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Image on the Cover
Sasha Vinci Trasfigurazioni

Reproducing artworks
by Spazio Forni Young of Ragusa and the artist Sasha Vinci

SPY Spazio FORNI young

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Transfigurations (particular installation SITE#1)

Giovanna Giordano had edited the first online GTK issue with passion, proficiency and determination and got ready to accomplish the currently published English version despite the cancer that struck her.
She passed by dreaming and planning the following issues and the future of GTK, which she considered to be her creation, and it was.
We started this path together and continuing without her means treasuring her inspiration and her smile in our hearts and in every single GTK issue.

The strung up (self-portrait)

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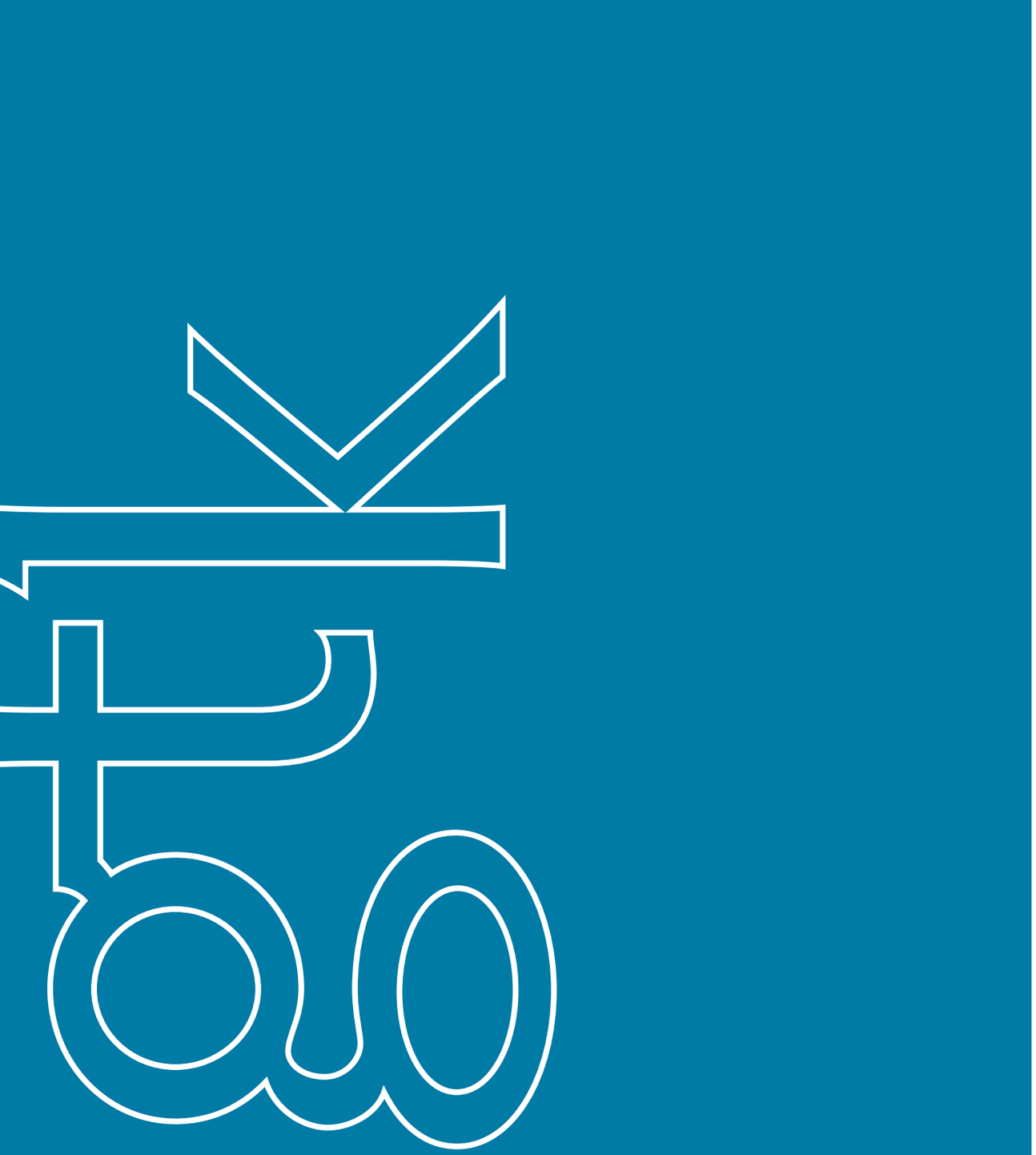


EDITORIAL

A journal as an open space of sharing and research. A journal as an opportunity of dialogue and comparison. A journal as a sign of attention to our time and of hope in a possible change. An online journal to be up to date and to make oneself heard among other significant and important voices that somehow help to debate about suffering and uneasiness. A bilingual journal in order to walk with freedom and deep breath through the world. A Gestalt Therapy journal, because research, dialogue, strain toward history and hope in a world that can be rebuilt belong to the DNA of Gestalt Therapy.

This is, in short, the sense and hope of our small challenge that would like to open a new door to Gestalt Therapy within the web, to its vocations and opportunities. Let us begin as always: with trepidation and maybe some concern, but also with the confidence that this has nothing to do with managing our heritage, but rather with offering an instrument of observation everyone, all of you, no matter if more or less occasional (and hopefully future faithful and passionate) readers are called to give content and development. In short, we would like this journal to be like an agora, a living space handed to therapists, experts, operators, man and women taking their job to heart, the small destiny they are protagonists of, because you cannot yield to banalities and nonsense, you cannot join the queue of said things that often overwhelm and discourage us.

Therefore, main point of our journal will always be research texts of the clinical theory area: articles or interviews that help to point out and open perspectives, in terms of Gestalt Therapy, on the most serious and urgent unease of our times. In this issue, you will find an interview of Valeria Conte regarding borderlines, edited by Rosa Grazia Romano and a long, but very fluent essay of Giovanni Salonia regarding *"The anxiety of acting between excitement and transgression"*; both will be like the appetizers of a style that continually go with our path.

We would like to give much space to poetry and arts: time after time, an artist will 'escort us', with his pictures and his creations, through the exploration of pain as well as through the prevision of a possible human treatment. This is a progress

of our online review, coming along in co-operation with the art Gallery Spazio Forni Young of Ragusa (Spy), which proposes the works of the artist Sasha Vinci for the first issue. We would like to thank him and the gallery. Then poetry: you will find two treasures in this issue. The first one is a memory dedicated to Alda Merini written by Paola Argentino, who had been in short but close relation to Mrs Merini. An inedited lyric, which Alda dedicated to her psychiatrist friend, came out from this relation between the two women and Paola hands it to us like a great gift. In the end, you can be delighted by the poem of the therapeutic relation shown in a text of rare beauty written by a young and promising poet: Giuliana Gambuzza. The usual important reviews (collected in "Readings") and a "frontier" section, dedicated to the new clinic applications (this time dedicated to Onotherapy and Gestalt, written by Francesco Padoan and Silvia Zuddas) complete the work. Or better, they start it. Have a nice trip.

You are here You exist (F.V.)

IN THIS ISSUE

Methodology of Pedagogic Research. She is member of the teaching body of the International Doctorate in Intercultural Pedagogy and Sociology at the same university. She published volumes, articles in volumes and in international journals for the sorts: Franco Angeli, Herder, Armando, La Scuola, Pensa MultiMedia.

Paola Argentino **pag. 77**
Psychiatrist, psychotherapist, she currently is leading responsible of the U.O. Connecting Psychiatrist of the Mental Health Department in Syracuse. Researcher of the Higher Health Institute for the national project of mental health and Alzheimer dementia. She is scientific-didactic coordinator and professor at the Master of II level established in Sicily by the Università Cattolica del Sacro Cuore and professor of the Gestalt Therapy Institute HCC Kairòs.

Giuliana Gambuzza **pag. 81**
Graduated in Philosophy with graduation thesis about Social Ethics, she has been writing verses "since she learned how to hold a pen in her hands".

Francesco Padoan e Silvia Zuddas **pag. 85**
Psychologists–psychotherapists, they both have been working in the clinical field for years. They carry out consulting, education and psychotherapy activities at their office and with private as well as public corporations. They are currently deepening the application of Gestalt Therapy's theoretic principles towards Onotherapy at the CO&SIA centre in the province of Udine.

Aluette Merenda **pag. 97**
Psychologist, psychotherapist, trained in Gestalt Psychotherapy at the Gestalt Institute HCC, University Researcher with the Education Faculty of Palermo University. She is substitute teacher of Developing Psychodynamics and Parental Relations at the Laurea degree courses in Psychology (V.O.), Educator of early childhood and intercultural Educator. She currently performs clinical activity as a teacher, is a member of the Gestalt Psychotherapy Postgraduate School staff of the Gestalt Institute HCC based in Palermo.

Fabio Presti **pag. 101**
Psychologist, psychotherapist, he trained at the Gestalt Institute HCC. He was born and lives in Rome, where he is performing clinical activities. Since the year 2000, he has been concentrating in the field of drug addiction. Currently, he is supervisor and coordinator of harm reduction projects for drug addicted people.

Sasha Vinci
Graduated at the Academy of Art in Florence. He lives and works in Scicli (RG). Arts director of the project "the first trip", realized and presented at the C.A.M. (Archaeological Museum Campus) in Selinunte. In 2008, be published Pass/O+, Arte E Critica (Arts and Critique) n. 56. Drops of art, abitare Magazine n. 1. Catalogue CAM Cantiere 1 "Il primo viaggio" (the first trip).

You are here You exist (F.S.)

THE ANXIETY OF ACTING BETWEEN EXCITEMENT AND TRANSGRESSION

Gestalt Therapy with the phobic-obsessive-compulsive relational styles

Giovanni Salonia

What do you say?
If I hug you really tight,
do I have a better chance
of escaping death?
Franco Marcoaldi[1]

1. Gestalt Therapy and psychopathology

Gestalt Therapy (GT)[2] reads phobias, obsessions and compulsions (POC) as dysfunctional relational styles that reveal several difficulties of the Organism (O.) to get in nourishing[3] contact[4] with the Environment (E.)[5], although it desires and intents it.

Indeed, in the hermeneutic of GT every psychic disorder reveals (and derives from) an interruption of the approaching process of the O. to the E.: an interruption that takes place in different moments of the temporal relational path that leads the O. to carry out contact with the E. Failure in the contact with the E. stops growth and produces symptoms.

Indeed, in the hermeneutic of GT every psychic disorder reveals (and derives from) an interruption of the approaching process of the O. to the E.

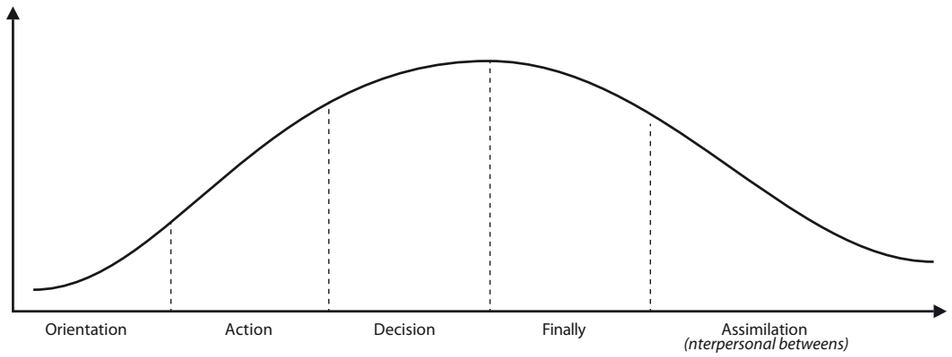
1 F. Marcoaldi (2008), *La potenza dell'abbraccio*, in *Il tempo ormai breve*, Einaudi, Torino, 61.
2 For an introduction to Gestalt Therapy: F. Perls, R. Hefferline, P. Goodman (1994) (or.ed. 1951), *Gestalt Therapy: Excitement and growth in the Human Personality*, The Gestalt Journal Press, New York,; I. Polster, M. Polster (1983) (ed.or. 1973), *Terapia della Gestalt integrata*, Giuffrè, Milano; M. Spagnuolo Lobb (ed.) (2001), *Psicoterapia della Gestalt. Ermeneutica e Clinica*, Franco Angeli, Milano.
3 Cf. G. Salonia (2001), *Tempo e relationship. L'intenzionalità relazionale come orizzonte ermeneutico della Psicoterapia della Gestalt*, in M. Spagnuolo Lobb (ed.), *Psicoterapia della Gestalt. Ermeneutica e clinica*, cit., 65-85.
4 'Nourishing contact' in the language of GT is a valid, functional encounter with the Environment.
5 The E. for GT is alterity in its variety (animate and inanimate).

An example. After having talked to a friend, I know (I become more aware of it when I concentrate)[6] 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 'all' I wanted to say? Did I interact as I wanted to?" If the answers are affirmative, the contact has been full and nourished friendship; if the answers are negative, the contact has been partly or totally disastrous. You talk about relational competence of a person, when he is usually capable of full contacts with the environment.

Another central point of GT psychopathology is given by the analysis of the precise moment where the interruptions happen throughout the course of contact. This goes from the need of the O. to its concrete realization which is the encounter with the E.[7] Such itinerary is articulated in precise stages, according to GT's contact theory: the first is orienting oneself (knowing where you want to go); the second is when energy comes out and the O. moves towards the E.; the third is the moment where the O. quite close to the E. by then, decides to surrender; finally, the encounter (the contact, at last!) happens; in the last phase the O. assimilates and grown due to the happened contact (Tab.1). Such stages – or phases – follow one another epigenetically: in each of the, the O. assimilates the previous one and prepares for the next one.

Another central point of GT psychopathology is given by the analysis of the precise moment where the interruptions happen throughout the course of contact.

Tab. 1



6 Cf., on this, G. Salonia (1986), *La consapevolezza nella teoria e nella pratica della Psicoterapia della Gestalt*, in *Quaderni di Gestalt*, 3, 125-149.

7 G. Salonia (1989), *Tempi e modi di contatto*, in *Quaderni di Gestalt*, 8/9, 55-64.

As you know, arouses each passage from one phase to the other desire and fear. At an evolutionary level, the child learns relational competence if in these passages he receives the specific evolutionary support from the parental figures.

As you know, arouses each passage from one phase to the other desire and fear. At an evolutionary level[8], the child learns relational competence[9] if in these passages he receives the specific evolutionary support from the parental figures. If the parental figure, instead of containing the child's natural anxieties, becomes frightened in his turn, the child will get scared as well with the adult's fear and his anxiety will become distress and terror: he will lose spontaneity in the experience of the O. and, instead of going ahead towards the full contact, will produce a symptom. Hence the symptom, in GT, cross-refers to the interruption of a progress towards the contact and is '*instead of*' the step that the O. has blocked because it was overcome by distresses. It is useful to specify that the interruption of the contact we are speaking about does not have to be read in behavioural terms, but at a level of corporeal and relational experiences. For instance, if two partners are having a telephone conversation and suddenly the line is cut off, there only is a behavioural interruption of contact (it does not concern the contact processes). If, on the other hand, one of the two feels offended and does not explicit it while conversing, but rather continues to talk, slowly and continuously reducing his interest in the interaction, you would talk about an interruption of the relational and corporeal experiences in this case, (even his body shuts himself away) although the verbal interactions continue.

Going back to the evolutionary phase, even support or lack of support in the evolutionary relationship passes through corporeity before passing through contents: the parental introjections ("Don't do this or that!") block the child's spontaneity, not so much because of the content rather than because of the corporeal tensions, the tone of voice, where the parent unconsciously acts on the child's body[10].

8 G. Salonia (1989), *Dal Noi all'Io-Tu: contributo per una teoria evolutiva del contact*, *Quaderni di Gestalt*, 8/9, 45- 53.

9 G. Salonia (1997), *Maturità* in *Dizionario di Scienze dell'Educazione*, Università Pontificia Salesiana, Roma, LAS-LDC-SEI, Roma, 662-665.

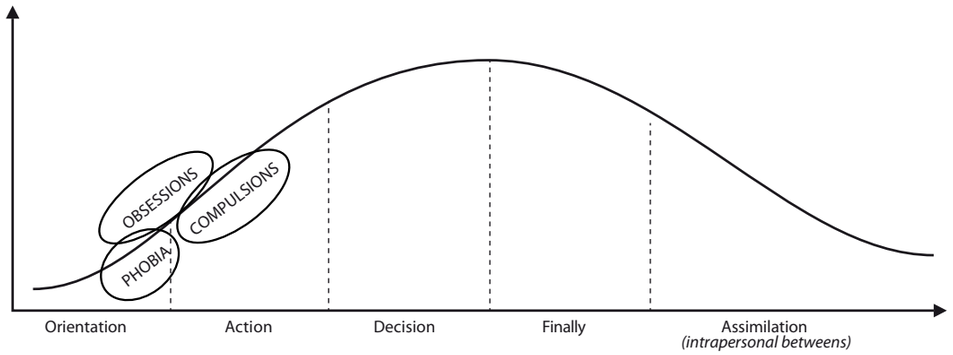
10 On the concept of intercorporeity cf. G. Salonia, *Edipo dopo Freud. Gestalt Therapy e teorie evolutive*, Il Pozzo di Giacobbe, Trapani, printing.

In conclusion, contact interruptions (which, according to the phase they occur in, take different forms of disorder)[11] are learned in the primary relationship, appear in the different relationships that the O. attempts to set up with the E. and could be able to find a solution and care in a therapeutic relationship.

2. What specific interruption for the phobic, obsessive and compulsive relational styles?

In the paradigm of GT – as already suggested – disorders differ according to the different moment in which the O.'s progress towards the fullness of the encounter has been interrupted. *Phobias, obsessions, compulsions* are disorders, which reveal interruptions of the contact[12] cycle in the specific moment (second evolution phase) where the O. begins to feel excitement and energy to move towards the E. (action/manipulation phase)[13] after being oriented towards the new direction. (Tab. 2). Indeed, the increasing excitement (increase of the width of breathing and energy, activation of the body) is a necessary preparation to carry on the intention of reaching the E.

Tab. 2



11 G. Salonia (1989a), *Tempi e modi di contact*, cit.
12 G. Salonia (2010), *L'anxiety come interruption nella Gestalt Therapy*, in L. D. Regazzo (ed.), *Ansia, che fare? Prevenzione, farmacoterapia e psicoterapia*, CLEUP, Padova.
13 Cf. C. Mascarello (2008), *La Psicoterapia della Gestalt con il disturbo ossessivo compulsivo: un caso clinico*, Master's thesis for the Scuola di Specializzazione in Psicoterapia della Gestalt, sede di Venezia. Istituto di Gestalt HCC Kairòs, Venezia.

Mr and Mrs Perls discovered that the arrival of teeth and chewing develops a form of aggressiveness necessary (which, contrary to what is usually asserted, is not anticipation of aggressiveness time, but the discovery of another kind of aggressiveness).

Aggressive energy[14], whose aim is to confront with the E. before encountering it, is developed in two stages with two separate forms: the dentition phase and the anal phase. Mr and Mrs Perls discovered[15] that the arrival of teeth and chewing develops a form of aggressiveness necessary for biting, seizing, deconstructing and assimilating the E.[16] Emphasis on such discovery (which, contrary to what is usually asserted, is not anticipation of aggressiveness time, but the discovery of another kind of aggressiveness)[17] leads to a radical change of the learning paradigm and hence, even of psychotherapy, replacing the 'passive' introjections theorized by Freud with deconstruction and assimilation. A significant moment of this change of relational paradigm is the moment when the baby 'bites the breast': with such gesture, he closes the interactive but calm mode of sucking and introduces, in being-with[18] the mother's body, the novelty of the power of the teeth. There are manifold responses that the mother's body can offer to the first bites at the nipple: she may leave off, bother, punish, smile, return and much more. There is an interesting rite in the Utku tribe, where the mother smiles and pronounces a kind of 'mantra' after the first bites: "He has no brain" (i.e., "he's not doing it on purpose")[19]. It is a delicate moment: the response of

14 Aggressiveness has a positive valency in GT, in that it indicates the strength to fulfill oneself. Cf. G. Salonia, M. Spagnuolo, E. Sichera (2001), *Dal "disagio della civiltà" all'adattamento creativo. Il rapporto individuo/comunità nella Psicoterapia del terzo millennio*, in M. Spagnuolo Lobb (ed.), *Psicoterapia della Gestalt. Ermeneutica e Cinica*, cit., 180-190.
15 F. Perls (1947) (or.ed. 1947/69), *Ego, hunger and aggression. The Gestalt therapy of sensory awakening through spontaneous personal encounter, fantasy and contemplation*, Vintage Books, New York.
16 Ibid.
17 A common thesis in the world of GT; cf., for example, I. From, V. Miller (1997), *Introduzione* to the classic text of della GT: F. Perls, R. Hefferline, P. Goodman, cit.
18 Differently from Stern (D. Stern (1995), *La costellazione materna*, Boringhieri Bollati, Torino) I prefer to speak of patterns not so much of being-with as of being-there-with, to recall the phenomenological tradition.
19 J. L. Briggs (2009), *Autonomia e aggressività nel bambino di tre anni. Il caso degli Utku*, in R. Le Vine, R. New (eds.), *Antropologia*

the mother's body (confirmation, recognition, discredit, punishment, abandonment) will mark the experience of aggressiveness in the child's body[20]. If the new power the baby is expressing receives negative corporeal feedback, it blocks, producing dread, destructiveness or wickedness spectres[21].
The aggressiveness of this phase has a distinctive feature due to the fact that it is connected with hunger and survival; this is why interruptions are so serious and so intense that they are set up as psychotic[22] in some cases.
Subsequently, attention (libido) is developed towards the anal sphincter[23] in the child's body. The child realizes that beyond receiving food from the E. (which he chews and deconstructs in order to assimilate it, or rejects it by spitting it out) he now has an own power: he can 'withhold' or 'let go' pooh from his body. Recognizing this power brings an epistemological change of perception of the self and of the other. The child learns another relational paradigm[24]: in fact, by controlling the anal sphincter (every sphincter is a border between inside and outside), he experiences a power that deals not only with his own body, but also the parental body, which – as the child realizes immediately – is waiting for the products of his decision. The outstanding difference between the two types of aggressiveness, which are developed at different times, also explains the variety of different symptoms and experiences in the different pathologies, depending on the moment when the interruption happen. Interruption in the teething phase (transition from receiving to manipulating) will lead to symptoms of POC

The aggressiveness of this phase has a distinctive feature due to the fact that it is connected with hunger and survival.
Subsequently, attention (libido) is developed towards the anal sphincter in the child's body now has an own power: he can 'withhold' or 'let go'.

e infanzie. Sviluppo, cura, educazione: studi classici e contemporanei, Raffaello Cortina, Milano, 301-319.

20 This is also true for bottle feeding, when the child begins to bite the teat on the bottle and the mother is irritated, tries shaking it to make the baby suck again or 'plays along'.

21 Many primary distresses spoken of in the literature and in infantile 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 containing them.

22 I am grateful to the psychiatrist Dr. Paola Argentino for this clinical clarification.

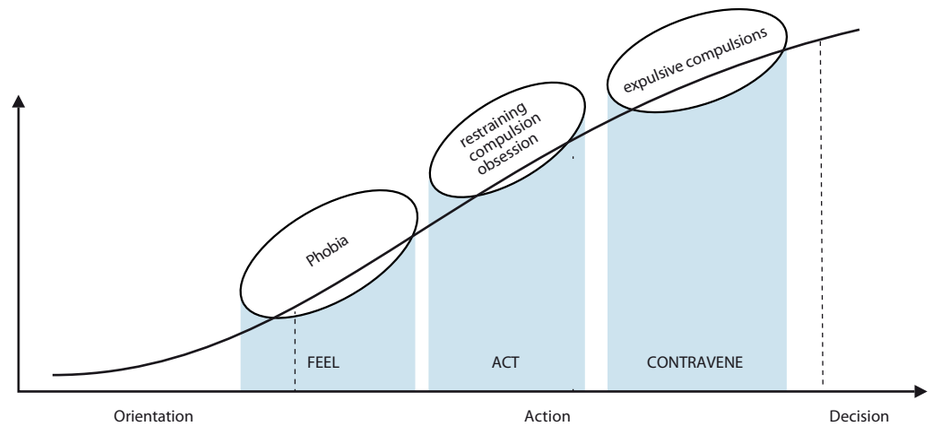
23 S. Freud (1989), *Tre saggi sulla teoria sessuale e altri scritti. 1900-1905*, in *Opere*, vol. IV, Bollati Boringhieri, Torino.

24 G. Salonia, *Edipo dopo Freud*, cit.

Phobias, obsessions and compulsions fall into the same clinical area, because they have in common dread (unsupported fear) as a response in the child's body to the fact that the parental body does not support the appearance of excitement and energy experiences.

disorders; whereas in the anal phase it will produce symptoms on the projective side (attribute the paternity of one's experiences to the E.).
Within this evolutionary picture, phobias, obsessions and compulsions fall into the same clinical area, because they have in common dread (unsupported fear) as a response in the child's body to the fact that the parental body does not support the appearance of excitement and energy experiences. In particular, in the phobic style the blocking of energy comes 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 by experiencing its first sensations, in the compulsive-expulsive style when the experiences of excitement have already been felt, but have been evaluated as destructive by the parental body and so, there is a desperate attempt to expel them. (Tab. 3, enlarged).

Tab. 3



3. Phobic relational style

Phobia is described as unmotivated, intense fear of an object or a space, unrealistically perceived as dangerous. As we will see further on, in effect the subject is not afraid of the object itself (not really afraid that it will harm him), but has a phobia of the sensations that are provokes in him. So phobia fundamentally concerns the distress of feeling certain emotions that the body evaluates as unbearable.

Phobia fundamentally concerns the anxiety of feeling certain emotions that the body evaluates as unbearable.

3.1. Anthropological remark: the anxiety of feeling [25]

The fear of feeling emotions is anthropologically innate in the human heart. Human beings boast of being 'rational animals', almost marking the boundary that ennobles them by separating them from animals with the adjective 'rational'. The fear is that an emotion may disturb the already established balance in the body and in the individual's relationships (does not the etymology of 'emotion' – *ex moveo* – refer to the drive to act?). The fear of sensations and emotions is connected to the fear of the body and to the negative impulses that may emerge from its background.
However, in order for the O. to achieve wholeness and fullness[26] in its development, it must experience and live through all the emotions, with faith in the spontaneity and self-regulation of the body and of the relationship[27].

25 I have introduced each disorder with an anthropological reflection in order to stress the anthropological meaning (which involves every existence) of every disorder and to enrich the ground of the therapeutic.
26 Integrity and fullness are the two fundamental needs of development: the former indicates the sensation of one's own individuality (I have the sense of my uniqueness in the world), the latter refers – Goodman would say – to the boldness necessary to express oneself completely. For a close examination of the concept of fullness, cf. also G. Salonia (2008), *La psicoterapia della Gestalt e il lavoro sul corpo. Per una rilettura del fitness*, in S. Vero, *Il corpo disabitato. Semiologia, fenomenologia e psicopatologia del fitness,* Franco Angeli, Milano.
27 G. Salonia, M. Spagnuolo Lobb, E. Sichera (1997), *Postfazione*, in F. Perls, R. Hefferline, P. Goodman, cit.

At the cultural level too, we have moved on from the philosophy of "understanding" to that of "feeling"[28]. Being-in-the-world is comprised in 'feeling' one's own presence in the world: in other words, feeling is understanding of the E. which directs and guides. Feeling refers back to the body as the place from which a genuine humanization of the human condition begins.
All this is learned first and foremost in the intercorporeity between the parental figure and the child. When the child, in his body which is growing, becomes aware of the tension of feeling, or rather of the intensification of the respiratory rhythm, he is afraid and seeks a body that will welcome him, a body which, by means of containment, will give the child's body the courage that makes it whole. If this happens, the child will learn to have faith in corporeal sensations, in emotions, and will have learned that they lead to relational and personal fullness. If the child's body does not 'find' the adult's (because the adult is absent or frightened), then the normal fear of one's own sensations is transformed – as already described – into terror, and becomes phobia: the breathing that was about to open out is blocked, the muscles are tensed and every gateway to emotional energy is closed. In phobia there is a distortion of perception, so that, in order to avoid feeling certain emotions, this sensation (of which the subject is terrified) is connected to an external object (as we know, it is easier to control the external rather than the internal enemy). Goodman writes: "The neurotic is convinced as by sensory evidence, were the concentrating self feels a gap in experience"[29].

28 L. Feurbach (1994) (ed.or. 1843), *La nuova filosofia si fonda sulla verità dell'amore, sulla verità delle sensazioni*, in *La filosofia dell'avvenire*, Laterza, Bari, 150; cf. also G. Bonaccorso (2006), *Il corpo di Dio. Vita e senso della vita*, Cittadella, Assisi. Knowledge of the world must be replaced with "feeling" the world: cf. M. Merleau Ponty (2003) (ed.or. 1945), *Fenomenologia della percezione*, Bompiani, Milano.
29 F. Perls, R. Hefferline, P. Goodman (1994), cit., 243; cf. also, on perceptive rigidity and correlated corporeal reactions, the text by V. Ruggieri (2002), *L'esperienza estetica. Fondamenti psicofisiologici per un'educazione estetica*, Armando, Rome.

For GT the cipher which, in the last analysis, grasps the intimate essence of the phobic relational style lies in the fact that by avoiding the phobic object the child protects the relationship with the parental figure, because he has had the terrible experience that bringing these sensations to the contact boundary would destabilize what is for her/him the fundamental relationship, in that it would create distress in the adult and make her/him feel anew the terror of being left alone with his fears.

For GT the cipher which, in the last analysis, grasps the intimate essence of the phobic relational style lies in the fact that by avoiding the phobic object the child protects the relationship with the parental figure.

3.2 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, he has a phobia about grasshoppers he is certainly not afraid that he will be devoured), but feels that the sensations that the proximity of grasshoppers provokes in 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 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 excitement of 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 corporeal 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.

The seriousness of the phobic disorder is connected to the partial or total impairment of the relational, professional and social life.

One phobia which is particularly serious is the fear of contagion, it is a more ancient fear than the others we will analyze, in that it is located in the very first phase in which one moves from introjections to energy/action.

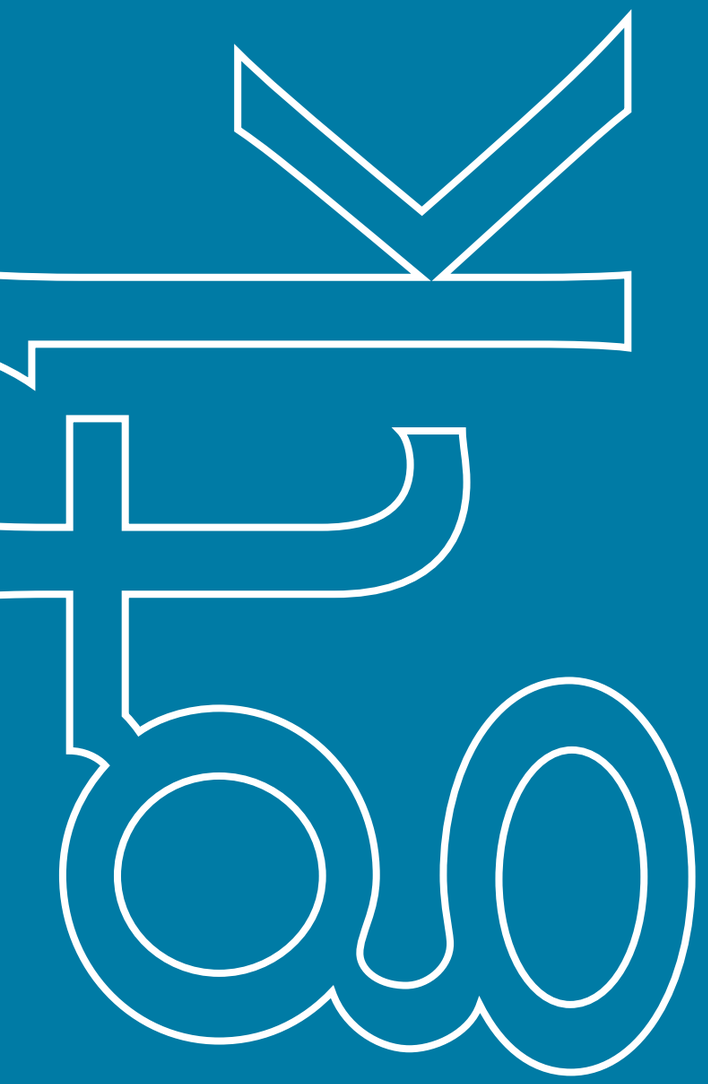
To understand the world of the phobic patient it is necessary to bear in mind that he is contextually attracted and terrorized by the phobic object: the sensations he wants not to feel – by means of phobic avoidance – attract her/him irresistibly, in that they belong to his identity and are a challenge to his fullness and to 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)[30]: phobias of contagion, diffusive invalidating phobias, monothematic phobias and posttraumatic phobias.

One phobia which is particularly serious is the fear of *contagion:* fear that the external object – by which one is terrified – may enter the body, whereas, when the phobia regards an object, the danger seems to be circumscribed and can be kept out, in 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 he feels constrained to avoid any place where 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.

It is a more ancient fear than the others we will analyze, in that it is located in the very first phase in which one moves from introjections to energy/action. This fear is often learned in a primary relationship in which the parental 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.

30 Cf. G. Salonia (2001), *Disagio psichico e risorse relazionali*, in *Quaderni di Gestalt*, 32/33, 13-23.
Theoretical and clinical aspects of serious distrubances (Psychoses) will be dealt with in a future paper.



If the person grows up with the feeling that even his corporeal borders 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 borders of the ego. This is why, 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 his perceptive field, to the point of shutting her/himself up in the house in an increasingly serious regression.

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.

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 he is able to avoid them without particular inconvenience. At the moment when the subject is attracted by a new evolutionary task (at affective or professional level) which will constrain her/him to come to terms with the phobic object, he will take into consideration the concrete possibility of turning to psychotherapy to overcome this limitation.

Monothematic phobias which only block the subject's sense of fullness.

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, he has an unpleasant sensation which takes on valences 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 re-establish the destroyed spontaneity of the O. In *post-traumatic* phobias the fulcrum of the disorder is constituted by questions and doubts that are seeking answers: the O. 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[31].

In post-traumatic phobias the fulcrum of the disorder is constituted by questions and doubts that are seeking answers.

4. Obsessive relational styles

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: action, in fact, is risky because you may make a mistake, you may be hurt, and action makes you personally responsible. Action is, in the last analysis, the place where the uniqueness of the person is expressed in irreversible fashion, becomes visible to the whole world and traces the lines of identity[32].

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.

31 It may happen that a trauma brings to the surface certain problematic aspects of the subject, so that s/he may pass from post-traumatic phobias to phobias of contagion.
32 Reflections on this in L. Saraceno (2007), *La vertigine della libertà. L'angoscia di Soren Kierkegaard*, Giunti, Firenze.

4.1 Anthropological premise: the anxiety of acting

When the child begins to be aware of excitement and of the energy of his body (the respiratory rhythm changes, he feels that he is moving towards action), is afraid of moving yet wants to move, but the parental body that is close to her/him is also afraid, a sensation of imminent danger assails the child. This mechanism of which we have already spoken does not, in reality, derive only from an individual difficulty of the parental figure in 'supporting' the action towards which the child is directed, but has cultural roots. In fact, we come from a social context in which the action is conceived to be dangerous, and hence had to follow thought. It was actually considered a mere consequence of thought: what was important was thinking; acting came afterwards as an emanation from thought. People attributed to thought even the function of preparing action as cautiously as possible. Action was interpreted as the site of many risks: irreversibility (once completed it can be denied, but not wholly cancelled), dangerousness (if you let yourself go without controlling the action you risk making mistakes, hurting), limitation (if I act I define myself and am exposed to judgment: I am the one who did *that* action), responsibility ("Who was it?" is the question the human being fears that he will hear addressed to her/him, so that phrases like "It was me!" or "It was you!" may be charged with dramatic valence and sound almost like a condemnation without appeal.

When Goethe writes in Faust "In the beginning was the action", he intuits the need for a reversal of the paradigm; seeing the action as constitutive of the identity and generating source of thoughts and of identity.

The action may come about without being preceded by thoughts and – despite this, or indeed because of this – may prove to be brilliant and artistic. In action we experience our uniqueness and creativity in full-bodied fashion.

When Goethe writes in *Faust* "In the beginning was the action"[33], he intuits the need for a reversal of the paradigm; seeing the action as constitutive of the identity and generating source of thoughts and of identity. Merleau-Ponty[34] stresses that the action has an original and primal valence as compared with thought. The action may come about without being preceded by thoughts and – despite this, or indeed because of this – may prove to be brilliant and artistic. In action we experience our uniqueness and creativity in full-bodied fashion. The

33 J. W. Goethe (1997) (ed.or. 1831), *Faust*, Mondadori, Milano.
34 M. Merleau-Ponty (1979), *Il corpo vissuto*, F. Fergnani (ed.), Il Saggiatore, Milano.

human being does not have the measure of her/himself only in "I think", but as an intimate element of his identity he includes "I can". The child who for the first time succeeds in taking hold of an object, or walking, is aware of a decisive change in the definition of the self, a definition which need not be preceded by awareness – on the contrary, at times it is only the action that will make us aware of certain experiences and will close incomplete experiences (open Gestalts). We speak – it is as well to specify this – of the action that takes form precisely in the experience of contacting the world and becoming history: a history, Gadamer would say, that is built together and did not exist before being acted.

This action – the right action – generates corporeal experiences and positive thoughts about the self, about others, about the world, about life[35].

The action that takes form precisely in the experience of contacting the world and becoming history generates corporeal experiences and positive thoughts about the self, about others, about the world, about life.

4.2 Clinical level

We start from the awareness that through obsessive thoughts the patient now, dysfunctional and painfully, cares about himself. The excessive control he exercises is due to the excessive lack of care on the part of the parental figures.

Since in the absence of the spontaneous evolutionary control by the parental figures 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 he considers dangerous. For F. Perls obsessive thoughts represent a pacifier[36]: 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 evolutionary 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 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.

Through obsessive thoughts the patient now, dysfunctional and painfully, cares about himself.

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?".

While the body (the corporeal pattern) of the phobic is, as it were, made smaller, the obsessive's body is very tense, since he is constantly, dramatically engaged in the appalling task of controlling the energies 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 O. 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.

The O. is opened or closed with regard to the emotion that attracts or terrifies it, in a suffocating teeter-totter.

Obsessive thoughts are distinguished in *syntonic egos*, when the subject understands the reasons for them, feels that they are his own (he must know whether he has turned off the gas, he must decide whether to mail the letter 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-year-old daughter of a former patient with obsessive relational style: "Mommy", she says furiously, "you

35 Laborit, in his studies on SIA (symptomsi inhibition action), showed that the block of action is at the origin of psychic and relational illness. Cf. H. Laborit (1990), *Elogio della fuga*, Mondadori, Milano.

36 "The dummy allows for 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 it". "There is hardly anything that cannot serve as a dummy, as long as it helps to avoid in reality. Take for instance the obsessional thoughts, which can go on for hours and hours, keeping the patient busy without leading to a decision or conclution": F. Perls (1947), *Ego, hunger and aggression*, cit., 135-136.

have to die, but not immediately – in five minutes". If the child is not supported and does not find a solution, he will be overcome by a distress of death: his own death, but also the deaths 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 is 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.

The background fear is of being separated, of having one's own emotions: becoming unique as the risk of death.

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 he does not carry out that particular action 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.

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.

5.1 Restraining compulsive actions

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.

A ritual gesture is performed in order not to carry out the gesture of contact, perceived as dangerous.

5.1.1 Anthropological level

At the anthropological level a ritual is a socialized gesture which has the task of regulating social relations: in its regularity and predictability, it is a rapid, mild synthesis of the fact that the relationship between the people concerned has remained peaceful and has not been undermined by events or negative thoughts against the other. When, on meeting a person, the ritual is not respected or is modified, the clear message is sent to the other that there is a wish to change (positively or negatively) the relational proxemics (coming closer or withdrawing).
We speak of *ritual* when the person no longer feels free to choose whether or not to carry out a gesture, but feels constrained to perform it in order to lower the level of anxiety. Here too, as in the case of thought, there is a paradoxical harmony: the person is afraid to act because of the risk that the action involves and so, blocking the 'right' action which would lead to contact, the O. invents a ritual action which aims to discharge the tension of not acting. A ritual gesture is performed in order not to carry out the gesture of contact, perceived as dangerous.

5.1.2. Clinical level

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, 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 O. These are idiographic gestures, perceived as obligatory (anancastic 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 *stereotypes* – 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 behaviours characterized by repetitiveness, and are a kind of corporeal discharge of a tension that becomes unbearable at corporeal level. A background element often found in tics is the impossibility of expressing disagreement in the family environment. Although they are perceived as atemporal and aspatial, close attention (microanalysis) reveals that they are connected to a sharp rise of emotional tension in the family climate. In a family session the parents spoke of their son's tics – in his presence! – which they could not understand. It was interesting to note that the tics emerged every time a particular word was repeated, which they used about their son.

A background element often found in tics is the impossibility of expressing disagreement in the family environment.

Tics too have a creative form which tells of the relational tissue in which they emerge. 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 stammerer is afraid. The person feels the drive to express himself, but also powerfully feels the block. From the corporeal point of view, the short circuit of stammering is 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 is 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 stammerer can sing well in a choir or even alone, because in this he is not expressing his uniqueness but returns to a confluence with a 'we' from which he is not differentiated.

In stammering there is terror of expressing a different or aggressive thought towards some family member of whom the stammerer is afraid.

5.2. Compulsive expulsive actions

5.2.1 Anthropological level: the anxiety of transgressing

Whereas in phobia the basic terror is of being overwhelmed by feelings, in obsessive thoughts and in restraining coercions it is of keeping under control the emotions that drive the subject to action, in expulsive coercions the subject has already had a certain experience of emotions in his body but was distressed (in terms of guilt or terror) by the face of the corporeal reactions of the parental figures, and hence tried frenziedly to free himself of guilt with gestures which, since they are ineffective, do not calm her/him and are endlessly repeated. Feeling these emotions (in particular those linked with aggressiveness and with sexuality) has provoked panic reactions, tension and withdrawal in the bodies of the parental figures, so that the child feels an obscure terror as though he had done something terrible 'against' his parents. The basic distress is of being abandoned or punished because he has transgressed against a prohibition. Perls had intuited that the feeling of guilt is linked to the fear of leaving confluence, and inducing guilt feelings is one way of hindering the child's differentiation. Expressions like: "Naughty girl!", "You shouldn't do things like that to your mommy", "You don't love your mommy if you do that", "You shouldn't even think of certain things" communicate to the child's body (starting from the very tone of voice!) the terror of punishment and abandonment as a reaction to a fault he is unaware of. But the drive towards personal uniqueness presses on the subject's body, so that he once again opens up

The basic anxiety is of being abandoned or punished because he has transgressed against a prohibition.

to emotions, to transgressing, and – once more – to attempting to purify himself, in a to-and-fro that provokes exasperation in his body and in the bodies of others.
In order to work clearly with patients who have a compulsive-expulsive style, it is useful to recall the various senses in which guilt may be understood. Neurotic guilt (sense of blameworthiness) arises from the distress of leaving confluence, which is declined as fear of solitude and of uniqueness, as terror of possible retaliations by the abandoned person; in contrast, feeling guilty because of a mistake one has made is healthy and expresses a sense of responsibility (indeed, it must be repeated that this risk must be accepted if we are to grow wholly and fully: human beings may make mistakes, may transgress and cause suffering to others). It is a mark of wholeness, in such cases, to recognize humbly and with dignity the mistake that has been made or the suffering caused.
A patient said that she was unable to resist being unfaithful to her husband and at the same time, was unable to take responsibility for doing so: she told herself that this should not have happened to her and tortured – herself and others – with compulsive expulsive gestures (continually washing underwear) to expel the wish to be unfaithful and the act of unfaithfulness.
It must be borne in mind that even healthy separation produces suffering (the solitude of the one who leaves and the suffering of the one who is left). As Rank[37] intuited, birth is a metaphor of healthy separation: labour for the child being born and for the woman giving birth. He speaks of an anthropological guilt – the debt (in German the word is *Schuld*, which means both guilt and debt) – contracted at the very beginning: every human being is a debtor both towards the person who risked her life to give her/him life, and towards the community in which he grew up. Passing through this healthy guilt is necessary to become unique, artists of our own lives. This anthropological guilt is expiated when we go back to the community no longer in a merged relational model, but handing over to the community our own unique, unrepeatable contribution.

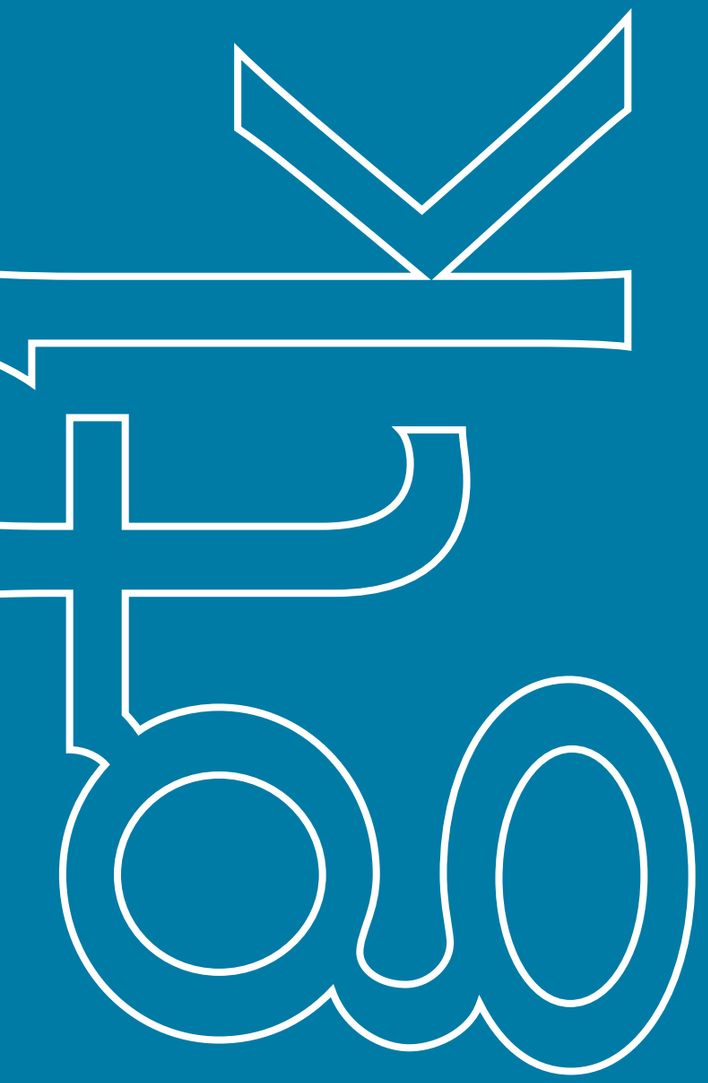
37 O. Rank (1990) (ed.or.) 1924, *Il trauma della nascita*, Sugarco, Milano.

The aim of the compulsive expulsive gesture is the wish to expel from one's body an experience that has become unbearable.

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.

5.2.2 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 distress. 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.
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 corporeal sensation that the body ahs felt with interest but which has provoked a disruption in the bodies of the parents. The subject is afraid he will be punished or abandoned because he has felt excitement and, in order not to be 'thrown out' of the relationship, he begins the vain attempt to 'throw out' of his body the experience and the need. He does so with a gesture which 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 have to 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 he feels at having to deny her/himself of a part of her/himself (stated to be unbearable for the relationship, and hence for his body).



6. The work of therapy with POC 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[38]. 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 evolutionary task. The 'direction in which' the O. is going (the 'where to go' at evolutionary level) is always the guideline of a work of therapy.

What proves very useful (to the patient and to the therapist) is starting with two or three family sessions[39] before personal work, so that both therapist and patient can go into their background against which the POC 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) disorder, 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 POC 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 DP the subject who is suffering from the POC 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

38 Cf. G. Salonia (1987), *Il lavoro Gestaltico con le coppie e le famiglie: il ciclo vitale e l'integrazione delle polarità*, in *Quaderni di Gestalt*, 4, 131-142; G. Salonia (1986), *La Consapevolezza nella teoria e nella pratica della Psicoterapia della Gestalt*, cit.

39 On GT and family therapy, cf. G. Salonia (2009), *Letter to a young Gestalt therapist for a Gestalt therapy approach to family therapy*, in *The British Gestalt Journal*, 18, 2.

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 POC symptom tends to give up the parental function, creating a considerable relational disorder 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 POC 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.

It is said that POC patients put the therapist's patience to the test. In fact phobias, obsessions and 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 POC patient to trust the reassuring words that you say to her/him is like saying "let go of 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 he stays with the patient's torment and gradually becomes visible to the patient (at first, in fact, the therapist is only 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.

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, he is trying to keep under control. In fact, the terror covers experiences that belong to the patient and which he needs in order to feel 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 not to talk about anything but 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 conspirator 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 the nevrotic "has loss contact with the ground of personality and only the symptom is in awareness"[40], 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: he thus passes from the perception of the disorder as an atemporal and aspatial 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 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 realizes 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

40 F. Perls, R. Hefferline, P. Goodman (1994), cit., 334.

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 corporeal relational experience is 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 corporeal patterns: the phobic body is 'contracted' (it welcomes no emotions), the obsessive body is tense, and specifically has the sphincters contracted; the compulsive body is agitated. Work on the body will always be within the awareness of the intercorporeity between the patient's and therapist's bodies.

The phobic body is 'contracted', the obsessive body is tense, the compulsive body is agitated.

Work on the body will always be within the awareness of the intercorporeity 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 his skin as the contact boundary in such a way as to mark the frontier between 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 O. have been mainly invaded. The therapist's task is to help the person to understand what specific emotions he has difficulty in feeling in his skin and not to experience them as infected by the E.
The work of therapy will revolve around two aspects: the definition of the borders 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 attempt 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 his corporeal borders as his own and impassable.

The work of therapy will revolve around two aspects: the definition of the borders of the skin, and the recognition of the feared emotions.

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 excitement and the energy which he is avoiding.

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 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 GT, of making her/him become aware of the corporeal and relational experience that the object evokes. For example, in the case of a patient who has a phobia of mice, he is asked on the one hand to imagine the presence of a mouse and, on the other, to feel what happens in 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 excitement and the energy which 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 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 youngsters (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 O. has difficulty in experiencing. In the last analysis, it is a case of re-establishing in the patient faith in himself through his trusting the therapist.
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, do not express. Often it is precisely in the description of the phobic object ("intrusive, disgusting, and slimy") that the patient expresses the experiences he is afraid of. Working on the phobias allows the O. to feel the emotions that drive it to encounter the other and to experience the spontaneity and fullness of the encounter and of his own world.
Dialog with the phobic object also proves useful (especially in working with monothematic phobias). The story of F. Perls is famous in the history of GT: 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 what 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 search 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 he enters a world of warmth and strength.

Phobia is indeed a closed door, but when one succeeds in opening it 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 to bear in mind certain preconditions already mentioned:

- Obsessive thoughts replace the parental figures and are a way in which the subject, in exaggerated fashion, tries to look after her/himself;
- The excess of control on the part of patients is an attempt to compensate for a serious lack of parental support;
- Obsessive thoughts express the subject's indecisiveness: on the one hand he feels attraction towards certain experiences and on the other is terrified by them;
- The interruption of contact which brings obsessive thoughts happens in the phase in which the O. feels emotions that drive towards action;
- The (active) emotions that drive towards action are basically aggressiveness and sexuality, because they lead the subject to move towards the other;
- The therapeutic intervention must above all facilitate corporeal 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.

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 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 corporeal energy rising, reaching a peak and descending. Perls states: "If a person suppressed aggression as in cases of obsessional 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 wool, or any kind of aggressive sport, such us football, will sometimes work wonders"[41]. 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 corporeal 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[42] – is a way of supporting 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, and 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 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 *impossible* certainties: "Can you guarantee that … the roof won't fall down, I won't get sick, it's not my fault, and 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 he is not even sure that he will be able to complete the sentence he has begun?

41 F. Perls (1947), *Ego, hunger and aggression,* cit., 116.
42 V. Janov (1970), *The primal Screem*, Delta Book, Dell Pubblishing Co., New York.

From the certainty of a parental relationship that one learns to tolerate the inevitable uncertainties of life.

How, then, should 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 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 behaviours 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 his trust in the therapist. 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 hail be unable to control them. The compulsive action does not express the spontaneity of the O., 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 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 tone 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 GT works not on behaviours but on relational experiences.

The difference in the meaning of these two gestures, which seem to be the same, recalls the principle that GT works not on behaviours but on relational experiences.

Every time she goes into the house, Giulia has to go out again to go check whether by chance she has knocked someone down while driving without realizing it. In certain periods this gesture becomes a nightmare that ruins her day. When I ask her why ever she would not have noticed if she had had an accident, she answers that her fear has to do with knocking someone down with the back of the automobile. Talking about the anger she has always had difficulty in expressing, she tells me that once, when she was fifteen, on a Sunday she went into a room where many family members and various relatives were gathered and one of them had made a remark in a loud voice about her build (at the time she was very solidly built) and in particular about the size of her backside. I ask her how she felt and she immediately replies: "It was a relation who was very fond of me". When I comment on her answer her anger, great anger, slowly emerges. And with it, great isolation: no one defended her and supported her anger. It becomes clear that there was no support for her anger because she had learned that it would have destroyed the bonds among her relatives. She remarks: "It wasn't the first time".

When I draw her attention to the strange similarity between her relative's comment on her 'backside' and her phobia of knocking someone down with the 'backside' of the automobile, a ringing laugh tells us that now, after understanding the wisdom of her organism, she can be freed of that tension and can give her body the spontaneity of expressing itself even by kicking in the backside… anyone who fails to respect her. Regarding her fear, I cannot say to her: "You won't knock anyone down" (who could tell?). I'll say rather: "I'll teach you to have faith in yourself when you're driving".

In this answer another element of compulsion is included: the fact that it happens precisely when Giulia expresses herself by becoming a driver, expressing her uniqueness which, however, she has not learned to trust.

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 he assimilate it? 'Who' does he become after experiencing this emotion?

In expulsive compulsions the work of therapy is devoted in prevalence to the personality-function of the self.

In expulsive obsessions the patient feels 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 his distress 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 will 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 corporeal 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 he feels (name and meaning of the emotion); how the emotion is perceived by his O. (pleasant or unpleasant, interesting or uninteresting) and finally how he evaluates the experience and on the basis of what criterion. The interruption happened when the O. received from the E. a decidedly negative evaluation of the experience in question ("How could you say that? 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 corporeal correlative (what part of the body feels tense when he feels guilty) and the cognitive pattern of feeling guilty (what model of being-there-with he has learnt).

Hence the therapeutic intervention will 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 corporeal and cognitive evaluation of those emotions.

The interruption happened when the O. received from the E. a decidedly negative evaluation of the experience in question.

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 evolutionary 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 distress of separating her/himself in gratitude but also in pain, discovering an unexplored faith in himself and in the person being left.

7. Towards the fullness of uniqueness and of the encounter

We have seen how POCs are disorders that arise precisely at the moment when the O. is preparing to become unique in feeling the energetic excitation of the emotions. Otto Rank[43] 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). In POC relational styles both phobias seem to be present: becoming unique in corporeal excitement 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…
Grossman[44], in a short, moving story, with a writers' intuition grasps the intimate connection and the reciprocal conditioning between uniqueness and belonging.
Ben and his mom are going for a walk, towards evening. His mommy looks at him and says: "You're such a sweetie, there's no one like you in the world!". He is upset: "I don't want there to be only one person in the world like me!". His mom tries to explain that everyone is unique and that this is a good thing, but the child is still unhappy: "So there's only one of each person in the world?". She nods her head yes. "So everybody's alone?" – He insists. "Don't you feel lonesome… on your own?". His mother confirms the solitude of every person, and hugs him. She holds him tight and feels his heart beating strongly just as he feels her heart. His mommy gives him a big warm hug. "Now I'm not alone", thinks Ben. "Now I'm not alone". And so his mother explains that that was why hugs were invented: to unite solitudes.
It may be added, thinking about POC patients, that only someone who is (has been) given a big warm hug can feel and handle his own uniqueness! And he can hug the other… because he is not afraid of dying or of living.

The patients, 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…

Only someone who is (has been) given a big warm hug can feel and handle his own uniqueness! And he can hug the other… because he is not afraid of dying or of living.

43 Cf. the stimulating presentation of the theories of O. Rank in E. Becker (1982) (ed.or.) 1973, *Il rifiuto della morte*, Paoline, Roma.
44 D. Grossman (2010), *L'abbraccio*, in *Ruti vuole dormire e altri racconti*, Mondadori, Milano, 17-30.

Abstract

The Author introduces a systematic reading of the phobic, obsessive and compulsive disorders in the perspective of Gestalt Therapy. The suggested hermeneutic reveals an original and enlightening re-reading of the FOC symptoms, founded on a thirty-year clinical experience one on hand, and an uncompromising and punctual adhesion to the principles of the theoretical model of the Gestalt Therapy on the other hand.
Each of the three relational styles is faced in a complete anthropological and clinical analysis, within a reference frame, that primarily defines the relational etiopathogenesis of the discussed symptoms and, more generally, of the psychological disorders, in a clear and clinically established vision.
The article ends with a further contribution about the specificity of the therapeutic work. A particularly useful section for all those who – in the different therapeutic approaches – work with POC disorders. The article introduces strict modalities of theoretical and clinical declension of GT and shares the researches of the Istituto di Gestalt Therapy HCC kairòs with the Gestalt Community, on a national and international level.

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gtk

THE BORDERLINE PATIENT: AN INSISTENT, ANGUISHED DEMAND FOR CLARITY

interview to Valeria Conte

ed. by Rosa Grazia Romano

In the clinical field the perception of an increase in the Borderline is by now generally shared. According to you, is there a connection between the social changes of post modernity and the increase of this pathology?

The history of psychotherapies and the birth of new epistemological models tell us a lot about the influence of social changes on the emergence of new pathologies. The patients change, and consequently do the treatment models, too. In the development of the Gestalt Therapy's (GT) concept of relationality, our Institute has developed and pursued, as the key to reading the relationship between society and the individual, the various, complex manners in which we stay in relationships. It is years that the Institute's scientific director, Giovanni Salonia, has been focusing his attention towards what he defines as the "basic relational model" (BRM), according to which society is modified and gives priority to the individual or to the community according to the context and the emerging needs (war, hunger, epidemics, etc.)[1]. The way subjects relate to each other, that is to say, always reflecting the time they live in[2]. If we look around, the contemporary person is immersed in a generalized sense of loss

The eternal wait

1 In fact we distinguish a BRM based on 'we', typical of periods of emergency, from a BRM based on the 'I', which is the one of the world we live in today. This reading key, fine-tuned by Giovanni Salonia, is extensively illustrated in G. Salonia (2005), *Femminile e maschile: un'irriducibile diversità*, in R. G. Romano, *Ciclo di vita e dinamiche educative nella società postmoderna*, Franco Angeli, Milano, 54-69.

2 Cf. A. Kardiner (1965), *L'individuo e la sua società*, Bompiani, Milano.

that leads him to experience the future, the job, relationships as if they were uncertain, to experience a sense of confusion where he feels that he has no reference points; and at the same time he is more than ever pressingly expected to be grown up, to be able to make it alone. Today children, adolescents, individuals – at any stage of their lives – have so many possibilities; there are no limits to their potentialities: in fact, experience is increasingly emphasized and *having to ask* is seen as weakness and incapacity. That way you learn to grow up on your own[3]. However, the contemporary community is not strong and the individual is born and grows up within a weak thought[4] and a formless liquidity[5]. This leads quickly from idealizing experiences – which are realized through the need and search of a rigid sense of belonging, like for example to fundamentalist groups (only apparently strong) – to an excessive depreciation of the other, with a worsening of self-referentiality and of an agonizing search for achievement.

This postmodern society has more and more one whose indefinite, insecure and uncertain borders. This necessarily gives life to subjects who are more and more indefinite, insecure and uncertain, and who meet many difficulties in their natural search for happiness[6]. We may define the whole of contemporary society as 'borderline', because the subjects, the life cycle, relationships themselves are increasingly characterized by unstable and uncertain borders and outlines. Therefore the challenge all psychotherapeutic approaches have to face, above all GT (that gives a special importance to the context), is to find new understanding methods of the unease and new methods of clinical interventions for Borderlines.

3 Cf. R. G. Romano (2005), *Ciclo di vita e dinamiche educative nella società postmoderna*, Franco Angeli, Milano.
4 G. Vattimo, P. A. Rovatti (eds.) (1998), *Il pensiero debole,* Feltrinelli, Milano.
5 Z. Bauman (2002), *Modernità liquida*, Laterza, Roma-Bari.
6 Considerations on this may be found in G. Salonia (2004), *Sulla felicità e dintorni*, Argo, Ragusa.

So, you're telling me that there's an interrelation between pathologies and the relational styles that define a society?

Yes, sure. We are talking about ways of being in relationship and building relationships that define the contemporary society with specific relational methods, which we can find on various levels and in the different emotional (relationship as a couple, parent/children relationship), educational, occupational and institutional contexts. This model of reading the "normal" unease of contemporary living allows us a wider understanding both of psychopathology and of the treatment and intervention models.

How does Gestalt Therapy describe Borderline pathology, or, we should say at this point, the borderline method of relationship?

In relationship the Borderline has specific features: confused relations, a climate of total ambiguity, ambivalent attitudes. I remember a young patient telling about the fact that she would often find herself in this kind of experience: *"I get confused... every time I talk to my parents, my father does so much for me... I'm grateful to him: he pays for my studies, he pays my expenses, but he never asks how I am*[7]*, on the contrary, every time I mention some difficulty with reference to his requests (often illogical and anyway regarding neither me not him) he accuses me of being ungrateful and makes me feel enormously guilty, I get confused and I don't know what I really feel… My mother always ask how I am and worries a lot about me, even too much, but I don't know if she really sees me… Her anxiety overwhelms me and I have to keep her at a distance to be able to do it on my own, as always… alone… alone with my emptiness".*

Many Borderline problems arise from this relational background. In fact, the affective relationships they set up are complicated: they swing from extreme dependence to flaunted independence and those who are close to them understand with difficulty how to find the right emotional distance from them.

In fact, the affective relationships they set up are complicated: they swing from extreme dependence to flaunted independence and those who are close to them understand with difficulty how to find the right emotional distance from them. The fear of being abandoned together with the fear of being absorbed is surely the extremes that dominate the relationships they create.

7 This is a kind of experience defined as 'emotionally distant'.

The fear of being abandoned together with the fear of being absorbed is surely the extremes that dominate the relationships they create. A patient of mine was involved in an extramarital relationship and expressed all her distress of being abandoned with violent and aggressive verbal attacks towards her partner, every time he talked about his life as a couple with his wife during the weekend. In fact, her huge fear of being swallowed up in an emotional bond made her live relationships where she was always subjected to betrayal; so, paradoxically, she saw his wife as… *the gooseberry* that took part in her relationship. She had never allowed herself a relationship with an "affectively free" man, because of her fear of abandonment and betrayal. When I asked her to think about the meaning of her affective relationships, often with men who were already emotionally bound, she swang between irrational answers and perfect answers, with no comparison of real facts (her ability of self-criticism and her logic did not help her).
The only thing that struck her was the fear of the betrayal she might suffer (which is equivalent to the fear of being abandoned). Inside of her, pain and fear alternated in a destructive suffering.
The instability and ambivalence of the behaviours that are often present in the borderline relational modality have their own internal logic: calming the confused feeling by having at the same time two experiences opposite to each other. In fact, it is impossible for them to conciliate opposed feelings, which they perceive as an attack on their own identity. In a clinical point of view, it is important to bear in mind that the use and sometimes abuse of substances, which represents a sort of *acting out*, should not be diagnosed and simply treated as mere dependence.

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The DSM IV-TR talks of "personality disorder", while Gestalt Therapy prefers to talk of "relational borderline disorder". Is it possible for a Gestalt therapist to connect these two worlds of psychopathology, descriptive and phenomenological, often irreconcilable to each other? And how can this be done?

My working experience, divided into two worlds (psychiatry on the one hand and psychotherapy on the other hand), allowed me to integrate aspects that in my opinion, can be conciliated above all in clinical practice. Working side by side with very different training and professional realities has been a complex, but certainly enriching challenge. Nowadays, the Diagnostic and Statistic Manual of Mental Disorders – DSM IV-TR – is used quite a lot in the psychiatric field: it puts the borderline pathology on axis II, within "group b" of personality disorders.
The descriptive epistemology is the basis of the ideation of a manual and has the great advantage of letting dialogue the different epistemological models, if used within diagnostic limits. Clinical standard procedure certainly enhances with the knowledge of the complex and variable pathology, which is, above all in case of the borderline, particularly elusive. It is no accident that the diagnosis of Borderline once was a "waste basket" where you could find all diagnostic confusions.
As for borderline personality disorders, among the specific behaviours described we can find: *desperate efforts to avoid a real or imagined abandonment; a picture of unstable and intense interpersonal relationships…*; impulsiveness *in at least two fields that are potentially harmful for the subject, such as spending, sex, substance abuse, dangerous driving, binges; periodic suicidal threats, gestures, behaviours or self-mutilating behaviours; strong difficulty in controlling anger…*[8].
The other way round, moving from a phenomenological approach, GT focuses on the corporeal relational experiences that are at the origin of behaviours (Giovanni Salonia talks about 'intercorporeity'[9] with reference to this) and reads the different psychic sufferings as contact interruptions[10].

8 American Psychiatric Association (1994), *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV), American Psychiatric Press, Washington D.C., it.tr. (1996), *DSM IV, Manuale Diagnostico e Statistico dei Disturbi Mentali*, Masson, Milano.
9 G. Salonia, *Edipo dopo Freud. Gestal Therapy e teorie evolutive*, Il pozzo di Giacobbe, Trapani, in press.
10 Cf., for example, G. Salonia (2010), *L'anxiety come interruzione nella Gestalt Therapy*, in L. D. Regazzo (ed.), *Ansia, che fare? Prevenzione farmacoterapia e psicoterapia*, CLEUP, Padova; V. Conte (2001), *Il lavoro con un paziente seriamente disturbato in psicoterapia della Gestalt. L'evoluzione di una relazione terapeutica*, in Spagnuolo Lobb M. (ed.), *Psicoterapia della Gestalt. Ermeneutica e Clinica*, Franco Angeli, Milano; G. Giordano (2001), *La casa, l'ambiente non umano e i pazienti*

In this perspective, the above mentioned self-destructive and impulsive behaviours (dangerous driving, binges, unsafe sexual encounters, antisocial behaviour, and suicide attempts) are *acting outs* that express the unsustainability of the inner tension and the need to calm down. Also the intense difficulty to control the Borderline's anger is a "rage" that does not appease and has to be understood as a search for clearness; as a need to calm the experience of confusion in the perception of one's inner experience.
So, the two worlds, the descriptive and the phenomenological one, can dialogue, as long as the differences complement each other in mutual respect and esteem and meet in the clinical procedure in a common intentionality: helping the patient to be well.

You said that we see confusion and ambivalence in the borderline's relational modality that expresses corporeal relational experiences. Can you specify what the clinical reading is that GT that gives of the body?

For a Gestalt therapist, when we talk of the "body" we mean the "id-function"[11] of the self. In fact, in Borderlines it is above all the corporeal experience that is compromised. Paradoxically, they turn out to be fairly well identified individuals; they sometimes seem rigid, settled, but unaware of their deepest and most intimate experiences: *"I'm different from my mother, very different, but sometimes I find myself with her fears inside me, her paranoia; however, I don't know if they're not mine, now… I understand it and this makes me get confused, I don't know what I really feel…"*

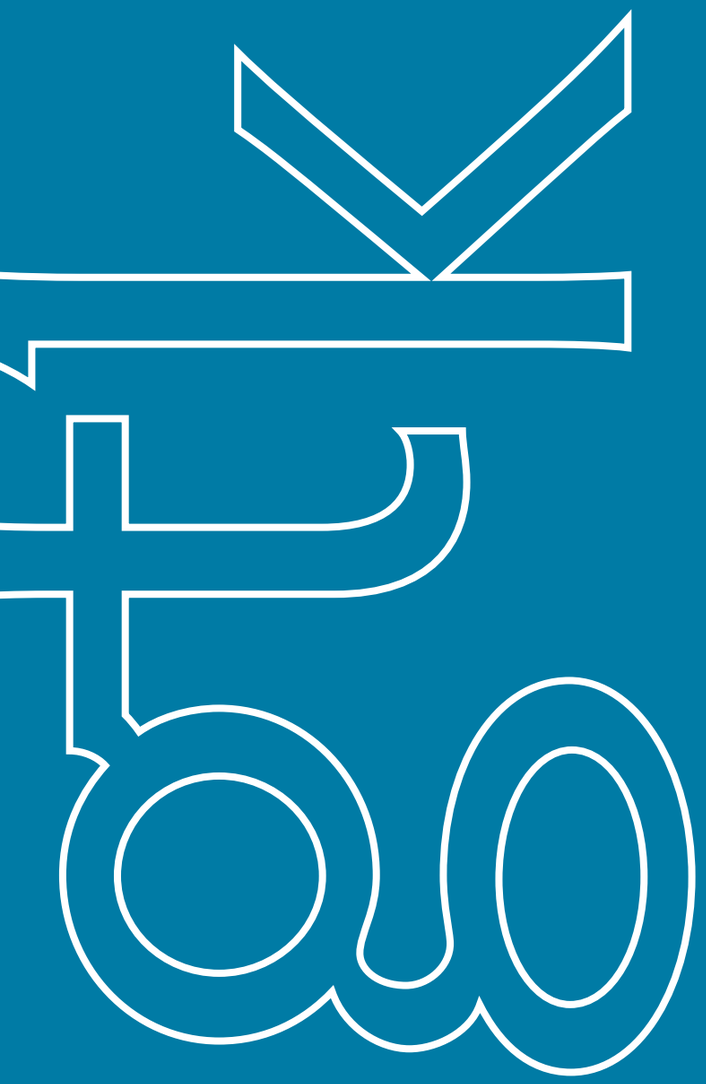
gravi. Un contributo teorico-clinico nell'ottica della psicoterapia della Gestalt, in *Quaderni di Gestalt*, 32/33, 70-79.

11 "The self is in id-function when it focuses on bodily sensation that came from 'within the shin' from the history of contact and from reaction to environmental stimuli. The question 'what do you feel' – so typical of Gestalt therapist – zeroes on 'where' and 'how' the organism finds itself in relation to the environment (organismic intentionality)"in G. Salonia (2009), *Letter to a young Gestalt therapist for a Gestalt therapy approach to family therapy*, in *The British Gestalt Journal*, vol.18, 2, cit, 39. Cf. also G. Salonia (2008), *La psicoterapia della Gestalt e il lavoro sul corpo. Per una rilettura del fitness*, in S. Vero, *Il corpo disabitato. Semiologia, fenomenologia e psicopatologia del fitness*, Franco Angeli, Milano.

The ability of feeling emotions, perceiving the emerging of needs, give a proper name to what you feel, requires a fluidity of the basic corporeal experience, which is compromised in the Borderline subject.

In the long psychotherapeutic course, the work done together has been to start discriminating what she felt from an undifferentiated jumble, to "chew" and analyze her corporeal sensations, to give a proper name to her feelings, to allow her body to start feeling and recognizing her needs and experiences.

The ability of feeling emotions, perceiving the emerging of needs, give a proper name to what you feel, requires a fluidity of the basic corporeal experience, which is compromised in the Borderline subject. The corporeal borders of the Borderline allow a permeability of the external experiences that have been mistakenly assimilated as one's own and at the same time a difficulty in containing and assimilating one's own feelings, which often seems impulsive and ungovernable. There often is a confusion in the experiences that disturbs the awareness levels; however, there are also forms of desensitization (lack of perception of one's own body). These sometimes lead to self-harming behaviours that paroxysmally express the need to feel oneself. It is in these cases that GT talks of disorder of the "id-function" of the self.
I remember Maria's emotional suffering and pain. It was six years that she was fighting against devastating and crippling scares. She never left the house except for work or for short trips. As she said, she no longer recognized herself: until she was 32, everything had been fine; she had dedicated herself to her job and her brilliant professional career; she was an independent, self-employed, active young woman. Suddenly, during a summer holiday on the beach, she had her first scare. Since then, her fear and anxiety to be on the beach blocked her insomuch that she is no longer able to go there. At the same time, however, her body begins to make itself felt, even if it is only through a symptom that expresses her devastating suffering in this first stage. In fact, her body was very rigid and controlled, because she was keeping a great dramatic secret. So she starts psychotherapeutic and pharmacological treatment. In the long psychotherapeutic course, the work done together has been to start discriminating what she felt from an undifferentiated jumble, to "chew" and analyze her corporeal sensations, to give a proper name to her feelings, to allow her body to start feeling and recognizing her needs and experiences. Some summer after, her body opens up to the opportunity of feeling something different, a desire starts to come out: to finally be able to go for a walk by the sea with a friend, after many years. She feels better, she trusts her body more, and



she feels pleasant sensations and so much energy. Her friend's proximity encourages and supports her.

"… Proximity that gives me comforts, security, affection. While lying under the warm afternoon sun on the beach, after a while my friend… embraces me… I let her do it, but at some point it's too much, all his is too much for me, it frightens me. What does it mean? What do I feel? Why do I feel excitement? ... Am I may be attracted to her? I'm afraid, I don't want to feel that… and I feel my anxiety growing. My "no" to stop her have no effect! I feel a strange excitement and I don't understand… That makes my anxiety grow, it terrifies me, I feel real panic. Some people come along and she stops. I'm embarrassed, I feel angry… the sea had been a nice experience... but it has been polluted, dirtied. I'll never come to the sea again and I won't go anywhere else!".

Maria told me about that afternoon during therapy, plunged into conflicting feelings, tears, fear, pain, anger. *"You see… I can't trust myself!! I thought I could make it and look what happens!"* She looked like a frightened and angry child, who finally - "going back home" – can tell her drama and her confusion. The experience of someone listening to her unhurriedly, without fear and without immediately attributing meanings and labelling her – this is new to her. She explains in minute detail what happened; she asks if it was her fault, and what she should do. It was important to explain to Maria that her body, still fearful of facing the pleasure and novelty (of the sea), needed a physical support to lean on (her friend) and that, as it often happens with Borderlines, she had been confused and invaded by experiences that were not her own. Going back to discriminate, chew, understand her sensations and support the evaluation of her experience, even through the logical connections provided by her, allowed her – little by little - to give what she felt a proper name. So she can finally remember and heal the wounds and the memories that the secret has kept in her body for so many years. She remembers her first going outs into the courtyard of her house – she was just six - *"I felt big and quick. I could keep up with all the boys' games"*. A world of games… what however – unfortunately! – became a world of repeated abuses and shameful fears, of measures of power and of blackmails. For years, for too many years, she starts to deny her body, to forget, to scotomise confused and painful, suffered and untold experiences. The excitement and the energy of feeling

grown up convert into pain and anger. It was only "thanks" to her first panic attack that her body told, revealed her secret; and her anger so much anger exploded and after so much pain, many tears come.
Thinking again about my patient, her slight body strikes me. Even the way she is dressed is teenage-like. The acquisition of new technical skills and her professional successes did not modify her experience of being small and fragile over the years, as if she did not "chew" the new and could not integrate it unitarily. Indeed, it often happens that these patients never leave their original home or their family and maintain the role of a never totally satisfied child. In fact, the Borderline subject is not able to update his self with reference to what he has become, who he is in life, the roles he plays (disorder of the "personality-function" of the self)[12].

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According to GT, what happens in the first few years of the child that frames a Borderline personality? Can we find common features in the family dynamics of Borderlines? What kind of family relationships is the Borderline born in?

As it has been said, *being borderline can be seen as an artistic invention in order to escape from the psychotic distress of the mother.* Around the sixth month, once the confluence has been assimilated, the child perceives more clearly its own borders through perception of the borders of the other: he begins to orientate himself, to interject. He finds himself bound to give proper names to his feelings (pleasant or unpleasant, good or bad, cold or hot). The mother who is "healthy" or "good" enough, as Winnicott would say, tunes in to the child's experience, foresees her child's needs and differentiates them from her own ones: a dance, a rhythm between giving and receiving begins. On the contrary, a confused and officious mother (in GT we call it "neurotic confluence") does not allow the child's experiences to come out. She

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12 "The personality is the system of attitudes assumed in interpersonal relation, is the assumption of what one is…is the structure of the self" F. S. Perls, R. F. Hefferline, P. Goodman (1994) (or.ed. 1951), *Gestalt Therapy: Excitement and growth in the Human Personality*, The Gestalt Journal Press, New York, cit, 160.

We may define the genesis of the Borderline pathology as being repeatedly and systematically defined by the other, without being seen and/or even before understanding and completing one's own experience.

confuses the child's experiences with her own and sends them back to him in a confused and ambivalent way.
In GT the first person that theorized on borderlines at a diagnostic and clinical level was Isadore From. He affirms that the mother's intrusiveness has interrupted in the child the process of experimentation and evaluation of her/his internal experience: instead of recognizing of what the child feels, the maternal figure interprets and evaluates the child's experience in a wrong way, confusing it with her own need. So, the child has been prematurely hyperdefined (*you're tired, you're sad, etc…)* with a false, misleading sort of empathy that does not allow him to learn the proper names for his feelings. The child's experience has been interrupted characterizing a difficulty in the process of symbolization and meaning of the experience.
We may suppose these words: *"I'm sitting on the floor in the room, the sun reaches my body... on the floor, it's a pleasant feeling, and it's warm, bright… lovely! And now… what's happening? I'm in my mommy's arms, she suddenly picks me up… it's unpleasant, it's cold, dark… and… I fall asleep!*
We may define the genesis of the Borderline pathology as being repeatedly and systematically defined by the other, without being seen and/or even before understanding and completing one's own experience (*"you're surely tired, off you go to bed "; "you're certainly sad, let me comfort you"; and so on*). This misleading anticipation of experience offered by the parent instead of a respectful support of the children's differences and requests of autonomy becomes a swindle. As a result the child grows in confusion about his experiences: confusion remains one of the cornerstones of the Borderline experience. As Giovanni Salonia says, as long as the child is "inside" the relationship with the mother he is "protected" from confusion. It is only when he goes out into the world that the confusion (giving wrong names to his experiences) will come out with frequent difficulty in his finding a place in the world and in relationships. On this specific aspect of Borderline experience the clinical intervention is structured and it requires closer examinations, which we are working on[13].

13 G. Salonia, V. Conte, *Gestalt Therapy e modalità relazionali borderline*, in press.

How long, on average, does the psychotherapeutic treatment last with a Borderline and what should the therapist know about the clinical Gestalt-like intervention?

With reference to the duration of treatment, you cannot expect a short - time therapy; with Borderline we are talking about long-lasting psychotherapies.
Generally, the starting point is difficult, contradictory, requests are ambivalent *("I'm not well… but it makes no difference, I actually know what my problem is", "I don't think therapy can be of any help"*). This attitude is highlighted in critical moments, but belongs to the relational background during the whole therapy period. These patients tend to interrupt the psychotherapeutic treatment, to act self-destructively, to make unusual requests, to go beyond the limit of professional relationship. "Stably unstable" is a good summary of the feeling one has when facing Borderline patients.
Borderline patients often present a varied symptomatology: from existential unease – not easy to define but certainly perceptible – to depression, anxiety, eating disorders, scares, phobias, addictions, etc... In the background of their history you can see an uneasiness that goes back to adolescence: you have the feeling that they have *always* been sick, when listening to them. Taking charge of them is not easy either. It is never clear and defined (in the request for therapy as well as in steadfastness). The time of request often coincides with an affective abandonment, a moment of temporary worsening of the ever-present distress and emptiness.
The relationship that the Borderline patient establishes with the therapist is characterized by two great relational fears – as Otto Rank teaches us: fear of the bond and fear of autonomy, which interweaves with various nuances in all relationships, but coexists in the Borderline and become fear of depending – on the therapy and the therapist – and fear of being abandoned. In fact, the Borderline worries dependency, but needs it, so he abandons… for fear of being abandoned; betrays… for fear of being betrayed. The presence of such contradictory experiences tested and learnt within the significant affective relationships, limits the possibility of taking charge; however,

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It is important to facilitate that clearness to Borderline that allows untangling the relational mesh. It is not just supporting self-expression (indeed, often he has to learn to hold back), but acting in a way that his feelings bring him into contact with his deepest and truest experience. That way he will learn to give proper names to emotions, to distinguish whom they belong to and to express them in accordance with his own rhythms.

at the same time it is the greatest resource that the therapist has to rectify and heal the old wounds and unfinished Gestalt (rectifying the past in the present, reliving the experience in the opposite direction).
Let us, for instance, go back to Maria's case: her body has been desensitized for years and today needs the (therapeutic) support in order to be able to trust her feelings, to feel excitation and energy again, to be able to dare to re-cross that "courtyard" (which has become the world today) without the terror of invasions and abuses, to open herself again to the desire of the other, whether male or female, without running away, learning to compete with a male who abuses his power but is attractive and with a female who does not protect and reassure.
It is necessary to work on the id-function of the self in the distinctive way in which one works with the Borderline: without touching/invading, without amplifying the experiences and feelings, always bearing in mind that his main difficulty is not awareness but *clearness* (to whom does what I feel belong).
It is important to facilitate that clearness to Borderline that allows untangling the relational mesh. It is not just supporting self-expression (indeed, often he has to learn to hold back), but acting in a way that his feelings bring him into contact with his deepest and truest experience. That way he will learn to give proper names to emotions, to distinguish whom they belong to and to express them in accordance with his own rhythms.
In this course, the therapist must promptly contain anger, a feeling which often breaks out and does not always correspond to the real experience, but is *"in place of"* other experiences, such as fear, pain etc. In this sense it is a serious clinical error to encourage the expression of an experience that would only produce an increase of the emotional intensity without first having understood its name and to whom it belongs to. After having learnt the experiences' name, the Borderline will be ready to learn the logical connections between acting and feeling (an important therapeutic moment). This allows the Borderline patient to put a frame – even a cognitive one – around his feelings.
Trust in the relationship and clarification of the experiences will help him to tolerate possible *errors* on part of the therapist:

this will be a great achievement, since the Borderline – just because of the division into good/bad, black/white, which he has employed to understand the world – cannot tolerate the coexistence in the same person of opposing perceptions. In therapy, like in all important relationships, Borderlines always seem to be expecting/fearing a "*false step*", since – as we have said – in relationships they easily pass from idealization to devaluation: a wrong behaviour from the person they idealize de-structures their world. Therefore, trusting and entrusting oneself to an important relationship, putting together two aspects of the same person requires long and intense therapeutic work, which reopens them to the world and to healthy relationships.

Abstract

The history of psychotherapies and the birth of new epistemological models tell us a lot about the influence, that social changes lead to appearance of new pathologies. Nowadays, the Borderline pathology is increasing and, as we know, patients are changing and treating models are changing as well. In the following interview, with synthetic language and at the same time a language rich of examples and clinical experience, we will see how the Gestalt Therapy describes the Borderline psychopathology and what typifies the specific discomfort of the borderline. This is a first systematization anticipating an upcoming contribution about new ways of clinical understanding and intervention for the treatment of borderline disorder in Gestalt Therapy.

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The strong up (self-portrait)

TO ALDA MERINI

Paola Argentino

The poem's title – "*Strapotere*" – is already an essence of burning sensations that enclose a world of hard distress, if you think that Alda Merini dedicated it to me… as a psychiatrist!

As a free gift to the readers of the new born online review "Gestalt Therapy Kairòs", we are going to publish an unpublished poem of the poet Alda Merini, in the first anniversary of her death: a warm, live and vibrant way to remember her, with the intense emotions aroused by her own verses.

The poem's title – "Strapotere" – is already an essence of burning sensations that enclose a world of hard distress, if you think that Alda Merini dedicated it to me… as a psychiatrist! She wanted to give it to me in sign of seal of our friendship, which was born honestly and vehemently after lively clashes and shared emotions; without false hypocrisy, like only she was commendable able to do.

I had fallen in love with her poetry and was the first who got in touch with her, in occasion of the international conference *"Disagio psichico e risorse relazionali" (Psychic malaise and relational resources)*, organized by the Gestalt Institute in Syracuse on May 2001. My aim was to invite her to take part at it as a speaker. I remember, still affected, our first phone conversation: *"Good morning, I would like to speak to the poet Alda Merini. When would it be possible to call and not to disturb her?"*.

With hoarse voice and a grumpy tone, on the other side of the phone came a question as answer: *"What do you want?"*. *"I am Doctor Paola Argentino…"* I began to reply, but I was immediately sharply hushed up by a flood of words, which syllables sounded like soldiers lined up as if they would attack me: *"You are already unpleasant to me; I can't stand people that introduce themselves with titles. Who gave you my phone number? And then, doctor… doctor… Of what?"*.

Given the raging reaction to my incautious introduction, I tried to calm down the 'boomerang' effect with a conciliatory premise. In a fearful tone, sensing the bombing I would have faced up by answering her second question, trying to reveal my professional identity. *"I wanted to invite you to an international conference about therapeutic communities… I am doctor in medicine and specialist in psychiatry"*.

Instant negative response with sudden interruption of the phone contact. It probably was a negative day… can happen to everyone! My tenacity made her call back. And as I was afraid of the fact that she would have hung up again, I did not even wait her to say hallo and swamped her with my words: *"You don't know me, but you already judge me. You dislike me, because I'm a psychiatrist. But aren't you doing exactly the same that has been done to patients in the mental hospital? They were labelled as "mad" and outcast, you label me as "psychiatrist" and refuse me… One should never lose the wish to experience the other in its essence. And I will tell you more: I also believe that the psychiatrists, who worked in the mental hospitals in the ante-Basaglia time (psychiatrist and promoter of Italy's psychiatric reform), acted in good faith, and used restraining instruments, because this was the cultural background of care they knew… I am simply inviting you to a conference as a guest of honour, because I admire you and you put your past on me. Well, if you prefer, I remove the 'title' and introduce myself again: I am Paola and that's it. I am Sicilian, I live in Syracuse and it is in this city we will do in May the conference I am inviting you to".*

So, in a more welcoming tone, the poet restarted to talk to me: *"I know Sicily, beautiful region… Pirandello. The whole south of Italy is land of great culture and is in my heart. I experienced deep years in Taranto, I loved Perri. The departure has not been untroubled… here in Milan you breathe a different air; more practical, concrete rather than poetic".*

In that precise moment our friendship began. It has been summarized by Alda Merini in the following poem:

One should never lose the wish to experience the other in its essence.

Transfigurations (particular installation SITE#1)

STRAPOTERE

La natura del volto di un poeta non ha radici.
Adagio cigola la sua porta al nuovo amico
e non si sa chi sia.

In effetti il passato è prodigioso…
Si aspetta sempre che qualcuno venga
senza chiamarlo e perda le tue tracce.

Cos'è il monumento del potere?
Qualcosa che vuol essere e non è…
una bianca bugiarda eutanasia.

O Meridione, che io tanto rimpiango,
fosse stata serena la tua morte…
invece di questi fradici unguenti
di malsana cultura.

Alda Merini

And now, on the long wave of such poetic verses, the memory of Alda Merini becomes more precious and intense, plunged in an ear-splitting silence, in order to present to the sky a grateful 'thank you' and a warm and 'antique' goodbye. The tribal one of the Navajo Indios: *"Goodbye great poet, shall you walk in the beauty!"*

EXCESSIVE POWER

The nature of a poet's face has no roots.
His door squeaks softly to the new friend
and you don't know who it is.

In fact, the past is prodigious…
You always wait for somebody to come
without calling it and looses your traces.

What is the monument of power?
Something that would like to be, but is not…
a white deceitful euthanasia.

Oh Meridione, I miss thy so much,
If only your dead would have been peaceful…
instead of these soaking ointments
of noxious culture.

Alda Merini

CATCH MY SOUL

Giuliana Gambuzza

Sitting in a red velvet armchair
I look at the empty one in front of me:
I'm waiting for you.
My gaze wanders
Searching for something
That compellingly catches its attention.
It alights
Like a fluttering butterfly
On the parquet
On the white gauze cloth,
On the glass table,
With your lens upon it,
On the desk spattered with books and letters
– words from elsewhere –
On the picture behind me
a slender woman,
A mother,
Holding in her arms
With loving care
The fruit of her flesh,
The fruit of her blood.
This is the therapy room:
Just you and me to make the room alive.
So it closes around us
Like a magic circle
Which threshold is forbidden to invade;
Its exclusivity,
That I love and hate,
Closes the doors of the world behind us
And we are in our small world:
Mutual emotions,
Words from the heart,
Depths that re-emerge.
We live our reality
In such a small space,
And yet our talking

PRENDIMI L'ANIMA

Giuliana Gambuzza

Seduta sulla poltrona di velluto rosso,
guardo quella vuota davanti a me:
ti sto aspettando.
Lo sguardo vaga
alla ricerca di qualcosa
che attragga irresistibile la sua attenzione.
Si posa
come farfalla svolazzante
sul parquet,
sulla tela di garza bianca,
sul tavolino di vetro
con le tue lenti sopra,
sulla scrivania sparsa di libri e corrispondenza
– parole dall'altrove –
sul quadro alle mie spalle
una sottile donna,
una madre,
tiene tra le braccia
con amorevole cura
il frutto della sua carne,
il frutto del suo sangue.
La stanza della terapia è tutta qui:
solo io e te a fare vivo l'ambiente.
Si chiude allora attorno a noi
come un cerchio magico
la cui soglia è ai più vietato violare;
la sua esclusività,
che odio e che amo,
ci chiude alle spalle le porte del mondo
e siamo nel nostro piccolo mondo:
scambievoli emozioni,
parole dal cuore,
abissi che riemergono.
Viviamo la realtà di noi
in un così minimo spazio,
eppure il nostro parlare

Breaks today's banks,
It wiggles out of everyday grip,
It is ambition to something human, but lasting.
Cure of my pains,
And we repair wounds
And stitch up flesh edges
And the agonizing cuts inflicted by life become life.

The encounters chain themselves
Like grains along a single sandy stretch,
Compact and continuous;
The path is fertile,
Even on the stretches done with efforts.
In the ceaseless internal intense activity,
While digging the deep layers,
While scratching the rock,
I hear an old pain
Calling me by name
Meetings link one another
Hard stretches along
Fruitful the way.
Does he already know me?
I strongly feel a sharing sense
– Accomplices of one single story –
And blowing down the turmoil of loneliness
And managing to tell the distress.

The two of us
Like power of expression
That beats the evil of the unsaid;
The two of us
Like an intense music
That follows the sweet rhythm
Of the said and the unsaid,
A silent full of sounds
And flow of emotions.
The two of us
Go on with determined pace
On our road to recovery,
Which is release from pain,
Which is wish to breath.

rompe gli argini dell'oggi,
si divincola dalla morsa della quotidianità,
è aspirazione a qualcosa di umano ma durevole.
Cura dei miei mali,
e ripariamo ferite
e ricuciamo lembi di carne
e gli strazianti tagli inferti dalla vita diventano vita.

Gli incontri s'incatenano
come granelli lungo un'unica distesa sabbiosa,
compatta e continua;
il cammino è fecondo,
anche nei tratti percorsi a fatica.
Nell'incessante lavorio interiore,
nello scavare gli strati del profondo,
nello scalfirne la roccia,
sento un dolore antico
chiamarmi per nome
che già mi conosca?
Sento forte il senso di condivisione
– complici di un'unica storia –
e il turbine della solitudine placarsi
e la sofferenza riuscire a dirsi.

Noi due
come la forza della parola
che sconfigge il male del taciuto;
noi due
come una musica intensa
che segue il ritmo dolce
del dire e del non dire,
un silenzio carico di suoni
e fluire di emozioni.
Noi due
proseguiamo con incedere deciso
lungo la strada della guarigione
che è liberazione dal dolore,
che è desiderio di respiro.

The fusion of thoughts,
The perfect adherence of the spirits…
But spectre of the unspeakable,
Presumed rules
That anchor me to the ground
And I cannot hover in the air myself today
And I am not able to trustful lapse into your arms.
Reappearing to life
And dreadful terror to die again.

Help me taking care of my new strength,
Reinventing my whole existence.
Guide me through the winding path interrupted for a long time.
Then,
Once alone with me
I will always keep alive your hand's heat,
That heat you warmed me up during rainy days.
And I will remember the gentle fondness of the light days
And the esteem
And the support.

Now I am searching for the feared contact;
Now I completely commit myself to you
And tell you:
«Giovanni, catch my soul».

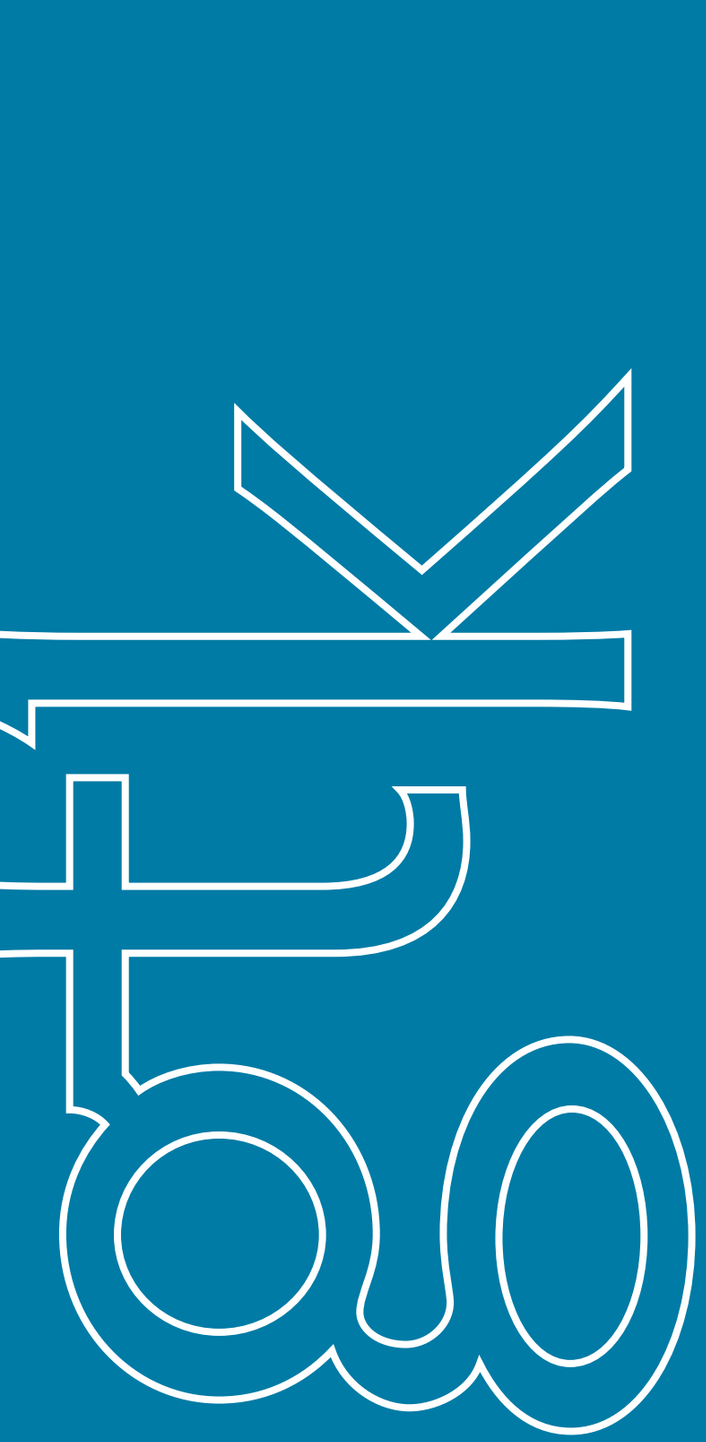
Acireale, February 5th, 2006

La fusione dei pensieri,
la perfetta aderenza degli spiriti…
Ma spettro dell'indicibile,
regole immaginate
che mi ancorano a terra
e non posso librare nell'aria la me stessa di oggi
e non riesco ad abbandonarmi fiduciosa tra le tue braccia.
Riaffacciarsi alla vita
e terrore agghiacciante di morire ancora.

Aiutami a custodire la mia nuova forza,
a reinventare intera la mia esistenza.
Conducimi lungo il tortuoso cammino a lungo interrotto.
Poi,
una volta rimasta sola con me,
conserverò per sempre il calore della tua mano,
quel calore con cui mi hai riscaldato nei giorni di pioggia.
E dei giorni di luce ricorderò l'affetto delicato
e la stima
e il sostegno.

Ora cerco il contatto temuto;
ora mi affido a te completamente
e ti dico:
«Giovanni, prendimi l'anima».

Acireale, 05 febbraio 2006



ONOTHERAPY AND GESTALT THERAPY

New Applications of Pet Therapy

Silvia Zuddas and Francesco Padoan

The donkey gives us time to listen to the other that is alive and gives the other the opportunity to prove himself, explain himself, to wind the folds that tangle him and make him un-intelligible, hidden, unapproachable. The donkey's mediation allows a relation to otherness and makes the opportunity of the being in progress actual, in a circularity that has no sense thinking interrupted. [...] in the slow course that leads to a change through consciousness and acceptance[1].

This work comes up from the integration of writers' theories and is based on the clinical experience born in the work with the ANFFAS[2] centre of Trieste, people of a day centre of the Province of Udine and with ADHD[3] affected children.
The purpose is to have a first sight towards the future treatment with animals in Gestalt Therapy, raising a questioning where to find some solution: which strength can a therapy with donkey assume when used in accordance with the Gestalt Therapy's point of view and followed by words that are able to grasp the patient on the relation and change he is living?

1 P. Reinger Cantiello (ed.) (2009), *L'asino che cura*, Carocci Faber, Roma, 35.
2 National Family Association of people with intellectual and/or relational disabilities.
3 Attention-Deficit/Hyperactivity Disorder in American Psychiatric Association (2000), *Diagnostic and Statistical Manual of MentalDisorders (DSM IV-TR)*, American Psychiatric Press, Washington D.C., it.tr. (2002), *DSM IV-TR, Manuale Diagnostico e Statistico dei Disturbi Mentali*, Masson, Milano.

Pet therapy and onotherapy

Nowadays the term *pet-therapy* includes itself two big categories of activities with animals. They are divided into Animal Assisted Activities (A.A.A.) and Animal Assisted Therapy (A.A.T.)[4]. The Animal Assisted Therapies are "therapies assisted by animals" with therapeutic purpose and directed to improve the patient's health conditions through the attainment of specific aims.

The choice of a donkey for the therapeutic treatment meets the Gestalt Therapy in the recognition of the relation's centrality: from historically instrument used for treatment (besides work), it becomes element of the working field, almost a co-therapist, which relation to the patient and to the medical specialist is placed on a level that goes beyond.

This animal has been chosen for its sociality, aroused by the presence of structures in its Central Nervous System that are delegated to work out the psychic pain of separation[5]. The second reason is the empathy, which is of very high value for the socialization and survival of the species, since it allows a person that is not able to take care of himself, to survive because others take care of him[6]: this feeling, that involves an *interaction*[7] also exists between donkey and human being[8].

As regards to the physical structure, there are some neotenic features; in other words, the somatic types of the pup remain in the adult: absence of an angular muzzle, position of the eyes, their dimension and proportion as to the rest of the head, together with the big and moving ears, make an approach to the donkey spontaneous and very close to what is genetically determined with the pups, so to encourage the relation through behaviour of care giving[9]. Moreover, when compared to a horse, the donkey's dimensions allow also children and people with physical disorders to approach to the animal without the help of thirds. Finally, whilst most of the other animals usually need to be received[10], the donkey is big enough to receive, answering to one of the essential needs of the patient in psychotherapy.

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Gestalt Therapy actively seeks for a co-operation of patient and therapist with body and mind, going beyond a dichotomy that is not in a position to give support.

When in contact with the animal, the relational character of the patient comes out clearly.

Corporal work in onotherapy

Gestalt Therapy actively seeks for a co-operation of patient and therapist with body and mind, going beyond a dichotomy that is not in a position to give support[11]. Indeed, even if the different authors that talked about such topic in Gestalt Therapy can assign more or less importance to the corporal work in therapeutic practice, it is also possible to assert that working with the body is an essential part of the process, so to lead Bloomberg to affirm that *"unlikely a treatment is composed of much chattering"*[12].

When in contact with the animal, the relational character of the patient comes out clearly and allows observing if he has a predilection for a verbal rather than corporal contact method. Moreover, if true that there can be blocks or resistances, scotomization or rigidity of the body, it is also true that activity with an animal naturally leads the interaction to a communicative level that can be considered non-verbal, even if able to maintain linguistic aspects.

In this process, after a variable time of knowledge and pre-contact[13], the corporal aspect becomes the central figure, while

4 Cf. www.salute.gov.it
5 Cf. G. Giovagnoli (2009), *EmotiOnos: le ragioni profonde della scelta*, in P. Reinger Cantiello (ed.), *L'asino che cura*, Carocci Faber, Roma.
6 Cf. F. B. M. de Waal (2008), *L'empatia negli animali*, in *Mente e Cervello*, 44.
7 Cf. M. Spagnolo Lobb, G. Salonia (2003), *Presentazione*, in P. A. Cavaleri, *La profondità della superficie. Percorsi introduttivi alla psicoterapia della Gestalt*, Franco Angeli, Milano.
8 Cf. G. Giovagnoli (2009), *EmotiOnos: le ragioni profonde della scelta*, cit.
9 Cf. P. H. Morris, V. Reddy, R. C. Bunting (1995), *The survival of the cutest: who's responsible for the evolution of the Teddy Bear?* in *Animal Behaviour*, 50 (6).
10 Cf. G. Giovagnoli (2009), *EmotiOnos: le ragioni profonde della scelta*, cit.
11 Cf. I. Bloomberg (1988), *Lavoro corporeo nella terapia della Gestalt*, in *Quaderni di Gestalt*, 6/7.
12 Ivi, 93.
13 Cf. F. Perls, R. F. Hefferline, P. Goodman (1997) (ed. or. 1951),

the verbal aspect becomes less important. In such a situation it is possible to work primarily on the reorganization of the persons relation with the own body[14] and indirectly on unconscious topics and its connected senses.
In this point of view, when working with donkeys the therapist can observe the motor pattern as well as relational patterns of child and adult, but also present again those patterns that have not been learnt or have lost flexibility, because strengthened in the interruption of contact[15].
The opportunity to cling on a mule allows the patient to take an ancestral position where skin and coat, border between self and otherness deeply get in touch. The patient lying down prone on the animals back may feel the heat and breath in a kind of complete *grooming* (mutual body care) that calls to mind parental care. This position allows enhancing the consciousness of one's own abdomen, giving a sense of containment as it happens during the feeding process, where a child can get lost between his mother's arms in a complete fusion with her. On the contrary, the additional movement, where the patient leans his back on the mule's back, gives the opportunity to carry out that separation that leads to open oneself to the world. So the therapist can work with his patients modifying these corporal experiences, allowing the patients to take back their ability to meet and separate flexibly from the other and lay the foundations for a sane dialogue.
Moreover, the slow and respectful approach towards the donkey encourages the appropriation of the patterns in a gradual way, according to the careful modulation of the therapist's activities, which has to use particular thoughtfulness by proposing his patient experiences that correspond to

Teoria e pratica della Terapia della Gestalt, Astrolabio, Roma; G. Salonia (1989), *Tempi e modi di contatto*, in *Quaderni di Gestalt*, 8/9; P. A. Cavaleri (2003), *La profondità della superficie. Percorsi introduttivi alla psicoterapia della Gestalt*, Franco Angeli, Milano.

14 Cf. M. Spagnuolo Lobb (ed.) (1990), *Quale approccio corporeo per un terapeuta della Gestalt? Conversazione con George Downing*, in *Quaderni di Gestalt*, 10/11.

15 Cf. R. Frank (2005), *Il corpo consapevole. Un approccio somatico ed evolutivo alla psicoterapia*, Franco Angeli, Milano.

The therapist's job consists in allowing his patient a fluid mobilization of the emotions and sensations that are accurately repressed or avoided.

the patient's therapeutic course. The therapist's job consists in allowing his patient a fluid mobilization of the emotions and sensations that are accurately repressed or avoided.

Methodological outlines: a clinical experience

The project was divided in series of six meetings of one hour each and the 8 ANFFAS groups of Trieste were involved: each group composed of six or seven adult patients affected by mental deficiency or mental disease combined with serious physical disabilities. The team was composed of two Psychotherapists, two expert donkey tamers and five donkeys. They all worked trying to go beyond the classical behavioural approach[16], focusing on relation and affectivity.
The planning quality arranged and examined together with the ANFFAS educators provided an adaptation of the intervention on every single patient as well as response to needs and developments of a whole group. Work has been done simultaneously on two sides: the cognitive one (language, body patterns and focal attention) and the relational affective one, allowing patients to encourage their own consciousness on the borders of contact.
It was possible[17] to operate on the different interruptions of the contact cycle during the therapy. Here a description as an example of the projective experience, where the attempted need, even if evident, cannot be expressed – with consequent projection of necessary aggressiveness on the animal to that expression[18]. In that situation the patient violently pulls the donkey with severe tones and verbalizations, like *"do not be stubborn, I am the one who gives orders!"*,

16 Cf. M. Zanobini (2005), *Disabilità mentale*, in M. Zanobini et alii, *Psicologia della disabilità e della riabilitazione*, Franco Angeli, Milano.

17 Cf. G. Salonia (1989), *Tempi e modi di contatto*, cit.; G. Iaculo (1996), *Tempo e relazione nel processo terapeutico con la struttura esperienziale narcisistica*, in *Quaderni di Gestalt*, 22/23.

18 Cf. F. Perls, R. F. Hefferline, P. Goodman (1997), *Teoria e pratica della Terapia della Gestalt*, cit.

or moves back frightened further to small movements of the animal, in response to the attempt to lead or stroke him. The interruption acts as soon as anxiety, for example coming from fear of being rejected or to fail, makes the flow of contact untenable.
In that specific modality of interruption much energy is available; however, the patient also perceives to repress it due to the impossibility of his own borders[19]. Treatment with the donkey seems to have some distinctive features able to represent a naturally adequate support. Indeed, if the therapist, well aware and professional in his role, has to place himself as holder of the patient's energy, letting him experience a relation that offers support, the donkey by nature embodies and receives, offering a moderate, calm, patient and non-judging response, able to infuse the air with confidence.

Conclusions

Through the experience of working with donkeys it has been put to the test that when it turns out to become difficult for a person to create a relation[20], the donkey acts as a bridge and catalyst, creating gleams of light in order to foresee the opportunity of an interaction[21] with the patient.

When it turns out to become difficult for a person to create a relation, the donkey acts as a bridge and catalyst, creating gleams of light in order to foresee the opportunity of an interaction with the patient.

19 Cf. G. Salonia (1989), *Tempi e modi di contatto*, cit.; M. Spagnuolo Lobb (1990), *Il sostegno specifico nelle interruzioni di contatto*, in *Quaderni di Gestalt*, 10/11.
20 Cf. G. Rondinella, A. Rizza (2001), *La relazione terapeutica con lo psicotico: descrizione di due casi clinici*, in *Quaderni di Gestalt*, 32/33.
21 Cf. M. Spagnuolo Lobb, G. Salonia (2003), *Presentazione*, cit.

Abstract

The neotenic elements, the sociality, the empathy and the inborn capability of being welcoming make the donkey an excellent co-therapist, able to encourage the process that brings the patient to change through awareness and acceptance. Especially after the pre-contact the body work comes out in a natural way, so that you may observe the patient's motor and relational schemes, and the psychotherapist will be able to suggest again what has not been learnt or has been missed as to flexibility. What strength may assume the therapy with donkey when acted according to the GT approach? This article tries to give an early answer with reference to a two-year lasting project, which involved about fifty patients.

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Salonia G. (1989), *Tempi e modi di contatto*, in *Quaderni di Gestalt*, 8/9, 55-64.

Spagnuolo Lobb M. (1990), *Il sostegno specifico nelle interruzioni di contatto*, in *Quaderni di Gestalt*, 10/11, 13-24.

Spagnuolo Lobb M. (ed.) (1990), *Quale approccio corporeo per un terapeuta della Gestalt? Conversazione con George Downing*, in *Quaderni di Gestalt*, 10/11, 25-34.

Spagnuolo Lobb M., **Salonia** G. (2003), *Presentazione*, in P. A. Cavaleri, *La profondità della superficie. Percorsi introduttivi alla psicoterapia della Gestalt*, Franco Angeli, Milano, 9-13.

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Transfigurations (particular installation SITE#1)

CHARTING THE BUMPY ROAD OF COPARENTHOOD: Understanding the Challenges of Family Life

McHale J.P. (2007), Zero To Three, University of Cornell

James McHale's book exhorts researchers and professionals who are interested in relational contexts, home life and evolutionary courses, as well as parents and children not to lose sight of the way towards care of emotional bonds. Through a careful and well-articulated longitudinal study about the joint management of taking care of the children in their first three years (*Families through time project*), the author lets us observe the *transition to coparenthood*: a critical way in conjugal life, where both parental partners confront each other, expressing different styles or alliances regarding their children's care and education.

Among different research branches aimed for the observation of parents-children relations, from crucial, protective and hazardous variables of developing processes (emotional, social) and from familiar trends, that surely make us understand the genesis of primary relationships, McHale's study on the families opens a perspective that goes beyond the unity of observation and dyadic formulations (mother-child, father-child): *the primary triad mother-father-child*, already fully analyzed by other research groups[1], is specifically seen as a parallel interactive background to dyadic experience. Moreover, it is also used as privileged field even in the services of mental health, for the (early) individuation of welcome procedures, evaluation and support to be addressed to parental couples and family groups. Further on it is used to encourage an effective connection between research and clinic by means of reliable codify-

1 E. Fivaz-Depeursing, A. Corboz-Warnery (2000), *Il triangolo primario*, Raffaello Cortina, Milano. Among the several researches and applications of the model LTP, cf. M. Malagoli Togliatti, S. Mazzoni (eds.) (2006), *Osservare, valutare e sostenere la relazione genitori-figli*, in *Il Lausanne Trilogie Play clinico*, Raffaello Cortina, Milano; Simonelli et alii (2009), *Il Lausanne Trilogue Play: potenzialità diagnostiche e prospettive di intervento nella valutazione delle competenze interattive familiari*, in *Infanzia e Adolescenza*, 8 (1).

ing systems of interactive methods directly observed between parents and children, without reducing the complexity of the family system and the becoming of family bodies in their organizing together.
The book seems not to be afraid of the challenges connected to the transition of *coparenting*, metaphorically represented by a bumpy road *(the bumpy road of coparenthood)*. First of all, it describes the features and its theoretic as well as clinic importance. Moreover, it relates to a focused study about waiting times of some couples that just have become parents, going through the first months of pregnancy up to the trot age as well as about the hopes and expectations nurtured by the same, thinking about family life during the last months of gestation and then after the child's birth.
The thorough attention to the description of the observation and evaluation procedures of the joint management of the care allows seeing the quality of coparenting alliance already after three months of the child's birth, even in clinical field. This is meant as the faculty of mutually supporting and working together in the profession of being parents. Such family alliance also becomes an indicative variable of the early adaptation level of the couple already three months postpartum (turning out to be the moment of greatest conjugal dissatisfaction) as well as of the connection between conjugal and coparenting functioning, analysed in groups of parents with children aged one, through home visits of the research group and the use of *Coparenting Scale*[2]and the *Coparenting and Family Rating System*[3], as evaluation systems of the family triad. The intertwined coparenting dynamics and the adaptation ability of the child, even observed when a new family member in the subsystem of siblings joins, is indeed emphasized through a report of several studies on groups of parents with babies, conducted by the author since the Eighties. The initial hypothesis was referred to the correlation between a good level of solidarity in the parental partnership and the presence of other coparenting co-operation and supporting indications, or to be more precise, of a lower number of conflict and disengagement indications.
The book has been edited avoiding technicalities and is also carried out by some motivating questions (referred to continuity of the time of coparenting adaptation and of the son), described in a long review on families' needs and on coparenting themes, characterized by a discovering attitude on what these families allow us to learn in the course of time: *what have we learnt and what should the families know?*
Moreover, there are epistemological observations of Gestalt Therapy on the evolutionary theories as well as on the Infant research on such theoretic and clinical considerations. These have been elaborated from the observation of the child in contact with his own care-giving environment that sees interactions as if they were a relational dance or a of being-with-us scheme.[4]
In other words, the observation of children through the interactions with the coparenting couple seems to bring out, in a fluent way, the implied sense of a vision of the growth seen as a progressive unity change *"of being-us-with"*, delineating steps of a paradigm change that opens to the relational triangle (coparenting couple and child) and where: the dyad between the two parental partners regulates every single parent-child dyad. Therefore, the relationship of a parent towards his own child evolves, if it comes from a valid support with and for the co-parent, who accepts the function and the evolutionary task. Indeed, the Gestalt Therapies' perspective highlights a relational being-environment integration process, seen as a creative act where the being approaches the environment in order to take what is useful for his own growth through a self-regulated process (compare organismic self-regulation) that lives on an internal (an not external) need in terms of relational backgrounds. However, the self-regulation has to be seen as

2 J. McHale (1997), *Overt and covert coparenting processes in the family*, in *Family Process*, 36.
3 J. McHale, R. Kuersten-Hogan, A. Lauretti (2000), *Evaluating coparenting and family-level dynamics during infancy and early childhood: The Coparenting and Family Rating System*, in P. Kerig, K. Lindahl (eds.), *Family observational coding systems: resources for systemic research*, Erlbaum, Hillsdale, NJ.
4 G. Salonia (2005), *Prefazione*, in P. L. Righetti, *Ogni bambino merita un romanzo*, Carocci, Roma.

a merely relational process when referred to relational backgrounds - between the participants to that relation - rather than to behaviour. Therefore, it allows to look to the relation between parent and son (and vice-versa), remembering the relational background between parents since they are parents, as well as the background of any parent towards relation of the other partner with the child[5].

As a conclusion, James McHale's work puts us in front of the challenge to start from the recognition of the limits of research and observations that exclusively consider the mother-child or father-child dyads. Going beyond study unities and pre-established clinical research to assume triadic unities as field of analysis, leads us to backgrounds of a child in front of two significative faces: towards a new epistemological horizon open to understand the evolutionary models and "to deepness of the own sacrifice" from the parents for the own partner and the own family.

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5 Cf. G. Salonia (2009), *Letter to a young Gestalt therapist for a Gestalt therapy approach to family therapy*, in *The British Gestalt Journal*, 18 (2).

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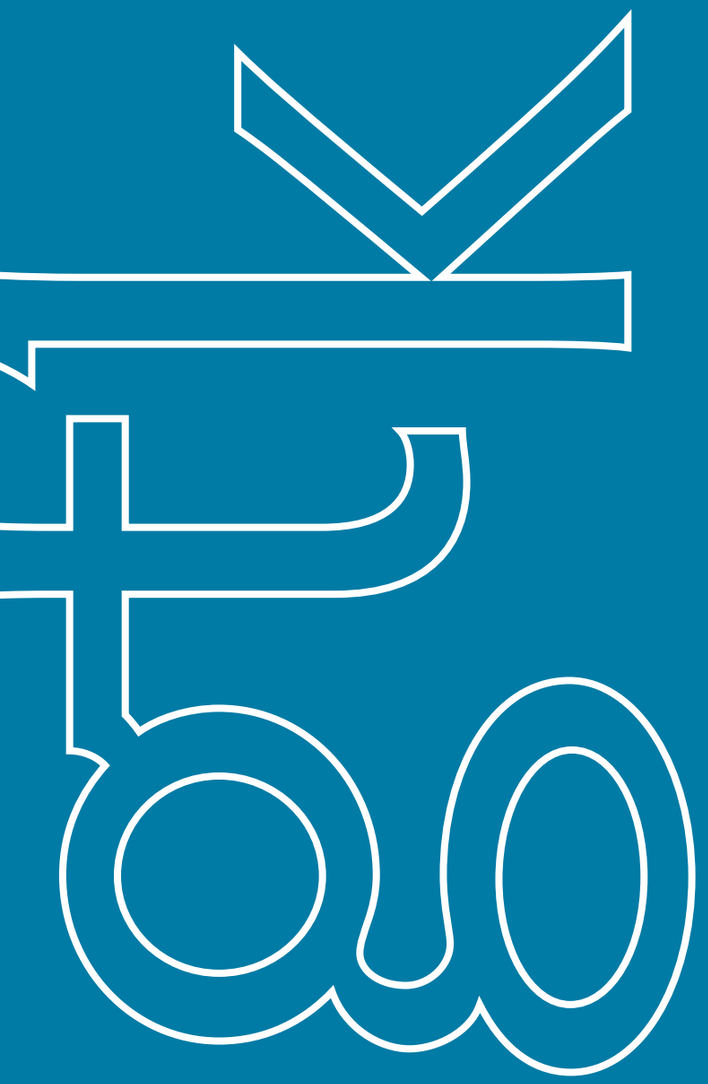


MINDFULNESS AND BRAIN:
Reflection And Attunement In The Cultivation Of Well-Being

Siegel D. J. (2007), Norton, New York

It is years that the engagement of Daniel Siegel is addressed to the research between different domains of knowledge (such as science and spirituality), in order to reach a deeper understanding of internal and interpersonal human experience. In particular, his scientific passion is addressed to "understand *how* relations help us to shape our lives and our brain". Since the beginning of the Nineties, the author has been trying to promote an interdisciplinary vision of mind, through the perspective of Interpersonal Neurobiology, integrating completely different study methods, like neuroimaging and meditation.

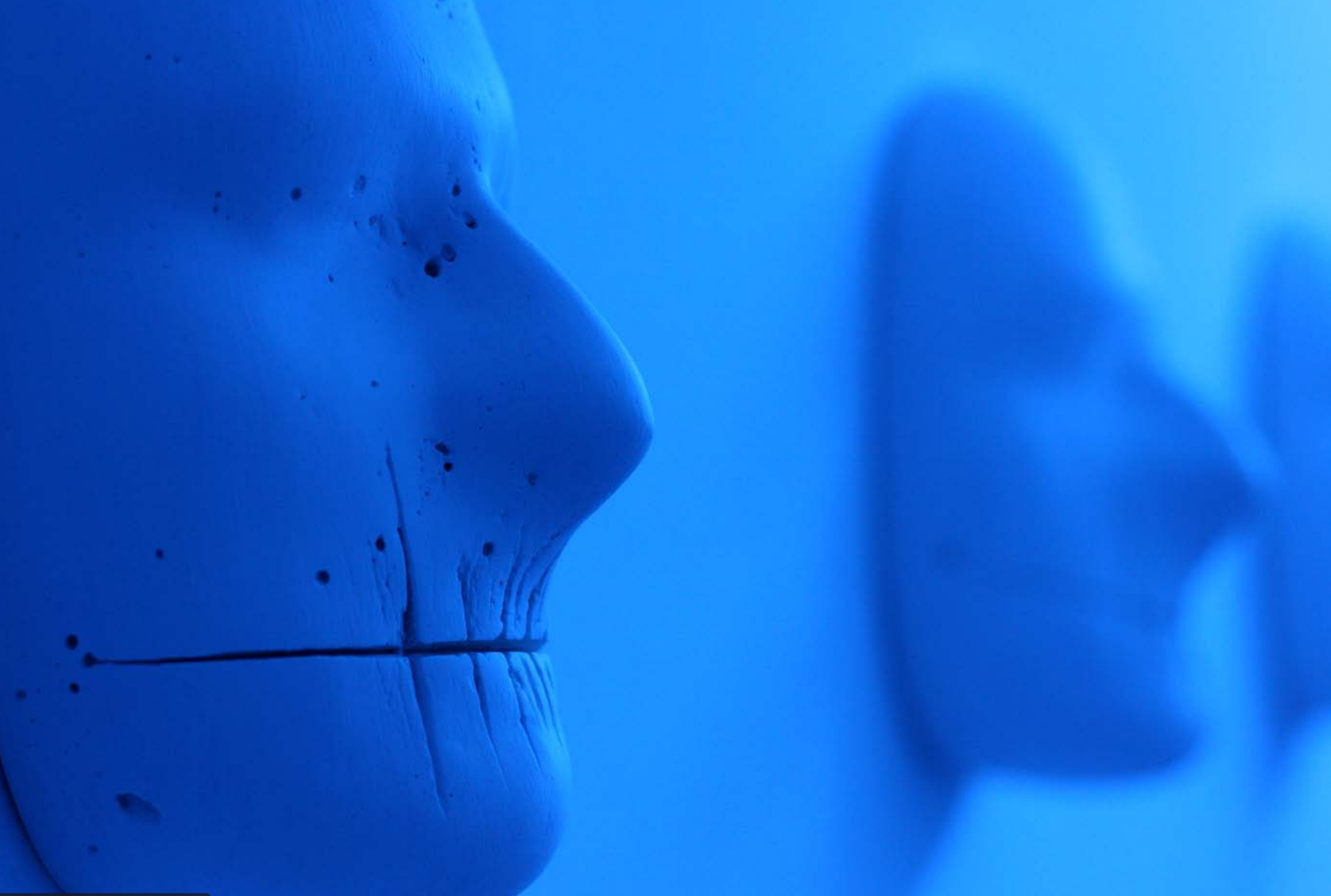
Going along the same double line of the meditative experience on one side and the empiric research on the other side, Siegel accompanies us through this interesting trip in the field of mindfulness and its practical use. The english word, usually translated as "mental presence" or "full consciousness", points out the ability of completely living the experience of the 'here and now', through the exercise of a conscious and non judging attention at the present moment. A similar "practice" can be found in the contemplative traditions all around the world: in the christian centering prayer as well as in yoga, in thai chi chuan as well as in the buddhist meditation.

Beyond its spiritual origin, mindfulness can represent an efficient antidote to an involuntary and unconscious lifestyle and is able to induce those backgrounds of torpor and existential emptiness we also find in our patients.

Contemporary society exposes us to fragmentary and complex stimuli; this creates a necessary condition for a progressive alienation of men. Indeed, according to the author we are less willing to establish those human interactions that turn out essential even to shape the connections between our neurons. In a context like that, it becomes difficult not only to agree with each other, but also agree with ourselves simply to breath and to "stay".

Siegel explains us with scientific richness and consistency the uses of mindfulness in the field of education, clinical medicine, psychotherapy and more generally to understand and promote the well-being.
Not only can mindfulness be seen as a sort of training within the therapy, but also the therapist's "mindful" attitude towards his patient turns out to be therapeutic itself. In fact, such tendency of empathetic opening towards the patient stimulates and promotes a mutual focusing of the attention about what comes out in the encounter of minds. The development of this process for which the protagonists begin to mutually resound with one's own mental state (syntonization), form for Siegel the hub of the therapeutic change.
An only risk: many of the concepts we meet in these pages (for example the attention to unfold the experience in the 'here and now', to do a complete experience freeing oneself of the bond of mental categories, the definition of the Self not as a "result" of integrative processes between organism and environment, but as the *process itself* of that integration) may infuse a certain sense of *dejà entendu* in the Gestalt Therapist. Maybe it is more gratifying to consider that the intuitions of Perls and Goodman of nearly sixty years ago, nowadays receive more and more confirmations.

Fabio Presti



Transfigurations (particular installation SITE#1)

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