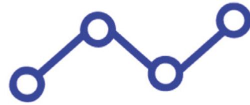

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Opinion Article

How the world became: a phenomenological-systemic reading of traumatic reorganization

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ABSTRACT

Trauma transforms the field of experience. Existence remains the same, yet the way one can experience it changes. Footholds and reference points reorganize – what once provided orientation becomes uncertain, the familiar turns strange, or simply no longer offers support. This transformation marks a discontinuity between what was, what is, and what will be, which becomes clearer when lived experience is approached through a dialogue between phenomenology and complex systems theory. The world does not return to "how it was before" simply because danger has passed, and therapeutic work takes the form of recalibrating safety thresholds, rhythm, and possibilities for contact. It involves recognizing the protective logic of emergent patterns and reopening a broader experiential organization in which trauma no longer constitutes the entire horizon. This orientation articulates itself in two complementary movements: participatory presence, which recognizes and accompanies lived experience as it unfolds, and experiential proposal, which invites the person to actively explore new experiential possibilities. Modulating between containment and exploration allows experience to become livable again, reopening margins of choice and a more flexible way of inhabiting feeling, thought, and action in the world.

Keywords
Trauma, Gestalt psychotherapy, Complexity, Phenomenology, Reorganization.

ABSTRACT IN ITALIANO

Il trauma trasforma il campo dell'esperienza. Il paesaggio dell'esistenza resta lo stesso, eppure cambia il modo in cui è possibile muoversi al suo interno. Si riorganizzano appoggi e punti di riferimento: ciò che prima orientava diventa incerto, il familiare diventa estraneo o, semplicemente, non offre più sostegno. Questa trasformazione introduce una discontinuità tra ciò che era, ciò che è e ciò che sarà, che diventa più chiara quando l'esperienza vissuta è letta attraverso un dialogo tra fenomenologia e teoria dei sistemi complessi. Il mondo non torna a "com'era prima" semplicemente perché il pericolo è passato,

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e il lavoro terapeutico prende la forma di una ri-taratura delle soglie di sicurezza, del ritmo e delle possibilità di contatto. Ciò implica il riconoscimento della funzione protettiva delle configurazioni emergenti e la riapertura di un'organizzazione esperienziale più ampia in cui il trauma non costituisce più l'intero orizzonte. Questo orientamento si articola in due movimenti complementari: la presenza partecipe, che riconosce e accompagna il vissuto così come prende forma, e la proposta esperienziale, che invita la persona ad esplorare attivamente nuove possibilità di esperienza. La modulazione tra contenimento ed esplorazione consente all'esperienza di tornare vivibile, riaprendo margini di scelta e modi più flessibili di abitare il sentire, il pensare e l'agire nel mondo.

Parole chiave
Trauma, Psicoterapia della Gestalt, Complessità, Fenomenologia, Riorganizzazione.

INTRODUCTION

A landslide reshapes the landscape. Paths that led down into the valley suddenly end. Trees where one used to rest disappear beneath meters of earth. The spring where one drank water remains yet becomes unreachable. The place stays, while moving through it becomes risky and, at times, impossible.

This image approaches what happens after a traumatic event. The field of experience reorganizes under new conditions of stability. When people try to orient themselves using coordinates from before, through perceptual habits, relational expectations, and implicit safety criteria, they stumble over terrain that now responds according to different rules. Trauma introduces a discontinuity into lived experience that persists even at a distance in time: a criticism may be experienced as an attack, feedback as a threat, and a relationship as a risk. In other cases, the body loses its voice and withdraws; feeling flattens into a form of absence. Sleep fragments or becomes the only place left; attention hardens into vigilance, or dissolves into a fog where nothing quite lands.

These transformations concern the very form of experience: the relationship with the body, the quality of time, the way the other is encountered. They reach into the relational space too, in how roles shift, who feels close, and what contact is still possible. The present article examines trauma as a catastrophic reorganization of the experiential field and explores how phenomenological-existential Gestalt practice may contribute to rendering this transformed experiential terrain habitable once again.

CLINICAL BACKGROUND

The reflections developed in this article arise from individual psychotherapy practice in private settings and from sustained clinical work with adults who had lived through traumatic experiences. The clinical vignettes are phenomenological constructions: composite cases, anonymized and substantially reworked, whose purpose is to render recurring field configurations visible and illustrate how they transform body, time, and relationship. They are not intended to constitute an empirical base or claim representativeness. The theoretical integration draws on phenomenological-existential Gestalt [1, 2] and complex systems theory [3, 4], whose dialogue forms the conceptual backbone of the reading proposed here.

TRAUMA AND IRREVERSIBLE TRANSFORMATIONS

The concepts drawn from complexity theory used in this article function as heuristic analogies: they offer a vocabulary for naming patterns that clinical observation makes visible, not a formal model that claims equivalence between physical dynamical systems and lived experience. Where a given analogy risks overclaiming, the phenomenological description of lived experience remains the primary reference. Within this perspective, the reading of trauma as a catastrophic transition, inspired by Thom [5], is offered as a working hypothesis. In keeping with this clarification, the following observable clinical anchors specify how each concept is used. *Attractor* refers to a repeated convergence of experience toward a narrow set of states, such as hypervigilance, emotional shutdown, or relational withdrawal, across changing contexts, with reduced access to intermediate gradations of response [6]. *Hysteresis* refers to the persistence of such states even when external conditions and relational safety improve: the person remains organized around old configurations even when the environment no longer requires them, such

that "being safe" is not sufficient for spontaneous reorganization [7]. *Critical transition* or *instability zone* refers to phases in which regulation becomes fragile and disproportionate shifts occur following minimal perturbations, such as a brief pause, a change in tone, or a sensory cue, often accompanied by increased moment-to-moment variability in affect or contact [8].

More broadly, these dynamics can be situated within the way living systems respond to perturbation, absorbing variation up to a point and reorganizing when that point is exceeded [5]. In this framework, trauma can be read as a threshold crossing. Before a traumatic experience, lived experience tends to maintain relative stability: the body has its rhythms, home feels like shelter, and the future remains something one can lean toward. By analogy with complex systems [3], trauma, whether as a single event or cumulative relational process, can be thought of as a perturbation introducing excessive variation: beyond a certain threshold, the previous organization collapses, and the system settles into a new arrangement [5].

This settling has an adaptive logic. The person as a system reduces experiential degrees of freedom and privileges simpler, more predictable, and more controllable modalities. In terms of complex systems, this dynamic can be described as capture by an attractor: the system tends to return to a few stable states even when the context changes [4]. Hypervigilance is a paradigmatic example: years after a car accident, entering an automobile can immediately reactivate maximum alarm even in the absence of real danger. Alarm becomes a default configuration, even when the environment no longer requires it, and drastically restricts openness to the lived world.

Some changes have memory. Beyond a threshold, it is not enough for the context to become safe again for the system to automatically resume its previous form. In dynamic systems, this phenomenon is described as hysteresis: even when the initial stimulus disappears, the system does not spontaneously return to its pre-existing arrangement. New stability requires specific work. This is why the therapeutic process does not orient toward restoring "before," but toward the emergence of new configurations, more flexible and vital, starting from the current form of experience. It is this form, bearing the trace of trauma, that becomes the working ground.

Post-traumatic experience, moreover, can be unstable, oscillating between extreme states: hyperactivation followed by drops into emptiness, hypercontrol alternating with losses of stability. Near a critical transition, the system becomes sensitive to small fluctuations [3]: minimal perturbations produce rapid and marked changes. A word, or a smell, is sometimes enough; frustration held for a moment tips suddenly into desperation; a real moment of contact disappears almost before it registers. In this sense, the system appears simultaneously rigid and unstable: rigid in that it narrows toward a handful of responses such as hyperactivation and shutdown, yet unstable, because the shift between them happens without warning and without any ground in between. Experience becomes difficult to modulate intentionally. Clinically, what matters is recognizing when the system is in an unstable zone and introducing measured variations. Small variations, such as a change in session rhythm, an invitation to bring attention to details that had remained in the background, or a silence that allows feeling to emerge, may sometimes support clinically meaningful shifts.

ORGANIZATIONS OF TRAUMATIC LIVED EXPERIENCE

From within an embodied and existential phenomenological tradition, drawing primarily on Merleau-Ponty's account of the lived body [9], Heidegger's analysis of temporality and being-in-the-world [10], and Husserl's notion of the pre-reflective life-world [11], trauma can be described not as an external diagnostic category but as a transformation of the very structures through which existence unfolds.

A key orientation for understanding these transformations comes from Husserl's notion of the Lebenswelt [11], understood here as the pre-reflective life-world. It designates the horizon of taken-for-granted obviousness within which experience is originally given in its bodily, temporal, spatial, and relational dimensions. Ordinarily, this background sustains existence without becoming an object of attention: it is the implicit ground from which the familiar world becomes available for orientation and action. Traumatic experience can be read as a rupture of this horizon. What had been simply given, the body as a reliable instrument, time as open and orient-

ed, places as inhabitable, and others as available, becomes uncertain and calls for active reorientation. The four subsections that follow describe how this rupture takes form within each of these dimensions.

The body

In ordinary living, the body supports experience without imposing itself on attention. It is the implicit structure through which the world remains accessible [9]. In clinical work with people who have lived through trauma, this transparency often breaks down: the body becomes opaque, cumbersome, sometimes foreign. In some cases, opacity takes the form of anesthesia. A woman says, "I feel nothing. My body is like dead." In other cases, it presents as hypersensitivity, in which minimal stimuli are experienced as intrusions and a gaze as a threat. A man recounts: "If someone brushes against me on the subway, my body stiffens as if I must fight. I know there's no danger, but the body reacts anyway." For those who have experienced physical violence, trauma is often inscribed in posture and breath. The body becomes organized as a permanent alarm device [12] and activates without conscious decision. The person does not "choose" the alarm: they find it upon themselves, before understanding what is happening. In this condition, feeling can become difficult to inhabit and name. Between sensation and recognizing it as "mine, here, now" [13], a discontinuity can open, and trauma interrupts the elementary circuit connecting feeling, recognizing, and naming.

Time

Existence unfolds through experience in a temporal continuity that links past, present, and future and gives orientation to life [10]. In trauma, this structure is altered: the future contracts, the past pushes into the present, and time no longer feels like something one can move through [14]. Often, the past re-emerges as an intrusion: images and sensations return with an intensity that is difficult to distinguish from the original experience, and for brief moments, the person finds themselves immersed in what happened. A woman who suffered sexual assault recounts: "I was in the car, stopped in traffic. I smelled a scent, a masculine cologne, and suddenly I was there again."

The past does not always return as a scene: sometimes time itself blocks. A man who lost his wife in an accident says: "For me it's always that day. When I wake up in the morning, for a moment I don't know she's dead. Then, I remember. And every time it's like it happens again. There's no after. There's only that moment returning, continuing." Here time loses the quality of possibility. The projective dimension also contracts: imagining change, formulating projects, and thinking about the future becomes difficult. The future no longer orients and assumes the form of repetition without development [15].

Space

Space also changes status. In daily living, the world constitutes a familiar, pre-reflective background, the spatial dimension of the Lebenswelt, whose overall disruption was described above. After trauma, this background loses continuity, and what once appeared familiar demands ongoing monitoring. A man who suffered an assault at home can no longer experience his dwelling as a shelter. In session, he says: "Entering the bedroom is like entering a minefield. I must evaluate every step." The domestic world becomes an environment to decipher, traversed by vigilance [16]. Places change meaning, and the system automatically responds to contexts associated with danger; a closed door or a dark corner can be perceived as a potential threat [17].

The Other and the Relational Field

This transformation also affects the intersubjective dimension and the relational field. On the level of lived experience, trauma often places the person in a position of strangeness toward others. In clinical work, the sense of not being understood emerges regularly: "Friends say 'I understand you,' but they can't understand. They weren't there." Or: "I stopped telling. I see in their eyes they want it to end, want me to return to normal." This sense of distance is often accompanied by shame. The person fears being judged, reduced to their traumatic experience. To protect themselves, they limit contact, hold back parts of their lived experience, avoid exposure, and reduce sharing. Experience remains without resonance, and solitude becomes profound [15].

On the field level, distances shift, rhythms change, and the small implicit agreements that made trust possible begin to dissolve. A man recounts being physically attacked while with a group of friends. What strikes him is the absence of intervention: "We were together," he says, "but in that moment I was completely alone." After the event, he continues seeing the same people and visiting the same places; apparently, nothing has changed, yet something does not fit. The relational field reorganizes, and the positions within it no longer hold in the same way [18]: someone who was reliable can suddenly seem out of reach; closeness no longer means what it did. Familiar reference points lose their obviousness; the weight of things shifts in ways the person cannot yet place.

TRAJECTORIES OF TRAUMATIC EXPERIENCE

In clinical work with people who have traversed traumatic experiences, recurring configurations emerge in how they inhabit experience. They vary depending on whether trauma took shape early within primary relationships or derives from circumscribed events but share a common trait: the continuity of lived experience weakens, sensations and emotions swing between extremes, and the coordinates that once oriented life no longer work in the same way.

In Gestalt vocabulary, these forms can be read in relation to contact interruptions [1], with clinically useful resonances rather than rigid correspondences. Interrupted pathways recall deflection, where approaching contact deviates before completion. Displaced references suggest forms of projection, when internal signals are attributed to context. Abrupt oscillations recall retroflection, in which energy is held back until stiffening or collapse. Surface adjustments evoke introjective processes, insofar as relational expectations come to organize what can be shown more strongly than what is actually felt. Unstable footholds point more broadly to a weakening of support, both bodily and relational.

Gestalt describes how experience interrupts or rigidifies in process; the phenomenological-systemic lens focuses on how, after fracture, the field seeks stability by restricting possibilities. The two perspectives observe the same phenomenon at different levels and can integrate without forcing. The five configurations that follow offer a way to make these trajectories visible.

Interrupted pathways: Some actions or projects that were once practicable now come to a halt. In other cases, they begin and then collapse. For a woman with sexual violence trauma, an intimate relationship may become difficult even to envisage: the possibility does not readily take form, and the path toward it remains closed. The same kind of interruption can affect ordinary movements such as leaving home, getting into a car, or entering a crowded room.

Unstable footholds: Support becomes unreliable in places where it was once taken for granted. A man who lost his son in an accident struggles to sleep and to eat regularly. Even his body no longer feels like a secure base. What once sustained him now wavers, and basic forms of restoration, such as rest or a sense of bodily presence, no longer provide grounding.

Displaced references: Signals that, once oriented, experience no longer functions in the same way. A person with early relational trauma may react to a slightly altered tone of voice as though it were aggression. The response is organized around a reference that is active, but no longer contextually grounded. A smell or a posture can be enough to call forth responses belonging to the past while presenting themselves as necessary in the present.

Abrupt oscillations: The emotional field loses continuity. Experience moves rapidly from hyperactivation to blockage, from relative clarity to confusion, through abrupt transitions with little intermediate modulation. A person may still appear lucid and then, within minutes, feel flooded or disorganized. This makes it difficult to anticipate one's own reactions or rely on one's own stability.

Surface adjustments: Internal experience is continuously adjusted to relational expectations. At a dinner with friends, a person may convert emptiness or vigilance into socially acceptable behavior, appearing quiet, polite, and present while inwardly feeling absent or on alert. Repeated over time, this operation produces distance. What is felt and what can be shown drift apart, and the effort of maintaining that gap gradually wears the person down.

These configurations describe recurring ways the post-traumatic field attempts to hold itself together. Recognizing them helps orient the work because they indicate what is interrupted, unstable, or out of alignment here and now.

PRESENCE AND PROPOSAL IN CLINICAL PRACTICE

Recognizing these trajectories changes the direction of intervention. The work does not seek to restore lost continuity: it starts from the form that is, as it is, and works on conditions for it to expand and breathe. In this perspective, the clinical process is organized around two complementary movements that traverse the entire journey: participatory presence and experiential proposal.

Participatory presence: This is a way of being there that allows the therapist and patient to remain together when the field becomes unstable, without the encounter breaking down. After trauma, the person often carries an implicit conviction: their own lived experience is too much, no one can hold it, and saying it destroys the relationship [19]. Participatory presence works on this point in a simple, concrete way: remaining. Remaining when what emerges is intense, or fragmented, or hard to hold, without the reflex toward control and without retreating. It is participatory because the therapist is touched by what they encounter. The involvement is felt, yet there remains sufficient stability to avoid being dragged into alarm or withdrawal. This capacity to be involved without being overwhelmed has an essential regulatory function [20]: in the here-and-now of the relationship, it demonstrates that experience can be sustained and contained. In practice, it is not an abstract attitude. It consists of small, precise, calibrated gestures: holding gaze while the person recounts something difficult; letting silence stand when it needs to; slowing down when things start to accelerate; sometimes finding a word that gives what is happening just enough form. These are micro-actions building a climate where experience can unfold without collapsing into the usual arrangements that guaranteed survival. This notion overlaps with therapeutic presence as described by Geller and Greenberg [21], but it emphasizes a specific function in post-traumatic work: showing, through the sustained continuity of the encounter itself, that even intense or fragmented experience need not rupture contact.

Experiential proposal: This movement accompanies participatory presence and opens action space within experience. Trauma affects the capacity to act: emotions, thoughts, and bodily reactions emerge invasively, and the person finds themselves undergoing them. They recount what happens, but often don't feel they can do something with it. The experiential proposal introduces a simple movement: doing something, here and now, with what is happening, so that lived experience is no longer only overwhelming. It serves to find a practicable path in the transformed landscape, to open where passage is closed. Sometimes it means returning to a bodily detail and following it for a few moments; sometimes it means changing distance by a few centimeters, shifting gaze direction; sometimes it means giving voice to what emerges; sometimes it means trying a boundary, a "no," a request, or an intentional interruption of an automatism. At other times, it means working with an image, a scene, an incomplete gesture, or a micro-action, making experience more habitable in the present. Proposals are calibrated to the person's and field's stability and can assume different forms [1]. The point is not the exercise itself, but the micro-transformation it makes possible: moving from experience that overwhelms to something more habitable, a margin of choice, and some thread of continuity between feeling and the ability to respond.

When the proposal is adequate, change often does not have the appearance of a "solution," but of a concrete variation in contact quality: breath expanding, body relaxing, gaze softening, a word finally finding its place. These are signs showing the field is no longer entirely captured by the survival arrangement.

The experiential proposal is related to, but not identical with, the classical Gestalt experiment [1]: whereas the experiment is typically oriented toward expanding awareness, the proposal in trauma work is constrained by the criteria of reversibility, minimality, and timing, making it a trauma-informed micro-experiment calibrated to the instability of the post-traumatic field. Reversibility means that exploration can be suspended, slowed, or interrupted when activation exceeds the stability threshold. A proposal remains viable if it always provides a return path: stopping, stepping back, or returning to a more stable foothold. In this way, the limit is respected, and experience does not turn into renewed overload. Minimality means introducing small, targeted shifts acting on leverage points. The aim is to interrupt consolidated automatisms that rely on the survival plane but are costly on the existential plane, thereby making previously excluded possibilities accessible [22]. A small step can open much;

a step that is too large risks destabilizing the field and preventing the experience from unfolding and reaching closure. Timing means modulating intervention according to the stability of the configuration. When the field is unstable, priority is given to presence and containment. When the encounter can hold, an exploratory step may be proposed, inviting the person to move actively within experience. In practice, the intervention follows what the process allows: supporting stability for as long as needed and introducing exploration when space opens.

This alternation between presence and proposal is itself readable through rhythm: the speed of the encounter, the density of pauses, the micro-movements of speech and body signal whether the field is expanding or contracting and orient the therapist's modulation accordingly.

After trauma, experience often loses rhythmic continuity. At times it speeds up abruptly; at others it drags or stalls. It can also swing quickly from one state to another. For this reason, regulating rhythm becomes an intervention in itself. When experience accelerates, one can introduce slowing. Returning to a phrase, pausing on a word, or inserting silences changes the temporal organization of the relationship and restores a temporality that can be inhabited, in which feeling can emerge without being immediately translated into narration [12]. A woman rapidly recounts a difficult episode, moving from one detail to the next without pause. The proposal is to stop and return to a phrase just said: "You said 'I couldn't do anything.' Stay there. What do you feel when you say it?" The woman slows and, after a few seconds, responds: "I feel a weight in my chest." When speaking, rhythm accelerates, and the body also tends to change rhythm: breath shortens, shoulders lift, and musculature contracts. Intervening in the rhythm of speech often indirectly affects the way of being in the body. At other moments, experience can freeze: the account interrupts, the body immobilizes, the person remains still. Here, the proposal can be a minimal gesture, chosen and slow, gently re-engaging the body and giving support to contact. "Stay on that chest weight. Place your hands on the armrests, slowly." After a few seconds, she says, "I can stay with this." Her breathing eases slightly.

When rhythm is regulated and stability increases, another step often becomes possible: putting words to what is happening. Words give form to experience, make it visible and shareable. If a person recounts a difficult episode and then interrupts, the gaze fixes and the breath changes, one can simply note: "Something changed now." The phrase brings attention to a passage in the encounter and opens space to notice what's happening. Naming also concerns the body. "There's tension in the shoulders," "breath stopped," "hands are clenched" make sensations more present and recognizable [9]. Sometimes this is enough for something to begin to change. Giving voice then means letting the phenomenon find minimal expression. An "enough," an "I'm afraid," an "I can't do it." In this way, words support the process, instead of closing it.

NOTE FROM A SESSION

This session excerpt shows, in continuous sequence, how presence and proposal interweave in trauma work.

A woman arrives at the seventh session and recounts an attempt to go out. Six months after a street assault, she no longer goes out alone. Saturday, she reached the entrance door and stopped. "I couldn't do it," she says, with frustration and shame. In the account, panic re-emerges: heart racing, short breath. The body reproduces it in the here-and-now, one hand on her chest, rhythm breaking. We slow down. I ask what she feels now. After some silence: "Still some of that. Here."

I propose staying with the sensation and breath, without forcing. After a few minutes, something releases slightly: "It loosens a bit." We return to the entrance door. "What did you see?" "Too many people." "And what were you telling yourself?" "I had to make it." When she repeats that "had to," her body stiffens. I ask what the body says instead. After a long silence: "I felt blocked."

Alongside the blockage emerges a clearer internal phrase: "It's not safe." In recognizing it comes shame, then judgment: "I feel stupid. Weak." We stay with this too, without discussing the content. I propose a simple hypothesis: that voice can be a form of protection. The body learned something six months ago and now repeats it as an alarm signal. She cries. "It's true."

Underneath emerges the fundamental fear: "What if I never go out again?" This is acknowledged without being minimized; it makes complete sense within her story and

current experience. We shift the objective: instead of forcing the exit, building a practicable next step. Gaining another centimeter. Saturday, there was already a step: reaching the entrance door. And that's not small.

We look for support for the next verifiable micro-step. She thinks of her sister: "With her I'd feel less alone, less exposed." The step becomes concrete: reaching the entrance door with her sister. "I could," she says. Not 'must'. We add a safety clause: if at the entrance she blocks, it's okay. Not a failure, but information, and we can return to work on it.

The session exemplifies how recognizing field configurations, such as interrupted pathways, unstable footholds, and displaced references, orients the work. We did not reconstruct the assault. We worked with what it left: a body on alert, a space that had become threatening, a threshold interrupting movement. We looked for ground, breath, and relationship, built a minimal crossing, and recognized the protective function of fear. The rest will come, step by step, at the rhythm her system can sustain.

TWO FORMS OF TRAUMA

The post-traumatic landscape does not have a single form. Sometimes trauma structures itself early, within unpredictable or incoherent primary relationships; other times it derives from a circumscribed event that abruptly interrupts the continuity of life [23-25]. In both cases rhythm, footholds, and the possibilities for contact change, and so does the way threat takes place in experience. In early trauma, especially when exposure is repeated and relational, threat tends to become diffuse and intertwine with attachment: it shapes how the other is anticipated before anything has happened, feeds shame, and slowly affects the capacity to remain in contact with oneself and with others [23, 24, 26]. In event trauma, the fracture is often more recognizable and what follows can oscillate between intrusive reactivations and avoidance, with a background sense of danger that lingers even when nothing in the present warrants it [24]. The two vignettes that follow show how this difference orients part of the work.

Early Relational Trauma

When trauma takes shape early within unpredictable primary relationships, the field tends to organize around automatic vigilance [27]. A woman brings to therapy a constant tension in intimate relationships, despite the absence of evident threats. In session, she speaks quickly, repeatedly asks for reassurance, and experiences every pause as a signal of danger. Over time, a history begins to emerge in which, as a child, she tried to read from small details whether the day would be "good" or "bad." In the present, that way of anticipating remains active: attention stays oriented toward the other, and the body remains contracted. Work begins with the rhythm of the encounter: small pauses, returning to a phrase, clarifying intention, pausing in order to feel rather than to be evaluated. Within these pauses, what had previously been covered by vigilance becomes more recognizable. One day, while recounting a discussion, she stops and notices "a tightness in the stomach." We stay there. After a long silence she says: "Anger." The point is not to discharge it, but to make it workable: to recognize its nuances, feel it in the body, and find possible ways to express it without having to immediately transform it into control or self-blame.

Single Event Trauma

When trauma derives from a circumscribed event, the fracture tends to be sharper. A fifty-two-year-old man suddenly lost his adolescent son in an accident. In the following months, he traverses days automatically and describes an absence of feeling, as if life continued from a distance. This closure is not voluntary: it is a protective response to overwhelming emotional impact [28], and attempts to directly approach pain produce further closure. Work then proceeds by lateral paths. The encounter orients toward memories and images of daily episodes. In one session, while recounting a mountain trip, he always interrupts at the same point. We stay there, at the point where the account breaks. Silence lengthens, breath changes. In a low voice, he says: "I can't say it." Shortly after: "I miss his smile." In this passage, experience takes form precisely where language couldn't go further. In subsequent sessions, work continues by alternating between listening and small experiments: bringing attention to his breath while pronouncing his son's name, drawing a shared place, and imagining telling him something left suspended.

THE THERAPIST'S POSTURE

Working with trauma demands a posture able to stay close to intensity while keeping an eye on field stability. This means phenomenologically reading what is happening in the patient and in the relationship as it happens. Speaking rhythm, breath, gaze, posture, micro-interruptions in discourse, and gesture are not isolated signals: they indicate whether experience remains habitable. This reading serves mainly to orient modulation between presence and proposal [21]. Sometimes experience is still traversable, and one can explore. Other times it restricts: breath shortens, gaze fixes or loses itself, body stiffens or empties, discourse accelerates or interrupts. In those moments, work returns to time and footholds: slowing, making space, reducing intensity, bringing attention back to the here-and-now, until contact becomes possible again.

This modulation does not follow fixed rules. It is a competence refined with experience and inevitably includes error: sometimes one goes too fast, at other times one holds back beyond what is necessary. Adjustment happens by listening to what the encounter returns, moment by moment.

The therapist, too, inhabits the encounter field as a person, not only as a professional role. Breath, bodily tensions, or a sudden inner pull to do something may all function as a process of information [2]. Noticing changes like these in oneself often suggests that the process is approaching a threshold at which intensity risks exceeding what can be fruitfully worked with. Table 1 summarizes some process indicators within the encounter to which attention may usefully return during the session.

Working with trauma means entering in contact with intense material and remaining. It requires tolerating uncertainty: it is not always clear what to do, and sometimes intervention consists precisely in not rushing toward a solution, letting experience take its form. This posture develops over time through self-work, supervision, and experience. A frequent risk is reparative acceleration. The desire to help can transform into

Table 1. Suggestions for orienting in clinical process. The first two columns describe encounter configurations, whose elements may coexist and shift rapidly during the session; the third suggests possible clinical movements.

WHEN ENCOUNTER SHOWS STABILITY (EXPERIENTIAL PROPOSAL PRACTICABLE)	WHEN STABILITY REDUCES (PRESENCE AND CONTAINMENT)	WHEN DESTABILIZATION OCCURS (SUGGESTED MOVEMENT)
Breath maintains relatively regular rhythm, with moderate oscillations	Breath shortens, blocks, or loses regularity	**Slow down. Invite attention to breath, without directing it**
Posture is stable and can modify without stiffening	Posture stiffens or collapses	**Reduce intensity; offer a minimal grounding gesture**
Gaze can meet and move away without fixing	Gaze fixes on a point or moves far away	**Name what is visible. Reduce demand and simply remain.**
Language maintains a thread: comprehensible phrases, connectable passages	Language fragments, jumps and discourse discontinuities appear	**Slow the rhythm of speech; fewer words, more presence**
Emotions emerge and remain tolerable	Emotions overwhelm, or extinguish abruptly	**Stay together. Breathe. Help maintain contact with oneself**
Attention can return to one's own feeling	Access to one's own feeling is foreclosed	**Return to the body; guide attention through small, reversible movements**
Pauses are sustainable	Silences activate urgency, flight, or closure	**Let silence stand, without rushing to fill it**
Emotional states show variability and gradations	Experience rapidly oscillates between emotional extremes	**Regulate rhythm first; stability before any proposal**
Body is present to experience	Body is experienced as distant, foreign, barely accessible	**Grounding: gently focus on bodily signals, without insisting**
Relational field maintains a sense of connection	Relationship loses continuity: the other appears distant or unreachable	**Return attention to the here and now; give feedback on what is happening**

a push to do, fill, shift topics, and propose techniques. These are understandable, often automatic movements that can, however, force the process and reinforce the implicit idea that there's something to be repaired quickly. In the post-traumatic landscape, work proceeds by verifiable steps, leaning on what holds in that moment. Slowness, here, is part of the intervention.

This work also affects the one who accompanies. Repeated exposure to traumatic material can leave traces, and vicarious trauma is a predictable consequence, not a sign of weakness [29]. Sleep disturbances, intrusive thoughts, hyperattention to danger, or a quiet emotional withdrawal are signals to be recognized and brought into supervision and other reflective spaces. Here too, noticing automatisms is not about self-blame; it is about recovering some margin of freedom.

Within this posture, there is also trust in life's self-organizing processes [30]. In complex systems, even when profoundly destabilized, an intrinsic capacity to reorganize toward more vital forms persists. Clinically, this means creating favorable conditions for experience to find a new form without being forced, remaining present and offering possibilities compatible with what the field can sustain [31]. Sessions that seem immobile can be phases of absorption and integration; transformation may mature slowly and then emerge suddenly. Within this perspective, simplexity becomes relevant. Berthoz [22] describes the capacity of living systems to find solutions sufficiently simple to be practicable and sufficiently precise to produce significant effects. In clinical work, this orients the therapist toward minimal, targeted interventions, chosen in relation to the ongoing process: an essential question, a slowing, a suspension, an invitation to bring attention to a bodily sensation in the background. Simplexity seeks the smallest shift that can support reorganization from within the person's own resources, without reducing the complexity of experience.

LIMITS AND PERSPECTIVES

This reading is intended mainly for situations in which trauma leaves a persistent reorganization of how experience is inhabited, rather than a circumscribed set of symptoms. The lens arises from individual work in contained and stable settings, with adults who can identify a relatively recognizable before and after. When trauma is early, cumulative, or transgenerational, the fracture between "before" and "after" tends to blur, and the framework requires adaptation, because reorganization does not have a single trigger point [23]. In group contexts or in immediate emergency settings, other dynamics come into play that remain in the background here.

The phenomenology presented here arises from a Western European and Italian clinical context; other cultural settings may generate different post-traumatic forms. The connection to catastrophe theory is analogical: it helps give form to discontinuity and reorganization and does not amount to a formal model. The framework offers orientation principles rather than a protocol and requires case-by-case adaptation.

Furthermore, the systemic lens may lead the clinician to privilege observation of patterns, thresholds, and recurrent organizations. This can be useful, but with some patients, the priority remains more immediate: staying in contact, offering presence, and closely following the movement of the field. The framework is also less precise in situations where experience does not settle into a relatively recognizable reorganization but remains for long periods in unstable oscillation between hyperactivation and shutdown.

A limit that emerges with particular clarity concerns trauma rooted in interpersonal violence. The systemic language used in this article is structurally amoral: it describes how experience has come to be organized, not who acted, nor within what context of power. This descriptive neutrality can reduce the risk of pathologizing the person's response, but it also risks dehistoricizing the damage. Someone who has suffered intentional violence at the hands of a person who held power over them does not simply inhabit a dysfunctional configuration; they inhabit a history in which the other chose to cause harm, and they carry a need for recognition that regulation alone cannot meet [23]. Participatory presence, as used in this article, already carries an implicit witnessing function: staying in contact with the intensity of what happened, without retreating from it, has a value that exceeds field stabilization. It is worth stating this explicitly: its absence, or its premature replacement by an experiential proposal, may reproduce the invisibility that characterized the original damage. At the level of the therapist's posture,

these contexts require additional vigilance in the use of self in the field. The therapist may become the projective carrier of the violent figure, and even small gestures, such as a shift in tone or a proposal that is insufficiently attuned, may be experienced as intrusion or overwhelm. In such situations, the clinical work often returns to a more fundamental task: offering a presence capable of holding an unstable and threatening field, so that the person may begin to experience the encounter as something other than danger. From there, the process may sometimes begin to move again, and the therapeutic relationship may gradually become possible as a reparative experience [20, 32]. These dynamics do not invalidate the orientation proposed here, but they do require that the modulation between presence and proposal be supported by ongoing supervisory work, so that the therapist remains in contact with their own experience of the encounter.

Alongside this proposal, there are structured interventions with empirical support for both circumscribed PTSD and more complex traumatic conditions, including phased approaches and specific procedures [33, 34]. At the same time, available evidence indicates that many people move through traumatic events by relying on spontaneous adaptive processes, without needing prolonged therapeutic accompaniment [35-37]. The proposal presented here addresses situations in which these processes do not suffice, or in which experience remains organized around rigid oscillations, restricted possibilities, and pervasive relational difficulties and, more broadly, a subjective sense of no longer being the same person.

Within contemporary Gestalt, various authors have already explored the encounter between phenomenology and trauma, with attention to bodily and relational dimensions [12, 38, 39]. The step attempted here is to extend this line in a systemic-complex direction, treating trauma as a reorganization of the experiential field. From here, several concrete developments open up: examining across clinicians whether the configurations described are recognizably identifiable in practice, exploring different cultural contexts, and qualitatively following process progression over time, including apparently static phases and turning points. Dialogue with neuroscience may also be useful, provided it seeks resonances between descriptive levels without reducing lived experience to neural processes.

CONCLUSIONS

Trauma transforms the territory of existence. Often this transformation takes the form of a profound reorganization that modifies how one inhabits the world. Intentionality, body, time, and relationship change, and experience tend to settle into configurations that rigidly orient ways of feeling, thinking, and acting. The hypothesis running through this work is that when the conditions of life change, what becomes clinically necessary changes as well. Suffering concerns not only what happened, but the way in which, in the present, one continues to live with coordinates that no longer hold.

Phenomenology describes from within how this transformation takes form in lived experience; complexity theory helps to read how it stabilizes, reorganizes, or remains constrained over time. Broken intentionality, an opaque body, blocked time, and relational misalignment [14, 40, 41] are often accompanied by a reduction in degrees of freedom and by configurations oriented toward survival. Clinical work concerns making the present habitable again and reopening access to the future, rather than recovering a "before."

Operationally, the proposed orientation rests on a continuous modulation between participatory presence and experiential proposal. Presence supports the possibility of staying in contact, making shareable what would otherwise remain locked inside. The experiential proposal introduces small, workable variations that reopen something without pushing what the field cannot yet sustain. The criterion remains the construction of workable footholds while respecting thresholds and rhythm.

A limit remains explicit throughout: this framework is a clinical working hypothesis and requires confrontation and research to clarify where it describes the phenomenon well and where it oversimplifies. An openness also remains; reading trauma as experiential reorganization allows one to think with greater precision about transitions, blockages, oscillations, and turning points in the therapeutic process, without reducing experience to symptom.

No one can bring anyone back to before the landslide. After trauma, one does not simply return to the world as it was. Clinical work concerns what becomes possible in changed conditions: recognizing where previous paths no longer hold, finding support where it can be found, and staying with shifts small enough to be real. It is here that transformation becomes practicable, and

life becomes possible again, not as it was and not all at once, but step by step, within a changed world.

Conflict of Interest

The authors declare no conflict of interest in relation to this manuscript.

Ethics Approval

This manuscript does not report human-subject research, does not involve identifiable participants, and does not include patient-level data. The clinical material is presented exclusively as composite, de-identified vignettes that do not correspond to any single individual and cannot be used for re-identification. For this reason, formal ethics committee or IRB review was not sought. The work was conducted in accordance with the ethical standards and confidentiality duties of the Italian professional code for psychologists and psychotherapists, and with the journal's principles for the protection of persons.

Informed Consent

Because all vignettes are composite, substantially transformed, and not attributable to any individual patient, written consent for publication of identifiable case material is not applicable. No names, dates, or other potentially identifying details are included in this manuscript.

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This article does not report results from a dataset. The clinical observations underlying the vignettes exist solely in composite, anonymized form within this text. No underlying dataset exists; therefore no data can be shared upon request.

AI Disclosure

The authors used AI tools to refine grammar, syntax, and translation from Italian to English. All theoretical content, clinical observations, and conceptual formulations are the authors' original work.

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