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Opinion Article

Avoiding retraumatization: six experiential skills in Gestalt trauma work

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ABSTRACT

This contribution aims to promote a dialogue between contemporary Gestalt psychotherapy and some evidence-based experiential psychotherapies currently employed in the treatment of psychological trauma. Starting from the assumption that experiential work with traumatized patients requires specific clinical preparation to reduce the risk of retraumatization, the article identifies six areas of clinical functioning considered central to trauma-oriented Gestalt practice. These areas emerge from a reflective synthesis that integrates contemporary literature on complex trauma, critical comparison with structured experiential models, and clinical observation. The article argues that attention to patient safety does not constitute a constraint on the depth of the therapeutic process, but rather represents a necessary condition for it, and proposes an evolution of Gestalt psychotherapy capable of maintaining continuity with its phenomenological assumptions while integrating the most recent clinical acquisitions in the field of trauma psychotherapies.

Keywords
Gestalt Psychotherapy, Complex trauma, Experiential approaches, Trauma-informed competencies, Therapeutic safety, Therapeutic presence, Clinical integration.

ABSTRACT IN ITALIANO

Questo contributo intende promuovere un dialogo tra la psicoterapia della Gestalt contemporanea e alcune psicoterapie esperienziali evidence-based attualmente impiegate nel trattamento del trauma psicologico. Partendo dall'assunto che il lavoro esperienziale con pazienti traumatizzati richieda una preparazione clinica specifica per ridurre il rischio di ritraumatizzazione, l'articolo individua sei aree di funzionamento clinico ritenute centrali per una pratica gestaltica orientata al trauma. Tali aree emergono da una sintesi riflessiva che integra la letteratura contemporanea sul trauma complesso, il confronto critico con modelli esperienziali strutturati e l'osservazione clinica. L'articolo sostiene che l'attenzione alla sicurezza del paziente non costituisca un vincolo alla profondità del processo terapeutico, ma ne rappresenti una condizione necessaria, e propone un'evoluzione della psicoterapia della Gestalt capace di mantenere continuità con i propri presupposti fenomenologici integrando al contempo le acquisizioni cliniche più recenti nel campo delle psicoterapie del trauma.

Parole chiave
Psicoterapia della Gestalt, Trauma complesso, Approcci esperienziali, Competenze trauma-informed, Sicurezza terapeutica, Presenza terapeutica, Integrazione clinica.

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INTRODUCTION

This contribution arises from the conviction that contemporary Gestalt psychotherapy (GP) must critically engage with the evolution of knowledge about psychological trauma and safe treatment modalities. In the last three decades, evidence-based experiential psychotherapies, particularly Emotion-Focused Therapy for Trauma (EFT-T), Eye Movement Desensitization and Reprocessing (EMDR), Accelerated Experiential Dynamic Psychotherapy (AEDP), Somatic Experiencing (SE), Focusing Oriented Therapy (FOT), and Internal Family Systems (IFS) have developed a systematic corpus of clinical competencies specifically calibrated for working with traumatized patients while reducing the risk of retraumatization.

The purpose of this work is to bring GP into dialogue with these modern humanistic and experiential psychotherapies, identifying convergences and divergences and, above all, extracting six areas of clinical sensitivity from this comparison that are relevant for offering safe and effective treatment to patients with traumatic histories. As highlighted in the recent collection edited by Dimaggio [1], addressing trauma today requires an integrated approach that draws on the clinical insights of different therapeutic traditions.

This is not an invitation to abandon Gestalt identity nor to replace it with technical eclecticism devoid of epistemological foundation. Rather, it is an appeal, supported by contemporary clinical literature, to recognize that experiential work on trauma requires specific competencies that integrate and expand, not replace, traditional Gestalt training. As argued by Courtois and Ford [2], the treatment of complex trauma requires a sequential and relationally grounded approach that integrates stabilization, protected processing, and consolidation. GP, in some of its operational declinations, with its emphasis on experiential intensity and immediate contact, can become iatrogenic if not modulated through trauma-informed awareness.

Patient safety is not a constraint that limits therapeutic depth, but the very condition that makes it possible. In trauma work, unregulated intensity does not produce transformation but repetition; forced contact does not generate awareness but fragmentation. The six areas of clinical sensitivity presented constitute recurring patterns that emerge from systematic observation of how expert therapists create conditions of embodied and relational safety, without which processing becomes retraumatization.

This contribution is addressed to Gestalt therapists in training, experienced professionals who wish to update their competencies, and clinical supervisors interested in integrating a trauma-informed perspective into Gestalt practice and teaching. My hope is that it may serve as a stimulus for constructive debate on how some currents of the Gestalt tradition can evolve while maintaining fidelity to their phenomenological principles while incorporating contemporary clinical acquisitions on trauma care.

WHAT DO WE MEAN BY TRAUMA TODAY?

To orient the dialogue between GP and evidence-based approaches, it is necessary to clarify what contemporary literature means by psychological trauma. The conception of trauma has considerably expanded compared to early formulations focused predominantly on single catastrophic events (Type I traumas). Today we recognize the existence of complex or developmental traumas (Type II traumas), characterized by repeated and prolonged exposure to adverse experiences, often of an interpersonal nature, occurring during critical phases of development [3]. Psychological trauma can be defined as a subjective experience of overwhelm: the event or series of events exceeds the person's capacity to integrate the experience, to give it meaning, to maintain a sense of continuity of self and safety in the world [4]. This overwhelm generates a cascade of neurobiological, psychological, and relational consequences: fragmented and unintegrated implicit memories, dysregulation of the autonomic nervous system, alterations in perception of self and others, difficulties in emotional regulation [5].

From a somatic perspective, trauma "freezes" incomplete defensive responses in the body; what Levine [4] describes as survival energy trapped in the nervous system. The body remains in a state of chronic alert (hyperactivation) or defensive shutdown (hypoactivation/dissociation), oscillating between these poles without returning to homeostatic equilibrium. The window of tolerance, that optimal range of activation in which the person can process information and emotions while remaining present and functional, dramatically narrows.

From a psychological perspective, trauma generates fragmentation: parts of the experience (bodily sensations, intense emotions, beliefs about self) remain split and not integrated into the autobiographical narrative. As illustrated by Giannantonio [6], traumatic memories are characterized by their implicit, sensory, and fragmented nature, lacking the narrative coherence typical of ordinary autobiographical memories. As theorized by IFS [7], the psyche organizes into "parts" that attempt to manage traumatic pain; some carry the memory and emotions (exiled parts), others try to keep them at a distance through protective mechanisms (protective parts).

From a relational perspective, trauma – especially interpersonal and developmental trauma – profoundly alters attachment patterns and the capacity for trust. As emphasized by Fosha [8], the most devastating trauma is not only the event itself but the fact of having experienced it in emotional aloneness, without support or validation. This generates what AEDP defines as "aloneness," an existential solitude that itself becomes traumatic and perpetuates in subsequent relationships, including the therapeutic one.

Post-traumatic symptomatology includes intrusions (flashbacks, nightmares, intrusive thoughts), avoidance (of stimuli that recall the trauma, of emotions, of relationships), negative alterations in cognitions and emotions (negative beliefs about self and world, persistent emotional states of fear, shame, guilt), and alterations in arousal and reactivity (hypervigilance, irritability, concentration difficulties, sleep disturbances). In complex traumas, pervasive emotional dysregulation, chronic dissociation, identity and self-image disturbances, and profound relational difficulties are added.

The traumatized patient brings to the session not only a story to tell, but a dysregulated body, a hypervigilant or dissociated nervous system, defensive relational modalities, and a specific vulnerability to retraumatization in the therapeutic setting. It is precisely this vulnerability that makes the development of specific clinical sensitivities by the Gestalt therapist relevant. Some Gestalt ways of working, particularly the tendency to rapidly intensify experience, to work with experiments that bring strong emotional content into figure [5], can easily exceed the patient's window of tolerance, generating flooding (emotional overwhelm) or dissociation, the exact opposite of the integrative processing sought.

GP IN DIALOGUE WITH NEW HUMANISTIC PSYCHOTHERAPIES: DIFFERENCES AND POINTS OF CONTACT

GP shares with modern evidence-based experiential psychotherapies a common root in the phenomenological, existential, and humanistic tradition. All value the client's immediate experience, the therapeutic relationship as an instrument of change, the centrality of embodied awareness, and trust in the organism's actualizing tendency [9].

Points of Contact and the Gestalt Plurality

Therapeutic presence is a transversal theme. This theme finds confirmation in contemporary research on therapeutic presence by Geller and Greenberg [10], who define presence as "bringing all of oneself to the encounter with the client, being completely in the moment at physical, emotional, cognitive, and spiritual levels." Kabat-Zinn [11] has contributed to the formalization of mindfulness practices that support this capacity for non-judgmental and embodied presence, now integrated across many therapeutic approaches.

The emphasis on direct experience rather than intellectualization constitutes a second point of convergence. GP invites "experiencing" rather than "talking about," bringing sensations, emotions, gestures into figure. Similarly, EFT-T works with experiencing, conscious immersion in the experiential flow, as a prerequisite for therapeutic change. Gendlin's [12] FOT explicitly teaches contacting the "felt sense," that global and initially vague bodily sensation that carries implicit meaning.

The holistic and organismic-environmental conception is shared: the person is not seen as a set of separate parts but as an organism in field, in constant interaction with the environment. This is reflected in Gestalt field theory and echoed in the systemic work of IFS, which, while using the language of "parts," maintains a vision of integration through the Self, and in SE, which sees trauma as an interruption of natural organism-environment rhythms.

The importance of the authentic therapeutic relationship and I-Thou dialogue characterizes GP and is strongly found in AEDP and EFT-T, where the relationship is not only the container but the active instrument of healing through dyadic regulation and undoing aloneness.

A Necessary Clarification: The Plurality of the Contemporary Gestalt Tradition

It is important to premise that when we speak of "GP," we inevitably operate a simplification of a rich and plural tradition. Multiple Gestalt currents exist, each characterized by its own emphases and sensitivities.

Many of these currents have already developed sophisticated attention to regulation, relational safety, and modulation of intensity. As highlighted by Fabbrini [13] in his recent contribution dedicated to the exploration of trauma, contemporary Gestalt has progressively integrated the trauma-informed perspective while maintaining fidelity to its phenomenological foundations, demonstrating how the Gestalt tradition evolves without betraying its epistemological identity. Contemporary Gestalt therapists have integrated contributions from interpersonal neurobiology, Polyvagal Theory, and attachment studies, developing refined sensitivities to building conditions of stability and respect for defenses as essential protective functions.

The analysis primarily addresses recurring tendencies in certain Gestalt practices, particularly those that emphasize more direct confrontation, rapid intensification, and early client autonomy, while also recognizing the existence of deeply trauma-informed Gestalt approaches.

Three levels are thus distinguished:

1. Historical Gestalt: the original formulations of Perls et al [14], with emphasis on awareness, responsibility, and intensifying experiments.
2. Contemporary Gestalt: the multiple current evolutions, many of which have already integrated neurobiology, attachment theory, and trauma-informed sensitivities.
3. Proposed evolutionary direction: the specific framework we present in this article, which systematizes trauma-informed competencies in dialogue with evidence-based approaches

Differences, Complementarities, and Reciprocal Integration

The main differences concern the degree of structuring, emphasis on safety and regulation, and approach to managing emotional intensity. These differences represent potential complementarities rather than incompatibility.

Structuring of the Process

Some Gestalt traditions privilege creative spontaneity and moment-by-moment adaptation to phenomenological emergence. Evidence-based approaches have developed more structured frameworks: EMDR has a protocol of eight precise phases [15], EFT-T distinguishes phases of alliance, processing, and resolution, SE follows systematic principles of titration and pendulation. This structure arises from the need to ensure safety for vulnerable populations and to enable empirical evaluation of effectiveness.

Emotional Intensity and Regulation

Some Gestalt traditions value full traversal of difficult experience as a path to growth. Trauma-focused approaches place primary emphasis on regulation: before intensifying, one must stabilize; before exposing, one must build resources [3]. The paradoxical theory of change [16] that change occurs when the client becomes what they are, not when pushed to change, a principle that implicitly respects organismic rhythms. With traumatized patients, these rhythms are temporarily compromised and may require more explicit and systematic external support.

Therapeutic Responsibility

In some forms of GP, much responsibility is placed on the client, with the therapist, who may frustrate requests for reassurance, favoring autonomy [14, 16]. In trauma-focused approaches, the therapist explicitly assumes the function of external regulator and actively offers coregulation, reassurance, and containment, recognizing that the traumatized patient has temporarily lost these capacities. The point is not to choose between support and autonomy, but to calibrate the sequence: first, sufficient support; then, gradual empowerment.

Management of Defenses

Some Gestalt traditions work to bring defensive mechanisms into awareness (retroflections, projections, introjections), while approaches like IFS explicitly negotiate with protective parts, thanking them and asking permission before accessing traumatic content. This recognizes

that defenses in trauma have had a life-saving function and must be respected.

Toward an Informed Integration: What They Exchange Reciprocally

GP can benefit from incorporating greater explicit attention to sequentiality (stabilization before processing), systematic assessment of the window of tolerance, explicit teaching of regulatory competencies, constant monitoring of arousal, more support in initial phases, more gradualness, and more explicit coregulation.

GP can offer more structured approaches phenomenological wisdom (how to remain faithful to emerging experience rather than imposing preconceived frameworks), creative flexibility (how to adapt interventions to the unique field of each therapeutic relationship), trust in organismic wisdom (how to discern when to follow signals from the patient's body even if the protocol would suggest otherwise), and emphasis on the relationship as a transformative event in itself, not just as a vehicle for techniques.

This dialogue does not impoverish GP but can enrich it, allowing it to be more effective and safer with a significant clinical population. As observed by Elliott et al [9] in their meta-analysis on experiential therapies, the effectiveness of these approaches is robust, but requires competent therapists who know how to balance facilitation of experiencing with support for emotional regulation.

THE THEME OF SAFETY IN THE THERAPEUTIC SETTING

The concept of safety in trauma treatment is multidimensional and represents the central theme around which every effective clinical intervention revolves. Herman [3] placed safety as the first fundamental stage of traumatic treatment, prior to any processing. Without safety as a base, every intervention risks being iatrogenic.

Dimensions of Safety

Physical, Environmental Safety and Predictability

The most basic level concerns the concrete safety of the setting: a physically protected space, predictable, without interruptions. The traumatized patient needs to know that nothing dangerous will happen in the therapy room. This includes chair arrangement that allows visual contact but also modulable distance, absence of sudden noises, consistency of schedules, and session duration.

The therapist's predictability is part of this safety: maintaining commitments, being punctual, clearly communicating any changes, and having stable professional boundaries. For patients who have experienced betrayals and unpredictability in reference figures, this concrete reliability is therapeutic in itself.

Relational Safety and Alliance

Relational safety is built through what Paivio and Pascual-Leone [17] call "safe and collaborative therapeutic alliance." As emphasized by Palvarini [18], the real relationship, understood as an authentic encounter between two concrete persons, itself constitutes a primary therapeutic factor, not simply the context in which technical interventions occur. In work with trauma, this real relationship becomes even more central: it is through the embodied and non-defensive presence of the therapist that the patient can experience for the first time a safe bond capable of containing intolerable emotions. It includes constant empathy and validation, absence of judgment, transparency about the therapeutic process, and shared power.

Geller and Greenberg [10] emphasize that authentic therapeutic presence, being fully emotionally available, open, and receptive, communicates safety at an implicit level. The patient perceives through nonverbal channels (tone of voice, facial expression, posture, breathing rhythm) whether the therapist is truly present and not overwhelmed by their pain.

Emotional Safety: Self-regulation and Coregulation

This dimension concerns the patient's trust in being able to experience intense emotions without being destroyed by them. It includes two complementary aspects:

Self-regulation competencies: The therapist actively teaches tools for managing arousal, grounding techniques, diaphragmatic breathing, visualization of safe places, access to positive internal resources [15]. Brief mindfulness practices can increase the capacity to observe one's emotions without being overwhelmed by them.

Dyadic coregulation: The therapist actively offers their own presence as an external regulator [8]. Neuroscientific research has confirmed that one person's nervous system can synchronize and calm in the presence of another's regulated nervous system. The implicit message is: "You are not alone with this pain; I am here, and it doesn't scare me. We can traverse it together."

Bodily and Neurophysiological Safety

SE has brought attention to safety at the level of the autonomic nervous system, built through repeated orientation in the present environment, pendulation between activating material and neutral or pleasant sensations, and gradual release of tremors, sighs, tears, and signs of neurophysiological discharge that allow the nervous system to complete defensive responses that remained frozen.

Safety as Foundation of Therapeutic Work

Safety as Prerequisite of Capacity for Choice and Responsibility

A crucial aspect is restoring the patient's sense of control over the therapeutic process. Trauma is, by definition, an experience of total powerlessness. Therapy must be the opposite: an experience of rediscovered personal mastery through agreed stop signals, requests for permission before proposing experiments, respect for the patient's "no's," and allowing choices about what to explore and when.

IFS formalizes this through negotiation with protective parts: before accessing traumatic memories, the therapist explicitly asks, "Is there any part of you opposed to the idea of exploring this today?" and respects any reservations [7].

Safety as Generative Condition

It is fundamental to emphasize that this emphasis on safety does not equate to avoiding difficult material or superficial therapy. On the contrary, safety is the condition that makes going deep possible. Only when the patient feels sufficiently safe can they allow themselves to open the doors to the most painful memories and emotions. Without safety, the defensive system remains hyperactive, preventing genuine experiential access.

A patient who knows they can stop when they want, paradoxically, goes deeper than one who feels trapped. A patient who has learned grounding techniques can allow themselves to feel more intense emotions, knowing they have an anchor. Safety, therefore, does not oppose therapeutic depth but generates it.

BASIC CLINICAL SENSITIVITIES: A GUIDE FOR EFFECTIVE CLINICAL PRACTICE

Based on the dialogue between GP and evidence-based approaches and rooted in the principle of safety as a condition of trauma work, we propose six areas of clinical sensitivity that we consider fundamental for trauma-informed Gestalt practice.

Epistemological Note

The six areas emerged as recurring and converging domains of clinical sensitivity through a reflective and narrative comparative analysis of the major trauma-informed experiential approaches (EMDR, EFT-T, SE, AEDP, IFS, FOT). This process is heuristic and hypothesis-generating in nature: it does not claim to constitute a systematic or empirically validated review, but rather a structured clinical reflection aimed at identifying transversal and clinically relevant themes across different trauma-informed traditions. As such, it is consistent with the opinion article format of this contribution. Each area proved clinically relevant for preventing retraumatization and sustaining safe experiential processing.

The guiding criterion in their identification was twofold:

- Transversal recurrence: these clinical sensitivities appear, in different forms, in all trauma-informed experiential approaches examined.
- Specific protective function: each area responds to a distinctive vulnerability of the traumatized patient, risk of flooding, dissociation, retraumatizing emotional aloneness, fusion with traumatic content, failed integration, or post-session destabilization.

I offer this framework as a contribution to clinical debate, not as a concluded protocol, and with awareness that each Gestalt therapist will integrate these sensitivities in cre-

atively different ways, faithful to their own phenomenology of the field and the specificity of each therapeutic relationship.

Schema of the Six Areas of Clinical Sensitivities

The "possible manifestations of mastery" proposed in Table 1 does not constitute standardized evaluation criteria or verification checklists, but orientative and non-exhaustive examples of how these clinical sensitivities might reveal themselves in concrete clinical practice.

Area 1: Building Embodied, Relational, Temporal Safety

This first area of clinical sensitivity concerns the capacity to actively create, together with the patient, a repertoire of resources for neurophysiological and emotional stabilization. This typically occurs in the initial phases of treatment but remains available throughout the journey. It is not about applying techniques mechanically but developing an embodied sensitivity to the need for bodily grounding as a condition for experiential processing.

Somatic grounding techniques: The therapist facilitates learning of ways to "ground" in the body and present environment through sensory attention. Examples include: feeling feet resting on the floor, noticing body weight on the chair, describing in detail five visible objects in the room, listening attentively to environmental sounds. Brief mindfulness body scan practices can increase non-judgmental bodily awareness.

Development of internal resources: Following the EMDR approach [19], the therapist guides the patient to identify positive resources, imagined safe places, memories of moments of strength or tranquility, protective figures, personal qualities, accompanied by pleasant or neutral bodily sensations that the patient learns to evoke voluntarily.

Table 1. Schema of the six areas of clinical sensitivities.

COMPETENCE AREA	SYNTHETIC DESCRIPTION	PRIMARY CLINICAL FUNCTION	POSSIBLE EFFECTS
1. Building embodied safety	Facilitate learning of grounding techniques, orientation to the present, and development of bodily resources	Create a background of neurophysiological and psychological stability before and during processing	The patient has self-regulation tools usable autonomously; reports sensations of stability and groundedness
2. Assessing and monitoring regulation	Recognize signs of hyper- and hypo-activation; assess window of tolerance; adapt interventions in real time	Prevent flooding and dissociation, maintaining patient in optimal zone of processing	The therapist promptly identifies dysregulation signals and modulates interventions accordingly; session remains within tolerable intensity
3. Modulating experiential intensity	Use titration (minimal doses) and pendulation (oscillation between difficulty and safety	Dose trauma exposure in processable ways, avoiding overwhelm	Work proceeds gradually; patient experiences intense but tolerable emotions without reaching dysregulation
4. Offering regulating relational presence	Communicate constant emotional availability; provide empathic validation; use one's own stability as coregulator	Realize "undoing aloneness"; allow patient to experience difficult emotions in containing relational context	Patient reports feeling accompanied; shows greater emotional openness; seeks contact in difficult moments
5. Facilitating dual awareness	Help patient maintain simultaneous contact with memory and anchoring to present	Prevent total fusion with traumatic content; allow conscious observation instead of reliving	Patient can describe experience using distanced language; maintains orientation in present despite emotional intensity
6. Integrating and closing experiences	Ensure adequate closure of each session; facilitate cognitive-emotional integration; highlight transformations	Prevent patient from leaving session dysregulated; consolidate learnings; build autonomy	Each session ends with patient in regulated state; presence of integrative reflections and sense of progress

Orientation to the present: A practice derived from SE, consists of repeatedly guiding the patient to notice where they are, what day it is, that there is no immediate danger. This apparent simplicity has profound neurophysiological impact: it activates the ventral-vagal system of social engagement, signaling to the brainstem that the environment is safe.

Agreed control signals: Explicitly establish that the patient can at any moment signal wanting to stop, slow down, or take a break. This restores control and reduces perceived fear during processing.

These practices do not replace the authentic Gestalt relationship nor phenomenological presence, but integrate and support them, offering the traumatized patient concrete self-regulation tools that amplify their capacity to stay in the deep experiential process.

Area 2: Assessing and Monitoring Regulation

The trauma-oriented therapist refines a sensitive capacity to read the patient's regulation and dysregulation signals, constantly modulating their interventions. This sensitivity is configured as an embodied phenomenological attention to micro bodily and emotional signals, indicating whether the patient remains within the window of tolerance or is surpassing it.

Recognition of hyperarousal: Breathing accelerates, body stiffens, agitation and sweating appear; pupils dilate, voice loses stability and expression colors with panic. These bodily and emotional signals indicate the patient is exceeding the upper margin of the window of tolerance.

Recognition of hypoarousal/dissociation: Signals that include fixed or lost gaze, with marked slowing of speech, monotone voice, pallor, collapsed posture, spatio-temporal confusion, references to feeling numb or "behind glass."

Optimal regulation: A patient emotionally touched but present, reports intense but tolerable emotions, shows emotional variability, presents natural physiological discharges (sighs, muscular relaxation), maintains orientation.

The therapist uses these signals as a guide to decide, moment by moment, whether to continue, slow down, or stop. Their responsiveness to the client's experience is a predictive factor of positive outcomes and reflects trauma-informed practice attentive to safety and regulation processes.

Area 3: Modulating Experiential Intensity

This area concerns the capacity to precisely dose how much traumatic material is brought into awareness. It is not about avoiding emotional intensity but calibrating it so it remains processable and integrative, not fragmenting.

Titration: Working with infinitesimal "drops" of trauma. Rather than inviting the patient to relive the entire event, focus on a minimal fragment ("try to recall only the image of the door, no need to go further"). Observe the bodily and emotional reaction. If manageable, another fragment can be added. If excessive, return to grounding.

Pendulation: Rhythmically oscillating between touching difficult material and returning to neutral or positive experiences. "Now feel a bit of that fear... and now shift attention to your feet on the ground... good... now return for a moment to that image... and now look out the window." This teaches the nervous system it can activate and then return to calm.

Respect for organismic rhythm: Following the wisdom of the patient's body [12]. If they say "I'm not ready," it is respected. If the body stiffens greatly, slow down. If liberating sighs or tremors emerge, leave space. The therapist becomes facilitator of the natural process of discharge and integration, not director imposing a rhythm.

Area 4: Offering Regulating Relational Presence

The therapist consciously uses their own emotional presence and the relationship as a regulation instrument. This is the area where the Gestalt tradition has always excelled. Regulating presence is not a technique that is applied, but a relational quality that is embodied.

Therapeutic presence: Being completely available in the moment, physically relaxed but attentive, emotionally open and receptive. This quality of presence is communicated implicitly, and the patient perceives it as embodied safety.

Constant empathic validation: Continuously communicating that the patient's emotions and reactions are understandable and legitimate. "It makes perfect sense that you feel this way," "Anyone in your situation would have felt terror." This reduces shame and self-criticism.

Explicit coregulation: The therapist communicates their availability to "carry together" difficult emotions. "I am here with you," "You are not alone with this pain" and uses their own regulated state (calm breathing, stable tone) to influence the patient's nervous system through dyadic resonance.

Metaprocessing: After emotionally relevant experiences, the therapist dedicates space to shared reflection on what happened. Questions like: "How was it for you to contact that anger?", "What do you notice now in your body?", "What impact did sharing this with me have on you?" favor consolidation of emotional learning and strengthening of the therapeutic relationship.

Area 5: Facilitating Awareness and Optimal Distance

The therapist actively helps the patient maintain awareness and not fuse totally with traumatic content. This requires delicate balancing: facilitating deep contact with experience while maintaining an observational space that prevents dissociative reabsorption.

Dual awareness: Explicitly recalling that "that is a memory, you are safe here with me now." During recollections, alternate questions about the memory with anchors to the present. This prevents total reabsorption in the traumatic past.

Distancing language: The therapist encourages use of linguistic formulations that introduce phenomenological distance between subject and experience. The passage from "I am terrified" to "a part of me feels terror" supports emergence of an observing position with respect to emotional experience.

Clearing a Space: Teaching the patient to temporarily "set aside" worries and emotions to create free internal space. This demonstrates one can take voluntary distance from overwhelming experience.

Parts work: When an overwhelming emotion emerges, help the patient recognize it as coming from a "part" and dialogue with it from the adult Self. "See if you can look at that child part from outside... there is your adult Self that can be with her without becoming her."

Optimal distance is neither defensive nor intellectualizing. It consists in the capacity to remain in contact with experience while maintaining an active observing function, a condition often indicated as necessary for deep change processes.

Area 6: Integrating and Closing Experiences

Each session that has touched traumatic material requires careful closure, and the therapeutic process as a whole requires progressive integration. This area emphasizes the importance of conscious management of temporal boundaries of the session and experiential consolidation.

Session closure: Verify the patient's state before they leave the office. If still activated, facilitate grounding (see Area 1) to bring them back to a regulated state. If traumatic material has remained "open," offer symbolic containment. Ensure the patient exits in a state of sufficient calm and grounding.

Cognitive-emotional integration: Help the patient make sense of what emerged. "What do you understand now that you didn't understand before?", "How do you see yourself now with respect to that memory?" Connect emotional experience to new narrative understandings, favoring integration between different experiential levels.

Highlighting transformations: Explicitly name positive changes. "Did you notice that today you managed to feel that fear without dissociating? That's an important progress." These recognitions consolidate sense of mastery and self-efficacy.

Development of regulatory autonomy: Propose practices between sessions (journaling, use of grounding techniques, bodily awareness) that build capacity for self-regulation independent of the therapist, in line with Gestalt value of autonomy and responsibility.

LIMITATIONS

Like any opinion article, this contribution emerges from a situated perspective — that of two Gestalt clinicians with experience in trauma work — and does not claim the neutrality of a systematic review. The six areas of clinical sensitivity proposed here arise from a reflective and comparative process, not from a standardized methodology: they are the result of years of clinical practice, supervision, and critical engagement with the trauma-informed literature, rather than a formalized research protocol. This is, at once, both the limitation and the value of the contribution: we offer a clinically grounded hypothesis, not an empirically validated certainty.

The selection of reference approaches — EMDR, EFT-T, SE, AEDP, IFS, FOT — reflects those most extensively documented in the international trauma literature but does not exhaust the full range of evidence-based psychotherapies currently available. Equally, Gestalt psychotherapy is a plural tradition: the critical observations contained in this article refer to recurring tendencies in some of its historical and clinical expressions, not to a monolithic entity. Many contemporary Gestalt approaches have already integrated sophisticated trauma-informed sensitivities, and the article explicitly acknowledges this internal richness.

What we propose is not a definitive framework, but a starting point for a dialogue we consider both necessary and urgent within the Gestalt community. We hope the six areas described may serve as generative hypotheses for future research: expert consensus studies, pilot training programs, and process-outcome research in Gestalt settings with traumatized patients could progressively verify their clinical utility and epistemological coherence. It would be meaningful, for instance, to explore whether and how these sensitivities develop within Gestalt training programs, or whether their presence correlates with better therapeutic outcomes in complex trauma work. We are aware of these limits and consider them an honest starting point for a conversation that, we hope, others will continue.

CONCLUSIONS

This article does not propose a definitive synthesis but opens questions that deserve in-depth clinical discussion. How can the Gestalt therapist discern, moment by moment, when experiential spontaneity serves healing and when it risks exceeding the patient's capacity for integration? How is this refined sensitivity to regulation formed that does not become technical hypercontrol but remains phenomenologically grounded?

The six areas of clinical sensitivity outlined require translation into the concrete practice of each therapist, within their own Gestalt epistemology and relational style. There are no protocols that can replace embodied presence and responsiveness to the unique field of each therapeutic relationship. What is proposed here is rather an orientation, a grid of attention that can inform – not determine – clinical choices.

Numerous questions remain open that require further elaboration. The integration of these clinical sensitivities into Gestalt training requires particular attention to preserve the phenomenological identity of the approach. Supervision experiences capable of sustaining the development of this dual sensitivity – fidelity to Gestalt and trauma-informed practice – merit systematic exploration and documentation. The evaluation of epistemological coherence of the proposed integration, distinguishing authentic enrichment from possible incoherent eclectic drifts, represents a critical challenge for the Gestalt community.

It is desirable that this contribution stimulate documented clinical experiments, published critical reflections, comparisons in training and supervisory contexts. Only through constructive and rigorous dialogue can the Gestalt community evaluate whether and how these evolutionary directions represent authentic enrichment or betrayal of its own identity. The position sustained here remains open: not certainties to defend, but hypotheses to verify in the complexity of clinical practice with traumatized patients.

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Informed Consent
Not applicable. This article does not contain any individual person's data in any form (including individual clinical cases or identifiable details).

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