's experience – The therapist's feeling faced with this symptom generally ranges from tenderness to disparagement, according to the emotions evoked in the therapeutic phenomenological field, which certainly recall the patient's habitual relational patterns, as they have developed starting from the primary relationships.

Shared intentionality – We may imagine that the intentionality of contact that can be retraced in the therapeutic phenomenological field is made concrete in the expectation – on the patient's side – that the therapist will protect the sketch of the self, and in the tension – on the therapist's side – to protect the patient's sense of wholeness (both with clearly protective attitudes – tenderness – and with attitudes that challenge the patient – disparagement).

5.9. Decompensations in the Examination of Reality

Diagnostic criterion – This is a deterioration, always momentary in the case of BPD, of the sense of reality, encountered in some cases of BPD, which does not alter the ability to verify reality (i.e. the ability to correct the distortions of reality after feedback). It is a criterion that was also introduced to describe a psychotic deterioration within the psychotherapeutic setting

(e.g. a psychotic transference). These are symptoms of depersonalization, derealization and hallucinations. They may be the fruit of neglect or abuse in childhood.

Patient's experience – The decompensations of the examination of reality are always linked to a stress the patient feels, either in her/his life outside therapy, or in therapy. For these patients, in fact, therapy is sometimes more figure, more pregnant than life outside, and hence it is also the source of powerful stress. For example, even not feeling recognized by the therapist in her/his own perceptive truth, perhaps expressed in a manner difficult to understand, may stress them to the point that they no longer feel the containment of the relationship.

Therapist's experience – The therapist's reaction in these cases is generally one of nurturing and feeling sorry for the patient, and also of curiosity (if not anxiety) towards what, in the session or outside, in the patient's relational life, can have provoked stress.

Shared intentionality – Since in the case of BPD the decompensation of the examination of reality is always momentary, hence not constitutive of experience, as in the case of psychosis, it is essential to associate it to the occurrence of synchronic factors in the patient's life. When it happens during therapy, decompensation is always linked to the development that the therapeutic process is favoring in the patient. Whether the patient "attaches" the decompensation of reality to other relationships or to the therapeutic relationship (negative transference), the therapeutic relationship is in any case involved in the momentary stress. On the one hand the stress contains a deterioration, a risk of going back to harmonious modalities of contact ("the voices come into my brain, I don't know if I'm the one who feels sadness or if it's my mother"), but on the other it contains the opportunity to change pattern, by means of the containment of the therapeutic relationship ("help me to separate myself off, help me to be myself"). The shared intentionality is thus the desire common to both patient and therapist let oneself go in the momentary madness, the telling of an unutterable fear, which constitutes a remedial experience.

6. Preserving the Sketch of the Self with Harmonious Dignity: the Gestalt Model of Work with BPD

6.1. The Aim

If the aim of treatment of borderline disorder shared by the psychodynamic approaches is the integration of the split parts of the self (moving from a borderline pathology to a neurotic organization, Clarkin *et al.*, 2000, p. 9),

Gestalt therapy is not far from this perspective, but, in line with the phenomenological perspective, it is focused on the support of what there is already, i.e. the patient's intentionality to protect that sketch of the self constructed with difficulty.

We share the reading of the suffering of BPD, but we maintain that what can resolve it is not the consciousness of the defenses activated, but rather the support of the intentional movement to reach the other wholly, not split, not damaged, but whole. This process, which is certainly shared – implicitly in practice - by all good therapies, is for Gestalt therapy the fundamental reference, the fulcrum of its model of operation.

I maintain that this perception of being whole is what the BPD patient is seeking all her/his life and is what s/he is asking of the therapist.

Here is an example of what this implies in clinical practice. A woman patient says: "Faced with alienation, grief, fear, I said to myself: 'if I always think, I hang onto something, I don't lose control, nobody can get me'. I didn't care and at the same time I saved myself". The therapist answers her: "Hanging onto the thought, you managed to not get lost. I'm touched by the grace with which you didn't let yourself be caught. I'll try in our relationship to protect this ability of yours to protect yourself on your own".

6.2. The "How": a Psychotherapy Based on Counter-Transference

All clinical approaches agree that in the treatment of borderline patients the patient-therapist relationship is fundamental. Kernberg (Clarkin *et al*., 2000) actually founded his model of "therapy based on transference", which permits therapeutic effectiveness precisely with this kind of patient, in that it analyzes what the patient experiences in the here-and-now with the therapist, i.e. how s/he brings into the setting the anguishes and the splits that characterize her/his experience.

For Gestalt therapy, the suffering of the borderline patient is a *Gestalt* of socio-cultural, genetic and primary relational aspects, and the way the patient lives the therapeutic relationship re-proposes a suffering that has remained open in fundamental relationships. Hence, the task posed to the therapist is to complete, in as relaxed a manner as possible, the intentionality that was interrupted in the primary relationships, which now brings suffering.

If the object-relation theories are focused on the analysis of the patient's transference in the here-and-now of the therapeutic session, in Gestalt therapy we focus on the counter-transference, by which we mean the use of the therapeutic sensitivity to intuit the manner in which, in the patient's perceptive field, the significant other (in this case the therapist) maintains the borderline rela-

tional pattern. This attention permits to intuit what the significant other may do to support the interrupted intentionality of contact[12].

Going back to the example "The moon's made of cheese" – "Yes, they're both yellow", the point is to grasp the *intentionality of integration* that is already present in borderline language. When the patient puts together two split realities, the moon and cheese, the therapist grasps the mental process that made it possible to put them together. Something that distinguishes our operation is therefore the fact that we do *not* attempt to bring the patient back to "reason", telling her/him that s/he is incapable of accepting that the moon is the moon and cheese is something else. If the patient says to the therapist "You're bad", we do not explicitly try to lead her/him to accept that the therapist may be good and bad at the same time. Rather do we seek to give her/him the experience of *being seen in her/his attempt to reach the therapist*, even though this attempt consists in casting on the therapist the anger that the primary caregiver was unable to contain (hindering her/him from tolerating her/his anger).

Being focused on counter-transference becomes, in the case of the BPD patient, almost an ethical norm. In fact, since the therapy happens in the here-and-now of the therapeutic contact, the background, ethical, contractual elements are more important than those of content. They create the basic security the borderline patient needs in order to slacken the mistrust in the environment and in her/himself. The therapist's attention to her/his counter-transferential reactions at times reveals emotions that cause her/him to go off the rails of the ethics of the setting (e.g. mistrust in the patient's examination of reality may lead the therapist to speak with a relative without asking the patient's permission; or the initial liking that was established between therapist and patient may favor a confluent perception in the therapist and induce her/him not to read a message that the patient sent her/him during the week, taking it for granted that it can be talked over in the session).

The therapist's anger, frequent with borderline patients, must be transformed into containing strength by the Gestalt therapist, instead of being naively brought into the setting with trust (in this case misplaced) in the value of the therapist's authenticity, a crucial value for Gestalt therapy. The problem is what we mean by the therapist's authenticity. As Kernberg himself says (Clarkin *et al*., 2000, p. 13), «Although deviations from normality are sometimes necessary […] in general (we consider them[13]) a moment at which the therapist should understand her/his counter-transference in order to understand what part of her/himself the patient is inducing her/him to put to use». We can therefore confirm the positive nature of the therapist's authenticity, as long as

[12] For a description of the diagnostic and therapeutic model of Gestalt therapy, see Spagnuolo Lobb (2011a), Chapters 4 and 5.

[13] My addition.

we do not understand it naively: borderline patients induce us to set in action the most split parts of our self and hence are those who above all others challenge our profound wholeness. In effect they are a continual incentive to improve our relational stability.

6.3. The Gestalt Therapeutic Process with the Borderline Experience

The patient with BPD needs therapy when her/his anxieties and anguishes are focused on a relationship, or a type of relationship. For example, s/he feels obsessed by certain colleagues at work who assign her/him to shifts s/he considers disadvantageous; or s/he feels angry with a friend who behaved coldly towards her/him when her/his father died; or s/he feels a generalized unease towards all those who attempt to approach her/him, in that s/he feels invaded by these people.

Consistently with what has been said thus far on the contribution of Gestalt therapy to the diagnosis and treatment of BPD, I now expound a paradigm of therapeutic processes, to serve as a guide for Gestalt clinical practice. It is a matter of competences of contact that the therapist maintains from beginning to end of the therapeutic path. We may call them *domains* of the therapeutic relationship. As we know, the progress of patients suffering from BPD may be very various and an effective therapy does not always end positively. Despite good work with the therapist, the patient may need to separate her/himself abruptly and/or with negative feelings ("I'm going because even you have disappointed me"). Moreover, it is well known that patients with BPD readily change therapist. In the first stage they idealize the relationship, but then, when they feel that they are faced with the concreteness of the necessary separations[14], anger dominates and they devalue the therapist they had adored. This is a protective move for the patient, who avoids becoming to intimate with the therapist, in order to protect the sketch of the self. I do not believe that when the patient devalues the therapist her/his basic intentionality is to defile the therapeutic relationship; this might rather be an intention, a case of pique that subtends the superordinate tension (the intentionality) to protect the self and to test the therapist's ability to contain anger and defilement. Although the therapeutic process can be begun only when the patient "stops" with a therapist, changing therapist nevertheless allows the patient to take something from the "abandoned" therapist, and it is very important that the next therapist not fall into the seductive trap of believing that s/he is really better than her/his colleague.

[14] The therapist's changing an appointment or turning down the patient's kind (seductive) request to go to the theater together may be experienced as a separation.

I shall now identify five domains that form the Gestalt competence to treat the patient with borderline suffering of contact. I prefer to speak of domains and not of stages of the therapeutic process, because I hold that knowing what competences of contact a Gestalt therapist can develop with a borderline patient can be a more pragmatic, concrete support than the description of stages which, above all in the case of the development of therapy for borderline suffering, may be insufficiently concrete and frustrating. The Gestalt therapist can look to these domains as a handbook of basic competences to treat borderline suffering.

Table 2 summarizes the specific competences and the therapeutic goal of each domain.

Table 2. Specific competences and therapeutic goals in the different domains

Domains	**Name**	**Competence of the therapist**	**Therapeutic Goals**
Domain 1	Secure, clear, non-manipulative attitude	1. Ability to contain 2. Clarity of professional ethics 3. No manipulation	To support the patients' primary intentionality to trust the specific therapist
Domain 2	Accepting the *now-for-next* in the patient's relational difficulties	Accepting the tension to be there wholly with the other, despite aggressive, devaluing language	The patient experiences the ability to preserve the sketch of the self with the other, despite the ambivalence that makes her/him lose the sense of wholeness
Domain 3	Making explicit the elements of shared reality	Creating the bridge between present reaction and painful relational patterns	To experience the consistency between the pain of the past and the present reaction. To feel the therapist's closeness in the attempt to integrate conflicting parts
Domain 4	Supporting self-regulation in the face of the primitive defences	Developing a therapeutic language that grasps the desire for integration between affection for the other and autonomy	To experience both the ability to reach the other and perceptive autonomy
Domain 5	Containing the borderline suffering through counter-transference	Listening to the counter transferral emotions and their therapeutic contextualization	To legitimize the patient's desperate experience and support the split with less anxiety and reactivity

6.3.1. First Domain

The ethical attitude is secure, clear and not manipulative.

A basic competence with which therapist and patient relate to each other concerns ethics. What is most important and primary to calm the anxiety of a patient with BPD is that the therapist show her/himself to be secure and clear at the ethical level, and not abusive.

In particular, the therapist must manage the relationship with three basic attitudes: 1) the strength of being in the relationship with competence and capability of containment of the potentially destructive aspects; 2) clarity to manage situations that present problems of professional ethics; 3) respect for what pertains to the self or to the other, i.e. not attempt to change the other.

The first attitude ensures for the patient a reliable environment of treatment, which will not turn out to be a Procustean bed. The typical example is when a relative of the patient's (mother, spouse or other) asks for news of the therapy or asks the therapist for help. Being faithful to the fact that the therapy is the patient's and that, however sick s/he may be, nothing can be done outside the setting without her/his permission, guarantees to the relationship that reliability the patient needs if s/he is not to fall into anxieties and hence unstable or impulsive behaviors.

The third attitude, respect for the situation and choices of the patient, prevents manipulations of any kind, including that of inducing the patient to do certain things for her/his own good, such as going to the gym, going on a diet, etc. It is a different matter if it is the patient who wants to go to the gym or to diet, or to have an opinion. In that case the therapist supports the patient's resources, or expresses her/his point of view simply as that, a point of view and nothing more. E.g. "Since you ask me, I'll tell you that in my opinion you could speak more clearly with your mother, but of course it's up to you".

In order to develop the relational competences of this domain, the therapist must be guided by the shared intentionality of their relationship: entrusting oneself to the therapist in order to traverse the patient's possibilities of independence.

6.3.2. Second Domain

Grasping the now-for-next*, the tension to preserve the sketch of the self, in the relational difficulties the patient suffers.*

Listening to the difficulties the patient complains of (whether these are in other relationships or within the therapeutic relationship) allows the therapist to grasp the tension towards being there wholly with the other, despite the ambiv-

alence experienced, which causes her/him to lose the sense of wholeness. One woman patient said: "I quite like the guy who does shiatsu for me. It scares me, because sometimes I feel bad. I feel he gets into me. I want to be calm. It's not time for shit anymore; I have a husband and above all my awareness. I'm through with craziness. I want your support to make it". Another woman: "That fucking woman that works with me was looking at me this morning, then she asked if I wanted a coffee. I told her coffee's not good for me. She irritates me, she's always looking at me, she gives me the feeling that she wants to suck up my energies. She's short on energy, she's envious. It's a pain working in the same room as her. Tomorrow I'm going to the boss to get transferred to another office". Yet another (weeping, speaks of her partner): "How can he not understand? I always have to do everything! He does nothing! I want a man with me, but he has no initiative, not a bit. It's distressing for me. I can't leave him I feel good with him. I don't know whether you understand me".

The therapist's empathy has to be lined with the paradoxical situation the patient is living through: whatever s/he does, s/he is sick. But s/he also has to grasp the energy-towards, the tension to preserve the sketch of the self, even in the situation that is perceived as impossible. These patients require support in order to succeed in not being touched to the very soul by the others (by the shiatsu trainer, the colleague, the partner), in order to protect themselves and safeguard the sketch of the self that they have built up with difficulty. A response to the first example might be: "The pleasure you feel when the shiatsu trainer is massaging you vitalizes you and at the same time makes you afraid you'll get lost. I can see that you're determined to protect what you've built up in your life and I'm at your side to reach this aim".

6.3.3. Third Domain

Elucidating the elements of shared reality (both the moon and cheese are yellow).

Saying that the moon is made of cheese is an attempt the patient makes to integrate discordant parts. This is what the BPD patient constantly does, and her/his language shows it. The colleague who is seen as wanting to suck energy justifies the proud closure and non-acceptance of the coffee. Elucidating shared realities means creating a bridge between the current reaction and painful relational patterns, recognizing the patient's "nucleus of truth". The same patient says: "When I was little my mother tried to poison herself, and I stopped her. What was I saying or doing to make her do such a thing? Was I so bad? Was I the murderer or the victim? I wasn't a child, but I had to be grown-up, if I can put it that way. I had to wipe myself out and humiliate myself, let myself be

humiliated. Terrible things. I wanted love, normality, and yet I touched so much pain. My colleague looks at me as if she knew, as if she expected something of me. How can you help me, since you're a normal person?". Experiencing the consistency between painful facts in the past and present reactions on the one hand calms the patient, on the other causes an increase in the anxiety linked to confusion and pain. The therapist must measure how much to work on the anxiety and how much on other things, on the basis of the patient's capability of containment (i.e. the strength of the ego). Borderline patients seem strong when they talk about painful facts, but since talking about them is not cathartic for them (as it is for neurotics), it rather relights a fire that had been quenched; what comes after is not easy for them; it exposes them to loneliness and anger. For this reason, the therapist must always be one step behind as regards expressing painful feelings, must let the patient self-regulate, and never overvalue the BPD patient's ability to contain her/his anxiety.

A possible response to this patient is: "When your colleague looks at you without saying what she's thinking, you relive your mother's ambiguity: she put the potty under your bed and you didn't know whether she was looking after you or using you to avoid your father; she abandoned herself to you in her suffering, but maybe she accused you of it, too. You want me to clarify these experiences, which you're reliving in the office with your colleague. I appreciate your turning to me with this request. I'm asking you if you feel understood from what I say to you, and I'd like you to leave all this suffering here, all that sometimes makes you afraid you're going mad. I'd like us to talk about this when you come here. I'd like you not to experience it too much on your own".

6.3.4. Fourth Domain

Supporting self-regulation in the face of the primitive defenses.

The primitive defenses (anger, split), as Klein stresses (1932; 1946), interfere in the therapeutic contact and hinder its development towards a closeness, perceived as dangerous for the self. The primitive defenses, i.e. the tendency to perceive the significant other in split fashion, are a characteristic of borderline experience, and represent its perceptive style, which we obviously cannot change. What we can do, on the other hand, is to adapt the language of therapy to this style; otherwise we shall end by repeating the request of the primary caregivers who, in the patient's childhood, did not recognize the child's intentionality of contact. For instance, instead of stressing: "You don't trust me, you are always suspicious", reassure: "You'd like to make me feel your affection and at the same time you want to be sure that that won't imply being curbed in your relationship with me".

The borderline experience fails in the attempt to combine affection for the other and independence. Anger is in some way a form of self-regulation: a requirement of visibility of this suffering.

The following dream, which a woman patient had, gives good expression to the devaluation towards the therapist and also expresses the destructiveness of anger. The situation involves a frustration that the patient perceived because of the change of date of a session, due to an unforeseen situation that the therapist failed to explain: "I dreamed that you were sleeping in the office where you work (*in the perceptive confabulation operated by the patient with the setting for the dream, there is already a message that is aggressive towards the therapist: confusion between private and professional life, inability to establish clear rules and boundaries in her own life*). I was arriving because I had an appointment with you for a session. I found you in bed, asleep ('*are you taking care of me or sleeping?*'). I couldn't make up my mind, but then I woke you. You had a strange expression. Then you put on an elegant light gray dress. And there were other women, maybe colleagues of yours, wearing the same dress. Like yours, their dresses were not good quality (*her anger goes so far as to strike even the colleagues, their clothes and so on*). You told me we couldn't do the session (*now her* fear is evident), because you had a kind of conference with the other people (and her *envy*). I got really mad, to the point where I told you to go to hell. I told you I'd never come anymore and that you couldn't act that way with me (*note the dignity with which she leaves, her desire for independence, not to depend on the therapist, and to love her at the same time*). You neglect me".

Supporting the patient's self-regulation may take this form: "Sometimes – when I have to change an appointment, or I don't answer the telephone or you see that I'm busy with other people – you get really angry, to the point where you'd destroy our relationship. It seems quite clear to you that you're right, and you don't accept the fact that I can have things to do that take me right away from you. I think both these things are important; your affection for me and your independence, and when you go you'd like not to give me up, your anger tells me how important I am for you".

6.3.5. Fifth Domain

The use of counter-transference to contain borderline suffering.

The therapist's awareness (the Gestalt translation of psychoanalytic "counter-transference") in the contact with the borderline patient helps both to understand what was missing in the primary relationship. Thanks to her/his embodied empathy, the therapist succeeds in forming an idea both of the type of con-

tact the patient co-created with the primary caregiver (the perceptive automatism with which the patient is in contact with the therapist) and of what s/he feels with the therapist (see Mahoney *et al*., 2007; Spagnuolo Lobb and Salonia, 1986). It is from this comparison that "the other side of the moon" (see Stern *et al*., 2003) emerges, i.e. the phenomenological condition that has favored the development of the borderline pattern of contact.

Faced with the patient's impulsive behavior, the therapist will feel the extraneousness and coldness that the parent (or caregiver) felt, but will also see the patient's need to be accepted with this feature of her/his character, to have a strong adult who will not run away in fear.

Alternatively the therapist will feel, alongside the sense of personal solidity, ambivalence in taking care of this patient, and will note that the patient may "go crazy with anger" in the face of the perceived ambivalence.

Listening to the counter-transferential emotions is in my view the crucial therapeutic tool in the treatment of borderline disorder, much more than for other disorders, precisely because this disorder is experienced in the "painful flesh" of the here-and-now of the therapeutic session.

Awareness of the therapist's counter-transferential feelings legitimizes the patient's desperate experience, and gives her/him the sense of not being crazy. Additionally, the solid presence of the therapist provides her/him with the possibility of enduring the split with less anxiety and reactivity.

Let us take an example. The patient tells the therapist: "When I was a little girl, aged 7 to 9, my mother left the light on in the room where she used to sleep with my father; that room and the one where I slept were communicating. She said I was scared and that she had to keep an eye on me (*this situation seems to me to be a concrete example of the hyper-definition on the adult's part which, according to Isadore From, is the suffering of the boundary that makes it necessary to develop the borderline language*). She put a potty under my bed, for me to pee. I was a prey to fear, especially of her. I think she was using me because she didn't want to have sex with my father. She would use me, she'd put me in the middle of things, she'd terrify me (she weeps, and her inability to contain the mixture of strong, conflicting emotions she feels is clear). I saw and experienced terrible things. She used to have crises and I was blamed for things I didn't understand. She'd choke, and look like she was on the point of death; I'd give her her drops and tell her I was sorry for what I'd done. It was like an intercourse, a death trap. I feel I want to scream. That's enough!".

The therapist, as such, empathetically feels great sorrow for the patient's confusion and despairing solitude, but if s/he tries to become immersed in the phenomenological field induced by the patient, if s/he tries to ask her/himself what s/he would feel in the place of the significant other (i.e. the mother), s/he will discover that what s/he feels is entirely different. S/he might feel angry be-

cause the patient is weeping, because she has too many problems, s/he may want to "use" the patient, who seems gentle and remissive, as a confidante, and at the same time as a consenting audience that validates her/his reality. These emotions inform the therapist that the patient has not been respected in her boundaries and in her perceptive independence. So s/he can direct her/his operation by focusing the patient's perceptive independence (e.g. often asking "What do you think about this? What would you like to do in this situation?"). But there is more: the therapist's reaction, faced with the patient's response to this kind of support, can once more be a litmus test of the patient's ability to create an independent perception and give herself permission to act in an identified fashion rather than depending on someone else.

Thus, step by step, the counter-transference understood in the perspective of the phenomenological field provides the therapist with the most suitable tool to penetrate the subtlest threads of both the patient's desires and her/his affective dependences.

7. Conclusions. Advantages and Limitations of Gestalt Treatment of BPD

To conclude this work, I would like to recall the conclusion of therapy with a patient with a borderline style of personality. We were in a positive phase. I had left for a conference in the USA and we had suspended our sessions for three weeks. While I was abroad, I received a simple text message: "I am very fond of you". I was pleased; it struck me as a good way to make a break in her loneliness, as she waited for my return. I would have liked to answer, but my cell phone was not licensed for this. The day after I got home, she sent me the following message: "I can't say I'm feeling too bad. I've had some pretty good moments. The best thing in my life is that you told me you were fond of me. I believed you. It was marvellous". I appreciated not only the fact that the positive side of the bond was maintained, with a non-accusing, indeed cautiously affectionate text message, but also that she did not call me immediately (as she would have done in the past). She called me after a few days, and we fixed an appointment. The balance of distance and closeness gave me a good feeling. We seemed to have reached a shared harmony in our relationship. It was the best moment to define the therapeutic work as completed.

In my experience with this type of patient, I have learned not to expect a total, lasting remission of the borderline symptomatology, but only the ability to experience the primitive split with less anxiety, to accept it, and nonetheless to build independent relationships, in which these patients can experience fullness and independence of the other.

Borderline patients may come back, after finishing therapy, for an occasional session, or, at a difficult moment of their lives, they feel the need to return to therapy. It is important that, if possible, the therapist still be there, affectively present (even if physically s/he may not have space or may be unavailable for other reasons).

Although Kernberg and his group state that psychotherapy «enables a wide range of patients with BPD to move beyond the borderline pathology towards a neurotic organization» (Clarkin *et al*., 2000, p. 9), I hold that the aim of treatment is not to change the style of contact, but rather to experience this style with less anxiety. I maintain that, as Gestalt therapists, we should not expect nor push for a different experiential structure of contact, but accept it as a self-regulating process and think how to develop a therapeutic language capable of grasping the experience of integration that already exists in borderline suffering (the moon is made of cheese, quite so). Above all, we should reflect the dignity and the harmony with which the patient attempts to overcome the suffering at the contact-boundary, protecting the sketch of the self.

The response of Gestalt therapy to the crucial problem of the treatment of the borderline disorder lies precisely in the phenomenology of perception: the patient with a borderline experiential structure perceives the other in black and white, because this is her/his perceptive style (resulting from a tissue of genetic and environmental aspects). Rather than thinking in terms of maturative objectives (which would allow us to evaluate whether the patient has achieved competences suitable to a concept we have of relational maturity), we must think in terms of situation: "Here and now the patient's competences interweave in this way, and this is the way s/he develops her/his intentionality of contact". The Gestalt attitude can only be of a phenomenological type: acknowledging of what exists and supporting its blocked intentionality, without presenting ideal behaviors and experiences.

In this sense, the Gestalt model will be able to provide a treatment of choice for this type of disorder, precisely because it respects the suffering that the wound of the boundary generates, and restores the dignity of the beauty with which it is traversed.

The time has come for me to protect myself
I want subjection to leave me
I want my heart to beat regularly
I want to protect myself and I want to breathe with my lungs
see with my eyes
understand with my heart and my intelligence
with my sensitivity I want to feel my strength
I want to free myself.
(From the diary of a BPD patient, at the end of therapy)

Comment

by Christine Stevens

I well remember the first client I worked with who had a strongly borderline process. It was early in my psychotherapy training and we had not yet got to the part of the course that formally addressed psychopathology. We had worked a lot on the dialogic relationship however, and I was focussing very hard on being present to my clients and practicing inclusion and genuine communication. This particular client baffled me however as the more "present" I tried to be, the more invaded I felt. I was overwhelmed by pages of closely written text sandwiched inside beautiful cards posted to me in between sessions, and an increasing sense of becoming merged into a "we-ness" during the sessions. Then sometimes during therapy, almost in mid-sentence, she would "disappear", cowering terrified behind her hands, inchoate and distraught and feeling like worthless rubbish, leaving me wondering what had just taken place.

It was all very puzzling until I discovered a description of borderline process and realised that I needed to pay much more careful attention to the moment by moment, subtle nuances of what was going on between us and indeed within myself. It would have been so helpful at that time if I had been able to refer to this paper, which is an in-depth account of the aetiology and treatment approach to Borderline Personality Disorder (BPD). It is ambitious in its scope to consider the phenomenon in relation to the particular field conditions pertaining to the socio-historical context of the late twentieth century. The author draws on her breadth of knowledge and experience across psychotherapeutic modalities and combines this with her particular sense of the aesthetic of the process orientation of relational Gestalt therapy, which makes this such a useful contribution.

Many of us working in private practice are less likely to encounter the more severe or complex "wound of the boundary", which is perhaps better supported by working therapeutically within the container of a multi-disciplinary psychiatric team. Borderline traits however are commonly encountered in everyday practice, and this paper provides a theoretical and clinical framework for understanding these complexities in some depth, whatever context we find ourselves working in.

One of the concepts from this paper that I have found particularly helpful in my own work is the idea of the "sketch of the self"; the client's intentionality to integrate. I warm to the optimism of the assertion that the intentionality of inte-

gration is "already present" in borderline language. The author argues that the "now-next" dimension of this process helps the therapist to focus attention on what the client's sometimes distracting longing for contact and therapeutic engagement is a movement towards. She asserts that the therapist must pay close attention to her/his own counter-transference responses, and use this as a frame to see the concerns and intentions of the client. It is this process which enables the therapist to regulate their own sense of overwhelm or disengagement, which can be such a feature of working with clients with this process. Listening carefully to the counter-transference and tuning into the intentionalities behind the language is more helpful than therapist self-disclosure or cathartic experimentation. Spagnuolo Lobb particularly warns Gestalt therapists against simplistic expression of anger or escalation of emotion when working with these clients, pointing to the importance of containment rather than becoming lost or fragmented from a terrifying lack of boundedness, which ungrounded cathartic work can trigger. Her phrase "preserving the sketch of self with harmonious dignity" is one I shall add to my therapist's first-aid box to remind me of what is possible when I am struggling in the throes of a difficult session!

Much of this paper is taken up with the author's very useful discussion of the nine DSM IV criteria for BPD, in relation to the experiences of the therapist and client and their intentionalities, with some clinical examples. I wish there had been more space to develop these examples further as they provide fascinating and sometimes tantalisingly brief illustrations of the author's approach. Perhaps this is work for another book! This analysis is an important section however, which develops a discourse for Gestalt therapists with other modalities on how a process-orientated relational therapy addresses each of these behavioural descriptors.

Overall, this chapter provides an important contribution to the theory and practice of working with clients with borderline processes from a Gestalt psychotherapy perspective. I am sure it will be essential reading for students and experienced practitioners alike.

From the Greatness of the Image to the Fullness of Contact. Thoughts on Gestalt Therapy and Narcissistic Experience

by Giovanni Salonia

Et lacrimis turbavit aquas
«Quod refugis?»... clamavit[1]
Ovid

1. "I/We" in the Various Cultural Contexts: the Basic Relational Model

Ever since the 1950s, with the dulling of world-wide fears with regard to war and hunger in the West, interest and attention towards the individual have taken pride of place over the previous valorisation of community memberships. A decisive upheaval in the relationship between the individual and society gradually evolved[2]. Interest in the community and institutions grew weaker and greater emphasis was placed on subjectivity, on the single person, on his/her creativity as well as on fulfillment of his/her potentialities. An intermediate phase in this transition encompassed the valorisation of aggressiveness and rebellion as ways of escaping from all ties (family or institutional) and reclaiming one's rights – in the face of one's duties – as an expression of one's own autonomy[3]: at the social level, youth rebellion in the 1960s, took the form of this emerging underground cultural revolution. Since the 1970s/1980s, at the

[1] And with his tears he disturbs the mirror of water, which breaks into ripples… "Whither are you retreating?" he exclaims (Ovid, *Metamorphosis*).

[2] In every historical context, a specific type of Basic Relational Model (BRM) prevails. For many centuries, social, political and cultural life was organised in accordance with a BRM of the "We" type, because of the common, widespread fear (of hunger, war etc.) that encouraged a strong need of aggregation and a choice of structured organization and favoured the institution rather than the individual. After the Second World War, the historical conditions led to a shift from BRM/We to a BRM/I, based on the preponderance of values regarding the individual rather than the institution. For in-depth analysis q.v. Salonia (2005a, 2011b).

[3] It was Otto Rank who introduced the positive rebellion value in therapy, claiming that the refusal to interpret on the part of the patient may occasionally have a positive value as an expression of growth of autonomy (Rank, 1990).

time of this “fatherless” society, when every external principal of aggregation and every point of reference had been abolished, the subject stood up as a producer of meaning. From this time onwards, taking care of one’s self and one’s own image became the theme that generated the social and cultural context and became the key to understanding all new interests: from permanent education to body building, from social-political fragmentation to the fragility of cohabitation. All these different facets of a single trend – the care of the Self – led Lasch to speak of the “narcissistic society” (Lasch, 1978). The cultural perspective is that of freeing oneself from suffocating ties of belonging (Cooper, 1991), to try out the possibility of autonomy and creativity in order to arrive at one’s own uniqueness. At the social level, progressive modifications took place – ranging from complexity (Morin, 1985) to fragmentation (Lyotard, 2002) and toward the liquid society (Bauman, 2002) – and led to the extreme consequences a trend towards self-reference, arriving at the point where one talked in terms of a horizontal society (Friedman, 2002) and, today, of a borderline society (Salonia, 2013). As described by Beck (2003b) and Giddens (2000), these transformations concerned both society and the family.

Over the last decade, these processes have taken on particular characteristics and configurations. At the time in which the narcissistic society was evolving, whereas individuals, volving in this new context (of giving expression to oneself and easing one’s relational and institutional ties), emerged from a style of primary socialization of the previous confluent contexts (the aforementioned Basic Relational Model /We), the young people of today have been socialised in a “narcissistic”, relational and emotional context, made up of fragile, uncertain and broken bonds (Conte, 2012). Today’s generation of young people are labeled as “emotional orphans” their fragility taking the form of difficulty in forming significant and lasting relationships, in a continuous oscillation between dependence and autonomy: *I cannot live with you and I cannot live without you.*

Today speaking of narcissism means bearing in mind that it is no longer a question of acquiring autonomy (Perls’ famous prayer: “I am I and you are you”), but rather of a fragile narcissism emerging from uncertain relationships, which lack stable ground, and often end up in borderline, anti-social or autistic confusion. For this reason, one must ask oneself whether it still makes sense to speak of narcissism as a pathology, whether it makes sense to speak of the hypothesis to remove Narcissism from the list of personality disorders in the next DSM (i.e V).

2. Narcissism in Gestalt Therapy: Diagnostic Orientations

2.1. The Thinking of Isadore From on Gestalt and Narcissism

It makes little sense to talk about narcissism in Gestalt Therapy (GT) hermeneutics, because of a typological definition and not a phenomenological, intra-psychic and non-relational one[4]. Whilst maintaining the term "narcissism"[5] – which is decidedly vague at the semantic level but shared by the *koinè diàlektos* of psychotherapy – according to Goodman it would be more precise to talk of narcissistic "orientation". In Gestalt terms, the narcissist, as a type, does not exist; it would be more exact to talk of a precise modality of interruption of the contact cycle which hints at a retroflection. In fact, From underlined within the Gestalt community the need for a precise language but also flexible enough for the worlds of psychotherapy to understand each other. And we would like to begin by presenting the ideas of From with regard to narcissism in Gestalt Therapy.

In the history of Gestalt psychopathology, Isadore From's lessons prove to be an unavoidable and decisive point of reference: I present them here, whilst aware of the difficulties of grasping succinctly the rigorous totality of his thinking. He himself would have liked me to write: «From's thinking regarding narcissism as I understood it»[6].

According to From narcissism is a clinical category: it is the name that we give to an experience of the Self. A narcissist – in the way he or she is described[7] – is someone who is unable to keep up an intimate relationship, someone who is placed in a state of anxiety by healthy confluence.

This is a definition that derives from our basic hermeneutics (a reading of life in terms of the Gestalt contact cycle), which is specific to our approach but

[4] In the analytic index of the first edition of *Gestalt Therapy: excitement and growth in the human personality*, the word "narcissism" and derivatives does not exist (see Perls, Hefferline and Goodman, 1951, 1997).

[5] As we know, the Gods punish the young man from Tespi, who refuses to open himself up to love as represented by the young nymph (later named as Eco), increasing his guilt: love for himself, or rather wonder (*narkè*) when faced with his own image, will lead young Narcissus to his death. For a critical, in-depth description of the various versions of the Narcissus myth, q.v. Bettini-Pelleinzer (2003). In 1898 two scholars, P. Nacke and H. Ellis, applied the *logos* of this myth to the sexual perversions in which the subject's preferred object is his/her own body. S. Freud would render this myth famous by using the term "narcissism" for a scientific pathology and a phase in child development. Freudian theories are here taken for granted (q.v. Freud, 1914).

[6] These were his words, accompanied by his friendly and intelligent smile, one evening at dinner in France, when I suggested the possibility of having his seminars published.

[7] We shall refer to the narcissist with the masculine pronoun "he" although the category obviously also includes females.

not incompatible or incomprehensible for professionals from other approaches (in the same way as, for us Gestalt therapists, whatever is described and decoded by others is not beyond our understanding). There is no insurmountable incomprehensibility but a diversity of language: when I go to a foreign country I can express myself in the foreign language in order to communicate, without losing my own language, in the same way interacting with other languages means remaining in contact (it is however obvious that for total and reciprocal comprehension it is essential for others to learn my language).

What we describe as narcissistic orientation, psychoanalysts and others would term anxiety of the symbiosis. Narcissists are rendered anxious by a healthy relationship: in other words, for them it is difficult to sustain a healthy confluence. This is also the reason why narcissists cannot be successfully psychoanalyzed, because they cannot bear healthy introjection which, once again, requires a healthy confluence. In GT, we neither seek nor want introjection.

The narcissist may also describe me, the therapist or himself, fantastically but cannot manage to utter a "We". Thus, from a sexual point of view, the disturbances occur above all in the final contact, when the I/You relationship is dissolved and becomes "We". The final sexual contact is at the point of orgasm and – at least for a while – there is no I/You relationship: a single thing which he cannot bear. The narcissist asks for therapeutic help because he suffers from loneliness: he is often not satisfied from the sexual point of view and is losing his friends.

The problem in working with a narcissist is his difficulty in accepting from the therapist something that he himself does not know. From the technical point of view, it is useful to use "We" as often as possible ("What can we do?").

Narcissists have lost, as the Ego-function of the Self, the demand for confluence. Narcissists become anxious at the moment of the final contact; being in total accord leads to anxiety; they are afraid to enter into a full contact even with those who are dealing with their fragility. In other words: «at a *phenomenological level*: they use the word "I" and "You", but never "We"; they cannot take anything from the other on account of the risk of confluence. At a *therapeutic level*: the therapist often uses the word "We", in order to stimulate anxiety» (Salonia, 2012e).

According to From, narcissism in GT is linked to a precise interruption of contact: retroflection. The Organism, driven by precise intentionality, is fully involved in terms of orientation and manipulation in interaction with the environment but, at the moment in which he should surrender himself to "final contact" (finally!), he is blocked by a feeling of anguish: instead of being applied to the environment, the energy that has been activated will be turned on oneself. This interruption provokes a sense of failure and anger. The final gesture,

which might have consented to the fullness of experience, is lacking. This type of narcissistic suffering derives from having had a confluent mother, who abandoned him and left him too early: this is the classic retroflective narcissist.

However, according to From, two other types of narcissist also exist: the one who has never had a confluent mother (narcissists with this type of background are very difficult, because they have had to learn how to do without confluence from an early age[8]) and the one who had a mother that was too confluent and left him too late (Salonia, 2012e). Therefore, apart from the retroflective narcissist (*too early*), there is also the autistic narcissist (lack of experience of primary confluence) and a confluent narcissist (*too late*) (Salonia, 2012e).

In this work, we shall be referring specifically to the retroflective narcissist, when the interruption arrives at the moment in which, with orientation and manipulation already having been activated, one is close to reaching the intentionality of contact. And, in order to understand an interruption of contact (pathology) in a non-schematic way, in the diagnostic GT framework it is necessary to bear in mind two perspectives: the theory of the contact cycle and the theory of the Self[9]. From's analyses, as we have seen, place narcissism within the theory of the contact cycle, individuating the specific interruption in retroflection. We shall now proceed to dealing with the theory of the Self and its phenomenological reference-points.

2.2. Every Interruption of Contact is Worth a Novel… a Family Novel

We saw how retroflection in the contact cycle is the interruption of the pathway leading to full contact: this interruption takes place because the subject has the bodily perception (often unaware) that his environment is too small to contain him. The previously activated energy is retroflected and thus directed towards his own body (Perls, Hefferline and Goodman, 1997; Salonia, 2010b). This perception (great Organism/small Environment) clearly rests on a Personality-function disorder of the Self (not perceiving oneself in a functional way, nor one's history in the world) (Salonia and Sichera, 2012b).

It is precisely from the Personality-function disorder of the Self that we should initiate proceedings for our analysis of the diagnostic and clinical processes. In fact, every interruption in the cycle of contact/withdrawal from contact, harks back to a history of primary relationships through which the subject

[8] This is the most interesting technical hypothesis at the level of relational diagnosis of autism: autonomy without confluence.

[9] One of the first and most valid contributions regarding Gestalt Therapy and narcissism is certainly that of the German group (Müller *et al.*, 1988).

has lived and learned, at the verbal and bodily level, about disturbed experiences of the Personality-function. Paraphrasing E. Polster (1998), one might affirm that every interruption is worth a novel… a family novel.

In line with the phenomenological matrix of Gestalt Therapy, an effective therapeutic procedure is to describe and bring out from the background those family dynamics in which a modality of interruption has been acquired.

We talk in terms of a family novel because the relational dynamics involved are those of the primary socialization, which recall family history. In this perspective, it is essential to refer to a Gestalt model of the family Self and family styles of contact (Salonia, 2009). One of the basic learnings which adds weight to Gestalt family therapy is precisely the functioning (within the family) of the three functions of the family Self: Id-function, Personality-function and Ego-function.

In the case of the narcissistic relational style (retroflective), the familiar genesis refers to a family in which a disturbed alliance is present (at the level of the Personality-function) between one of the parents and their child; they live as if their asymmetrical relationship were symmetrical and contextually exclude the co-parent or are opposed to him/her (Salonia, 2005b). In this way, in a play of disturbed interactions, the parent will have childlike experiences and behaviours (not suited to the figure he/she has become: someone who is taking care) and the child will be expected to have acquired adult experiences and behaviours (provoking an interruption in his healthy organismic spontaneity). Because of his/her unaware need to close the *gestalts* that have been opened in his/her own history, the parent will respond with a bright smile when the child's behaviour responds to his/her expectations but will become depressed when the child's behaviour does not correspond to his/her needs. The child does not perceive his real needs as being treated: he is not perceived by the parent as someone to be taken care of, but as someone that can himself deal with his own deprivations, his own interrupted dreams[10]. The parent's eyes will not always be an uninterrupted source of light but a spotlight, pointed in his direction only when the child behaves in such a way as to please the parent. In order to always maintain this light, the child will have to learn to sacrifice parts of himself and satisfy the parent: in other words, he will have to deny himself so that he becomes the desired image in the eyes of the parent.

Little Jaromil, in *Life is elsewhere* (Kundera, 1992) cannot speak spontaneously, from the moment he realizes that every phrase uttered, even the most banal, is assessed by his mother (who would like him to be a poet) in terms of "poetry" (maternal smile) and "non-poetry" (depressed maternal face).

The parts of himself that he cannot express and which backfire against his

[10] A. Miller (1982) was the first who describes masterfully the family drama that weaves together a childlike mother and a "grandiose" child.

own body are experienced by him as inadequate (the parent does not like them) and therefore they seem dirty to him, ugly and perhaps nasty. The child is rewarded for this sacrifice, receiving unsuitable confirmations of his contact boundary: the feeling of being unique, the grandiose savior (that is what his mother has made him feel by elevating him above her partner); therefore, he always has to physiologically occupy a central position and know everything (what he does not know is not important). He confuses affection and admiration ("I feel loved only if I am applauded"); he cannot bear rejection or denial, which are perceived not as a contained and limited experience in an interaction but as disapproval of the whole person.

The lack of contact with the other parent will prove to be particularly punitive for the growth of the child: for the male, non-contact with his father will usually make him feel that he is exempt from rules and limitations, accompanied by the intimate feeling of terror-attraction of meeting him; for the female, along with the negation-disapproval of her own femininity, she will be accompanied by a deep-seated longing for the maternal body.

Recent studies (Mitchell, 2000) have shown the dynamics of the disturbed parent-child confluence to be a determining factor in the origins of narcissistic experiences because, apart from preventing a meeting with the other parent, they prevent the child from having relations with his siblings. The connection between narcissism and sibling relationship emerges as one of the most intriguing therapeutic areas: the narcissistic wound does not concern the parents-child triangle but derives from the presence of siblings that unequivocally (and unnecessarily) jeopardizes the central and unique status of the narcissist. It is the lack of shared experience with siblings that determines in the narcissist his feeling of unease and of being out of place, when he finds himself in the midst of a group. The most effective treatment for narcissism, therefore, might seem to be – as we shall see – the re-discovery of the fullness of peer relationships: the sibling (Salonia, 2007a).

The affective life of the "narcissist" is marked by this distorted, initial and uninterrupted confluence, whence there emerges the anguish of every new contact, perceived as a further experience of suffocation and sacrifice to the other. In his emotional relationships, after the phase of wonder and seduction, the narcissist will begin to feel every request made by the other as suffocating, every refusal unbearable: he will endeavor to re-propose a relational style in which he does not actually see the other but is only interested in his own exclusive need to be seen and applauded. In every type of relationship, he will obviously have no faith in the environment (he will view it as restricted and unable to contain him). For this reason, when he encounters dissent either he does not express it, he removes himself from the relationship (he goes "under water") or he expresses it with disdain and rejection of the other. He says (to himself and

to others) that he does not need anybody. With these relational wounds, his affective life will be an area of suffering for himself and for others, whereas professionally he might well have achieved considerable success.

3. Gestalt Work with Narcissistic Experiences

3.1. Why Gestalt Therapy with Narcissistic Patients? New Therapies for New Patients

In the 1950s, as we have seen, cultural changes led to subjectivity becoming a primary value as regards memberships. There was also an emergence (or increase) in new forms of pathology, in particular narcissism and borderline personality disorders (Salonia, 2010b; Gaddini, 2002).

Classical psychoanalysis encountered considerable difficulties with these new patients. As Kohut would have said, they were accustomed to treating *the guilty man* and found themselves ill-equipped for the new one: *the tragic man* (Kohut, 1976b). Twenty years later, he himself recognised that (at least in the first phase of analysis) the central interventions of the psychoanalytical method - interpretation and back-reference to the primary childhood relationships - are not suitable for narcissistic patients, because they are perceived by them as humiliating and therefore unbearable.

In fact, the narcissist will feel as "at home" and understood (and treated) with the new models of therapy in which the therapist places, at the centre of treatment, acknowledgement of the other's experiential world (with empathy) and the anthropological and therapeutic centrality of experience as it occurs (the famous "here and now"). Kohut himself started anew from these elements in his revision work on the psychoanalytical model with narcissists.

Gestalt Therapy, which emerged precisely to respond to evolving anthropological changes in the 1940s, immediately proved to be a "suitable" therapeutic model, also for narcissistic (and borderline) patients: the therapist remains in the here-and-now of the patient's relational experience, helps the patient to restore his healthy aggression and assessment of experience and endeavours to accomplish relational intentionality. We shall now see how it is possible to try to treat narcissists with Gestalt Therapy theory and practice.

3.2. Why Should the Narcissist Go into Therapy? Tears Like Kairòs

The first question that emerges is the simplest: bearing in mind the mistrust with which he views his environment, how does the narcissist end up in thera-

py? It is certainly not an easy decision for him. I remember the reply of an important person years ago when it was suggested he go into therapy with me: “It would take twelve Giovanni Salonias to cure me!”. In what might have seemed a haughty reply, there lay hidden the desperate solitude and great pain of the narcissist: I suffer but nobody is capable of curing me.

In poetic mode, Ovid explains to us why pain is the (wasted) opportunity for a cure for Narcissus: «*Et lacrimis turbavit aquas* […] *“Quod refugis?”* […] *clamavit*» (And with his tears he disturbs the mirrored surface of the water, which breaks into ripples…“Whither are you retreating?”, he exclaims) (Ovid, *Metamorphosis*, III, 475-477). When he starts crying, his tears create ripples on the surface of the water and for a moment his reflected image disappears. It is the god *Kairòs* passing through: Narcissus, in that moment, might have realised that it was only an image, understood it was a trick…but the opportunity passed by unseized (the god’s forelock[11]). The poet continues: «*non tulit ulterior*» (he could bear no more) (Ovid, *Metamorphosis*, III, 487): he invokes his image and waits for the waters to calm and for his image to reappear. Then there is the tragic outcome: Narcissus drowns so as to be united in a passionate and mortal kiss with his image.

Pain is often the result of depression due to professional or romantic failure (for males) or panic attacks (for females) and presents a wonderful opportunity for the narcissist to consider the hypothesis of going into therapy; however, going into therapy, as we shall see, does not imply… becoming a patient.

3.3. Whither Now: Beyond the Phobia of Belonging, Beyond the Phobia of Individuation

As previously suggested, the aim of therapeutic work with narcissistic patients is to restore the ability to enter into a healthy confluence. This objective is arranged in two stages.

The first, being that of elaborating and learning to see the other and overcoming the anguish of belonging. This is rendered feasible by traversing the retroflective blockage, with which, in every relational experience, progress is interrupted because the narcissist is hampered by his own fear of trusting. To see the therapist as a “You” whom one can trust is the first step. He will then become capable of experiencing and recounting the therapeutic relationship as a “history built-up together”.

As we shall see, the progress of therapeutic treatment, depending on the intricacies of the therapist-patient pairing, may also enter another significant var-

[11] Reference here is to Greek mythology, according to which the *Kairòs* had to be seized by his forelock at the right moment (*kairòn gnoti*).

iant: (the patient's) falling in love. Archaic and decisive, therapeutic relational themes become a feature of the work bringing, in a paradoxical way, the phobia of differentiation to the contact boundary. The narcissist-in-love demands a symmetric relationship: the therapist's "no" to his pleas for a symmetric and romantic involvement will come to be seen as humiliating. Being brought back to one's status as a patient will foment anger at the humiliation and deception (Personality-function disorder), with moments of profound anguish of individuation.

As the Polsters point out (Polster and Polster, 1983), the second objective of clinical work is to learn healthy confluence in an asymmetrical relationship. This entails being helped to find oneself without feeling discredited. How to achieve these aims? I shall attempt to describe several examples of clinical treatment.

3.4. Therapeutic Treatments

We are well aware of the interweaving and intersecting of the various levels of the work and therefore, with regard to didactics and process, we have proposed time-based scanning, which on the clinical level usually proves to be coherent and effective.

3.4.1. Working on the Personality Function of the Self: Between Symmetry and Asymmetry

In line with established Gestalt clinical practice, therapeutic work starts off from the Personality-function disorder. The narcissistic patient begins therapy but does not consider himself to be a patient. He has an unshakable perception of the environment as small and incapable of containing him.

In the first phase of therapy, therefore, he will try (in aware and unaware ways) to stay on an equal footing with the therapist, perhaps even attempting to defy him. He will claim that he only started therapy because it is interesting to have somebody with whom to discuss one's self without being contradicted or in order to know how psychotherapy functions or even to give the therapist interesting new elements for a future article.

In reality, he is attempting to test out the therapist to see whether he is any different from those people who took care of him in his primary relations (will he be able to contain all his facets, including the abrasive ones?). For these reasons, he will exhibit his own (economic, cultural and whatever other) power, discrediting and even disdaining (not always in a veiled way) the therapist. In

fact, accepting the down position entails considerable anguish for him, as well as extreme humiliation.

The moment of paying for the session constitutes unavoidable humiliation. This is the most embarrassing moment for the patient: he may try to forget it (and the therapist, if he has been at all charmed by the patient, will risk encouraging him and forfeiting his fee!) or he may say that he has money problems (perhaps after speaking during the session about his latest fabulous purchase); he might try to pay more than necessary (because he does not respect a professional who demands such an insignificant fee) or he might comment on the transaction with a venomous aside ("What sense is there wanting to help and get paid?).

The therapist occasionally runs the risk of being seduced by the patient. Oscar Wilde (Wilde, 2003) comments that the spring does not see Narcissus because, on the contrary, it sees its own beauty in his eyes… it sees itself in him (*«In the mirror of his eyes I saw ever my own beauty mirrored»*). The therapist can be easily flattered by a patient who is particularly skilled or special at the social level.

A colleague of mine sought advice, asking me whether she could accept an invitation from her patient, a famous actor from the theatre, who from time to time offered performances for a very few intimate invitees. She would have willingly accepted in an attempt to create a good feeling with the patient, but on further discussion she became aware of the fact that by participating and applauding she would have confused her role in treating him (at the Personality-function level). A lot of therapy with narcissistic patients is actually cut short because of this confusion of competences.

The dividing-lines between therapy and life (in particular with narcissistic patients) must always remain clear and untouchable. Another area that can similarly become a battleground is that of rules for the therapeutic setting. "Isn't it perhaps true", the patient will claim "that outside the session conversation can become more spontaneous?". This argument will take on different forms: the more intense the conflict (e.g.: falling-in-love not reciprocated by the therapist or indifferent contempt towards the therapist), the more aware the patient will become of the archaic distortions of the Personality-function of his own Self. Probably because they have never related to their father figures, it is often males who tend to violate rules (starting by not respecting starting and finishing times); whereas women, on the other hand, will respect the adored paternal figure to the point of ignoring their urge to be unconventional.

It is clear that the therapist must remain on his own therapeutic seat (Personality-function) without allowing himself to be affected by narcissism («I am good because I was chosen by a special patient") nor upset by disapproval ("Perhaps I really am less good than him" or "How dare you?") nor worried by

seduction ("How can you understand me better than my partner?) and so on. If he avoids these risks he may be able to empathize with the great suffering of the narcissist (Johnson, 1986) and mark out the boundaries firmly and respectfully, without resorting to super-ego impositions ("these things are not permitted in therapy") and without humiliating the patient (treating him like a capricious child).

Each test that the therapist passes (remaining in the caregiver position) will implicitly help nurture in the patient's body the hope of finally being able to trust and be trusted.

When catching (and eventually postponing or elaborating) the patient's life experiences, I prefer to give priority to those experiences leading to the phenomenological field of pain, courage and irritation, postponing focus on those feelings that are related to inadequacy (i.e. humiliation, impotence, competition etc). It often happens that the patient, after expressing disapproval (and even hatred), is moved by the emergence of feelings of gratitude from his body towards the therapist who has welcomed him, and begins to risk sharing humiliating experiences. To feel respected and understood, even after a violent assault, and to sense the therapist's firm and resolute presence, provide a base for the patient to acquire awareness of his profound wounds and to begin to actually see himself as a patient and going into therapy.

3.4.2. Working on the Id-Function: Corpus Putat Esse Quod Umbra Est[12]

The Id-function disorder in the narcissistic patient can appear in various forms; for instance with desensitization and retroflection, which produce chronic bodily tension. Sacrificing oneself (parts of one's self), during one's past personal relational history, means – in the words of A. Lowen (1984) – the loss of contact with one's own body and with one's own Self. At the level of inter-corporeity (Salonia, 2011c), the image from one of my patients was particularly significant: with his hands he depicted his mother's embrace in sculptural fashion: one of his hand was closed up in a fist, whereas the other one (his mother) clasped him tightly, suffocating him. He is the son who is suffering, because he cannot embrace fully; he has to keep his own body closed up so as to avoid the emergence of experiences of which his mother might disapprove. Desensitizing himself and drawing back to the external boundaries become the best way to avoid depression for the mother and humiliation for himself.

The Self withdraws and shows itself at the contact boundary not always and not completely. One's own body experience will be replaced – as Ovidio, once more, already surmised – by the image of himself or rather the shadow. It is the

[12] He thinks to be a shadow that which is a body (Ovid, *Metamorphosis*, III, 417).

image of himself that he saw in his mother's eyes, without realising that it was only an image and only a part of his own Self. In this disturbed perception of the Self, his pain becomes desperate: in fact he seeks outside his own body (in admiration and applause: in the eyes of others), instead of searching within himself, within his own body. «*Quod cupio mecum est*» (What I desire is within me) (Ovid, *Metamorphosis*, III, 466) – says Ovid's Narcissus – but what he is seeking is in the body of the other and in his own body and not in the image reflected in the mirror. In the words of the poet, he is confusing shadows with bodies.

In order to re-store the Id-function, it may be useful to begin by inviting the patient to concentrate on his own body, to re-establish "the Self that concentrates" (Perls, Hefferline and Goodman, 1997). Even if he sees this invitation as a way towards relaxation, in reality – as F. Perls suggested (Perls, 1947) – in this way he will learn to listen to his own body (and himself) and will become the active protagonist of the therapeutic process (as opposed to the passivity of the techniques of free association, which he might perceive as humiliating). It is not only a question of coming into contact with one's emotions, but coming into contact with oneself (it is also the psychoanalysts who nowadays affirm that the body is the unconscious! (Recalcati, 2000).

Whilst listening to himself (as opposed to the relational style to which he is accustomed), he will gradually come into contact with those parts that were undesirable to the parental figure and, therefore, considered dirty, nasty and humiliating. It will be like a descent into Hell. There will be a radical metamorphosis. He will eventually declare: "This is me!" ("Iste ego sum") (Ovid, *Metamorphosis*, III, 403), no longer with the grandiose tones he employed when looking in the mirror but with the wise sadness of one who has discovered his own limits: those limits that (like excrement[13]), when they are acknowledged as one's own, lose their unpleasantness and make one feel more fully wholesome.

Carlo was coming into contact with his breathing when all of a sudden he exclaimed: "Bastard! You deceived me!". In a single moment, his infantile idealization of his mother collapsed and there began for him the painful road to discovering that he had not been loved unconditionally (as a subject) but like a dream-figure. In therapy, he would repeat over and again: "I don't want to be my mother's dream!". Ovid had foreseen this, placing in the mouth of Tiresia these mysterious words: "He will die if he gets to know himself". In fact, when the narcissist discovers himself, his mother's dream of him dies along with his image of his mother.

[13] M. Kundera (1985) wrote entertainingly about the incompatibility between God and excrement, applying it to "he who thinks he is God" and excrement, which of all the limits is the most bodily expressive.

Knowing himself, the dream dies and the image dies. But his body will once more be inhabited: after expressing so much anger, he will learn the power of weakness, of calm, serene and tender gestures; perhaps, he will cautiously discover his bodily needs and expressivity; he might well approach them with the typical awkwardness of someone who is just learning to dance (Polster, 1988). In other words, following the death of the idealized parent, to whom he was linked by a distorted confluence, there begins the recovery of the other parent's body: the previously despised body of the father or mother re-emerges powerfully, opening up the narcissist's body experience, always present but always denied or rather retroflected. At this point, the therapist and the patient are ready to work fully on retroflection.

3.4.3. Working on Retroflection: the Environment Becomes… Great!

Retroflecting instead of proceeding to express oneself fully in the contact cycle has become an unconscious habit to avoid the anguish of surrendering oneself to the other and thus risk being refused and discredited. As Goodman reminds us, this style makes us feel that we have been "left out" or excluded from the environment. The feeling of solitude is considerable but the patient experiences the anguish of surrendering himself even more strongly. Working on retroflection is not simple, precisely because it occurs unconsciously and produces other behaviours of the gesture (or "instead of" gestures), that should express on the contrary a surrendering of oneself (Salonia, 2010b).

In order to sensitize the patient to his retroflective style, one can start, a few minutes before the end of the session, by asking the patient which word he has not spoken, which gesture he has not made, which request he has not presented. The answers to these questions provide precious information regarding experiences that have caused the patient the greatest unease and anxiety. Another strategy suggested by From is to ask the patient to remember the dreams he has had during the session: these are often elaborations on retroflective experiences. There is his famous account about the seminar in which, on the second day, a participant said to him: "I had a little dream" and From replied, with a wink: "You meant to tell me I was little". Knowing From, we might guess that the previous evening he had already glimpsed that participant's fleeting reaction of surprise at seeing From's diminutive figure.

Apart from the narration, which is always incomplete and imprecise (as From would say), it emerges that the therapist has to spot, at the phenomenological level, syncopated micro-movements (darting eyes, fixed jaws, lip-biting, etc.) which express the retroflection short-circuit between the need and the anguish at expressing oneself.

As Perls reminds us boredom and a lack of topics of conversation often reveal a patient's difficulty in carrying forward relational themes to the outer contact boundary (aggressiveness towards the therapist, requests perceived as humiliating, fear of being undervalued etc.). On occasion, the patient will actually begin talking about dramatic subjects only in the last few minutes of the session, which does not mean that there has been little time (for which one should prolong the duration of the therapy), but that the fear of trusting in the therapist is considerable. As previously mentioned, this process can often be facilitated by asking the patient, five minutes before the end of the session, to reflect on what he might want to ask or say to the therapist. It is interesting to note that in cases where the patient does not recall anything, it is enough to suggest that the patient does not have to share what emerges, in order to remember things immediately (and often with a naughty smile). Even while respecting the clause, one will always be able to work on catastrophic fears. In order to loosen up retroflection, it is essential to create a relationship of trust in which the patient feels protected from disapproval, humiliation and disappointment. In this kind of relationship, the patient needs to feel his therapist as a "great Environment", capable of providing him with containment and because this Environment does not require containment. An unequivocal sign of an experience of retroflection, that is loose and has arrived at a full contact (surrendering oneself trustingly to the therapist) is the gushing forth of true gratitude in the patient's eyes and lips. As From remarks, the narcissist does not know how to say "thank you"; and Ovid had already spoken of Narcissus as haughty and ungrateful: «*Tam dura superbia*» (Of such stubborn pride) (Ovid, *Metamorphosis*, III, 354).

"Thank you" would mean acknowledging the fact of receiving from the other; therefore, he either does not say it or he says it in excessive way (Salonia, 2011b). The genuine "thank you", in working with narcissists, is the expression and sign that he has managed the experience of contact (finally!).

3.4.4. The Therapist-Narcissistic Patient Relationship

A feature of narcissism is the lack of trust in the relationship and in particular in the helping relationship. Whoever has grown up with the idea of being the best does not know how to ask. He has the feeling inside of having been cheated: he has been asked to carry out tasks beyond his years (looking after the dreams of a parent) and for these tasks he has sacrificed himself. As against other psychic suffering, the feature of narcissism is precisely that of being wounded when asking for therapeutic aid. For these reasons, the real therapeutic issue could be said to be the therapist-patient relationship in working with narcissists.

Another characteristic that distinguishes therapeutic treatment of the narcissistic patient rather differently regards gender identity. Whereas in other psychic suffering gender identity does not bring about significant differences, in the case of narcissism these differences are greatly accentuated, albeit within certain relational styles (e.g. retroflection). It therefore becomes necessary to study carefully the differences between male and female narcissism. Whilst the father's request to his daughter moves in the direction of renunciation of the actual female body in order for her to remain "a little girl" or to "masculinize herself", the relationship between mother and son does not necessarily present this type of request (Conte, 2012).

The gender difference in the therapist-patient pairing also affects the progress of therapy. Whereas, for example, initially, the male narcissist might happen to fall in love with his female therapist, it is highly unlikely that a female narcissist will fall in love with her male therapist (De Risio, 2004): obviously the interactions will be intriguing in different ways.

Returning to the issue regarding therapeutic objectives, one might affirm that the therapeutic relationship with narcissistic patients can progress on two levels of functioning. The basic level is that of elaborating the "We" phobia. If one asks a narcissist: «How is therapy going?" he will answer: "I'm satisfied with myself" or "I'm doing some great work". Perhaps after a few months he might say: "I'm learning a lot from you". The "you" is either non-existent or irrelevant or at any rate in the background. Learning to see the "you" as a figure and being able to say: "We're working well" is a highpoint of arrival in every therapeutic relationship with a narcissist.

And an even more involving level in therapeutic relationships depends on the gender matching of the therapeutic pairing: when the patient falls in love with the therapist. In this interaction, the narcissist's fear of individuation emerges. The therapist's "no" (which cures the Personality-function) enables the narcissist to pass through ("go out is go through") the whole range of feelings of anger, pain, refusal and exclusion. It will teach him how to be loved in a healthy confluence; it will teach the maturational function of not having power over the other and the sense of wholeness in acknowledging the Personality-function boundaries.

In my opinion, these dynamics are behind the conviction, present in many approaches (confirmed by clinical psychology), that two therapeutic ways are necessary for the narcissist, in particular if one is preparing to become a therapist, so as to develop and work on both phobias of belonging and of individuation. It is widely accepted that these two are always linked in some way.

At this point we are ready to talk about the end of therapy.

4. Narcissus Closes Therapy: a Little Sadder Perhaps but “with” Others

When does therapy with (and of) the narcissist finish? Let us try to describe a few changes that are the sign of on-going therapeutic treatment.

At the level of Personality-function:

- change of perception of parent with whom he/she had had the narcissistic alliance, no longer an idealized image but a living body;
- recovery of the body of the despised or ignored parent or rather of the parts of one’s own body connected to the parent’s body;
- reintegration with the bodies of brothers and sisters after learning the sense of fullness provided by the experience of co-centrality (“I” at the centre, but with other people);
- full and serene experience of being in one’s own place in the network of bodies and relationships.

At the level of Id-function:

- restored capacity to feel and inhabit one’s own body;
- acceptance of limits (from excrement to the physical, from tiredness to illness);
- awareness of bodily needs;
- change of viewpoint: he/she will see beyond the image of living bodies and will discover the beauty of deformed but vibrant bodies;
- capacity to have empathy with the bodies of others and their needs.

At the level of contact cycle:

- Capacity to surrender oneself to the contact (“finally”);
- Perception of diversity (otherness, biography) not as an obstacle.
- accepting refusal by the other as respect for otherness that does not deny closeness;
- feeling himself and his own experiences as “unique” but not as the only ones;
- experiencing the difference between the search for greatness (outside the body) and the search for fullness (which follows the feeling of wholeness in one’s body);
- accepting dependence, knowing when to ask without humiliating oneself;
- sharing one’s objections and not withdrawing from confrontation;
- feeling the energy of experiences, which he/she has always tried to avoid: fragility, ordinariness, embarassment at entering into contact with the child-like parts of oneself.

The former narcissist leaves the therapist's studio with a feeling of gratitude. He/she has abandoned the dream-for-two (or "for a few") of which he/she was a prisoner, having become available to build up with others the dream of "the company of men", welcoming and sharing the limits and the grandeur of existence, in gratitude and contrast, in tenderness and humility.

He/she feels sadder, but this sadness is very different from the depression he/she felt at the falling of the curtain and the final rounds of applause (Johnson, 1987). He/she is wiser, more alone but also able to feel the closeness of other "solitary" people, with whom to share the experience of meeting as bodies (and no longer as shadows).

Comment

by Bertram Müller

It is always worthwhile to read articles on Gestalt Therapy by Salonia. Reading his thoughts on narcissistic experiences one can learn a lot about theoretical, diagnostic as well as about methodological issues on this subject. I do agree with Salonia that besides what was developed by Laura and Fritz Perls, Isadore From's lesson, especially on Gestalt Therapy diagnostics, proved to be an unavoidable and decisive point of reference until today. Although I share with Salonia the opinion that in the Western world we probably more than ever live in a narcissistically oriented society, I would not consider this a negative development. However, I would not suggest removing narcissism as a diagnostic category from the list of the next DSM just because this narcissistic typology seems to be a collectively accepted epidemic in our society. Depression is even more common and widespread! The growing number of so called narcissists in our society could even be positively seen as an ephemeral side effect of a general cultural transition from a collectively oriented culture, to a society with more and more self-creative individual ethic norms and personalities, as Rank would see it as "the artistic personalities". A person with a narcissistic experience structure could be seen as artiste manqué*, a person who just doesn't dare to go all the way in empowering him or herself as an individual in its own rights, in order to be reconnected with and welcomed as an individual, self-responsible part of the collective, loved by others.*

I hesitate to follow Salonia's idea that narcissism in our time is a phenomenon of a fatherless society. Not so much within the last 70 years in Europe but within the last 1000 years millions of fathers were killed in wars, leaving children and wives alone. But my disagreement with Salonia's point of view is not

so much linked to his hypothesis on narcissism caused by a fatherless society, but with his biographical, causal approach in diagnostics as such. If you try to account for the assertions of Salonia, his considerations with regard to narcissism based on the theory of the self and the considerations of Isadore From, it is all the more surprising to detect that Salonia doesn't fully make use of the fundamentally new concept of Gestalt Therapy as well as From's contribution to understanding and healing narcissism, but instead falls back into a biographic, causal understanding of a narcissist. I would not use the word "narcissistic orientation" but "narcissistic experience structure" which points out that this specific way of experiencing is not a label or even a stigma of a person but is always made anew in a given moment in the present, of course also somehow connected with experiences of one's past. I wouldn't either use – and I don't remember that Isadore From did – the word "interruption of contact". Isadore From would say there is no such thing as contact. There is intentionality, there is withdrawal, there is a loss of ego-functioning, and there is context. The "danger" in using the word "contact" in a therapeutic context is that it will too easily be seen as a specific notion for a behavior.

A person with a narcissistic experience structure in a given moment cannot, according to From's Gestalt-diagnostic concept, tolerate the experience of confluence with another person in the phase of full contact. Instead he would need to protect himself by experiencing differences (retroflections) between him and the outside, using mental and behavioral mechanisms to stay away from the other person who is experienced as too close and thus too dangerous. I outline this well-known concept in order to point out the extraordinarily practical advantage of this Gestalt-therapeutic definition. In his teaching I. From often made references to clinical and psychoanalytic concepts of the narcissistic phenomenon, not to level but to outline the fundamental differences between Gestalt diagnostics and these traditional concepts when he said: "Isn't it amazing that a child, who experienced a lack of primary confluence, or a child who had to learn at an early age through the sudden loss of the mother to live further without sufficient confluence, or a young adult at the age of 14 and more, whose mother could not let him go to explore his own way, by not supporting him in his individual own will and identity, could develop more or less the same narcissistic structure of experience? How come?" Isadore From would have asked his students. And his answer was like this: it was not the biographical (bad) experience as such that caused this narcissistic structure of experience. It is a reaction formation, it is a creative adjustment to an unpleasant experience of too much closeness with a significant other person which created step by step these specific coping skills including retroflection to keep a distance from significant other people. Therefore, in therapy one has to focus on the experiences in the present and not on a behavior or personal

characteristic like retroflection. This narcissistic typology of experience structures (as Goodman would say) are created always anew in the here and now. They are to be seen as loss of ego-functioning in the here and now as well as creative adjustments in order to prevent a closeness with and dependency on a therapist which is experienced as unpleasant and without escape. This Gestalt-diagnostic focus on the structure of experience and not the content of experience, considers any causal biographic and determination of behaviour as somehow obsolete if not distracting from the present creation of this specific dysfunctional structure of experience. In contrast to this, Salonia postulates three types of narcissists: even if he used the notions as a short form of a specific experience structure this would lead to a confusion in the understanding of retroflection and confluence as notions describing a specific structure of experiencing and not a trait of a personality! This is also in fundamental contrast to what Salonia claims at the beginning of his article, by warning us not to label persons. Salonia even emphasizes this biographic conception of a diagnosis more by introducing speculations on unsolved conflicts between siblings as a specific influence in the development of narcissistic tendencies. Whether this has some truth in it or not, Salonia's thoughts on biographic causes of narcissistic structures of experience in my opinion tend to lead away rather than head towards a consistent Gestalt-therapeutic concept of these narcissistic structures.

Salonia does not mention the ego-function at all and he does not give us an example of how to undo the loss of ego-functioning or the personality- or id-function disturbance in an ongoing therapeutic procedure. He does not show clearly enough how the artful switching of different therapeutic interventions, for example from focusing on the awareness (id-functioning), the identifications (personality-function) and actions of the patient from moment to moment might be co-created. I do not follow G. Salonia when he suggests focusing on the first part of the therapy process with a "narcissistic patient" primarily on the personality-function. It is an interactive dance from moment to moment between the three functions which eventually leads to a decrease in the id and personality function disturbance and at the same time to a reenactment of the ego-functioning.

I think that the gender identity between therapist and patient is in all different diagnostic categories a specific issue which has to be focused on in the therapeutic interaction. For the development of a narcissistic structure of experience Salonia postulates for "male narcissists" a specific, preferred constellation of a "father and little girls". In my experience this is not specific for male narcissists. I also do not share the experience that female narcissists will not fall in love with the male therapists that easily.

All critical remarks aside, my final summary is: Salonia must have pro-

found experience in the treatment of narcissism when he writes "the former narcissist leaves the therapist's studio with a feeling of gratitude". This kind of experience a therapist only has when profound work has been done.

Hysteria: Formal Definition and New Approach to a Phenomenological Understanding. A Psychopathological Reconsideration

by Sergio La Rosa

Hysteria, as a matter of weight in modern psychopathology, poses several challenges.The first is to dispel the myth related to a male chauvinist diagnostic concept, and the second, redefining the concept, is probably equivalent to scientific suicide as it is a complex and hard task.

After a first attempt to define and redefine the concept in order to understand it in its true dimension, it seems that no attempt is sufficient. Our mission will be understanding hysteria as a social phenomenon, as a pathology that is not limited to the feminine universe, or understanding it as a relational manifestation that dates back to the anthropological origins of culture. Part of the mission will also be to shed light on a concept that, by reason of being broadly disseminated and massive, may appear not to contaminate modern relations.

Use and customs, as is frequently stated in any reconceptualization of modern psychiatry, is the limit that defines a behaviour as pathological or not. It seems that we, when in the role of psychopathologists, perceive certain behaviours as more or less pathological, based on their impact on society. As Foucault (2006) very well describes in the *History of Madness*, societies establish what is normal and what is not. This is more visible in the history of hysteria than in any other diagnostic observation. In fact, when we attempt to understand it through the DSM IV classification, it seems to have disappeared in the maelstrom of personality disorders.

Along the course of centuries, hysteria shifted from being a useful defense of natural selection in the evolution process, to a more or less severe anomaly. Indeed, the very word "hysteria" must be used very carefully to avoid falling into the banal concepts used to explain its meaning, which frequently do it in a poor or misleading manner.

In this paper I attemp to approach what in my view are the most relevant aspects of this overused term and its multiple manifestations, to describe possible clinical approaches and to revise its meaning from the Gestalt psychotherapy perspective.

How can we understand the concept of hysteria today, one hundred years after the creation of psychoanalysis, where Freud puts the weight of the theory on two etiologies, Sexual Trauma and Oedipical Signification? Clearly, for general psychiatry today, hysteria is a cluster of symptoms and diverse manifestations that cannot be satisfactorily understood based on a single diagnosis. Indeed, only by dissecting the complexity and understanding the symptom as part of the subject and not as the subject itself can we undertake a phenomenological approach.

Before proceeding to the "dissection" of the concept, let us go back to its origins. It was precisely during the late 18th and early 19th centuries when the notion of *hyster* became part of the psychopathological universe.

In those days "use and custom" would define the expected behaviour for the middle and high classes, the low classes being beyond any observation, relegated to mere survival (Levi-Strauss, 2009). What was understood as "appropriate behaviour" in the sex roles, determined not only the etiquette, but also the appropriate way of expressing emotions.

What is correct and desirable is very well described by Stoker (1993) in his masterpiece *Dracula*. In this novel, the main female characters, Mina and Lucy will be severely punished for expressing their desires, which were only confessed in secret to female friends.

On the other hand are the "prince's wives". They are totally free to express their desires but such desires can only be consummated when authorized by the prince. They have already been punished, in fact, they are dead-in-life.

In this story we are exposed to a key social element in those days. Man was the regulator of the woman's intentionality to make contact and society was the regulator of the intentionality to make contact at large.

This is a vast "field" that defines the general lines of the "what and the how" and is clearly not limited to that historical period.

The Victorian era is very well described in the literature, as well as the problems encountered to express personal desires and the implied consequences. Not only Stoker, but many other authors, such as Bronte (1979) and Balzac (2006) dealt with this matter.

Showing emotions in public was not considered "proper" social behaviour, as Zinker (1979) recalls in his didactic texts.

From our current perspective it is not difficult to understand how Freud (1977) related hysteria to traumatic sexuality.

In Stoker's book, every male emotional manifestation will be as severely punished as female manifestations. Expressions of desire were rated inferior behaviours, and the very prince is a proof of this. Desire and darkness are indivisible. In fact, "poor" Mina's husband will be tempted and then sexually en-

slaved in a form of slavery in which contradictions and guilt create more havoc than the prince's wives.

This was the ideal field and time to develop a more or less convincing theory of hysteria aligned with the Freudian sexual theory. What is the reason then for hysteria to be a specific feature of feminine psychopathology since the origins of psychotherapy? Is it simply because of the social conditioning to simulation that the fathers of psychoanalysis saw in their female patients?

Most of the Freudian school patients those days were women. In a way, they were the first laboratory animals of the psychoanalytic laboratory. Simulation of symptoms was the main source of confusion and speculation for the founding fathers of psychoanalysis. Symptoms of marked repression or inhibition, almost always associated to histories of abuse or ill treatments in a framework of intense psychological conflict without awareness of simulation (currently this is not an absolute criterion) by the patient. For that reason simulation of the symptom may not be considered a pretended expression in the sense of "intentional pretence" (Munchausen syndrome or *sine-materia* disease).

Which root do these symptoms have in our anthropological history? Why is it that a reaction that starts out as a defensive tool in natural selection becomes pathological? Here we can see the other face of creative adjustment, an expression of how decontextualised or extemporaneous "defense" becomes a symptom.

If we observe mating behaviour in the most highly developed species of primates, we will see a large amount of energy used in the exaggeration of sexual qualities to attract the opposite sex: the more exaggeration or simulation, the greater the reproductive success.

Reproductive opportunities of individuals that do not show a grossly exaggerated behaviour are lesser, for which reason they should "learn" to exaggerate natural qualities to preserve their social status and have their own offspring. This behaviour, studied by modern biology, indicates that not only the most beautiful or the strongest have an opportunity, but also those who behave as such.

Individual primates who are non-reproductive, whether due to age or illness, regularly form cooperative groups. The same also applies to females who are devoted to the care of offspring. The leaders of these cooperating groups test the allegedly sick or disabled individuals, and therefore believable simulation or exaggeration acquires vital importance for their survival. It becomes evident then that human beings have "learned" this behaviour in the history of evolution.

Offspring who are not yet of reproductive age are also welcomed into these non-reproductive groups, since they are dependent individuals, "dis-abled" in a strictly functional and utilitarian sense.

By this I mean that the progeny and the females might resort to simulation as a way to avoid being abused by adult males. At first, this adaptative behaviour appears more like creativity at the service of evolution than like a pathological behaviour. In fact, human evolution is a long and continuous process in which extreme behaviours are the only option to counteract the threat of the disappearance of the species.

Speculation led to the search for certain etiological "certainties" in the neurological origin of hysteria.

Psychobiological theories developed in the 1970s describe hysteria as an average expression of neuroticism, with an overtly high level of extroversion in more than 60% of the studied cases (Eysenck, 1970) and concomitant cortical hypoactivation, with a profound lack of vegetative inhibition (Cloniger, 1978).

This may get to the point of inhibition of the dominant hemisphere, with the resulting sedation or misunderstanding of somatic motor signals of an endogenous nature (Henry, 1981). In the 1990s, Vallejo made a contribution to the diagnostic definition of the DSM IV classification: a lesion without a lesional or deficitary pathogenesis, in which simulation symptoms prevail with secondary benefits related to the development of a care-seeking role (demanding care from others).

We see that such "profound lack of vegetative inhibition" or that "somatic motor signals of an endogenous nature" are nothing but an organic expression of the symptom: a body that expresses itself where words are insufficient to define an anxiety that cannot be expressed by words, or an intentionality devoid of confidence in the satisfaction of full contact.

An individual that expresses himself hysterically does so from an additional demand that, because of lack of awareness or an extemporaneous need to relate "to others" using the "simulation" advantages, or because of a "number of repressed or contained desires", forces his body to work in such a way that there is no other way out but making it sick.

What is repressed is in turn potentiated, as the fathers of psychotherapy used to say. But the matter here is how and what somatic consequences this will bring about in time (Polster and Polster, 1993).

Since the body that expresses does not attain its objective in a satisfactory manner in spite of devoting so much energy to what is being expressed, the failed contact attempt that will never be fulfilled becomes the very "core" of hysteria. In fact, full contact is only possible in a genuine expression of intentionality, simulation is an inexorable obstacle.

There is no need to clarify that the accumulation of unsatisfactory contacts is the ideal culture medium for a psychological and relational conflict, and such is the reality of a hysterical "contact" (Salonia, 2000b).

If we tried to understand the constellation of symptoms that hysteria represents from a phenomenological perspective, we should attempt to verify what kind of experience the subject is living in the hysterical expression.

Only going through hysterical experience in all of its phases can we rearticulate the repercussion of the symptom in the modern relational fabric (Spagnuolo Lobb, 2000b). But, what is a hysterical expression, how can it be quantified or proven in the context of clinical practice and diagnosis? We must take into account that simulation, that has powerful and clear secondary benefits, does not exclude the therapeutic space, rather the contrary holds true.

The therapeutic space is an experiential microworld where the relational mechanisms developed in the subject's daily life are put to the test. Previous contacts are assumed as a "capital" that will be available to the Gestalt therapist. In this new therapeutic relation, the "advantage" implied by the "simulation of the subject that expresses himself in a hysterical manner" tells the therapist the way to follow. Gestalt psychotherapy may provide support to cope with the difficulty and the frustration created by incomplete and unsatisfactory contact.

In this respect our current culture is no better than the Victorian times. The fact that simulation is "diluted" in the tide of post-modern culture has made the notion of hysteria disappear from the teaching and practice of modern clinics (Frankl, 1995), merely because simulation and its consequences are currently understood as a cultural, rather than psychopathological response.

The nature of clinical practice in Gestalt therapy provides room for understanding the symptom as a contribution and not as "something" that must be deleted, and it is precisely the hysterical symptom where the Gestalt therapist will initiate the co-creation of a non simulation contact model. Precisely that which is an "advantage" for the relational habits of the subject will be an "advantage" for the therapist to display the frustration stemming from the incomplete experiences of the subject. The use and resignification of the symptom is the first step in the therapeutic co-creation.

1. Discussion

Simulation is an efficient resource in terms of secondary benefits. The simulator attracts solidarity, attention and is even appealing to others, but the price to be paid by the simulator is high. The "others" do not establish contact with him, nor does the simulator with "others", not at least in a satisfactory manner. The contact, almost always failed in terms of completion, takes place with the person the others believe to be establishing contact with, the simulator estab-

lishes contact not being able to be himself. Solidarity, attention or attraction are not directed at him but at the individual the others believe him to be. The paradox is that from the hysterical perspective there is no genuine possibility to express the real intentionality. In the subject's perspective, what is failing in the contact is the "other" that does not understand or value the hysterical subject. It is the "other" and not the subject in question who must change or be changed, even replaced.

In the hysterical paradox, the drive to repeat satisfactory contacts leads the hysterical subjects to repeat the same frustrating or frustrated contact experiences with new "others".

The interlocutors in frustrating experiences change, not so the experiential model. On the contrary, the model becomes reinforced with time and the enhancement of the symptoms, that in the beginning may be pretended but end up acquiring strong and real somatic manifestations.

In hysteria there is a body that suffers through pain or insensibilization, and at the same time a mind striving for repetition.

How can the subject associate the lessons learned from frustrating experiences, not as an experiential growth baggage but as a reminder that «what is not satisfied in the practical or affective aspect must be overcome at any price»? (Ellis, 1962).

A frustrating experience is a fundamental aspect of the self's growth (Spagnuolo Lobb, 2000b). A child that does not stumble does not develop autonomous balance. Discovering that not everything one wants is possible is the most enriching contribution of maturity. Confusing what one wants with what one feels, an aberrating way of overcoming frustration by attempting to overlap the personality function with the id function, will result in an introjective learning with the ultimate goal of pursuing the advantage of avoiding the loss experience. But the non-acceptance of a loss implies dissatisfaction; only experiential contrasts will allow us to experience satisfaction as such. The loss experience enhances the possibility of living to the full. Loss and gain are inexorably linked to the experience that leads to maturity. It could be said that the hysterical experiential assimilation always becomes "lame" as pleasure is inevitably replaced by "enjoyment" in an attempt to avoid the risk of pain or rejection.

It seems – and so it is – that the objective is more important than the relation.

We might think that the subject of hysterical expression is like a child that has managed to persuade others to support him (continuously) to avoid stumbling. This is not a naïve notion, it is the hysterical subject who establishes the relations with others in a naïve manner, sacrificing parts of his own nature, parts of his autonomy, and fundamentally part of his genuine desires. It is the

consequences of simulation sustained in time and not simulation itself what creates the hysterical neuroticism. In fact, if we go back to primates, the individual that survives through simulation achieves the goal of surviving and not being “abused” by the dominating group. But rarely will this individual be able to express the genuine nature of his desires without running the risk of being discovered. Being discovered also implies displaying a desire or intentionality that is impracticable for the subject who is used to simulating, used to disbelieving in the feasibility of a successful contact without simulation. The genuine manifestation of intentionality is a force of erotic nature, whereas simulation bears the paradox of the thanatoic stain.

In the words of a patient of remarkable beauty that I have been treating for some time and has repeatedly changed partners: *“I’m not the problem with men, it is men who do not appreciate that they have to pay a price to have a woman like me. I am not ready to put up with a man who does not make me feel like a queen, I’d rather die”*.

Another example is a handsome and well off young man: *“Why should I suffer?”, “I have everything for not suffering, I do not understand why I should go through this”, “I did everything sufficiently well. Or is there anything I did not do and I did not realize I should have done?”*.

These aspects that make the contact experience so elusive or frustrating will be the aspects to be reinforced for the subject of hysterical expression in every new relational experience. The mere possibility of resigning contacting without advantages is terrifying, or at least unnecessary. Such strong “introjective and sometimes projective resistance” was the reason why many psychotherapy schools in the Sixties and Seventies rated hysteria as incurable, a long lived prejudice in the French school and up to a certain extent in the English school. This also led to “eradicating” the concept from the modern clinical language. “That which cannot be explained or understood, broken down and then classified, does not exist…”. In fact, the mere attempt of redefining such a broad concept entails a great risk, particularly from a phenomenological perspective.

The hysterical disorder is founded on a hysterical personality, which is in turn sustained by a variety of uses and customs that in modern society are deemed appropriate to the extent that they do not let the acting subject fail in his manipulative objectives. In fact, no individual that plays with the advantage of simulation recognizes himself as anxious to the extent that his manipulation is relatively successful.

Only the body will react, and the body is the only ally of the therapist in

trying to lead the subject of hysterical expression to a relative state of "awareness" of frustration within success.

In the same way as simulation is the first neurotic evidence for the therapist, the somatic symptom is the first evidence of suffering for the subject. This means that the inexorable maladjustment in the contact process that stems from manipulative simulation produces physical symptoms. Manipulation is successful but does not create the kind of satisfaction that results from relational contact. There is no possible full contact in the strict sense for a subject that cannot be himself or display the very nature of his own intentionality.

There is no doubt that symptomatic manifestations of hysterical expression are relational by nature. Even some apparently individualistic manifestations, such as anxiety enhanced by real or imaginary financial difficulties, acquire a relational dimension when understood as a loss of the advantage the subject relates to when establishing contact in his own way.

The expressive means needed by the subject to sustain said advantage are not as important as intentionality repeated in time that seeks no other purpose but an "unequivocal and absolute affective approval", a form of approval that does not imply the risk of loss or disqualification: an imaginary, idealized and deeply individualistic approval.

The fact that simulation is an emblematic symptom of the differential diagnosis of hysteria does not make simulation an absolute synonym of hysteria; the same is to be thought of somatoform manifestations that are seldom conversive.

Expected somatic manifestations, which are not conversive in most cases, are rather an admirative exaltation of the individual's body or a need to make it even better; mainly in what is known as non-differentiated somatoform disorder.

It is not only through symptoms that one must understand hysteria, but through the relational intentionality.

We must accept that simulation symptoms acquire a somatic potential that is commensurate with the repetition of non satisfactory experiences. Hysterical behaviour reinforces through repetition and turns into distress as relations fail, having attained a minor objective but neglecting the significance of satisfaction as such.

In the hysterical experience the relation with the other is not important, what is important is that which "must" result from the relation. Based on this

dynamic the subject tends to “affective abstraction”, in which the frustrating aspects of the relation are abolished to give rise to what can be achieved through seduction. Paradoxically, this behaviour seeks the affective support of the “other”.

Lacan (1975) elaborated a hypothesis by which “my desire is the desire of the other”. Of course Lacan ignored the concept of confluence as a form of resistance to contact.

These dynamics seek to avoid loss and frustration, but at the same time bear all that is sought to be avoided. Manipulative experiences are deeply disturbing for the hysterical subject as well, not only for the relation. The immediate future is polarized into the potential risk of loss and the affective dependence on the “other” that permits himself to be manipulated.

These relational symptoms appear rather late, usually preceded by psychosomatic symptoms: hyperventilation, vertigo, sleep disorders, etc. The act of “becoming aware” is severely relegated to a secondary level; becoming aware has a subversive nature in relation to the needs and objectives of the subject. Manifestations such as neuroticism, extroversion, impulsivity or excessive susceptibility are behavioural features adopted by the subject to define himself or by which others define the subject.

The reason why the most controversial term in the history of psychotherapy has become lost in time is the most curious chapter in the history of psychopathology. The fathers of psychoanalysis did not think that a simple concept – which was simple as long as it was not deviated from the sexual theory – would devour itself. They may have had the intuition that hysteria was a universal phenomenon, but for them it was not possible to understand that mass communications would make it part of regular daily life, to the extent of becoming a social pattern, rather than a form of expression of psychological suffering.

The most obvious example is the social trend to perceive popular sports, film or political stars as always happy and successful. The general acceptance of how said idols manipulate reality in order not to lose their condition, plus the social displacement of permanent values to be replaced by surrogate values, lead to the belief that, by reason of being broadly disseminated, hysteria is risk free. The social environment and culture play a determinant role in providing the subject a platform to display hysterical expressions (Ullman and Krasner, 1969; Martin, 1978).

The two groups of symptoms described by DSM IV consist of six dissociative and seven somatomorphic manifestations. They are presented as clusters of symptoms that respond to different emotional stimuli, a notion that can be easi-

ly refuted when one observes that the somatomorphic aura is the first and early response to frustrated contact.

This somatic warning is usually anaesthetized by the subject that reinforces his defensive and "known" mechanisms to try new experiences that he anticipates will be satisfactory. Symptoms repeat themselves or are reinforced, the body is the first to speak, and also the last.

With respect to dissociative amnesia, dissociative fugue and non-specific dissociative disorder, we can cluster these three behaviours as a clear dysfunction of the capacity to assimilate frustration; the experiential baggage of the subject displaying such manifestations has automated the response to avoid pain. This response finds its origin in repeated attempts to deny traumatic ideas and memories that progressively acquire a dissociative nature as a result of sustained repetition.

As for somatomorphic symptoms, both non-differentiated and conversion symptoms, we also find that the somatic response is an explosive way of releasing the relational distress through the only escape valve that is not controlled − at least not fully controlled − by the subject. Dissociation in its most complex states "resists" any emotional expression that challenges the level of reality tolerated by the subject.

This, which appears to be a puzzle, regains its composure if we attempt to see somatomorphic and dissociative symptoms as a persistent detection of frustrated contact.

If we see the symptom as an unavoidable warning of the certainty of reiterated dissatisfaction, we will be able to approach the first step of the subject to the acceptance of the avoided and feared risk. The subject will talk about the symptom, and it is the symptom that will allow him, even from simulation or amplification, to reveal his distress or anxiety, his frustration and intuitive fear of future failures.

Frequent Symptoms

Dissociative Disorders	
Dissociative amnesia	Traumatic memory block out
Dissociative fugue	Amnesic "escapes" from the traumatic space
Dissociative identity disorder	Adaptable personalities
Depersonalization disorder	Insufficient knowledge of the Self

Dissociative possession disorder	Trance, mystic possession
Disorders with dissociative components	Post-traumatic or acute stress Disorder
Somatomorphic Disorders	
Somatization disorder	Prolongued imaginary Symptoms
Undifferentiated somatomorphic disorders	Deficit and sensory Symptoms
Conversion disorders	Pain without origin, pain without pain
Chronic pain disorder	Imaginary symptoms, fear
Hypochondria	Imaginary or enhanced defects
Dismorphic body disorder	Exaltation of the body seeking Approval
Undifferentiated somatomorphic disorder	

The somatic symptom follows a sequence that, even if not mathematical, repeats itself with few variations.

The intention to establish contact stems from excitement loaded with frustrating past experiences of mental or physical abuse at very early ages or from adult age frustrations, from which the dynamics of the simulative manipulation becomes dissociated.

The first somatic manifestations are mild apnea, vertigo and mild tachycardia.

Frustrated contact experiences result in rage, intolerance and sadness – initially in a veiled and superficial manner.

The resulting assimilation tends to reinforce the manipulation mechanisms with an anaesthetic response related to the awareness of the loss and the perception of the frustrated relation.

The cycle starts again, integrating new and more efficient defenses, seeking to increase the efficiency of simulation.

Somatomorphic symptoms tend to be enhanced in each new relational experience.

Repetition cycle

Intentionality to establish contact → Simulative manipulation → Somatomorphic symptoms → Frustrated contact, unfulfillment → Emotional manifestations → Partializing assimilation, amnesia, anaesthesia → Reinitiation of the experiential process →

2. Conclusions

As may appear obvious, the reasons stated by the subject in the therapeutic consultation will be tangential and dissuasive in respect of the expression of the distress. It might be expected that in the subject's discourse the accent is in the description of his own virtues and skills and in the frustration experienced in his relations as "they do not value or share his standards".

From this dynamic organism-environment perspective, the co-creation of the Gestalt clinic starts by giving visibility to the genuine intentionality of the subject and understanding how and where the subject stops being "himself" to prioritize the result of the relation and not the relation itself.

Underestimation of the subject's symptoms might lead the therapist to become part of the subject's repetition and frustration circle, affirming and reinforcing resistance to contact, or reinforcing the neurotizing relational mechanisms that the subject experiences in daily life.

The most valuable tool for the therapeutic co-creation is the joint verification by the therapist and the patient of how satisfactory is the contact resulting from manipulation with simulative features and what are the short term objectives that, once satisfied, blur the relation.

The new contribution will be reproducing a satisfactory contact model in the therapeutic experience, in which simulation becomes unnecessary.

All this is being said of a pathology that is apparently non-existent, imaginary or, in the best of cases extinguished or socially justified.

The resignification of the relational fabric in which hysterical behaviour takes place makes us think of a "hysterogenic" society.

It is almost natural for the notion of hysteria to disappear from modern psychiatric textbooks. It all seems to indicate that the only problem with hysteric principles is that they do not work. For all the rest, the generalized behaviour of engaging in compulsive seduction, exacerbation of extroversion and simulative manipulation will continue to be applauded in the post modern society.

The most significant contribution of Gestalt therapy is to understand the process beyond the symptom or the symptom as an indivisible expression of

the process. In the case of hysteria, more than ever, the therapeutic co-creation consists in revisiting old pathways in which new and fulfilling experiences can be pursued.

Comment

by Valeria Conte

La Rosa's article has the double merit of providing an interesting reconsideration from a gestaltic viewpoint of the hysterical symptomatology seen as "relational manifestation" to the clinician, and of identifying the modalities in which it is present and can be confused with (camouflaged) in the post-modern social background.

Recent literature, above all the psychoanalytic, tells us about the difficulty in defining symptomatological appearances of the hysteric subject; as Maj (2002, p. 10) states: «…what happens in hysteria is also happening in schizophrenia; everyone thinks they have a thorough knowledge of the concept, but then, when it comes to expressing it in operational terms, you realize that you miss it». Other Authors tried to assign this "clinical elusiveness" of hysteria to the fact that it «[…] takes the form of what basically interests those – doctors, psychotherapists, priests – whose attention it requires» (Mattioli and Scalzone, 2002, p. 103).

From a gestaltic point of view, such an impasse has probably been strengthened by the old charge made by Kovel; according to him, Gestalt Therapy encourages the possibility of hysteric manipulation due to its emphasis on emotions or, as the author says «it creates an opening for mystification and hysterical possession» (Kovel, 1991, p. 174).

In his work, La Rosa recognizes the "core of hysteria" in the accumulation of «incomplete and unsatisfactory contacts» due to the hysteric subject's attempt to avoid the risk of pain – or refusal – through simulation. However, referring to researches by Salonia (2012c), fear is the main experience of hysteric distress. Goodman's sentence that «everything is pertinent» (Perls, Hefferline and Goodman, 1994) for the hysteric acquires clinical significance, seeing that the hysteric lives some sort of contagion experience, the environment encroaches on his/her own borders and everything happening outside can latch on to the self. Indeed, it's fear that has not allowed the subject to enter into introjections; he/she remains obsessively yearning for confluence and does not manage to indentify his need and assimilate experience. The hysteric agrees before listening, is at the mercy of feelings. We may say that he/she does not have, but is *the sensation he/she feels.*

A concept that is similar to the simulation symptoms La Rosa talks about, is the "imitative transference" Gaddini (2002) speaks about, that defines a modality of interacting that nullifies "the border" with the therapist, in order to prevent therapy from causing a change. Therefore, the final aim of the therapy is to intervene at the moment of fear (Salonia, 2012c) in order to «create a therapeutic contact experience that can be satisfactory without necessarily reverting to simulation».

In my opinion, the attention that the author gives to the body both as stage of hysterical distress and as «the only ally of the therapist which may try and lead the subject of hysterical expression to a relative state of awareness of frustration within success» needs to be reconsidered as a central aspect of the clinical work in light of the theory of the body in Gestalt Therapy (Salonia, 2008a). Going from the body as a manipulation instrument to the lived-in body is a long therapeutic path, which will provide a new experience of his/her own body and the body of others.

The inability to assimilate experience with its frustrations and the continuous interest in the "advantages" of relation rather than the relation itself – La Rosa discusses this at length – seem to be a clear expression of the inability of the hysterical subject to update his/her personality function. The inability to assimilate experience, disorder of the personality function of the Self, is a most interesting phenomenon that characterizes the particularities of relational manifestations in post-modern society (Salonia and Sichera, 2012a), the impact of historical and social contexts with the onset of specific pathologies may explain the current increase in this diagnosis.

The phenomenological description of hysterical symptomatology offered by La Rosa agrees with this interesting parallelism between society and hysteria[1]*; indeed, the author states that «the resignification of the relational fabric in which hysterical behaviour takes place makes us think of a "hysterogenic" society».*

In his contribution, the author introduces the importance and the necessary challenge to understanding hysteria as a social phenomenon not just bound to the female universe. I would like to finish in the feminine, with an image of Antigone, a woman in Greek mythology, whose seductive strength lies in the fact that she faces with full consciousness the peril of death and in whose womb Sophocles sings the passage «[...] from womb icon of "hysterical" fear to womb icon of welcome to life, any life» (Salonia, 2012d, p. 26).

[1] La Rosa states that it is possible to find hysteria "diluted" in the tide of post-modern culture".

Violent Behaviours

by Dieter Bongers

The following chapter deals with violent and deviant behaviour and ways of changing this violent style. When it comes to a discussion about sexual predators and serial killers, it gets highly emotive and even colleagues ask "do you really want to work with these people?". My position is that working with offenders prevents further victims and often helps the offender themselves.

Because most of the stories don't start with serial killing or running amok, there is a chance of intervention much earlier in a criminal career.

The main institutions which take care of such clients are prisons, asylums and, very famous recently, "correction camps"; some delinquents are treated by psychotherapists.

"When a Patient is obliged to have therapy" was the subtitle, suggested by the editors of this book. This seems to be strange for Gestalt therapists at first sight: can this be a good *Gestalt*? Forced to be the victim of a therapist, even if it is a kind and well-trained Gestalt therapist? When the client is sent to the therapist by court or by another local authority (e.g. the Youth Correction Department or the Probation Service), is it possible to co-create a therapy under such preconditions?

I have done therapeutic work like that for more than 25 years for more then 10 years I was the Therapeutic Director of an institution that treated young offenders and criminals by education, psychotherapy and professional training (*Arbeitserziehungsanstalt* in Switzerland). But still there are some questions for me as to whether imposed therapy really helps people change. Is it ethical? Where do you draw the line?

There are historic examples of how psychiatry and psychotherapy were abused by the state (and how Paul Goodman would say, by the "organized society"). In Germany the Nazis used the psychiatric clinics for their program of euthanasia, for what they called a "mercy killing" of those, who were considered not worth living.

In the 1950's there were trade unionists diagnosed as *querulatorische*

Persönlichkeit (troublemakers, habitual complainers; to look at it as a disease may be typically German) – half way to being seen as psychopaths, because they were fighting against a very strong, successful economic system. Which behavior is to be called deviant is not primarily a question of medicine and psychology; instead this is a political and cultural question.

Highly aware of the danger of merely fulfilling the needs of the state and the organized society, I had the idea to have a critical co-Author to this chapter – always reflecting if what I was about to say would lead to more freedom and autonomy – we will welcome Paul Goodman in this chapter several times.

«A free society can not be the substitution of a "new order" for the old order; it is the extension of spheres of free action until they make up most of the social life» (Paul Goodman, 2010, May Pamphlet, p. 25).

In this chapter, I will deal with Gestalt therapy with clients who do not want to have treatment, at least at the beginning of the therapeutic process.

My point of view is that you can do such a therapy in a Gestalt way, because even in these cases it is all about building up a therapeutic relationship and about dialoging. And that is very much the same as it is with the "normal", self-paying, and interested client.

So I will deal with the issue of "resistance" a lot – the inner and outer forces for not changing anything and with the question how to handle this resistance (and cooperate with the resistance) as a Gestalt therapist.

The second point is to describe what is pathological in the behavior – does the individual suffer? Who suffers in the environment and what circumstances in the field cause the suffering?

As I said before, "deviant behavior" is very much influenced by the social culture and its point of view. So it is a cultural question whether homosexuality is called "queer" or "gay". Until 1992, when the ICD (International Classification of Diseases edited by the World Health Organisation - WHO) with edition 10 took out the diagnosis of homosexuality as a disease, you could be charged and forced to be treated; and in some countries it is still so in 2012.

It is good to keep in mind, that one of the main authors of Gestalt therapy, Paul Goodman, was thrown out of several institutions during the 1950s because he was gay and because he was not willing to hide that. Nelson Mandela was in jail because of alleged terrorism; afterwards he was the president of South Africa.

So we should be careful to ask ourselves: what kind of diagnosis shows up in what kind of field?

The aim of a therapeutic dialogue with any client is for a Gestaltist to help the client become who he is, not become somebody else (Beisser, 1990 Paradoxical Theory of Change). So it is the start of every co-creative therapy to find out who the client is and equally important to convey who the therapist is.

When I used to work with young offenders and addicts I learned to share with them some experiences of my own youth and the tradition in my family to abuse alcohol. The clients need to get to know me personally and parts of my background to establish confidence.

In the beginning of all these therapeutic relationships there is a lot of suspicion – what does this man want to do to me? Is he an agent of those people I disliked all of my life? Is he going to brainwash me?

Pitzing (2009) who works with sexual predators in Germany says that the most important concept in this work is to join the idea of a therapeutic alliance with the need for control by society.

Fiedler (2004) who is famous for his work on personality disorders and sexual deviations says that there has to be a shift away from control and prevention of relapse to orientation on resources and "coaching" of the offenders for a new perspective on life. Originally Fiedler was a behaviour therapist, here he joins the Gestalt perspective.

So more than any other issue the question of being trustworthy for the client emerges.

This is more than an attitude and more than an intellectual concept. In the process of dialogue the client has to feel that you want to meet him or her, that you really want to understand what is going on. To know about the shadow side of life is helpful; understanding what happened is not the same as supporting the act.

The concept of "the Shadow" in C.G. Jung's writings explains that all of us have unconscious parts, parts which we neglect and deny. We rather identify with the socially desirable parts and try to avoid the dark side. Abrams and Zweig (1991) give a broad overview on what we are doing with our shadows.

In Gestalt we have a concept of integration between polarities and an idea of working out from the "middle mode". This means we do not stay with the polarity of good and evil, trying to encourage the client to stay on what we deem to be the better side.

We really believe in: be the one you are – take full responsibility for your life! Integrating the bad part, the aggressive and envious side is risky but worthwhile.

With addicts for example, there is in most cases a part of the personality that wants to quit the addiction and live a better life. If you are able to connect to that part, you can support this point of view. But you also have to stay in touch with the addicted side to understand when and where the drug craving starts and which methods of lying to oneself the addicted person has established.

There is an similar phenomenon when working with sexual offenders and

other clients who seem to be perverted to the public. In their world they have special and sometimes very peculiar desires but often this is very near to their heart and it is not easy at all to deny their lust and desire.

If you just argue from the point of view of political correctness and social desirability, you would not meet the part of the offender that really wants to get a kick out of dominating or hurting other people.

If there is another part, ie. a shy guy who wants to be seen and loved and does not dare to show it (and mostly there is such a part), you have to come into contact with that needy part, and this is mainly an issue of trust. From a Gestalt perspective, we therapists are not guardian angels; instead we are experienced human beings who know that there is no end to integration.

If you really want to do a dialogical therapy, this is very different from "behavior modification" – to really make a change the client has to be aware of his inner conflicts, his desires and the possible ways out of his dilemma. You can teach some strategies of being sober and to stay sober in certain situations, but the addicted person has to decide whether he wants to stay sober and sometimes several times a week (or even several times a day!). It is not very useful to look at this addicted part of the personality only as a resistant part that has to be conquered. The process will be better supported if the client and the therapist know and accept that there is an addicted part.

And the violent offender might decide to stay in the mode of a warrior – at the end of the day he has to take the consequences.

> To me, the chief principle of anarchism is not freedom but autonomy. I am restive about being given orders by external authorities, who don't concretely know the problem or the available means. Mostly, behavior is more graceful, forceful, and discriminating without the intervention of top-down authorities, whether State, collective, democracy, corporate bureaucracy, prison wardens, deans, pre-arranged curricula, of central planning. These may be necessary in certain emergencies, but it is at a cost to vitality. By and large, the use of power to do a job is inefficient in the fairly short run. Extrinsic power inhibits intrinsic function. As Aristotle's said, "Soul is self-moving" (Paul Goodman, 2010, Freedom and Autonomy, p. 58).

If we look at therapy with offenders, we have to consider that there is a lot of violence in the field we live in. Thousands of people are killed in TV films every day – nobody could raise a child in an atmosphere of total harmony. And there is a lot of structural violence in the world, e.g. keeping two thirds of the world population away from the main resources of prosperity. Some hundred millions do not even have clear drinking water – this is violence and sometimes these field conditions raise rage.

Some of the men who committed a gun rampage (*Amoklauf*) felt clearly en-

titled to take revenge for all the injuries that they have had to sustain. F. Leibacher, who killed 14 politicians in Zug, Switzerland, wrote in his suicide note, that this was the day of fury against the local Mafia. In his mind, he was a lonely hero.

Cho Seung Huy killed more then 30 people in an attack at the Virginia Tech in 2007. In a video he recorded he declared that he felt humiliated and that he committed the murder like Jesus Christ for the sake of the future generations who could not help themselves. He really was desperate and isolated. He could not talk to his family or friends any more. This prepared the ground for his criminal act. He thought killing would lead to justice.

Violence has not to be that spectacular, in our daily work there is a lot of violence in the family and in relationships.

During the last several years the issue of "stalking" has become more and more important: There were thousands of stalking events between former intimate relatives or ex-partners and a lot in relation to celebrities. Meloy and Gothard (1995) gave a definition of stalking: «the wilful, malicious and repeated following and harassing of another person that threatens his or her safety» (p. 258).

So what we get in our practice is often a threatened person and somebody who feels rejected and often obsessed. Mostly there is very little interest in the stalker being treated but there is a substantial risk that the stalking turns into real violence (see Rosenfeld, 2004). If we undertake therapy with somebody who is stalking it is important to clarify that there ought not to be any physical and psychological violence, and we have to realize what are the needs and trauma that are driving the offender.

So we have to understand the impulse of an offender who gets into rage and attacks somebody to get an idea of what it is to feel homicidal wrath. I personally think it is not pathological to have some impulses of hitting and even killing when you are in rage. Having mean fantasies about an enemy is not a character disorder. Simon (1997), a famous US Forensic Psychiatrist, puts it like this: bad men do what good man dream!

What you can do as a therapist with a young man (or sometimes a young woman) who has committed violence is to dialogue about self-control and what caused all his hatred. What gets you into the rage? What different modes of handling the rage do you have or are you able to develop? Is there a moment when you are able to take responsibility and step out of the tension in the field? If the offender is aware of what is happening, he or she can make up their mind and decide: stay in, escalate the conflict, try to overcome or step out, leave and surrender. If you are in a blind fury, things are happening to you, but if you aware of some choices, you can feel and act responsibly.

A long time ago the psychoanalyst Karen Horney wrote: «If we try to hurt or kill, it is because we feel threatened, humiliated and misused, it is because we feel rejected and treated unfair; it is because we feel, or it is really like that, that our urgent needs are not fulfilled» (1945, p. 41).

We can sometimes meet with people, who have committed terrible crimes. It is not very useful to speak for example about pacifism to young offenders, I found that it is more fitting to their way of thinking to speak about the ethics of envy and violence.

Is it ethical to envy people who own billions of Euro and can buy everything, including political power? Is it ethical to kill a tyrant, f.e. what Staufenberg tried to do with Hitler? If the offender accepts you as somebody who knows about rage, hatred and greed for money, they would involve themselves more easily in the process.

When I worked with a lot of offenders in the Youth Prison, I often stated my point like this: you can continue to become a criminal! Let us consider this way: if you do more robbing and drug selling, what are your chances of staying out of prison? You are already known to the police; is what you get worth the risk?

How much would you have to pay for the "pleasure" of continuing on the criminal way? In my experience this discussion of pros and cons is much more effective than preaching about a better an more ethical world.

As a therapist you should look for the suffering of your client. Some will tell you that they don't suffer at all, but at least some feel very restricted by being in jail. So helping the client take a broader perspective of his situation might allow him to see the costs and his individual losses, if he continues taking drugs and using violence.

It is often very useful to contact the family of the offender and to have them around in a family setting. The offender himself often says that he does not feel any remorse. This is quite different in the presence of a depressed mother and a crying baby brother, who tell the offender that they are missing him a lot.

In a way this form of therapy is to teach feeling again and to name these feelings.

Eidenbenz (2011) writes about a center in Zürich, Switzerland, where they work with addicts, especially with online addiction. They made a lot of progress working in a family setting whenever the addict himself was not very interested in coming. The identified client therefore got the chance to bring up issues in the family that contributed to his trouble and pain.

Conclusion: if the client is obliged to have therapy it is the task of the therapist to work on a stable therapeutic relationship, the amount of suspicion and resistance might be higher than usual, but the ways of establishing trust are just the same: dialogue and respect for autonomy.

For the therapist it is often a real challenge to find appreciation for ways of looking at the world, which seem strange to him. With racists and sexual offenders this is often a walk on the edge (and sometimes it is impossible for some therapists).

I am sure, not every Gestalt therapist is skilled and willing to work with violent men or women – not everybody is willing to work with strongly depressed clients. Finding out your strengths and weaknesses in your work as a therapist is part of professional training and supervision.

I am confident that with a supportive Gestalt network personal limitations can be clarified. This work is possible for Gestalt therapists and worth while doing.

Working with the offenders, stalkers and others is not only helping them but it is victim protection, too. So, if we succeed in this work, there will be less pain and suffering for the offenders themselves and for their victims. And this is ethical.

1. Case N. 1: Daniel

Daniel was a young man, 24-years-old, very intelligent but socially isolated.

Daniel had not worked for more than a few months in his life and received rent because of a serious psychotic illness when he was 21 years old. He was very interested in psychology and owned a lot of literature by Freud, Jung and Perls.

He did not think of himself as sick, he called it a "difficulty to decide what is good or bad". He did a lot of self aggressive cuts with a knife or a razor blade, especially on his left arm.

In several internet blogs he wrote articles about mankinds miserable treatment of animals, particularly horses and dogs. He criticised a school that trained dogs for the blind for castrating the dogs, just because they then were easier to handle. In his view the castration of horses was a brutal crime.

Because he proposed to have sexual encounters with animals (he said it would be more humane to stimulate male dogs with the hand than to castrate them) he was charged and the authorities took away his dog.

First he fell into a deep depression with ideas of suicide, afterwards he began a stalking campaign against those state employees who signed the court order to take away his dog. His words were: you took away the thing in my life that I loved most – now I will create hell for you and the people you love.

I was engaged to determine if there was any serious danger for the veterinarians and the people in the animal home, where the dog was kept.

ICD 10 classification: "F 65. Disorder of sexual preference":

- G1 The individual experiences recurrent intense sexual urges and fantasies involving unusual objects or activities.
- G2 The individual either acts on the urges or is markedly distressed by them.
- G3 The preference has been present for at least 6 month.
- F65.8 Other disorders of sexual preference: a variety of other patterns of sexual preference and activity, including making obscene telephone calls, rubbing up against people for sexual stimulation in crowded public places, sexual activity with animals, use of strangulation or anoxia for intensifying sexual excitement.
- ICD 10 X78 auto aggressive self-harming with a knife.

If you look at these classifications it is more confusing – these forms of sexual activities differ very much. Yet they have in common what people in many parts of the world would call "perversion".

But let us stop here for a second – there are some strange forms of loving animals – in the literature of the German cavalry at the end of the 19th century it was very common hearing officers say, that they loved their horse much more than their wife.

When we see some elder women carrying their pets in a precious bag very evidently replacing a human partner – is that perversion? Is that a disease?

It is not long ago that being bisexual was classified as a mental disorder – we should be very clear about the fact that a lot of social influences are important when it comes to declare what's perverted and what is not.

I am in no way justifying sex with animals, but I want us to be fair and not prejudiced.

Daniel was suffering in several ways, he lived a very isolated life in a one room flat, with nearly no contact with his family. His peers were companions in the zoophilie scene, who liked to be very provocative. His sexual experiences with women were negligible. He especially disliked «female hysteric animal-rights activists»; when he talked about these women, he was really disgusted. And vice versa they were disgusted by him and his attitudes.

During the day he had uncontrollable emotional mood cycles, especially in the evening and at night.

He had more than 10 deep scars on his left upper arm and he could tell a story of loss and desperation about everyone of them. One of the biggest scars was from the time when his last dog died; he had loved this dog very much. After cutting himself he fainted and later he wore the dog`s collar every day around his neck.

We had some meetings in my office during this whole process and Daniel was suspicious in the beginning. He asked me who was paying me for seeing him and did some research on the internet, on what was published about me. When he found out that I used to work with young criminals he liked that and

told me that now he was convinced that I know a lot about daily madness.

We talked about loving animals and how important it was for him to respect the autonomy of the dogs he used to live with. He had an older girlfriend with whom he communicated mostly by mail. He told her a lot about his family and that he felt not seen and respected by his father.

When talking to me he always wanted to be regarded as a sort of colleague. So he sometimes cited psychological reviews and sections of the Protection of Animals Act.

During the whole process suspicion came and went. Once he asked me how I could handle the conflict of nearness and distance because I was called into the field by the Health-Department who wanted to protect their employees.

I explained that I could well stand the ambiguity to look after the state employees not to be harmed and to try to understand his needs and goals. During our time together he sometimes had some trust in me – sometimes the trust was lost again.

Once he called me at night and was upset – in the forensic psychiatric report about him he had found an e-mail he had once sent to me when he was in a rage. In this e-mail he described being desperate and thinking about suicide and violence against his opponents. In this situation I decided to give the e-mail to the attorney at law and to the psychiatrist, who was responsible for the expert report. I had been worried that some harmful things might happen and that I would have missed an opportunity to prevent this.

Daniel was angry but he listened to me and I told him honestly that I was anxious and I wanted to prevent suicide or manslaughter. He was silent for a second and then his voice changed. He told me that he was able to perceive fine signals and that he had been touched by one of the Doctors who had told him, that he was scared of him. Scaring other people was not part of his self-image, he liked to argue and provoke, but he did not want to be seen as dangerous. After this he was willing to talk with me over the next few days about living without his beloved dog.

So sometimes it might be very little that you can give to your clients, but in a case like this, it is most important to stay in touch and to allow the client to experience a way being cared for that he or she has missed most of his or her life.

Let us hear Paul Goodman to the issue of correcting others:

> I suppose the most sickening aspect of modern highly organized societies is the prisons and insane asylums, vast enclaves of the indigestible, that the rest live vaguely aware of, with low-grade anxiety.
>
> […] But instead, there persists and grows the Godlike assumption of “correcting” and “rehabilitating” the deviant. There is no evidence that we know how; and in both

prisons and asylums it comes to the same thing, trying to beat people into shape, treating the inmates like inferior animals, and finally just keeping the whole mess out of sight.

The only rational motive for confining anyone is to protect ourselves from injury that is likely to be repeated. In insane asylums, more than 90 percent are harmless and need not be confined. And in prisons, what is the point of confining those – I don't know what percent, but it must be fairly large – who have committed one-time crimes, for example, most manslaughters and passional or family crimes, while they pay up or atone? People ought indeed to atone for the harm they have done, to get over their guilt and be "rehabilitated", but this is much more likely to occur by trying to accept them back into the community, rather than isolation and making them desperate. Certainly the old confession on the public square was a better idea. It is doubtful that punishing some deters others. Varying the penalties has no statistical effect on occurrence, but only measures the degree of abstract social disapproval.

[…] There are inveterate lawbreakers and "psychopathic personalities" who cannot be trusted not to commit the same or worse crimes. (I think they will exist with any social institutions whatever). It is unrealistic to expect other people not to panic because of them, and so we feel we have to confine them, instead of lynching them. But our present theory of "correction" in fact leads to 70 percent recidivism, usually for more serious felonies; to a state of war and terrorism between prisoners and guards; and to increasing prison riots. Why not say honestly, "We're locking you up simply because we're afraid of you. It is not necessarily a reflection on you and we're sorry for it. Therefore, in your terms, how can we make your confinement as painless and profitable to you as we can? We will give you as many creature satisfactions as you wish and we can afford, not lock you in cells, let you live in your own style, find and pursue your own work – so long as we are safe from you. A persisting, and perhaps insolible, problem is how you will protect yourselves from one another".

It may be objected, of course, that many sober and hardworking citizens who aren't criminals are never given this much consideration by society. No, they aren't, and that is a pity (Paul Goodman, Little Prayers and Finite Experiences).

I am in contact with Daniel from time to time and ask him how he is doing. He has sent me a lot of articles around zoophilia and what people think about perversion.

Recently he told me that he is ashamed that he got to the same level as his opponents, threatening them and he was very thankful to me, because I did much more than the Health Department had asked of me.

2. Case N. 2: Martin

Martin was 35, a drug addict, HIV positive and homosexual. He told me that he had become infected on a trip to San Francisco in his younger days, when it was not common to use a condom and practice safer sex. He did not commit any brutal crimes but he tried to cheat the insurance companies and was arrested. During this time in prison his older boyfriend died and left him some money. The court sent him to therapy because of the addiction and the HIV infection. At that time the German law was, if you had committed any sort of crime as an addict the court could order treatment of the addiction. The slogan was "Therapy instead of punishment".

I used to work in a small hospital, which was a centre for working with addicts on probation. In the hospital the clients organized their lifes themselves buying food, cooking, cleaning the house and doing work in the garden.

The concept was living in a "Therapeutic Community". Therapy was mainly in groups, very similar to the 12 steps of Narcotics Anonymous and Alcoholics Anonymus. "*The drugs have ruined my life, there has to be surrender, the drug is stronger than I am!*" (see Bongers, 1999; Reinke, 1987).

Martin was very depressed in the beginning, the time in prison was very hard for him, he came from a well respected family and was not a real "junkie" in his opinion. He had a good sense of humour, in the groups we often met each other by making ironic comments about good intentions and we both liked dark humour about diseases and dying. In this institution individual therapy was not usual, the common belief was, change of the addicted identity had to take place in groups. Martin insisted on getting some support in individual sessions and because of his HIV infection, he succeeded and chose me.

ICD 10

F 11.21. Addiction using Opioids (sometimes Cocaine and Alcohol) currently abstinent in a protected environment.

B 20.1. Infectious and parasitic Disease because of HIV.

In therapy he started trusting me and connecting to me more and more. He was a very lonely person with a lot of losses in his life. So he developed the attitude "*Things are always going bad for me, I am a loser!*".

He liked to play around with that attitude and to shock other clients who were full of good intentions. He really liked to talk with me about cheating the insurance companies and how to handle a gold credit card, if you don't have any money at all.

He was very pleased that I did not tell him to be brave. In a way he played around with the idea of dying young and to having some more wild years after

therapy. I think as a gestaltist you have to accept very different ways to be in the world. At that time there was no efficient medicine to treat HIV and it would have been insensitive to tell somebody how to handle a disease which was obviously lethal. Though abstinence from drugs was the common goal in the hospital, I knew Martin would play around with heroin and cocaine after therapy, and I accepted that.

Martin enjoyed having moments of laughter and ease. When he finished therapy he invited me and my wife to a good italian restaurant and he paid with a Gold American Express card. In our professional community you could question if it is correct to go out for dinner with a client and letting him pay, is this too intimate?

In a way I developed a countertransference with Martin, I liked him and I enjoyed (mostly) spending time with him. One part of our work was creating a novel together ("The disastrous end of the life of Martin") in which he would describe the scenes of suffering and desperation he expected or feared, this was relaxing and relieving for him. Sometimes you have to give space for fears, e.g. the fear of death. At the end of our work I suggested that he write an alternative ending for the novel, a happy ending, just to please Hollywood oriented readers who really want a nice ending.

Mainly my work was to accompany Martin in a existential crisis. To have a companion in misfortune, not a healer, was all he wanted from me.

3. Case N. 3, Carina

Carina was a 25 year old woman and a member of a right wing party. She was first accused of violent behaviour and malicious arson, when she was 19. When I met her she was married with two children and tried to run a small business selling books and clothes.

She received her last sentence for violating the law against racism: she had printed books with racist content and linked her personal homepage to homepages of the "Blood and Honour" Group, which is very proud to call themselves "National Socialists". In her youth she had been in prison for six months because she had set fire to a local migrant home.

The court sent her to therapy so she should prove there that she had left the right scene.

In Europe most of the right wing people are men, rarely women have a position in these organisations. But recently more women attack others in public. In relationships the violence is started and sometimes forced by female partners (see Strauss, 2006).

Looking at the experiences of the policemen, who work with minors, they

agree that still most of the troublemakers were male, but the number of violent girls is increasing.

In Switzerland the only prison for females had to be rebuilt recently to improve security. We might see even more female offenders in future.

I was her second therapist, the first one accompanied her for two years and had been very eager to control Carina's steps. Several times he had noticed activities on the internet, which were clues that she still was in contact with the old friends in the right wing scene. Carina wanted very much to quit this therapeutic relationship, she asked her probation officer if she could come to me, because others from the right wing scene had told her I was o.k. and not in the habit of controlling my clients.

When we first met she was fairly open, telling me that she did not need anything from me! The court wanted her to come to therapy for one more year, she had to pay my bills herself, no money from the justice department, no money from health insurance.

So this was the beginning – what should we do together?

In her view the fire raising in her younger years was wrong, it was out of fun and she and her friends had consumed a lot of alcohol that evening. She had then also wanted to show the others in the right wing party that a girl is able to get things done, most of her companions were male and they were "showy and chickenhawks", she said.

Now she was not active in a political field and felt monitored and controlled by the authorities. Her opinion of living in Switzerland was, that it all would be much easier if they would deport about 500.000 foreigners, that's all.

So our meetings were uneasy, Carina was suspicious and not very cooperative, several times she called 15 minutes before the appointment and declared she could not come because of too much work. She was very late paying the bills as well, it took a long time and a rude reminder until she paid.

ICD 10

F 11.10 Harmful use of alcohol, uncomplicated state of withdrawal.

Probable cause (or suspicion) of F 60.2 Dissocial Personality Disorder, there were at least 3 criteria present:

- Gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations.
- Very low tolerance to frustration and a low threshold for discharge of aggression, including violence.
- Marked proneness to blame others, or to offer plausible rationalizations for the behaviour that has brought the individual into conflict with society.

In our therapy sessions I told her that I was not intending to change her. We

could spend some time together and look upon her situation; we were both forced to meet by a local court. So we discussed the financial situation of her business and the situation of a young professional with little children, when you are supposed to work 60 hours a week.

A lot of the time we discussed how things changed once she became a mother. She used to be very independent and now she not only had to look after the kids, she also had to accept her partner paying part of her bills.

When we touched on political themes I told her my position, without being provocative and I sensed Carina being careful and vague. Her experience was that she was in a danger to be trapped, and she did not like that. So I was very open and transparent in my work, we wrote the letter to the court together in a session so she could see there is no hidden agenda.

In my opinion Carina was not a dissocial person, she was very radical in her opinions and full of hatred against some members of society, especially certain foreigners. As a woman she was sometimes overcompensating, she had to appear even braver than the men in her field. But she was able to have compassion for her friends and her children and her dog and she liked to speak honestly.

For me it is a very crucial point – am I able to tolerate racism?

Is it acceptable to have a very nationalistic patriotic attitude?

In Switzerland these organisations on the right wing are legal and without a lot of influence, so it is an issue of freedom of opinion for me. In these times of globalization there is a certain reaction of forced patriotism, mostly the young racists think they have to defend their families, country and neighbourhood. Carina thought she could easily defend herself.

And I could agree that we both together defend the freedom of opinion, even if I very much disagreed with her political theses. This attitude made Carina become familiar with me and brought her a new concept of handling differences.

So the therapeutic goal was not to change her opinions but to establish a good-enough contact to dialogue on our differences. So that she could understand that although I have a different position to her that this could be as well as threatening as enriching for us both.

But to be honest – this was not an easy task.

I like to end this chapter with a last piece of the work of Paul Goodman, he make quite clear that his position is not "that human nature is good". It is important to organize our lives in a way that we don't give away all the power:

> Since, by and large, my experience is roomy enough for me, I do not lust for freedom, and more than I want to "expand consciousness". I might feel differently, however, if I were subjected to literary censorship, like Solzhenitsyn. My usual gripe has been not that I am imprisoned, but that I am in exile or was born on the wrong planet; recent-

ly, that I am bedridden. My real trouble is that the world is impractical for me, and I understand that my stupidity and cowardice make it even less practical than it could be.

To be sure, there are outrages that take me by the throat, like anybody else, and I lust to be free of them. Insults to humanity and the beauty of the world that keep me indignant. An atmosphere of lies, triviality, and vulgarity that suddenly makes me sick. The powers-that-be do not know the meaning of magnanimity, and often they are simply officious and spiteful; as Malatesta used to say, you just try to do your thing and they prevent you, and then you are to blame for the fight that ensues. Worst of all, the earth-destroying actions of power are demented; and as in ancient tragedies and histories we read how arrogant men committed sacrilege and brought down doom on themselves and those associated with them, so I sometimes am superstitiously afraid to belong to the same tribe and walk the same ground as our statesmen.

But no. Men have a right to be crazy, stupid, and arrogant. It's our special thing. Our mistake is to arm anybody with collective power. Anarchy is the only safe polity.

It is a common misconception that anarchist believe that "human nature is good" and so men can be trusted to rule themselves. In fact we tend to take the pessimistic view; people are not be trusted, so prevent the concentrations of power. Men in authority are especially likely to be stupid because they are out of touch with concrete finite experience and instead keep interfering with other people's initiative and making them stupid and anxious. And imagine what being deified like Mao Tse-Tung of Kim II Sung must do to a man's character. Or habitually thinking about the unthinkable, like the masters of the Pentagon.

To me, the chief principle of anarchism is not freedom but autonomy (Paul Goodman, 2010, p. 57).

Comment

by Bernhard Thosold and Beatrix Wimmer

First and foremost we very much appreciate that this important issue of enforced therapy has found entrance in this comprehensive book about Gestalt Therapy's approach to psychopathology. It is not a new finding, but nevertheless striking, that Gestalt therapists are often acting prominently in the field of enforced therapeutic treatment and, at the same time, there is not a lot of literature published about this topic by Gestalt therapists. During our literature research in books as well as international journals of Gestalt Therapy, we were not successful in finding extensive theoretical reflection on that topic.

The large range of topics dealing with enforced therapy that are addressed by Bongers, from stalking to gun rampage, from racism to the big field of addiction, could fill books on its own on each of these issues.

Bongers has to be merited for his effort to make the broad field of enforced therapy known. To our understanding, it becomes evident that this field of therapeutic work is to be recognised and addressed as a specific field of psychotherapeutic work with e.g. children, families or individuals with a psychotic experience. We are reminded of the special conditions of the clients' grounds and environment within the therapeutic situation. At the same time, we have to be aware that approaches and attitudes that are considered common sense in so-called voluntarily chosen therapy are to be questioned whenever an enforced therapy context comes into play.

Even in voluntarily chosen therapy, situations can occur in which enforced arrangements have to be effected: e.g. if the client's life or life of others is threatened. Risk to self or others is the basis for admitting somebody to a psychiatric unit without his/her consent, for example if somebody is in the stage of becoming psychotic or a client with severe anorectic symptoms in denial of his/her life-threatening condition.

At this point, it is important for us to differentiate between different contexts of enforced therapy. Regarding "diagnosis", a distinction can be made between a sexual offender and a person consuming illegal drugs, at least in regard to the amount of danger he/she can cause to him-/herself and/or to the public. Another important difference might be the spectrum of possible settings such as in-patient or out-patient institution, private practice or therapy within prison surroundings, which have an impact on the therapeutic situation.

While Bongers, in his case vignette "Carina", states «we were both *forced to meet by a local court…», it is our opinion that in this case it is only the client who is obliged: Therefore, the obligation is part of the client's ground and not the therapist's ground. There might be, of course, situations where the therapist becomes part of the oppressive system when, for example, practicing therapy within a prison, but even then the therapist does not enforce the therapy upon the client. The therapist simply offers the gift of a therapeutic relationship.*

This aspect is an implicit part in Bongers' text and absolutely goes in line with our own experience. Being successful in the context of enforced therapy depends on the client's and therapist's ability in the co-created situation to find the distinction between enforced context and therapeutic relationship.

Referring to Bongers' question, "Is this ethical?", we want to quote from this book's chapter about ethics by Dan Bloom: «being open to ethics is at the heart of our humanness and therefore is implicit in the practice of psychotherapy» (Bloom, 2011b), meaning that in every therapeutic situation we are called to engage in the topic of ethics, because «ethics […] sustains the therapy process itself, indeed is a condition for it» (Bloom, 2011b).

The therapist is called to take into account that this context is part of the

field/situation of the therapeutic process and as a Gestalt therapist is competent and able to make use of these environmental conditions in co-creating a situation that supports personal growth for both client and therapist.

Referring to Bongers' introduction, being asked if he "really wants to do that work?" we want to answer: The moment we have clarity about the obligation being in the client's ground, is what we want to call "the automatism of justification" no longer necessary. In our view, this work does not need any justification; it is remarkable that treatment of depression seems to be more highly valued than treatment of aggression (Blankertz, 2010), when Bongers comes to describing his work with violent offenders.

Looking at other professions dealing with this clientele, such as members of the legal or medical professions, as well as socio-critically-minded citizens, it is pretty much common sense that deviant behaviour is recognised as a consequence of cognitive and psychological suffering and therefore calls for professional treatment in a supportive relationship. One must, of course, be aware of the limitations of such a treatment.

Our own work in the field of enforced therapy is related to clients with dependencies on legal and illegal substances. This applies to individuals having been sentenced to "therapy instead of imprisonment" or therapy within imprisonment. Given that enforced therapy with clients with addictions is a specialised area itself, this context calls for differentiation emerging from different backgrounds.

Relating to the topic of voluntariness, it is our experience that there are clients who, at the end of the therapeutic process, appreciated having undergone the procedure of obliged therapy. Maybe for the first time in years (or in their lives) they were able to develop a sober view of how they lived their lives before the treatment. The enforced context elongates the period of fore-contact and the establishing of a therapeutic alliance is one of the primary aims for the therapeutic process.

The expression "forced to be victim" seems to be comprehensible, in particular when the bad reputation of enforced therapy is addressed, but what we can see in Bongers' case examples is how much the gift of the therapeutic relationship becomes figural. Reading this chapter, we come to the conclusion that there could be much worse happening to a client than to be "forced to be [Dieter Bongers'] victim" in a therapeutic relationship!

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Authors

Nancy Amendt-Lyon (Austria), Dr. phil., is a psychotherapist, psychologist, trainer and supervisor in private practice in Vienna. She is an experienced Gestalt therapy trainer and has authored numerous publications on Gestalt therapy and gender issues. She is a member of the EAGT, the Austrian Association for Psychotherapy and is Chair of the Austrian Association for Gestalt Therapy (www.oevg-gestalt.at).

Contact: nancy.amendt-lyon@oevg-gestalt.at

Daan van Baalen (Norway), MD, PhD Is a psychotherapist, psychiatrist, pathologist, trainer and supervisor, is rector of Norsk Gestaltinstitutt College,he has been teaching Gestalt therapy since 1976 mainly in the Netherlands, Norway and many other European countries. He has been working as general practitioner, as a researcher on the Erasmus University Rotterdam, the Netherlands and as Gestalt therapist in private practice in Norway and the Netherlands. His main interest has been and is how medicine and Gestalt therapy are compatible. Is member and is and was board member of EAGT and EAP.

Contact: daanbaalen@c2i.net

Talia Bar-Yoseph Levine (Israel/United Kingdom), D. Psych. Jerusalem Gestalt Inst; past head of the MsC in Gestalt psychotherapy, Metanoia Institute UK, registered clinical psychologist. Talia is a business consultant in Israel, Europe, USA and Asia, an international trainer and teaches at Tel Aviv U. Israel. Talia is on the editorial board of the *Gestalt Review* and edited *The Bridge. Dialogue Across Cultures and Gestalt Therapy: Advances in Theory and Practice*.

Contact: t_choice@012.net.il

Stefan Blankertz (Germany), born 1959, is a novelist and social scientist. He got his teeth onto Paul Goodman since 1973 and published translations of

and books about Paul Goodman and Gestalt therapy ever since. His most recent novel deals with Paul the Apostle.
Contact: sblankertz@gmx.de

Martine Bleeker (The Netherlands) studied Developmental Psychology at the Rijksuniversiteit Groningen (1985-1992) and followed the Gestalttraining at the Nederlandse Academie voor Psychotherapie in Amsterdam (2000-2004). She works as Gestalttherapist in her own practice and works as a psychologist in a nursery home in Amersfoort. She supports the carers in their work with demented people.
Contact: www.info@de-ont-dekking.nl, info@de-ont-dekking.nl

Dan Bloom (United States), Doctor of Law, Licensed Clinical Social Worker, is a psychotherapist in private in New York City. He teaches, supervises, gives workshops, and lectures internationally. He was editor-in-chief of *Studies in Gestalt Therapy: Dialogical Bridges* and is an associate editor of the *Gestalt Review*. He was president of AAGT and of the NYIGT, where is a Fellow. His writings are published widely.
Contact: dan@djbloom.com

Dieter Bongers (Switzerland), MD, is a Psychologist, Dr. phil. and Gestaltpsychotherapist. He absolved the training in Gestalt therapy by IGG in Berlin; in Gestalt OE with the Gestalt Institute of Cleveland (GIC); and a training in Couples und Family therapy in the Center for Intimate Studies (Mass). Since 1984 he does Psychotherapy and Consulting and worked several years with addicted people. From 1991-2001 Dr. Bongers worked as the Therapeutic Director of an Institution for Correction with young male offenders. Actually he works in Liestal, Switzerland.
Contact: dieter@bongers.ch

Philip Brownell (United States/Bermuda), MDiv, Psy.D. is a clinical psychologist. He worked on the Intensive Care Unit of a co-occurring disorders treatment hospital and sees numerous cases of addiction in his private practice in Bermuda. He is the author of *Gestalt Therapy for Addictive and Self-Medicating Behaviors*, co-convener of The Research Conference, and editor of the *Handbook for Theory, Research, and Practice in Gestalt Therapy*.
Contact: philbrownell@logic.bm

Willi Butollo (Germany), Prof. Dr. phil., Psychotherapist, Head of Clinical Psychology Department; Univ. Munich, 1973-2012. Trained Behaviour Therapist, Gestalt Therapist (graduated from GTILA and San Diego Gestalt Insti-

tute). Founder of Munich Institute for Traumatherapy 1997 and Institute of Psychotherapy and Supervision, 1982. Author of books on anxiety disorders, post-traumatic stress disorders, therapy research. UNICEF consultant for South-East Europe since 1993.

Contact: kontakt@trauma-ambulanz.com

Nathalie Casabo (France), after 20 years working in Contemporary Art, she studied philosophy and trained in Alcohology and Gestalt-therapy. She uses a Gestalt approach when she leads training workshops, designed for employees of various public administrations in improving reception of disabled people. As alcohologist and Gestalt therapist, she has had a private practice in Lyons, since 2008. She belongs to the European College of Gestalt Therapy.

Contact: nathalie.casabo@wanadoo.fr

Elisabetta Conte (Italy) is a psychoterapist, psychologist, trainer and supervisor. She teaches in the Gestalt Psychotherapy Training Programs of the Istituto di Gestalt HCC. She was for many years the joint coordinator of the Institute's branch in Venice. She works in a private pratice. She has published many papers in the field of psychotherapy and she is part of the editorial board of the journal *Quaderni di Gestalt.*

Contact: betticonte@libero.it

Valeria Conte (Italy), is a psychologist, psychotherapist, Director and Teacher of the GTK Institute and post-graduate school of Gestalt psychotherapy. She works with psychotic patients in a mental health department, examining in depth the work with serious patients (psychotic and schizophrenic) as well as with couples and families as for research and didactics. Member of the Scientific Committee of the international Gtk review.

Contact: valeri.conte@gmail.com

Hans Peter Dreitzel (Germany), MD, is Professor em. of Sociology, FU Berlin, and Gestalt Therapist, Trainer, Supervisor. He is author of many articles and books in both fields (see homepage: Dreitzel Gestalt Therapie), among them: *Gestalt and Process. Clinical Diagnosis in Gestalt Therapy - A Field Guide*, EHP 2010.

Contact: peter.dreitzel@yahoo.de

Ken Evans (United Kingdom), MD, is co-director of the European Centre for Psychotherapeutic Studies (www.eurocps.eu) and Visiting Professor of Psychotherapy, USEE. Since 1994 he has taught research at university validated programmes and training institutes in the UK, Czech, Italy, Norway, Swe-

den and nations of the former Yugoslavia. He is co-author (2009) with Linda Finlay of *Relational Centred Research of Psychotherapists*, Wiley Blackwell.
Contact: ken@eurocps.eu

Gianni Francesetti (Italy), Gestalt therapist, psychiatrist, international trainer and supervisor, program coordinator of the International Training on Gestalt Approach to Psychopathology. President of the EAGT and of the Italian NUO (FIAP, Italian Federation of Psychotherapy Associations), Past President of the SIPG (Società Italiana Psicoterapia Gestalt), member of the EAP, NYIGT, SPR. He has authored many papers and chapters and edited books on Gestalt therapy approach to psychopathology.
Contact: gianni.francesetti@gestalt.it

Ruella Frank (United States), Ph.D., is founder and director of the Center for Somatic Studies, faculty at the NYIGT, and teaches throughout the United States, Europe and Mexico. She authored *Body of Awareness: A Somatic and Developmental Approach to Psychotherapy*, available in four languages, (Gestalt Press, 2001), and co-authored *The First Year and The Rest of Your Life: Movement, Development and Psychotherapeutic Change*, available in three languages (Routledge Press, 2010).
Contact: ruellafrank@gmail.com www.somaticstudies.com

Michela Gecele (Italy), psychiatrist, psychotherapist, she teaches on the Gestalt Psychotherapy Training Programs of the Istituto di Gestalt HCC. She has been working for 19 years in a public mental health service and for three years she has coordinated a psychological and psychiatric service for immigrants. She has authored articles and books in the field of psychiatry, psychotherapy and transcultural matters. She is a member of the HR&SR Committee of the EAGT.
Contact: mgecele@hotmail.com

Leslie Greenberg (Canada), Ph.D, is Distinguished Research Professor Emeritus of Psychology at York University in Toronto, Ontario. He has published extensively on research on the process of change and is recipient of the 2012 American Psychological Association award for Distinguished Professional Contribution to Applied Research. He conducts a private practice for individuals and couples and trains therapsits internationally in Emotion-focused approaches.
Contact: lgrnberg@yorku.ca

Neil Harris (United Kingdom), MA, Bachelor of Medicine and Bachelor of

Surgery degree, Member of the Royal College of Psychiatrists, UKCP Registered Psychotherapist, has been practicing as a Gestalt therapist for 16 years, and as a child and adolescent psychiatrist for 20 years. He has a particular interest in the mental health needs of fostered and adopted children with traumatic early lives. He has a private practice and works with Family Futures Consortium (London) and with the Child and Adolescent Mental Health Service (Guernsey, Channel Islands).

Contact: drneilharris.org or neilph@aol.com

Marta Helliesen (United States), MD, is a sex therapist in private practice in New York City. She approaches sexuality from a comprehensive perspective and has developed unique interdisciplinary treatment modalities for sexual problems based on Gestalt therapy, neurobiological theories, and breath and body awareness. Her work with individuals and couples ranges from gender struggles to intimacy issues to alternative lifestyle.

Contact: marta@mkhelliesen.com

Giuseppe Iaculo (Italy), PhD, is a psychotherapist, trainer and supervisor. He is the author of *Le identità gay. Conversazioni con noti uomini gay ed un saggio introduttivo sul processo di coming out* (2002) and of several articles about social psychology, psychopathology, clinical practice, therapist awareness and psychosomatic. He teaches psychotherapy in several Institutes. He lives in Naples and works in a private practice in other Italian cities.

Contact: giuseppe.iaculo@fastwebnet.it

Elena Křivková (Czech Republic), MD, is a psychotherapist, psychiatrist, trainer and supervisor. She has been working in a psychiatric hospital, mainly with neurotic and addicted patients. Currently she works in a private practice. She is interested in problematic personality disorders, she teaches this topic in several courses. She is a member of EAGT.

Contact: elena.krivkova@gmail.com

Brigitte Lapeyronnie-Robine (France), MD, is a psychiatrist, Gestalt therapist, trainer and supervisor (Institut Français de Gestalt-thérapie). She works currently in private practice. Author of: *La confluence, approche d'un concept de la Gestalt-thérapie*, L'Exprimerie, 1999.

Contact: b.lapeyronnie@wanadoo.fr

Sergio La Rosa (Argentina), BD, is a psychotherapist, psychoanalist, gestaltist, trainer and supervisor. He teaches psychotherapy and psychopathology at postdoc HCC Italy and HCC Kairòs in Italy and another postdoc in Mexico,

Spain, Argentina, Usa and Chile. He has been working in a psychiatric institution in Argentina, mainly with schizophrenic patients. He currently works in a private practice in Italy and Argentina.

Contact: sergiolarosa.gestalt@gmail.com

Nurith Levi (Israel), PhD, is a certified psychotherapist, supervisor, family and Gestalt therapist. Former Dean of Students at the academic College Beit Berl, senior lecturer, the School of Social Work at Ben Gurion and Tel Aviv Universities. Chairperson of the Israeli Association for Gestalt Therapy. Chairperson of training Standards Committee, EAGT. In private practice mainly with families of children and adolescents.

Contact: levi.nurith@gmail.com

Philip Lichtenberg (United States), PhD, is Mary Hale Chase Professor Emeritus at Bryn Mawr College. He was a founding member of The Gestalt Therapy Institute of Philadelphia. He is the author of 6 books and many articles and chapters. He continues to teach at the Institute and to supervise psychotherapists.

Contact: phl.els.lichtenberg@gmail.com

Richard E. Lompa (The Netherlands), MSc is a practicing Gestalt therapist/trainer/supervisor in Amsterdam. As chair of the EAGT ethics committee for nine years, he was influential in the creation and establishment of their Code of Ethics and Complaints and Appeals Procedure. While a member of the ethics committee for the NVAGT, he helped to produce a Code of Ethics with a Complaints and Appeals Procedure for this national Gestalt Association.

Contact: silo@wxs.nl

Irina Lopatuhina (Russia), 50 years, is a Gestalt-therapist of the Moscow Gestalt Institute and the author of the book *The slave of Food*. Therapy specialization: work with the eating disorders. More information here: www.lopatuhina.ru

Dave Mann (United Kingdom), MSc (Psychotherapy), Dip Supervision is a UKCP Registered Gestalt Psychotherapist, Supervisor and Trainer. He is a core trainer on a BSc programme at The Sherwood Psychotherapy Training Institute, Nottingham where he has a busy private practice. Dave is author of *Gestalt Therapy: 100 Key Points & Techniques* (Routledge 2010). He delivers training and supervision nationally and internationally.

Contact: dp.mann@virgin.net

Gonzague Masquelier (France) is a civil engineer and psychologist. He

has been the Director of Ecole Parisienne de Gestalt (EPG) for 20 years. Currently he works in a private practice, as Gestalt therapist, trainer in a dozen countries and supervisor. He also works in Organisations as Gestalt coach and consultant. He is a member of EAP and EAGT.

Contact: gonzague.masquelier@wanadoo.fr

Joseph Melnick (United States), PhD, is a psychologist and organizational consultant who has published extensively and teaches worldwide. He has served on the Faculty and Boards of The Gestalt Institute of Cleveland and the Gestalt International Study Center, where he currently chairs the Cape Cod Training Program. He is the Founding Editor of the *Gestalt Review*, a contemporary Gestalt journal.

Contact: josephmelnick10@gmail.com

Frans Meulmeester (The Netherlands). In 1977, I was invited by a school for nurses and nurse aids to teach psychology on old age. Since then I work in this field of geriatrics, already for more than 35 years as a trainer, consultant and supervisor. I build up my knowledge mainly, by working with the old people myself too. They were my teachers. Beside this work, I also work as Gestalt therapist and trainer and staff member in several Gestalt institutes in Europe.

Contact: info@lifeisaninvitation.nl

Maria Mione (Italy) is a psychotherapist, psychologist, trainer and supervisor. She teaches on the Gestalt Psychotherapy Training Programs of the Istituto di Gestalt HCC. She was for many years the joint coordinator of the Institute's branch in Venice. She works in a private practice. She has published many papers in the field of psychotherapy and she is part of the editorial board of the journal *Quaderni di Gestalt.*

Contact: maria.mione@alice.it

Peter Mortola (United States), PhD, is Professor of Counseling Psychology at Lewis and Clark's Graduate School of Education and Counseling. He is the author of *Windowframes: Learning the art of Gestalt play therapy the Oaklander way* (Gestaltpress, 2006), the culmination of 10 years of inquiry and research on Violet Oaklander's methods of both child therapy and adult training. www.lclark.edu/faculty/pmortola

Contact: pmortola@lclark.edu

Bertram Müller (Germany), Dipl. Psych, clinical therapist, trained in Gestalt Therapy with Isadore From, Laura Perls, Erving and Miriam Polster, Bob

Martin. Founding co-director of the Institute for Gestalt Therapy (JFG Düsseldorf) and founding co-President of the German Association of Gestalt Therapy (DVG), he is a Gestalt Trainer and Supervisor in Germany, Holland, Italy, Serbia, Malta. Artistic Director of Tanzhaus nrw in Düsseldorf, he is the author of several articles on subjects like Diagnostics, Art and Gestalt Therapy, the works of Otto Rank and Isadore From.

Contact: bmueller@tanzhaus-nrw.de

Myriam Muñoz Polit (Mexico), (1948) is a pioneer of the humanistic psychology and Gestalt therapy in Mexico. She holds a PhD in Human Development. In 1985 founded the Humanist Institute of Gestalt Psychotherapy, considered the largest world Gestalt Institute, of which she is currently Rector. In 1997 started *Figura Fondo* magazine. She is the author of many articles and books, passionate about the topic of emotions, dreams, symptoms and love relationships.

Contact: myriam@gestalthumanista.com

Oleg V. Nemirinskiy (Russia), PhD, is a founder (in 2000) and director of Moscow Institute for Gestalt Therapy and Consulting. In 2007-2008 and 2011-2012 he was a president of the Association of Russian Language Gestalt Institutes. He teaches Gestalt therapy in Russia, Belorus and Ukraine and works in private practice. He authored the book *Personal Growth in a Therapy group* (1990) and many articles in different journals.

Contact: migtikon@mail.ru

Peter Philippson (United Kingdom) is a Member of the Gestalt Psychotherapy & Training Institute UK, a founder member of Manchester Gestalt Centre, Full Member of the NYIGT, Senior Trainer for GITA (Institute for Gestalt Therapy, Ljubljana) and Past President of the Association for the Advancement of Gestalt Therapy. Peter is the author of *Self in Relation*, *The Emergent Self* and *Gestalt Therapy: Roots and Branches*, and many other chapters and articles.

Contact: peterphilippson@gmail.com

Jean-Marie Robine (France), psychologist since 1967 and Gestalt-therapist from the mid-70ies. Founder of Institut Français de Gestalt-thérapie in 1980, the first created in France. Past president of EAGT in the 90ies. Founder of journals of GT, author of 7 books translated into several languages. As an international trainer, he teaches GT all over the world. He also authored the first article ever published about shame in GT in 1991.

Contact: jm.robine@me.com

Jan Roubal (Czech Republic), MD, is a psychotherapist, psychiatrist, trainer and supervisor. He teaches psychotherapy and psychiatry at Masaryk University in Brno. He has been working in a psychiatric hospital, mainly with depressive patients. Currently he works in a private practice. He is a member of EAP, EAGT, SPR, chair of the EAGT Research Committee.

Contact: jan.roubal.cz@gmail.com

Giovanni Salonia (Italy), Gestalt Psychotherapist (trained by E. and M. Polster, I. From, J. Zinker). Trained in Client-Centered Therapy, Bodytherapy, Family Therapy. He directs the School of Gestalt Psychotherapy since 1980. University Lecturer (Palermo, Rome). Director GTK International Journal Psychotherapy. Full Member NYIGT. He wrote about: Gestalt Therapy and lived time of the contact, the developmental theory, cultural contexts, psychopathology, personality function.

Contact: salonia.giovanni@gmail.com

Peter Schulthess (Switzerland), MSc, is a psychotherapist practicing in Zurich. He teaches Gestalt therapy mainly in the Swiss Branch of the Institute for Integrative Gestalttherapy Würzburg, but also in several other countries. He has a rich experience in therapy of dependent behaviors. He is a member of various associations, such as EAGT, EAP, SPR, International Federation for Psychotherapy, World Council for Psychotherapy.

Contact: peter@pschulthess.ch

Katerina Siampani (Greece), Msc in Counseling and Psychology, is a Gestalt psychotherapist trainer and supervisor, instructed in Art and Sandplay therapy. She worked for many years in YWCA (Young Women's Christian Association). Last ten years she's been working in Greek Association of Alzheimer's Disease and Related Disorders, with both demented people and their caregivers. At the same time, she works in a private practice. She is a member of EAGT.

Contact: siampk@ccpsychotherapy.eu

Antonio Sichera (Italy) teaches Modern and Contemporary Italian Literature in the University of Catania. Formed at the intersection of Hermeneutics, Lexicography and Gestalt Therapy, he wrote on matters of literary theory, clinical and philosophical as well as on many writers of Italian and European Literature. He teaches Hermeneutics and Epistemology in the School postgraduate specialization in Gestalt Therapy of Institute HCC Kairòs in Ragusa, Rome and Venice.

Contact: asichera@unict.it

Margherita Spagnuolo Lobb (Italy), director (since 1979) of the Istituto di Gestalt HCC Italy, international trainer, full member of NYIGT, past-president and first Honorary Member of EAGT, Honorary President of Italian Association of Gestalt Psychotherapy (SIPG). Editor of the Italian Journal *Quaderni di Gestalt*, her most recent book is *The Now-for-Next in Psychotherapy* (2011). With Gianni Francesetti, she leads an International Training in Gestalt Psychopathology.

Contact: margherita.spagnuolo@gestalt.it

Christine Stevens (United Kingdom), PhD, is a psychotherapist, trainer, supervisor and editor of *The British Gestalt Journal*. Working in private and National Health Service practice she is a faculty member of the Doctorates in Psychotherapy at Metanoia Institute London. She is Programme Leader for MA Pastoral Counselling at St John's College, Nottingham England and supervisor for GITA (Institute for Gestalt Therapy, Ljubljana). She runs a Clinical Training Unit for Psychotherapy in Primary Care.

Contact: therapy@mappmed.co.uk

Bernhard Thosold (Austria), Gestalt therapist, Psychotherapist in private practice in Vienna. Founding member of the Austrian Association for Gestalt Therapy (OEVG). He has 25 years of experience and is specialised in psychotherapy with substance abusers in the field of enforced therapy in organisational contexts as well as in private practice.

Contact: be.tho@utanet.at

Carmen Vázquez Bandín (Spain), PhD, clinical psychologist, psychotherapist, international trainer and supervisor. She is founder and director of the Centro de Terapia y Psicologia (CTP) in Madrid, Spain. She works in a private practice. She is a member of Spanish Association for Gestalt Therapy, EAP, EAGT, NYIGT. She is author of papers and books about Gestalt Therapy. She is founder and co-director of Asociación Cultural Los Libros del CTP, a publishing company about Gestalt Therapy books in Spanish.

Contact: ctpvazquez@correo.cop.es

Ivana Vidakovic (Serbia) is a psychologist, psychotherapist, teacher and supervisor at EAPTI Gestalt Studio Belgrade. She has been working for 13 years in International Aid Network and Center for Rehabilitation of Torture Victims. She is a member of EAP, EAGT, International Trauma Treatment Program, International Society for Traumatic Stress Studies.

Contact: ividakovic@ian.org.rs

Gordon Wheeler (United States), PhD, is author or editor of some dozen books and over 100 articles in the field. His work has emphasized the integration of Gestalt therapy with relational psychology, focusing on self and support, lifespan development, intimacy and shame, gender, community, and coaching, and Systems Constellations. Gordon teaches widely and serves as President of Esalen Institute in Big Sur CA.

Contact: gordonmwheeler@gmail.com

Beatrix Wimmer (Austria), Psychologist, Gestalttherapist, Accredited psychotherapist by the Austrian Ministry of Health, vice president of the Austrian Association for Gestalt Therapy OEVG, member of Ethics Committee of EAGT. The author has 25 years of experience and is specialised in psychotherapy with substance abusers in the field of enforced therapy in organisational contexts as well as in private practice.

Contact: beatrix.wimmer@oevg-gestalt.at

Gary Yontef (United States), PhD, ABPP. Formerly on the UCLA Psychology Department Faculty and Chairman of the Professional Conduct Committee of the Los Angeles County Psychological Association, he is in private practice and consults internationally. He has also worked in psychiatric hospital and clinics. He is a co-founder of the Pacific Gestalt Institute, past president and Faculty Chair of the Gestalt Therapy Institute of Los Angeles. Among his publications: *Awareness, Dialogue and Process*.

Contact: yontef@pacbell.net

Jelena Zeleskov Djoric (Serbia), PhD, is a psychotherapist, psychologist, research fellow, assistant professor and trainer. She teaches psychotherapy at the Institute for Gestalt Therapy Belgrade. She worked at the University. Currently she works at the Institute of Criminological and Sociological Research. Also, she works with patients in a private practice. She is a member of APA and EAGT.

Contact: jelena.zeleskov.djoric@gmail.com

Lee Zevy (United States) Former President and current Fellow of the New York Institute for Gestalt Therapy where she trained and has been working in many capacities since the 70's. As a founder and current clinical Director of Identity House, a 40 year old Walk-In Peer Counseling and Psychotherapy Community Mental Health Center for the LGBTQ Community, politics has always been an integral part of her life. Lee has a private practice in Gestalt therapy and is also certified as Integral Coach.

Contact: lzevy@verizon.net

APA: American Psychological Association
ABPP: American Board of Professional Psychology
EAGT: European Association for Gestalt Therapy
EAP: European Association for Psychotherapy
EAPTI: European Association for Psychotherapy Training Institute
ECP: European Certificate for Psychotherapy
NYIGT: New York Institute for Gestalt Therapy
SPR: Society for Psychotherapy Research
UKCP: United Kingdom Council for Psychotherapy

EAGT

Commento [MRC8]: Lo metterei nella pagina 4 del copy: va bene?

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