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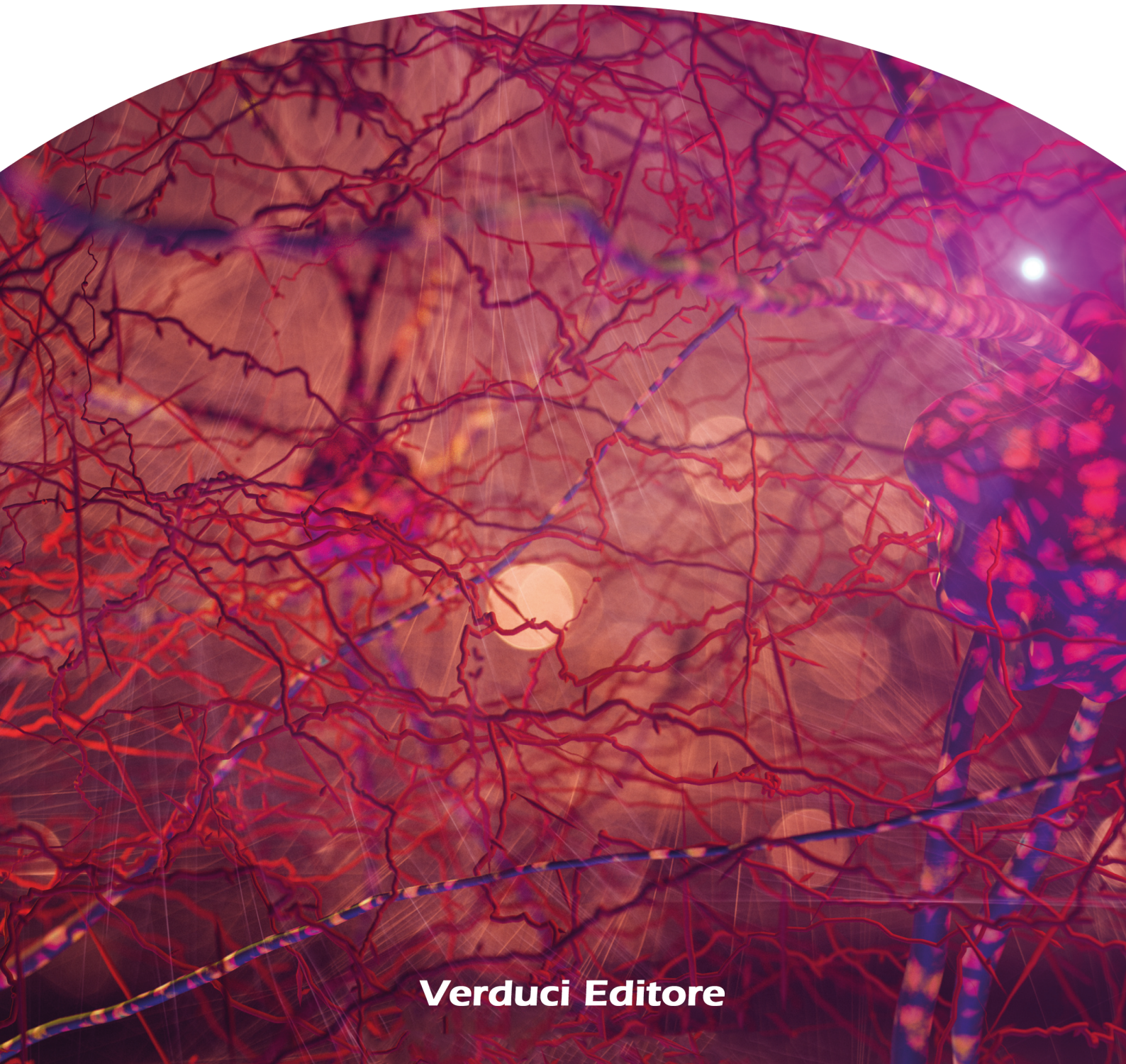

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Opinion Article

Trauma as a Fracture of the Ecological-Relational Field: Gestalt and Ecopsychological Contributions to the Clinical Understanding of Complex Trauma

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ABSTRACT

The prevalence of complex trauma and chronic psychological suffering has prompted renewed reflection on clinical models that focus exclusively on traumatic events or individual vulnerabilities. Simultaneously, the ecological crisis and the degradation of living environments affect emotional, bodily, and relational regulation processes. This opinion article proposes a reinterpretation of complex trauma through a Gestalt field perspective integrated with insights from ecopsychology. Within this framework, trauma is conceptualized not only as a response to a critical event but as the outcome of a systemic fragilization of the organism-environment field. The impoverishment of the ecological-relational field may weaken implicit supports for self-regulation, co-regulation, and experiential continuity, thereby increasing vulnerability to stress and chronic distress. The article examines theoretical and clinical implications of this perspective, with attention to regulation, rhythm, embodiment, and the expansion of the therapeutic field beyond an exclusively dyadic relationship. Natural environments are discussed as potential regulatory contexts that may support sensory orientation, physiological stabilization, and experiential integration in trauma work. Although this contribution is primarily theoretical, it suggests that incorporating the ecological-relational field into trauma conceptualization may broaden the clinical horizon of psychotherapy and encourage attention to environmental conditions that sustain psychological well-being and continuity of the self.

Keywords
Complex trauma, Gestalt psychotherapy, Ecopsychology, Ecological-relational field.

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ABSTRACT in ITALIANO

La prevalenza del trauma complesso e della sofferenza psicologica cronica ha promosso una rinnovata riflessione sui modelli clinici focalizzati solo sugli eventi traumatici o sulle vulnerabilità individuali. Parallelamente, la crisi ecologica e il degrado degli ambienti di vita influenzano i processi di regolazione emotiva, corporea e relazionale. Questo articolo d'opinione propone una reinterpretazione del trauma complesso attraverso una prospettiva gestaltica di campo integrata con i contributi dell'ecopsicologia. In questa cornice, il trauma è concettualizzato non solo come risposta a un evento critico, ma anche come esito di una fragilizzazione sistemica del campo organismo-ambiente. L'impoverimento del campo ecologico-relazionale può indebolire i supporti impliciti di autoregolazione, co-regolazione e continuità esperienziale, aumentando così la vulnerabilità allo stress e alla sofferenza cronica. L'articolo esamina le implicazioni teoriche e cliniche di questa prospettiva, con attenzione alla regolazione, al ritmo, all'embodiment ed all'espansione del campo terapeutico oltre una relazione esclusivamente diadica. Gli ambienti naturali sono considerati potenziali contesti regolativi in grado di sostenere l'orientamento sensoriale, la stabilizzazione fisiologica e l'integrazione esperienziale nel lavoro sul trauma. Sebbene questo contributo sia principalmente teorico, suggerisce che includere il campo ecologico-relazionale nella concettualizzazione del trauma possa ampliare l'orizzonte clinico della psicoterapia e promuovere l'attenzione alle condizioni ambientali che sostengono il benessere psicologico e la continuità del sé.

Parole chiave

Trauma complesso, Psicoterapia della Gestalt, Ecopsicologia, Campo ecologico-relazionale.

INTRODUCTION

The increasing presence of traumatic experiences, chronic psychological suffering, and psychopathological diseases over the past decade has prompted a critical re-evaluation of psychopathological models grounded exclusively in individual or environmental explanations. At the same time, the ecological crisis and the distancing from direct contact with nature have been associated with emerging forms of psychological distress, highlighting the fragility of the conditions that support emotional, bodily, and relational regulation. This article offers a generative theoretical lens for understanding trauma not only as a response to a critical event but also as the outcome of systemic dysregulation of the organism-environment field, combining the Gestalt field perspective with contemporary ecopsychological frameworks. This contribution proposes a reading of complex trauma that considers the impoverishment of the ecological-relational field, conceptualizing nature as an active component of regulation, co-regulation, and experiential integration.

THEORETICAL PREMISE: THE FIELD IN GESTALT THERAPY AS AN ORGANISM-ENVIRONMENT SYSTEM

Within Gestalt therapy, trauma is not understood as an isolated episode or a purely intrapsychic characteristic. Rather, it is conceptualized as a breakage in the dynamic relationship between the organism-environment field [1]. In the traditional Gestalt formulation, such a breakage involves continuity of contact, the organism's ability to modulate exposure and withdrawal, the I-functioning, and the ability to take effective action [1]. From a contemporary field-oriented perspective, this disruption extends beyond the memory of the traumatic event itself, affecting the system's ongoing capacity to maintain authentic contact in the present. The organism loses trust in the field as a source of support and orientation, resulting in a constriction of the horizon of possibilities, known in Gestalt theory as the now-for-next [2].

Building on this perspective, an ecopsychological approach further broadens this view. The environment is no longer limited to social, cultural, or interpersonal dimensions [3-5], but explicitly includes the natural world as an essential component of the field [6]. Trauma can therefore be understood as a complex disconnection: from others, from bodily self-perception, from relational and affective processes [3-5], and from the broader ecological context [6].

In this sense, the field is no longer exclusively human, but ecosystemic. It follows that structural weakening of fundamental supports [3-5] may increase vulnerability to trauma even in the absence of a single extraordinary event [6]. From this standpoint, the ecopsychological integration thus expands the Gestalt framework: the therapeu-

tic field may include the natural world as a third, non-human yet relational regulator [1, 2]. Nature is not conceived as an alternative setting or neutral backdrop, but as an active component of the field, capable of performing specific regulatory functions particularly relevant to trauma work.

CORE HYPOTHESIS: NATURE AS A REGULATOR OF THE FIELD

Ecopsychological and psychophysiological research highlights how exposure to natural environments can promote key regulatory functions, including stress reduction [7], regeneration of attention [8], by activating evolved affiliative dispositions toward living systems (biophilia) [9]. From a Gestalt perspective, these processes may be conceptualized as foundational supports of the field, operating on multiple levels:

- Physical grounding: rhythm, respiration, sensorimotor support, and landscape qualities [2, 8];
- Relational grounding: experiences of interdependence, mutual care, and continuity between self and the living world [3, 9];
- Symbolic grounding: meaning-making, belonging, and positioning the self within a broader ecosystemic matrix [3-5].

The ecological-relational field refers to the set of human and non-human conditions that co-constitute processes of regulation, perception, and contact. Compared with the classical Gestalt notion of the organism-environment field [1], this formulation makes explicit the specific role of the ecological dimension as an implicit and continuous support of experience, highlighting how its rhythm, variability, and livability influence the organism's possibilities for integration and response [3, 6, 8].

At the neurophysiological level, these processes can be understood as facilitating states of calm and safety associated with vagal functioning and the capacity to remain in contact without collapsing into hyperarousal or shutdown [10]. The hypothesis proposed is that the impoverishment of these supports, or their replacement with hyperstimulating environments, may be a factor of traumatic vulnerability [6] and limit both self-regulation and co-regulation capacities [8-10].

TRAUMA AND FIELD IMPOVERISHMENT: AN ECOPSYCHOLOGICAL PERSPECTIVE

Within contemporary ecopsychology, constructs such as ecological grief, solastalgia, and clinical and psychosocial formulations of eco-anxiety describe forms of suffering linked to environmental degradation or loss [11-13]. From this perspective, eco-anxiety is understood not simply as concern about the ecological crisis, but as a persistent difficulty in finding orientation, trust, and continuity in one's relationship with the surrounding world. From a Gestalt field perspective, these conditions may be interpreted as field impairments, that is, alterations in the quality of the organism-environment field that reduce the system's capacity to process critical experiences. Phenomenologically, this may appear as a diminished sense of ground, a weakening of familiar supports, and a reduced ability to rely on places, rhythms, and sensory continuities that previously sustained contact and regulation. This may involve:

- Disruption of the flow of continuity between oneself and the environment, with loss of orientation and experiential "ground" [11, 12];
- Loss of contact routines (places, rituals, cycles) that previously supported emotional and bodily regulation [8, 11];
- Reduction of opportunities for creative adjustment [1, 2].

Within this perspective, trauma concerns not only the impact of what has happened, but also a contraction of what can still happen within the field. What can no longer happen refers to the reduced availability of ecological, relational conditions that previously supported orientation, regulation, and restorative contact, reliable places, rhythms, and sensory continuities through which the organism could regain ground, modulate arousal, and re-establish a sense of continuity with the environment. Thus, suffering concerns not only the event itself but also the loss of the conditions that would allow for reparative experience [6, 11, 12].

TRAUMA AND EMBODIMENT: THE ENVIRONMENT AS AN EXTENSION OF THE BODY

In Gestalt therapy and ecopsychology, the body is where trauma primarily manifests, altering respiration, internal rhythms, sen-

sorimotor processes, and self-regulation [14-16]. Somatic and sensorimotor perspectives emphasize that regulation unfolds through countless micro-movements, orienting responses, and the completion of interrupted action tendencies [15, 16]. From this point, the body is not only a container of suffering, but the primary place in which the field organizes itself. Experiences of safety and threat emerge first through physiological, postural, and perceptual configurations. The environment functions as a sensory scaffold that directs attention and regulates activity, supporting states of vigilant calm or, conversely, amplifying hypervigilance and defensive closure [10]. Environmental features also facilitate attentional restoration and recovery [8]. For example:

- Walking on natural terrain and exposure to non-artificial sounds (rhythm, bilateral movement, variability) support sensorimotor integration and orientation [15, 16], promoting physiological stabilization [10, 14, 15];
- Exposure to natural light contributes to rhythmic and attentional synchronization, with effects on alertness and recovery [8, 10];
- Contact with complex, variable sensory stimuli supports neural plasticity and modulation of excitation and withdrawal [8, 10, 14].

The traumatized body is thus not only dysregulated, but de-environmentalized: deprived of ecological conditions that historically co-supported regulation. Regulation is therefore not only an "internal" process, but depends on access to sufficiently rhythmic, variable, and non-invasive contexts that allow the system to reorient without coercion [10]. Consequently, the loss of such conditions may contribute to a form of sensory monoculture that reduces nervous system flexibility [8, 10, 14] and increases vulnerability to traumatic stressors [15, 16].

NATURE AS CO-REGULATOR AND NON-JUDGMENTAL WITNESS

In Gestalt trauma treatment, safety is understood as an emergent quality of the field, constructed through contact and co-regulation. Co-regulation between therapist and client constitutes a central axis of the therapeutic process, particularly in complex trauma, where trust in the field as a source of support and orientation has been compromised [1, 2].

Nature as an Implicit Co-Regulator of the Nervous System

Extensive trauma literature emphasizes that recovery depends on bodily processes and the restoration of physiological self- and co-regulation [14, 15]. Van der Kolk [14] and Levine [16] describe trauma as compromising the organism's capacity to experience safety in the present, maintaining the nervous system in persistent states of hyperarousal or collapse. Within this framework, natural environments may function as implicit co-regulators [3-5], operating at rhythmic, sensory, and neurophysiological levels, and facilitating states of calm alertness and safety [16]. Porges' polyvagal theory provides an explanatory framework: environments perceived as safe, non-threatening, and rich in signals of life promote ventral vagal activation, supporting states of connection, curiosity, and openness to contact [10]. Empirical studies show that exposure to natural settings is associated with improved autonomic regulation, including increased heart rate variability [17, 18]. From a Gestalt perspective, these processes may be understood as foundational supports of the field.

Nature as a Non-Judgmental Witness and Safe Contact Space

A central issue in trauma work is the possibility of being seen without being evaluated or threatened [14]. In this sense, nature may be conceptualized as a non-judgmental witness: a living presence devoid of evaluative intent, offering diffuse containment of the field. The absence of requests, performance, or adequacy reduces relational pressure and allows the organism to experience fewer defensive states of presence.

From a Gestalt perspective, this form of contact supports an unforced awareness [1], in which experience need not be immediately organized into a clear figure. This is particularly relevant in the early phases of complex trauma treatment [14, 15, 19]. Ecopsychology further emphasizes that engagement with natural processes supports the recognition of nonlinear rhythms, normalizing states of retreat, slowness, and transition [9, 20]. Clinically, this may translate into the capacity to tolerate quiet states without collapse and move through activation without perceiving it as dangerous.

ECOLOGICAL DYSREGULATION AND EMOTIONAL DYSREGULATION

The impoverishment of the ecological-relational field reduces implicit self-regulatory supports and increases traumatic vulnerability [9, 21, 22]. From a Gestalt perspective of the field, this impoverishment concerns not isolated environmental factors but the overall quality of the conditions that sustain contact, orientation, and modulation of excitation and retreat [21, 23, 24]. Trauma, in this sense, is not solely the result of a critical event, but the outcome of a systemic fragility of the field that limits available resources for coping with stressors [14, 15, 21].

Several authors argue that the relationship with the natural environment builds a structural dimension of the psyche. Lingiardi's metaphor of the psyche as landscape highlights the link between subjective organization and engagement with living, complex environments [22].

Vulnerability to Traumatic Events and Integrative Processes

A field lacking adequate regulatory support, where reliable rhythms, relational cues, and environmental anchors are weakened or inconsistent, may leave the organism with fewer resources to orient within experience [9, 21]. The loss of connections and systemic complexity can manifest phenomenologically as reduced sensory differentiation, difficulty identifying bodily signals, and a diminished sense of continuity between self and environment. In such conditions, disorganization in the stress response system may appear in lived experience as oscillations between hyperactivation, emotional flooding, or states of withdrawal and numbness [14, 21].

When the field becomes inflexible, predictable, or excessively stimulating, the organism has fewer possibilities to respond creatively to unexpected events, relying instead on rigid or defensive patterns. Experiences that might otherwise be gradually metabolized can therefore remain unintegrated and acquire traumatic qualities. Integrating a traumatic experience requires a sufficiently stable field in which sensations, emotions, and meanings can reorganize over time. Embodied perception develops through ongoing dialogue with a more-than-human world capable of mirroring and modulating sensory experience. When this dialogue weakens, orienting cues may become uncertain, and the organism may struggle to maintain contact. In therapy, this may appear as narrative fragmentation, reduced bodily awareness, or repeated shifts between activation and freezing [14, 15, 23].

Reduction of Creativity and Creative Adjustment

In the Gestalt psychotherapy approach, health is closely linked to the capacity for creative adjustment. Creativity, however, is not an exclusively intrapsychic resource; it emerges from the interaction between organism and environment. Human evolution was shaped by a deep relationship with complex natural environments that stimulated exploration, play, and learning. Contemporary human-built environments, often standardized and highly functionalized, may reduce opportunities for sensory and symbolic exploration, contributing to a progressive rigidity of responses [9, 25].

Amplification of Dissociative States and Post-Traumatic Rigidity

The hyperstimulation characteristic of many urbanized and technological contexts – marked by constant noise, artificial light, speed, and attentional fragmentation – may interfere with physiological regulatory mechanisms [10, 26, 27]. In the absence of natural rhythms and sensory pauses, the organism may increasingly rely on dissociative defenses or hypercontrol as survival strategies. From an integrated polyvagal and ecological perspective, these responses can be understood as adaptive attempts to cope with a field perceived as chronically invasive or unpredictable [10, 14].

CLINICAL IMPLICATIONS FOR GESTALT PSYCHOTHERAPY

Conceptualizing complex trauma as a dysregulation of the ecological-relational field directs a reconsideration of the processes of clinical intervention. In Gestalt psychotherapy, change emerges from the dynamic interaction between organism and environment [1], a perspective further expanded by ecopsychology [3, 6, 9, 28]. Within this

framework, the introduction of natural elements into the therapeutic process does not take the form of prescriptive techniques but emerges from the phenomenological field, guided by the therapist's attention to processes of contact, regulation, and awareness. The focus on these elements is co-constructed within the relationship, supporting the unfolding of the contact cycle [1, 2].

Regulation, Rhythm, and Support

In complex trauma, the capacity for self-regulation is fragile and discontinuous [14, 15]. Regulation cannot be imposed, but requires sufficiently stable, coherent, and predictable contexts [2, 10]. Natural environments can offer such conditions: exposure to regular rhythms (waves, wind, natural paths) can modulate arousal and support bodily orientation [8, 10, 17]. These experiences are introduced from what emerges in the here-and-now of the session. For example, the therapist may invite the patient to attend to breathing or bodily sensations while observing or interacting with a natural element, facilitating the transition from pre-contact to figure formation in the contact cycle [1]. Activities such as walking, observing the sea, or touching natural elements (water, sand, leaves) may emerge within the relational field as experiential supports for awareness and self-regulation without introducing performative demands [6, 28]. The therapist may also propose micro-experiments, such as synchronizing breathing with natural rhythms or using natural materials for sensory grounding, accompanying the client in recognizing variations in arousal, continuity of contact, and the capacity to remain in the experience [1, 15]. In this way, the work unfolds along the contact cycle, fostering both mobilization and assimilation of experience [2].

Aesthetic Experience and Reorganization of the Field

The aesthetic quality of experience signals the degree of integration of the field [1, 19]. In complex trauma, this function is often compromised, with a reduction in sensory vividness and in the capacity to attribute meaning [14, 22]. Natural contexts characterized by a non-chaotic complexity can support processes of perceptual and affective reorganization [8, 9, 18]. In the therapeutic process, the therapist may orient attention toward emerging elements of experience (forms, colors, movements), supporting a non-forced awareness [1]. Aesthetic experience does not constitute a direct goal, but a possible outcome of a sufficiently organized field [20, 24]. Activities such as observing the light among the leaves or drawing natural elements can become moments of integration if supported by relational presence, facilitating contact and symbolization [28].

Expansion of the Clinical Field

A further implication concerns overcoming an exclusively dyadic conception of the therapeutic relationship. The clinical process can be considered part of a broader field that also includes non-human elements [24, 27]. In this perspective, the environment can mediate the intensity of interpersonal contact, facilitating a less threatening sense of belonging, particularly relevant in cases of complex trauma [14, 15]. The inclusion of the natural context, therefore, supports the therapeutic process not as an additional technique, but as an extension of the field, within which the patient can experience new modes of contact, regulation, and continuity of experience. As highlighted by Danon et al [28], the expansion of the field makes it possible to conceive care as a shared process between the individual and the environment, in which non-human elements also participate in the regulation and organization of experience.

Positioning with Respect to Other Trauma Models

The proposed model is in dialogue with the main contemporary approaches to trauma, including those of Van der Kolk [14], Levine [16], Ogden [15], and Porges [10], sharing their attention to bodily processes and neurophysiological regulation. While integrating these contributions, it maintains the phenomenological autonomy proper to Gestalt psychotherapy, placing at the center the organism-environment field and processes of contact [1, 2]. In this perspective, trauma is understood not only as individual dysregulation but as the expression of a weakening of the ecological-relational field, offering a complementary interpretative key to existing models.

CONCLUSIONS

This article has proposed a reinterpretation of complex trauma as an expression of a fracture in the ecological-relational field, integrating Gestalt psychotherapy with contemporary ecopsychological perspectives. Trauma is thus understood not only as the outcome of a critical event or an intrapsychic dysfunction, but as the result of a progressive compromise of the conditions of contact, regulation, and continuity that sustain organisms in their environment [3, 6, 11]. The impoverishment of this field, particularly in its ecological dimensions, may reduce implicit support for self- and co-regulation, increasing vulnerability and limiting possibilities for experiential continuity and aesthetic integration [22, 26, 27].

Limitations

This contribution is theoretical and reflective and does not present original empirical data. The proposed hypotheses require further clinical and empirical investigation. A further limitation concerns the risk of conceptual overextension: the integration of Gestalt psychotherapy and ecopsychology is proposed here as a general framework rather than a set of specific protocols or clinical guidelines [24, 27].

Future Directions

Clinically, greater recognition of the ecological-relational field may orient interventions that are more sensitive to patients' environmental conditions, broadening therapeutic reflection on access to regulatory and rhythmic contexts. From a research perspective, future studies should include qualitative and longitudinal designs that explore interactions among ecological conditions, emotional regulation, and trauma processes, as well as clinical investigations assessing the impact of therapeutic interventions that incorporate elements of the natural world within the field.

In conclusion, incorporating the ecological-relational field into trauma conceptualization expands the clinical horizon of Gestalt psychotherapy, orienting therapeutic work not only toward symptom reduction, but toward the restoration of conditions of belonging and continuity with the living world [1, 24, 28].

Conflict of Interest
The authors declare no conflict of interest.

Authors' Contributions
All authors contributed to the conception, writing, and revision of the manuscript, and approved the final version.

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Mini Review

Trauma moralization in victimization fields: shame, self-blame, and victim blaming

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ABSTRACT

Shame, self-blame, and victim blaming are central dynamics in victimization processes, especially in contexts of interpersonal violence and coercive relationships. This mini review explores these experiences not as isolated individual reactions, but as processes shaped within relational, social, and institutional contexts that influence recognition, credibility, and meaning after trauma. Drawing on victimology, psychotraumatology, and phenomenological-Gestalt theory, the paper introduces the concept of "trauma moralization" to describe how traumatic suffering may progressively become interpreted in moral terms, shifting attention from violence and relational asymmetry to the victim's perceived responsibility, adequacy, or credibility. The paper examines victim blaming, self-blame, and secondary victimization as interconnected field processes operating across subjective, relational, institutional, and socio-cultural dimensions. Particular attention is given to embodied and relational aspects of shame and self-blame, including bodily contraction, hypervigilance, interruptions in contact, and restriction of agency. Finally, the paper discusses the clinical and ethical implications of a non-moralizing and dialogical approach aimed at supporting recognition, restoring contact, and reopening possibilities for agency and meaning after trauma.

Keywords

Trauma moralization, Shame, Self-blame, Victim blaming, Secondary victimization, Victimization processes, Phenomenological-Gestalt approach.

ABSTRACT IN ITALIANO

La vergogna, l'auto-colpevolizzazione e la colpevolizzazione della vittima costituiscono dinamiche centrali nei processi di vittimizzazione, in particolare nei contesti di violenza interpersonale e nelle relazioni coercitive. Questa mini review esplora tali esperienze non come reazioni individuali isolate, ma come processi modellati all'interno di contesti relazionali, sociali e istituzionali che influenzano il riconoscimento, la credibilità e il significato attribuito all'esperienza dopo il trauma. Attingendo alla vittimologia, alla psicotraumatologia e alla teoria fenomenologico-gestaltica, il lavoro introduce il concetto di "moralizzazione del trauma" per descrivere come la sofferenza traumatica possa progressivamente essere interpretata in termini morali, spostando l'attenzione dalla violenza e dall'asimme-

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tria relazionale alla responsabilità, all'adeguatezza o alla credibilità percepite della vittima. L'articolo esamina la colpevolizzazione della vittima, l'auto-colpevolizzazione e la vittimizzazione secondaria come processi di campo interconnessi che operano attraverso dimensioni soggettive, relazionali, istituzionali e socio-culturali. Particolare attenzione è dedicata agli aspetti corporei e relazionali della vergogna e dell'auto-colpevolizzazione, inclusi la contrazione corporea, l'ipervigilanza, le interruzioni del contatto e la limitazione della capacità di agire. Infine, il contributo discute le implicazioni cliniche ed etiche di un approccio dialogico e non moralizzante volto a favorire il riconoscimento, ristabilire il contatto e riaprire possibilità di azione e di attribuzione di significato dopo il trauma.

Parole chiave
Moralizzazione del trauma, Vergogna, Auto-colpevolizzazione, Colpevolizzazione della vittima, Vittimizzazione secondaria, Processi di vittimizzazione, Approccio fenomenologico-gestaltico.

INTRODUCTION

This mini review explores how shame, self-blame, and victim blaming develop within victimization processes and traumatic relational contexts. Rather than treating these experiences as isolated intrapsychic reactions, the paper examines them as processes shaped within relational, social, and institutional contexts that influence recognition, credibility, and meaning after violence.

Drawing on victimology, psychotraumatology, and phenomenological–Gestalt theory, the paper proposes the concept of trauma moralization to describe the shift through which traumatic suffering gradually becomes interpreted in moral terms as a matter of guilt, inadequacy, or personal defect.

From a Gestalt field perspective, experience emerges within a dynamic organism–environment field in which meaning is continuously co-created relationally [1]. In these situations, the focus progressively moves away from violence and relational asymmetry and toward the victim's behavior, credibility, or identity.

Against this backdrop, the paper situates the recent Italian legislation on femicide (Law of December 2, 2025, No. 181) not as an object of legal analysis, but as a symbolic and institutional horizon for how trauma enters the social field, between recognition, generalization, and the risk of moralization. The law can be read as an attempt to acknowledge the specificity of gender-based violence and to counter denial and minimization; however, like any normative dispositif, it operates through categories and definitions and thus carries a structural risk: transforming lived traumatic experience into a typological object and, indirectly, into a moral issue. The critical point is not the norm itself, but how it is mobilized within cultural and institutional frames that may select credibility and legitimacy on the basis of implicit expectations.

Critical victimology has shown that victim recognition is mediated by normative criteria and social selection mechanisms [2, 3]. Credibility does not follow automatically from harm but from conformity to implicit models of a "recognizable victim," while discursive and institutional frames regulate the conditions for access to recognition [3]. In this context, victimization fields are structurally shaped by power asymmetries that condition speech, protection, and legitimation [4]. Italian victimology has described victimization as a dynamic, relational process, placing secondary victimization at the center – not as an additional event, but as a continuation of trauma through contextual responses that generate delegitimation and blame [5]. As traumatic suffering enters the social field, it is often interpreted through implicit moral expectations and judgments [6].

Psychotraumatology has shown that interpersonal trauma disrupts meaning systems and bonds of trust, and that social and institutional responses characterized by doubt or blame obstruct repair and foster chronicity [7]. Trauma is also embodied: it involves not only memory and narrative but also affect regulation, bodily states, and dissociative processes. Chronic shame and traumatic exposure may also affect affective regulation and implicit bodily organization [8]. Shame may involve experiences of global self-devaluation and exposure that deeply affect relational positioning and self-perception [9, 10]. Shame is often experienced bodily before becoming fully narratable. Muscular tension, bodily contraction, freezing, hypervigilance, lowered gaze, or difficulty sustaining

spontaneous contact may become part of how traumatic moralization is lived. Accordingly, shame and self-accusation cannot be reduced to "dysfunctional thoughts"; they should be understood as complex adaptive outcomes – often somatically rooted – within relational fields experienced as threatening or judging.

From a phenomenological–Gestalt standpoint, these dynamics can be read as field perturbations and disruptions of the contact process [11, 12]; under asymmetry and moral constraints, agency narrows and experience tends to organize into configurations dominated by shame and guilt. This supports the proposal of an integrated victimological and phenomenological–Gestalt reading of trauma moralization, taking femicide legislation as a symbolic–institutional horizon and discussing clinical and ethical implications in terms of preventing secondary victimization and restoring agency.

METHOD

This contribution is a theoretical and conceptual mini review integrating perspectives from victimology, psychotraumatology, and phenomenological–Gestalt theory. The review follows a narrative and interpretive approach to develop an integrated conceptual framework rather than to provide a quantitative synthesis of empirical findings. The literature search was conducted using PsycINFO, Scopus, Web of Science, and Google Scholar. The review primarily considered theoretical, clinical, and victimological contributions published between 1975 and 2025. The main keywords included: "victim blaming", "self-blame", "secondary victimization", "trauma", "shame", "moralization", "Gestalt field theory", "contact interruptions", and "phenomenological Gestalt therapy". Sources were selected for their theoretical relevance to the topics explored in the paper, with particular attention to studies on victim recognition, embodied trauma, shame processes, relational asymmetry, and field dynamics in traumatic experience.

TRAUMA MORALIZATION: THEORETICAL FRAMEWORK

"Trauma moralization" refers to the process through which an experience of violence is progressively removed from its relational dimension and field rupture, and reinterpreted in terms of responsibility, guilt, or personal defect. In this shift, trauma is no longer only what happened; it becomes what it supposedly "says" about the person who suffered it. Suffering turns into judgment, and the victim risks being implicitly positioned as the accused. The concept of the ideal victim shows that recognition is not automatic but depends on implicit models of a "pure" and narratively coherent victim [2]. It has also been shown that institutions and public discourse do not merely "record" trauma; they co-produce its visibility, credibility, and treatability [3]. Within this framework, trauma moralization can be understood as the effect of a dispositif that shifts attention from power asymmetry to the person's adequacy, from the violent relationship to the victim's conduct. While trauma moralization overlaps with victim blaming and secondary victimization, the concept specifically refers to the process through which traumatic suffering progressively becomes interpreted through moral categories concerning the victim's adequacy, credibility, responsibility, or worth. This process does not emerge only at the individual level but develops within broader social and institutional contexts that shape how trauma is interpreted. The field tends to neutralize the disturbance caused by violence by producing morally reassuring narratives that restore a compromised symbolic order through the attribution of responsibility, suspicion, and the redistribution of blame onto the victim. The link to secondary victimization is especially clear: moralization is one of its most insidious forms because it transforms access to protection into a pathway of moral verification (coherence, credibility, "respectability"). From a psychotraumatology standpoint, if interpersonal trauma breaks meaning systems and bonds of trust, institutional suspicion and blaming are not "neutral": they can consolidate helplessness and block reparative processes [7]. This consolidation also occurs at the bodily level: shame and self-blame can stabilize as embodied states (closure, freezing, hypercontrol) that are not reducible to cognitive judgments [13]. From an integrated victimological–phenomenological–Gestalt viewpoint, trauma moralization can be understood as a process through which victimization fields regulate traumatic disruption rather than as a simple evaluative distortion. When violence introduces a radi-

cal rupture in predictability and relational order, the social and institutional field faces a perturbation that exceeds its habitual forms of integration [7, 13]. In response, the social field attempts to restore coherence after the disruption produced by violence: relational asymmetry is translated into a personal trait, relational fracture into a conduct problem, violence into a credibility issue [1, 3, 4]. Victim blaming, self-blame, and institutional typification thus appear not as separate phenomena, but as interconnected ways through which traumatic experiences become socially reorganized and stabilized, while containing the disturbance produced by trauma at the cost of relocating its burden onto the victim [2, 4-7]. In this sense, moralization is not an accident of judgment but a structural mode of managing victimization through which social and institutional fields organize recognition, legitimation, and treatment, sometimes producing and reproducing secondary victimization [1, 4, 5]. These dimensions of the field should not be understood as separate or fixed levels, but as interconnected processes continuously influencing one another across subjective, relational, institutional, and socio-cultural experience [14].

These articulations can be synthetically mapped across different field levels (socio-cultural, institutional, relational, and subjective), as summarized in Table 1.

VICTIM BLAMING AS A SOCIAL DEVICE

Victim blaming is often described as a bias or an individual judgment error; however, victimological approaches interpret it as a social device for regulating the field [1, 4]. Interpersonal violence disrupts shared assumptions (safety, predictability, trust) and generates collective anxiety. These dynamics may also reflect broader sociocultural processes that regulate vulnerability, legitimacy, and emotional expression within social fields. The field then tends to "close the fracture" with narratives that restore a moral order: if blame can be placed on the victim, the world becomes symbolically controllable again and vulnerability can be kept at a distance [2, 15]. In this logic, victim blaming not only targets the victim but also organizes the context, sustaining the reassuring illusion that there is a safe separation between "those who suffer harm" and "those who are safe." Access to recognition depends on conformity to implicit models of the "ideal victim"; those who deviate (ambivalence, ties to the perpetrator, context, or non-linear behaviors) are more exposed to suspicion and blame [3]. These dynamics are often embedded in institutional practices, where demands for narrative coherence and "appropriate" behavior can become moral se-

Table 1. **Mapping trauma moralization processes across different field levels.**

FIELD LEVEL	PROCESS	DESCRIPTION	FUNCTION IN THE FIELD	REFERENCES
Socio-cultural	Victim blaming	Implicit or explicit attribution of responsibility to the victim for the experienced event	Reduction of collective anxiety; restoration of a moral order and an illusion of control	[2-4, 15]
Institutional	Secondary victimization	Traumatic reorganization of experience through practices of evaluation, credibility filtering, and typification	Normalization of violence; transformation of recognition into a moral verification pathway	[1, 4, 5, 19, 20]
Relational	Trauma moralization	Transformation of relational rupture into an issue of guilt, defect, or personal inadequacy	Symbolic stabilization of the field after perturbation	[1-3]
Subjective	Self-blame	Internalization of blame and self-accusation as a relatively stable configuration of experience	Maintenance of minimal coherence of meaning and bond with the field at the cost of self-accusation	[6-10]
Phenomenological-Gestalt	Contact configurations (introjection, retroflection, confluence)	Organization of experience through modes of contact interruption in asymmetrical and judging fields	Closure of field disorganization and reduction of uncertainty, with restriction of agency	[1, 11, 12, 17, 18]

lection [4]. Gestalt phenomenology allows victim blaming to be described as an attempt by the field to restore a "good form" after perturbation: blaming the victim produces a stable (though unjust) explanation, reduces anxiety, and rapidly closes meaning disorganization [1, 11, 12]. The cost is substantial: it prevents recognition of the relational and structural nature of violence, normalizes asymmetry, and prepares the ground for the internalization of accusation. Moralization, victim blaming, and self-blame are therefore not mere cognitive "distortions," but social and relational responses through which the surrounding context attempts to restore stability after violence [1, 2, 4], while shifting the weight of violence from relational asymmetry onto the person who suffered it [3, 7], setting the stage for the transition from victim blaming to self-blame [15].

SELF-BLAME AS THE INTERNALIZATION OF MORALIZED FIELDS

Self-blame is the subjective counterpart of victim-blaming: self-accusation as the internalization of blame and a relatively stable configuration of experience. A distinction is commonly made between behavioral and characterological self-blame; the latter, centered on being "fundamentally wrong," is more strongly associated with chronic shame, diminished self-worth, and impaired agency [15]. From a victimological and relational perspective, however, self-blame does not arise in a vacuum: it develops within fields saturated with moral judgments and normative expectations that filter credibility and legitimacy [1, 4]. Following interpersonal trauma and betrayal, guilt and shame can function as meaning-repair devices: if the fault is mine, the world remains orderly and experience can be held within an apparently coherent frame [7]. In traumatic relational contexts, self-blame may coexist with dissociative processes and fragmented forms of self-experience [16]. From a victimological–Gestalt standpoint, self-blame can be understood as a contact configuration produced within victimization fields marked by power asymmetries and moral constraints, organized through contact interruptions, such as introjection, retroflection, and confluence [1, 11, 12, 17]. Introjection may appear in the unquestioned internalization of blaming messages and moral judgments. Retroflection may emerge when anger and protest are redirected toward the self rather than toward the violent relational context. Confluence may make it difficult to distinguish one's own experience from the expectations and accusations of the surrounding field. In this framework, self-accusation is not an individual distortion but a way in which the field is organized within relational and institutional contexts that can generate or consolidate secondary victimization processes [1, 4]. Its embodied dimension confirms that self-blame is not only a narrative but also a relatively stable mode of regulating experience, involving bodily and affective levels of subjectivity [14]. Spontaneous engagement with the context becomes restricted, and the person may experience an increased vulnerability to moral judgment, prompting a continuous monitoring of the environment [18]. Self-blame is frequently accompanied by bodily and relational changes. The person may become chronically self-monitoring, emotionally contracted, or excessively oriented toward anticipating judgment and disapproval. Contact with others may lead to a loss of spontaneity and to becoming organized around control, justification, or fear of exposure.

SECONDARY VICTIMIZATION AND THE INSTITUTIONAL FIELD

Secondary victimization describes the reactivation and reorganization of trauma through social and institutional responses. Victimization can be understood as a process involving the perpetrator, the victim, and the institutional field in which the event is handled; within this field, practices of listening, verification, and protection, although necessary, may produce delegitimation and blame, turning help-seeking into a new scene of exposure [5]. Not all victims have the same access to recognition, because credibility depends on implicit models of the "deserving victim" [3]. Institutions do not operate neutrally: they co-produce narratives, define standards of "good testimony," and select what is speakable and what becomes suspicious [4]. Institutional systems may also shape forms of self-surveillance and normalization that become progressively internalized within subjectivity, regulating which emotional expressions are socially sanctioned [19]. This entails a structural risk: reducing lived process to case and profile

and turning traumatic complexity into required coherence. This mechanism operates as a real form of power, where institutional frameworks define the boundaries of the speakable, casting doubt on anything that deviates from established standards [20]. Interpersonal trauma can also be understood as a struggle for recognition, suspended between truth and denial, testimony and silence [7]. When the institutional field responds with suspicion or minimization, it reactivates the very helplessness dynamic that characterized the original violence. In phenomenological–Gestalt terms, the institutional field tends to "freeze" experiential fluidity into typified forms: if trauma is a rupture of meaning and contact, translating it into procedural grids can produce a closed field in which the person can move only within predefined roles [1, 11, 12]. The person may progressively experience institutional encounters as emotionally constricting, hypervigilant, or frozen, with a corresponding reduction in spontaneity and relational trust. From this perspective, secondary victimization can be understood as a field pathology: a systemic effect of the institutional organization of traumatic experience rather than the outcome of isolated ill intent [1, 4].

CLINICAL AND ETHICAL IMPLICATIONS: TOWARD A NON-MORALIZING FIELD

If moralization, victim blaming, self-blame, and secondary victimization are field processes, clinical and institutional intervention cannot be reduced to correcting symptoms or individual beliefs; it must interrogate and transform the relational and symbolic conditions that organize trauma in moralized forms. From a phenomenological–Gestalt perspective, the primary task is not interpretation but the construction of a sufficiently safe field in which the contact process can restart, suspending judging frames and implicit blame criteria [1, 11, 12]. A non-moralizing field does not imply neutrality toward violence, but rather a dialogical and phenomenological stance capable of recognizing traumatic experience without reducing it to moral evaluation or predefined categories of legitimacy. Shame and self-blame should not be treated as "errors" to be corrected, but as outcomes of coercive or invalidating field organizations, consistent with psychotraumatology's emphasis on recognition in trauma repair [7]. This shifts the center of gravity: from evaluating the person to reconsidering the relational and institutional conditions that enabled violence and subsequently moralized its effects. Ethically, the central stake is removing trauma from the moral tribunal. As critical victimology and psychotraumatology show, any implicit demand for coherence, adequacy, or conformity to the model of the "good victim" risks reproducing the same logic that turns the wound into proof and experience into suspicion [2-5, 7]. An integrated victimological and phenomenological–Gestalt approach can function as a critical regulatory principle, oriented toward preventing secondary victimization and keeping the singularity of lived experience open. As self-blame gradually loosens, the person may begin to recover differentiation, bodily presence, relational trust, and a less defensive experience of contact. Experiences previously organized around shame, fear, and self-surveillance may slowly become more open to recognition, agency, and relational legitimacy. In this horizon, the recent Italian femicide legislation (Law of December 2, 2025, No. 181), while representing a significant signal of institutional recognition, also highlights a structural risk present in any dispositif: translating experience into category. For legal recognition not to become a new reduction of meaning, it should be accompanied by practices capable of safeguarding the singularity of experience and protecting it from moralizing typification.

CONCLUSIONS

This paper proposed an integrated reading of shame, self-blame, and victim blaming as field configurations within victimization processes. The central assumption is that these phenomena cannot be adequately understood if reduced to intrapsychic distortions; rather, they should be conceptualized as outcomes of relational, social, and institutional fields that interpret traumatic experience through implicit moral expectations, producing a moralization process in which suffered violence risks being transformed into the person's fault. Victimology highlights the processual nature of victimization and its structural vulnerability to secondary victimization [2, 5], while analyses of the "ideal victim" and institutional frames show that recognition is selective and conditioned by implicit models of legitimacy [3, 4]. Psychotraumatology further demonstrates that repair depends on

recognition and that trauma is also embodied in affect regulation and bodily states [7]. A phenomenological–Gestalt contribution allows these processes to be read as field perturbations and contact disruptions, in which guilt and shame organize as relatively stable configurations in coercive and judging fields [1, 11, 12]. In this perspective, normative and institutional frames—including femicide legislation—are part of the field that organizes trauma: tools for protection and recognition, but also potential producers of typification. This supports the need for a clinically and institutionally grounded non-moralizing orientation that restores trauma as suffered harm, reopens the space of contact, and supports agency and meaning. Keeping the singularity of lived experience open is not only a clinical choice but an ethical stance against the risk that the victim may once again become judged rather than recognized.

Conflict of Interest

The author declares no conflict of interest.

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Data Availability Statement

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The author used artificial intelligence tools exclusively for language and grammar editing of the manuscript.

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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.

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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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Ethics Approval
This work does not constitute experimental research on human subjects and therefore does not require formal ethics committee approval. The work is based on theoretical reflection and literature review conducted according to professional ethical standards.

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

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

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Opinion Article

Trauma and embodied awareness: Gestalt phenomenology and psychoneuro-endocrinoimmunology – toward an integrated approach to trauma psychotherapy

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ABSTRACT

Psychological trauma is one of the most complex clinical challenges in contemporary psychotherapy because it involves the whole embodied person rather than a purely mental event. This theoretical integrative article proposes a model for understanding trauma as a multilevel interruption of organism-environment contact by integrating Gestalt phenomenology and psychoneuroendocrinoimmunology.

Drawing on recent literature, the paper discusses how traumatic experience manifests simultaneously at neurobiological, neuroendocrine, immune, and phenomenological levels. It further introduces the concept of crystallization of the organismic field as a bridge between lived experience and biological processes, including epigenetic changes and chronic postural and fascial organization. On this basis, the article outlines clinical implications for embodied trauma psychotherapy, emphasizing grounding, work within the window of tolerance, co-regulation in the therapeutic relationship, and the development of interoceptive awareness. The proposed framework is intended as a conceptual map for clinical practice and future empirical research rather than as a report of original empirical findings.

Keywords

Psychological trauma, Gestalt psychotherapy, Psychoneuroendocrinoimmunology, Neurobiology, Phenomenology, Embodied awareness, Epigenetics.

ABSTRACT IN ITALIANO

Il trauma psicologico rappresenta una delle sfide cliniche più complesse della psicoterapia contemporanea, poiché coinvolge l'intera persona incarnata e non un evento esclusivamente mentale. Questo articolo teorico-integrativo propone un modello per comprendere il trauma come interruzione multilivello del contatto organismo-ambiente attraverso l'integrazione tra fenomenologia gestaltica e psi-

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coneuroendocrinoimmunologia. Sulla base della letteratura recente, il contributo discute come l'esperienza traumatica si manifesti simultaneamente a livello neurobiologico, neuroendocrino, immunitario e fenomenologico. Viene inoltre introdotto il concetto di cristallizzazione del campo organismico come ponte tra esperienza vissuta e processi biologici, incluse le modificazioni epigenetiche e le organizzazioni posturali e fasciali croniche. Su tale base, l'articolo delinea le implicazioni cliniche per una psicoterapia del trauma orientata all'embodiment, con particolare attenzione al grounding, al lavoro entro la finestra di tolleranza, alla co-regolazione nella relazione terapeutica e allo sviluppo della consapevolezza enterocettiva. Il quadro proposto intende offrire una mappa concettuale per la pratica clinica e per future ricerche empiriche, e non la presentazione di risultati empirici originali.

Parole chiave
Trauma psicologico, Psicoterapia della Gestalt, Psiconeuroendocrinoimmunologia, Neurobiologia, Fenomenologia, Consapevolezza incarnata, Epigenetica.

INTRODUCTION

In the foundational text of Gestalt therapy, Perls, Hefferline, and Goodman stated that "the organism does not adapt passively to the environment but actively creates its own field" [1]. This pioneering vision, which placed embodied experience and dynamic interaction at the center of the therapeutic process, today finds a meaningful dialogue with modern neuroscience and, in particular, with psychoneuroendocrinoimmunology. Contemporary psychotherapy, therefore, faces a crucial epistemological challenge: how can the growing body of neurobiological evidence on trauma be integrated without falling into a mechanistic reductionism that betrays the depth and uniqueness of the phenomenological approach?

The understanding of trauma has undergone a radical transformation in recent decades. It is no longer viewed simply as a historical event stored in the psyche, but as a persistent condition that alters the very physiology of the organism [2]. Trauma can thus be understood as a fundamental interruption of contact, not only at a psychological level but also at a profoundly biological one, reverberating through the nervous, hormonal, and immune systems and preventing the natural fluidity of creative adjustment [3].

The central thesis of this work is that there is no contradiction, but rather a profound complementarity, between Gestalt phenomenology and psychoneuroendocrinoimmunology. Far from reducing subjective experience to chemical processes, this perspective offers a scientific language for describing the embodied texture of phenomenological experience, validating the intuition that every movement of the psyche is also a movement of the body and of the field. This opinion article is theoretical and integrative in nature: it is based on a conceptual discussion of the literature and does not report original empirical findings. In the following pages, trauma will be explored as a multilevel interruption of contact, the crystallization of the organismic field will be examined through the lenses of epigenetics and somatic organization, and the clinical implications of a truly integrated therapeutic approach will be outlined.

THEORETICAL FOUNDATIONS

Trauma in the Gestalt Phenomenological Perspective

In Gestalt theory, health is defined by the organism's capacity to form and dissolve gestalts fluidly, creatively adapting to the environment in a continuous process of organismic regulation [1]. The contact cycle describes this movement from pre-contact to full contact to post-contact. Drawing on Kurt Lewin's field theory, Parlett emphasized that human behavior can only be understood by considering the total situation and by avoiding reductionistic analyses based on isolated variables [4]. The meaning of every event, behavior, or experience emerges from the overall configuration of the field at a given moment.

Trauma, in this perspective, is a catastrophic interruption of the contact cycle. It is unfinished business that remains frozen in present time, preventing the completion of the defensive response and crystallizing the organism in fixed survival modalities. Contact interruptions such as retroflection, deflection, or projection are not merely mental defense mechanisms, but total configurations of being-in-the-world. Gestalt awareness is therefore not a cognitive act, but an immediate embodied experience of the here-and-now, often made difficult or inaccessible by traumatic experience.

PNEI as the Scientific Framework of Embodied Experience

Psychoneuroendocrinoimmunology studies the bidirectional interactions among psyche, nervous system, endocrine system, and immune system, demonstrating that there is no functional separation among these domains. In this sense, it provides a scientific framework for the mind-body-environment unity postulated by Gestalt theory. According to Porges, the autonomic nervous system continuously scans the environment for signals of safety or danger, a process defined as neuroception, and organizes physiological responses that often precede cognitive awareness [5]. In trauma, this integrated communication network becomes altered: the organism loses homeostatic flexibility and remains trapped in defensive states that phenomenology describes as field rigidity.

TRAUMA AS A MULTILEVEL INTERRUPTION OF CONTACT

Neurobiological Level

At the cerebral level, trauma profoundly alters the structures responsible for threat processing and memory. Functional neuroimaging studies consistently show hyperactivation of the amygdala, accompanied by reduced function of the ventromedial prefrontal cortex, which is necessary for fear inhibition and emotional regulation [6,7]. Simultaneously, reductions in hippocampal volume and functional impairment are often observed [8]. Since the hippocampus is crucial for the temporal contextualization of memories, its malfunction causes the traumatic event not to be filed as past, but to be experienced as an intrusive and ever-present condition. In phenomenological terms, the patient may live in a here-and-then that obscures the actual here-and-now. Furthermore, in dissociative subtypes of post-traumatic stress disorder, a functional disconnection between emotional and cognitive areas has been documented [9], offering a measurable correlate of the avoidance of direct contact with the intensity of experience.

Neuroendocrine Level

The hypothalamic-pituitary-adrenal axis is the main effector of the stress response. In chronic trauma and post-traumatic stress disorder, this system shows a complex dysregulation. While acute stress typically elevates cortisol, chronic trauma may be associated with paradoxical decreases in basal cortisol levels or flattening of its circadian curve, reflecting exhaustion or dysfunctional receptor adaptation [10,11]. From a Gestalt perspective, this dysregulation can be read as a crystallization in the mobilization phase of the contact cycle. The organism remains chemically prepared for action, or collapses in the impossibility of acting, without ever fully accessing discharge, relaxation, and withdrawal.

Immune Level

Research in psychoneuroendocrinoimmunology has robustly documented the link between early trauma and systemic inflammation in adulthood. Individuals with histories of childhood adversity exhibit elevated levels of inflammatory markers, including C-reactive protein, interleukin-6, and tumor necrosis factor-alpha [12,13]. This chronic pro-inflammatory state can be interpreted as a body that continues to defend itself against an invisible threat even decades after the traumatic event. It offers an extraordinary biological parallel to the Gestalt concept of retroflection: defensive energy that cannot be directed toward the environment is turned inward and may manifest as inflammatory or autoimmune processes.

Phenomenological Level

All these alterations converge in the patient's lived experience. Contact cycle interruptions are not abstractions, but somatic realities. Retroflection may manifest as chronic muscular tension and sympathetic hyperactivation. Projection, often interpreted solely psychologically, may be rooted in a hyperreactive amygdala that lowers the threshold for perceiving danger and colors the environment with threat. Traumatic confluence, in which self-other boundaries become blurred, may be accompanied by deficits in proprioception and interoception, making it difficult to distinguish one's own sensations from those attributed to the aggressor or to the environment.

THE CRYSTALLIZATION OF THE ORGANISMIC FIELD

The Gestalt concept of crystallization today finds an important point of dialogue with epigenetics. Recent studies suggest that childho-

od trauma can alter deoxyribonucleic acid methylation, particularly in genes involved in stress regulation, such as the glucocorticoid receptor gene NR3C1 [14-16]. These chemical modifications may make the organism more or less sensitive to stress hormones, biologically stabilizing particular response patterns to the environment. Trauma is therefore not only remembered; it may also become functionally inscribed within stress-response systems, contributing to vulnerability according to the three-hit model, in which later outcomes derive from the interaction among genetic predisposition, early adversity, and subsequent stressful events [17].

As Van der Kolk famously observed, the body keeps the score [2]. Unexpressed emotions and interrupted defensive movements may become structured in chronic muscular tension and in changes in connective tissue organization. These characterological armors are not inert: they send continuous afferent signals to the brain, confirming a state of alert. Sympathetic hyperactivation keeps muscles prepared for action, and over time, the structure of the body may adapt to its defensive function, limiting breathing and mobility and literally restricting the possibilities of contact with the world.

FROM THEORY TO PRACTICE: CLINICAL IMPLICATIONS

The Here-and-Now as a Neuroregulatory Intervention

If trauma is a temporal collapse, the therapeutic act of bringing attention back to the here-and-now can be understood as a neuroregulatory intervention. Focusing attention on present-moment sensory experience helps reactivate prefrontal functions and modulate amygdala activity, thereby interrupting the loop of traumatic re-experiencing [18]. Functional neuroimaging studies also suggest that present-moment awareness is associated with increased activation of medial prefrontal areas and reduced amygdalar activity [19], supporting the clinical intuition that attention to present experience may facilitate top-down emotional regulation.

The Window of Tolerance and Stabilization

Gestalt-oriented intervention must operate within the window of tolerance, that is, the range of activation in which information can be processed without the patient slipping into hyperarousal or hypoarousal [20]. Stabilization strategies such as autonomic tracking, careful titration of activation, and support for sensory orientation are essential prerequisites for undertaking more expressive or cathartic work safely.

Grounding and Orientation as Neuroregulatory Interventions

Grounding is not merely a metaphor for stability. Inviting the patient to feel the support of the chair or the contact of their feet with the floor activates proprioceptive and tactile pathways that may signal safety to the nervous system. Similarly, active visual orientation in the surrounding environment can support exploratory functions that counterbalance defensive immobilization. Within an embodied Gestalt framework, these practices help restore the possibility of contact by re-establishing sensory anchoring in the present field.

Field Support and Polyvagal Theory

According to polyvagal theory, safety is a physiological condition necessary for therapeutic work [5]. The therapist can therefore function as an external biological regulator: through vocal prosody, facial expression, pacing, and calm presence, the clinician may support activation of the patient's social engagement system. This process of co-regulation is one of the most concrete expressions of field support, because it offers a relational and physiological basis from which new modalities of contact can be explored.

Interoceptive Awareness and Heart Rate Variability

Heart rate variability is a reliable index of autonomic flexibility and emotional regulation capacity and is often compromised in post-traumatic stress disorder [21, 22]. Interventions aimed at developing interoceptive awareness stimulate neural networks involved in the integration of the bodily self, especially the insula and anterior cingulate cortex [23, 24]. Approaches such as Sensorimotor Psychotherapy and embodied mindfulness-informed Gestalt work can therefore help restore the interrupted connection between bodily perception, affect regulation, and relational presence [25].

Responsibility as Neurobiological Response-Ability

Finally, the Gestalt concept of responsibility, understood as response-ability, can be reinterpreted as the organism's biological capacity to respond flexibly and contextually, rather than to react automatically to crystallized traumatic patterns [1]. In trauma, the nervous system loses this flexibility and may oscillate between hypervigilance and dissociative collapse. Thanks to neuroplasticity, however, corrective experiences in therapy can reshape functional pathways and gradually restore the capacity to discriminate between past and present, between actual danger and traumatic memory, and to choose relational responses appropriate to the current context [26].

DISCUSSION

The proposed integration between Gestalt phenomenology and psychoneuroendocrinoimmunology highlights a profound convergence: the "how" of phenomenological inquiry finds its "what" in neurobiological mechanisms. The aim is not to reduce lived experience to biology, but to use scientific knowledge to refine clinical sensitivity and to support a more nuanced reading of the embodied field. In this sense, the body is not an object among objects, but the very subject of experience [27]. A phenomenologically embodied psychotherapy recognizes that working on the relational field also entails regulating interacting nervous systems [28].

Limitations

Several limitations of the present work should be acknowledged. First, the proposed model is theoretical and has not yet been directly tested through original empirical studies. Second, the article offers an integrative and non-systematic discussion of the literature; therefore, it should not be interpreted as an exhaustive review. Third, the correspondence proposed here between Gestalt phenomenological constructs and biological markers is clinically promising but still partly inferential and requires clearer operationalization before strong causal conclusions can be drawn.

Future Research Directions

Future research should examine this framework through multimethod designs capable of integrating clinical, physiological, and immunological indicators. Potential measurable outcomes include heart rate variability [21,22], basal cortisol levels and diurnal cortisol slope [10,11], inflammatory markers such as C-reactive protein, interleukin-6, and tumor necrosis factor alpha [12, 13], and validated measures of post-traumatic symptoms, dissociation, and interoceptive awareness [24]. Process-oriented studies could also investigate changes in therapeutic alliance, co-regulation, grounding capacity, and embodied awareness across treatment. In this way, the efficacy of Gestalt-informed embodied trauma psychotherapy could be evaluated not only in terms of symptom reduction, but also through markers of resilience, flexibility, and integration.

CONCLUSIONS

Trauma is neither solely a psychological event nor solely a neurobiological dysfunction; it is an interruption of the organism-environment field that spans all levels of embodied experience. Gestalt phenomenology offers an irreplaceable experiential framework for encountering the other, while psychoneuroendocrinoimmunology offers a language for understanding the underlying mechanisms that shape such encounter. The integration of these two perspectives may support interventions that are more clinically sensitive, scientifically grounded, and responsive to the unity of the human person. The framework proposed here should now be considered a conceptual basis for further empirical validation and for the refinement of embodied trauma psychotherapy.

Conflict of Interest

The authors declare that they have no conflict of interest in relation to the present article.

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The data generated during the present study are available, upon reasonable request, from the corresponding author.

Artificial Intelligence

The authors declare that they have used artificial intelligence software to improve the grammar and syntax of the article.

Authors' Contributions

[Author 1]: conceptualization, methodology, writing of the original manuscript.
[Authors 2, 3, and 4]: data management, formal analysis, manuscript review and editing.

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Systematic Review

Body-Oriented Gestalt Trauma Therapy (GTT): A Systematic Literature Review

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ABSTRACT

Objective: Body-oriented Gestalt therapy represents an integrative approach to trauma treatment that emphasizes body awareness, interoceptive and proprioceptive sensations, and bottom-up processing of traumatic experiences. This systematic review examines empirical evidence for body-based interventions in trauma treatment, with particular focus on Gestalt principles of awareness, contact, and organismic self-regulation.

Materials and Methods: A systematic search was conducted in PubMed, Scopus, Web of Science, and PsycINFO databases for the period 2015-2025, following PRISMA guidelines. Inclusion criteria comprised randomized controlled trials (RCTs), quasi-experimental studies, and systematic reviews of body-oriented trauma interventions.

Results: The analysis identified promising evidence for several body-oriented approaches, including Somatic Experiencing (d = 0.94-1.26), trauma-sensitive yoga (d = 1.07), sensorimotor psychotherapy, and dance movement therapy. Common therapeutic mechanisms include enhanced interoceptive awareness, regulation of the autonomic nervous system through polyvagal pathways, and completion of interrupted defensive responses.

Conclusions: Body-oriented Gestalt approaches demonstrate significant potential for trauma treatment, integrating phenomenological awareness principles with neurobiological mechanisms of bottom-up processing. Further RCTs are needed to establish standardized protocols and evidence-based guidelines.

Keywords

Gestalt therapy, Trauma, Body-oriented approaches, Somatic Experiencing, Interoception, Polyvagal Theory, PTSD, Body awareness, Self-regulation, Systematic review.

ABSTRACT IN ITALIANO

Introduzione: La terapia della Gestalt orientata al corpo rappresenta un approccio integrativo al trattamento del trauma che enfatizza la consapevolezza corporea, le sensazioni interocettive e propriocettive, e l'elaborazione bottom-up delle esperienze traumatiche. Questa revisione sistematica esamina l'evidenza empirica degli interventi corporei nel trattamento del trauma, con particolare attenzione ai principi gestaltici di consapevolezza, contatto e autoregolazione organismica.

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Materiali e Metodi: È stata condotta una ricerca sistematica nei database PubMed, Scopus, Web of Science e PsycINFO per il periodo 2015-2025, seguendo le linee guida PRISMA. I criteri di inclusione comprendevano studi controllati randomizzati (RCT), studi quasi-sperimentali e revisioni sistematiche su interventi corporei per il trauma.

Risultati: L'analisi ha identificato evidenze promettenti per diversi approcci corporei, inclusi Somatic Experiencing (d = 0.94-1.26), yoga trauma-sensibile (d = 1.07), terapia sensomotoria e danza-movimento-terapia. I meccanismi terapeutici comuni includono il potenziamento della consapevolezza interocettiva, la regolazione del sistema nervoso autonomo attraverso la teoria polivagale, e il completamento delle risposte difensive interrotte.

Conclusioni: Gli approcci gestaltici orientati al corpo mostrano un potenziale significativo nel trattamento del trauma, integrando principi di consapevolezza fenomenologica con meccanismi neurobiologici di elaborazione bottom-up. Sono necessari ulteriori RCT per stabilire protocolli standardizzati e linee guida basate sull'evidenza.

Parole chiave

Terapia della Gestalt, Trauma, Approcci corporei, Somatic experiencing, Interocezione, Teoria polivagale, PTSD, Consapevolezza corporea, Autoregolazione, Revisione sistematica.

INTRODUCTION

Psychological trauma represents a pervasive public health concern, with post-traumatic stress disorder (PTSD) affecting approximately 5.6% of the general population and higher rates among specific groups, including women (twice the male prevalence) and individuals with migration histories (up to 47% at risk) [1, 2]. The recognition that trauma is encoded not only cognitively but also somatically has led to growing interest in body-oriented therapeutic approaches that address the physiological dimensions of traumatic stress [3, 4].

Gestalt therapy, developed by Fritz and Laura Perls alongside Paul Goodman in the 1950s, has always emphasized the unity of mind and body, viewing the organism as an integrated whole in constant interaction with its environment [5, 6]. The Gestalt concept of 'awareness' encompasses not merely cognitive recognition but includes bodily sensations, emotional states, and relational dynamics occurring in the here-and-now [7]. This phenomenological approach to human experience positions Gestalt therapy as a natural framework for integrating body-oriented trauma interventions.

Contemporary neuroscience has provided substantial empirical support for body-oriented approaches to trauma. Van der Kolk's [8] seminal work, 'The Body Keeps the Score,' crystallized decades of research demonstrating that traumatic memories are stored implicitly in procedural and sensorimotor systems, often inaccessible to verbal processing alone. The polyvagal theory, developed by Porges [9, 10], has offered a neurophysiological framework for understanding how the autonomic nervous system mediates responses to threat and safety, with direct implications for therapeutic interventions targeting the body.

The concept of interoception – the perception of internal bodily states – has emerged as a critical mechanism linking body awareness to emotional regulation and mental health [11, 12]. Research has demonstrated that interoceptive dysfunction is common in trauma survivors, manifesting as either blunted or heightened sensitivity to internal signals [13]. Body-oriented interventions may address these disruptions by enhancing interoceptive awareness and facilitating the integration of somatic experience with cognitive and emotional processing.

Several body-oriented approaches have developed specifically for trauma treatment, including Somatic Experiencing (SE), developed by Peter Levine [14, 15], sensorimotor psychotherapy [16, 17], trauma-sensitive yoga [18, 19], and dance movement therapy [20, 21]. While these approaches share common elements, such as attention to bodily sensation, emphasis on autonomic regulation, and processing of implicit traumatic material, they have largely developed independently, with varying degrees of empirical support.

This systematic review aims to synthesize the current evidence base for body-oriented trauma interventions through the lens of Gestalt therapy principles. By examining how concepts such as awareness, contact, organismic self-regulation, and field theory manifest in body-based approaches to trauma, this review seeks to establish theoretical coherence across diverse modalities and evaluate their empirical efficacy. The integration of Gestalt phenomenology with contemporary neuro-

science offers a comprehensive framework for understanding both the mechanisms and outcomes of body-oriented trauma therapy.

MATERIALS AND METHODS

Study Design

This systematic review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines [22]. The review protocol was developed *a priori*, specifying research questions, inclusion criteria, search strategy, and data extraction procedures.

Eligibility Criteria

Inclusion criteria: (1) Studies examining body-oriented interventions for trauma, PTSD, or complex trauma; (2) Randomized controlled trials (RCTs), quasi-experimental studies, systematic reviews, or meta-analyses; (3) Adult participants (≥18 years); (4) Published in peer-reviewed journals between January 2015 and December 2025; (5) Full text available in English or Italian; (6) Outcomes including PTSD symptoms, body awareness, dissociation, affect regulation, or related constructs.

Exclusion criteria: (1) Case studies without control conditions; (2) Conference abstracts without full-text availability; (3) Studies focusing exclusively on pharmacological interventions; (4) Non-peer-reviewed literature; (5) Studies without standardized outcome measures.

Search Strategy

Systematic searches were conducted in PubMed, Scopus, Web of Science, and PsycINFO databases. The search strategy combined terms across three conceptual domains: (1) Population/Condition: 'trauma' OR 'PTSD' OR 'post-traumatic stress' OR 'complex trauma' OR 'traumatic stress'; (2) Intervention: 'body-oriented' OR 'somatic' OR 'Gestalt' OR 'body awareness' OR 'Somatic Experiencing' OR 'sensorimotor psychotherapy' OR 'trauma-sensitive yoga' OR 'dance movement therapy' OR 'interoception' OR 'proprioception'; (3) Study type: 'randomized controlled trial' OR 'RCT' OR 'systematic review' OR 'meta-analysis'. Boolean operators connected search terms within and across domains.

Study Selection Process

Initial screening involved review of titles and abstracts against inclusion criteria. Full-text articles were obtained for potentially eligible studies and assessed independently. Reference lists of included studies and relevant reviews were hand-searched to identify additional eligible articles. Discrepancies were resolved through discussion (Figure 1).

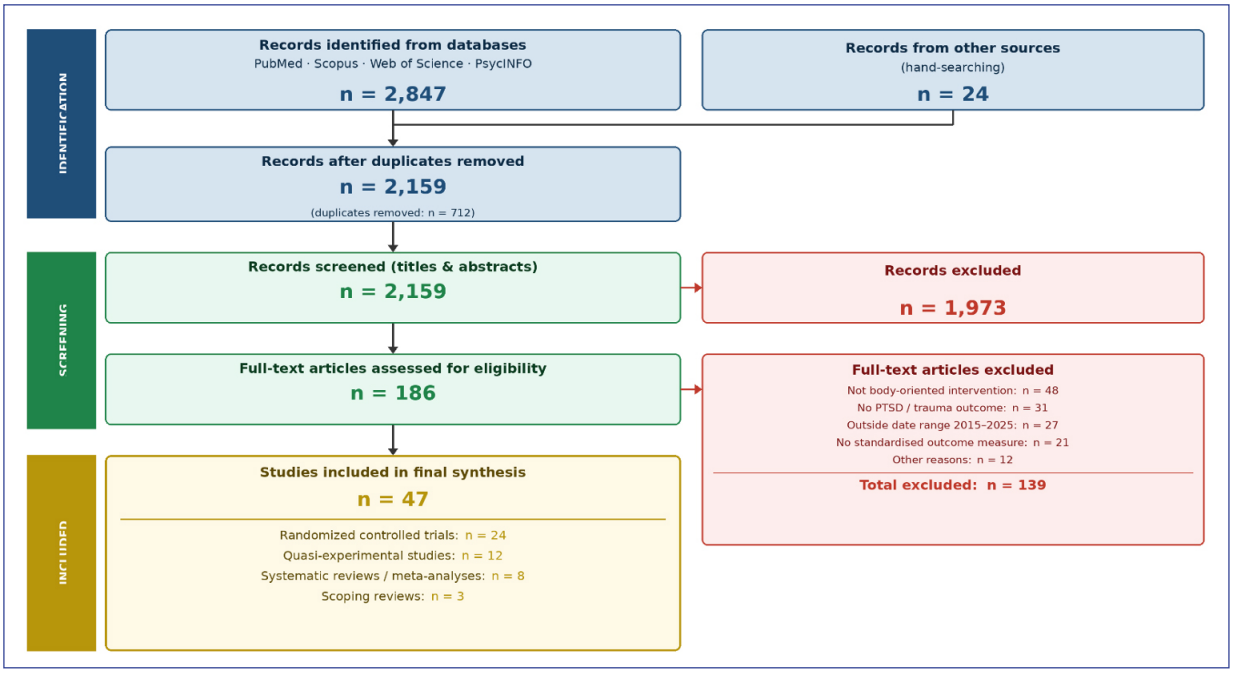

Figure 1. PRISMA 2020 flow diagram illustrating the study selection process.

Data Extraction and Synthesis

Data extraction captured study characteristics (design, sample size, population), intervention details (type, duration, delivery format), outcome measures, and key findings, including effect sizes where available. Given heterogeneity across interventions and outcomes, a narrative synthesis approach was adopted, organizing findings by intervention type and theoretical mechanism. Risk of bias was assessed using the Cochrane Risk of Bias tool for RCTs and the JBI Critical Appraisal Checklist for quasi-experimental studies [23].

RESULTS

Study Selection and Characteristics

The systematic search identified 2,847 records across databases. After removing duplicates (n = 712) and screening titles and abstracts (n = 2,135), 186 full-text articles were assessed for eligibility. Of these, 47 studies met the inclusion criteria and were included in the final synthesis. The included studies comprised 24 randomized controlled trials, 12 quasi-experimental studies, 8 systematic reviews or meta-analyses, and 3 scoping reviews (Table 1).

Intervention types represented in the literature included Somatic Experiencing (n = 9), trauma-sensitive yoga (n = 14), sensorimotor psychotherapy (n = 5), dance movement therapy (n = 8), body-oriented group therapy (n = 6), and integrative body-mind approaches (n = 5). Sample sizes ranged from 24 to 226 participants, with the majority studying women with histories of interpersonal trauma.

Somatic Experiencing

Somatic Experiencing (SE), developed by Peter Levine [14], represents the most extensively researched body-oriented trauma therapy. The approach emphasizes guiding clients' attention to interoceptive, kinesthetic, and proprioceptive experiences rather than to cognitive or emotional content, thereby facilitating the completion of thwarted biological self-protective responses and the discharge of excess autonomic arousal [15].

Kuhfuß et al [24] conducted the first scoping literature review of SE effectiveness and key factors, identifying preliminary evidence supporting SE as an effective treatment for PTSD-related symptoms. The authors noted that SE may also be useful for other disorders, though they emphasized the need for more rigorous RCT research with unbiased methodologies.

Brom et al [25] conducted a landmark RCT comparing SE to a waitlist control in 63 participants with PTSD. Results demonstrated significant reductions in PTSD symptoms (Cohen's d = 0.94-1.26) and depression, with effects maintained at follow-up. The study provided strong evidence for SE's efficacy, though the authors called for replication and comparison studies against established treatments.

The theoretical basis of SE aligns closely with Gestalt principles of organismic self-regulation. Payne, Levine, and Crane-Godreau [15] articulated a neurophysiological model in which SE interventions restore functionality to what they term the 'core response network' – the interconnected subcortical systems that govern autonomic, limbic, motor, and arousal functions. This bottom-up processing approach differs fundamentally from cognitive therapies, instead addressing trauma through the body's innate self-regulatory mechanisms.

Trauma-Sensitive Yoga

Trauma-sensitive yoga has emerged as a well-researched body-oriented intervention with strong empirical support. Van der Kolk et al [18] conducted a pivotal RCT with 64 women experiencing chronic, treatment-resistant PTSD randomized to trauma-informed yoga or supportive women's health education. Results demonstrated that 52% of the yoga group no longer met criteria for PTSD at study completion, compared to 21% in the control group (d = 1.07 for CAPS scores).

Nguyen-Feng et al [26] extended this research by examining treatment moderators in the original trial, finding that Trauma Center Trauma-Sensitive Yoga (TCTSY) was most efficacious for those with adult-onset interpersonal trauma in addition to childhood trauma, suggesting the importance of matching intervention to client characteristics.

Mitchell et al [27] reported similar findings in a pilot RCT of Kripalu yoga for women with full or subthreshold PTSD, demonstrating decreases in re-experiencing and hyperarousal symptoms. Secondary analyses revealed improvements in emotion regulation and decreases in alcohol and substance use, suggesting broader effects on self-regulatory capacities [28].

Table 1. Charting Table of Included Studies — Body-Oriented Interventions for Trauma (n = 47).
Systematic Review: Body Oriented Gestalt Trauma Therapy (MS_306)
Data charted according to JBI Manual for Evidence Synthesis (Aromataris & Munn, 2020). Studies ordered by year of publication within each intervention category.

AUTHOR(S)	YEAR	COUNTRY	AIMS / PURPOSE	POPULATION & SAMPLE SIZE	METHODOLOGY	INTERVENTION / DURATION / COMPARATOR / OUTCOME MEASURES	KEY FINDINGS
Somatic Experiencing							
Payne, Levine & Crane-Godreau [15]	2015	USA	Articulate the neurophysiological model of SE, presenting interoception and proprioception as core trauma therapy mechanisms.	Theoretical review; no primary clinical sample. Clinical observations from trauma-exposed populations	Conceptual/theoretical paper with integrative literature review.	Intervention: Somatic Experiencing (SE). Duration: Not specified (theoretical). Comparator: None. Outcomes: Interoceptive/proprioceptive awareness, autonomic regulation, PTSD symptom reduction.	SE restores functionality to the 'core response network' (subcortical systems governing autonomic, limbic, motor and arousal functions) via bottom-up processing. Aligns with Gestalt organismic self-regulation; differs from cognitive therapies by addressing trauma through the body's innate regulatory mechanisms.
Brom, Stokar, Lawi et al. [25]	2017	Israel	Evaluate the efficacy of SE for PTSD in a randomized controlled design compared to waitlist control.	Adults with PTSD (DSM-IV); n = 63 (SE: n = 32, waitlist: n = 31); predominantly interpersonal trauma.	Randomized controlled trial (RCT).	Intervention: Somatic Experiencing (SE), individual sessions. Duration: Not specified in the manuscript. Comparator: Waitlist control. Outcomes: PTSD symptoms; depression.	Significant reductions in PTSD symptoms (Cohen's d = 0.94–1.26) and depression *vs* waitlist; gains maintained at follow-up. First RCT of SE; authors call for replication and active comparison studies against established treatments.
Kuhfuß, Maldei, Hetmanek & Baumann [24]	2021	Germany	Review the effectiveness and key factors of Somatic Experiencing (SE) as a body-oriented trauma therapy.	Trauma-exposed adults with PTSD or trauma-related symptoms; mixed clinical populations across included studies.	Scoping literature review.	Intervention: Somatic Experiencing (SE). Duration: Variable across included studies. Comparator: Variable (waitlist, TAU, active control). Outcomes: PTSD-related symptoms; somatic complaints.	Preliminary evidence supports SE efficacy for PTSD-related symptoms. SE may be useful for other disorders. Authors emphasize the need for more rigorous RCTs with unbiased methodologies and standardized protocols.

Continued

Table 1 *(continued).* Charting Table of Included Studies — Body-Oriented Interventions for Trauma (n = 47).
Systematic Review: Body Oriented Gestalt Trauma Therapy (MS_306)
Data charted according to JBI Manual for Evidence Synthesis (Aromataris & Munn, 2020). Studies ordered by year of publication within each intervention category.

AUTHOR(S)	YEAR	COUNTRY	AIMS / PURPOSE	POPULATION & SAMPLE SIZE	METHODOLOGY	INTERVENTION / DURATION / COMPARATOR / OUTCOME MEASURES	KEY FINDINGS
Trauma-Sensitive Yoga							
Mitchell, Dick, DiMartino et al. [27]	2014	USA	Test feasibility and preliminary efficacy of yoga as intervention for PTSD symptoms in women (pilot RCT).	Women with full or sub-threshold PTSD (DSM-IV); pilot RCT. N not reported in manuscript text.	Pilot randomized controlled trial (RCT).	Intervention: Kripalu yoga (not trauma-specific protocol). Duration: Not specified in manuscript. Comparator: Not specified in manuscript. Outcomes: Re-experiencing; hyperarousal; emotion regulation; alcohol/substance use.	Decreases in re-experiencing and hyperarousal symptoms. Secondary analyses showed improvements in emotion regulation and reductions in alcohol/substance use, suggesting broader self-regulatory effects. Pilot findings require replication.
Dick, Niles, Street, DiMartino & Mitchell [28]	2014	USA	Examine mechanisms of change in a yoga intervention for women with PTSD, focusing on mindfulness, psychological flexibility and emotion regulation.	Women with PTSD; secondary analysis of pilot RCT sample [27].	Secondary analysis of a pilot RCT.	Intervention: Kripalu yoga. Duration: Not specified. Comparator: Not specified. Outcomes: PTSD symptoms; mindfulness; psychological flexibility; emotion regulation.	Mindfulness, psychological flexibility, and emotion regulation identified as mechanisms of change mediating yoga's effect on PTSD. Supports the body-based pathway to improved affect regulation.
van der Kolk, Stone, West et al. [18]	2014	USA	Evaluate trauma-sensitive yoga (TCTSY) as adjunctive treatment for chronic, treatment-resistant PTSD in women.	Women with chronic, treatment-resistant PTSD; predominantly childhood interpersonal trauma; n = 64 (yoga: n = 31, control: n = 33).	Randomized controlled trial (RCT); assessor-blinded.	Intervention: Trauma Center Trauma-Sensitive Yoga (TCTSY), group format. Duration: 10 weekly 60-min sessions. Comparator: Supportive women's health education group. Outcomes: PTSD (CAPS); dissociation (DES); depression (BDI).	52% of yoga group no longer met PTSD criteria at completion *vs* 21% controls (d = 1.07 on CAPS). Significant reductions in dissociation. Supports body-based approaches for complex, treatment-resistant PTSD.
West, Liang & Spinazzola [19]	2017	USA	Explore participant experiences of TCTSY as a complementary treatment for PTSD through qualitative inquiry.	Women with PTSD and histories of interpersonal trauma; qualitative sub-sample from the van der Kolk et al. [18] RCT.	Qualitative descriptive analysis; semi-structured interviews.	Intervention: TCTSY group sessions. Duration: 10 weeks. Comparator: None (qualitative substudy). Outcomes: Lived experience; body awareness; sense of agency.	Participants reported increased sense of agency, improved interoceptive awareness, and reduced avoidance of body sensations. Yoga facilitated trauma processing inaccessible through verbal approaches alone.
Nguyen-Feng, Clark & Butler [26]	2019	USA	Synthesize evidence for yoga interventions targeting psychological symptoms in trauma-exposed individuals; examine treatment moderators.	Trauma-exposed adults; pooled sample across included studies; TCTSY most efficacious for those with adult-onset interpersonal trauma in addition to childhood trauma.	Systematic review and quantitative synthesis (meta-analytic).	Intervention: Various yoga modalities including TCTSY. Duration: Variable across included studies. Comparator: Waitlist, TAU, active control. Outcomes: PTSD; psychological symptoms.	TCTSY most efficacious for participants with adult-onset interpersonal trauma in addition to childhood trauma. Highlights importance of matching intervention to client trauma history and characteristics.

Continued

Table 1 *(continued).* Charting Table of Included Studies — Body-Oriented Interventions for Trauma (n = 47).
Systematic Review: Body Oriented Gestalt Trauma Therapy (MS_306)
Data charted according to JBI Manual for Evidence Synthesis (Aromataris & Munn, 2020). Studies ordered by year of publication within each intervention category.

AUTHOR(S)	YEAR	COUNTRY	AIMS / PURPOSE	POPULATION & SAMPLE SIZE	METHODOLOGY	INTERVENTION / DURATION / COMPARATOR / OUTCOME MEASURES	KEY FINDINGS
Sensorimotor Psychotherapy							
Langmuir, Kirsh & Classen [17]	2012	Canada	Evaluate a body-oriented group psychotherapy adapted from sensorimotor psychotherapy for trauma survivors.	Adults with complex trauma/ PTSD; predominantly women with childhood abuse histories; n = 24.	Pilot quasi-experimental study; pre-post design without control group.	Intervention: Sensorimotor psycho-therapy adapted to group format. Duration: Not specified in manuscript. Comparator: None. Outcomes: PTSD; dissociation; emotion regulation; somatic awareness.	Preliminary evidence for feasibility and acceptability. Significant pre-post reductions in trauma and dissociation symptoms reported. No control condition; results require replication in controlled design.
Gene-Cos, Fisher, Ogden & Cantrell [31]	2016	UK	Examine sensorimotor psycho-therapy group treatment for complex PTSD, including effects on affect regulation.	Adults with complex PTSD. N and clinical setting not specified in manuscript text.	Quasi-experimental study; pre-post design without control group.	Intervention: Sensorimotor psycho-therapy, group format. Duration: Variable (not specified in manuscript). Comparator: None. Outcomes: Traumatic symptoms; affect regulation.	Positive outcomes in reducing traumatic symptoms and improving affect regulation. The group setting provided opportunities for relational healing alongside somatic processing. No control condition limits interpretation.
Classen, Hughes, Clark et al. [30]	2021	USA	Evaluate a body-oriented group therapy (Trauma Body Group; TBG) adapted from sensorimotor psychotherapy for complex trauma survivors.	Women with complex trauma histories; n = 32 (TBG: n = 16, waitlist: n = 16).	Pilot randomized controlled trial (RCT); assessor-blinded; waitlist-controlled.	Intervention: Trauma Body Group (TBG) — adaptation of sensorimotor psychotherapy for group format. Duration: Not specified in manuscript. Comparator: Waitlist control. Outcomes: Body awareness; anxiety; soothing receptivity.	Significant improvements in body awareness, anxiety, and soothing receptivity *vs* waitlist. Effects maintained at six-month follow-up. Provides preliminary evidence for group sensorimotor psychotherapy with complex trauma.
Dance Movement Therapy							
Levine & Land [33]	2016	USA	Synthesize qualitative findings on dance/movement therapy (DMT) for individuals with trauma through meta-synthesis.	Trauma-exposed individuals; pooled qualitative data across included studies.	Meta-synthesis of qualitative findings.	Intervention: Dance/movement therapy (DMT). Duration: Variable across included studies. synthesis). Outcomes: Embodied processing; creative expression; relational connection.	Key themes: embodied processing, creative expression, and relational connection within therapeutic context. for nonverbal expression of traumatic experience that may complement verbal processing.
Dieterich-Hartwell [34]	2017	USA	Propose a reference model for dance/movement therapy in the treatment of post-traumatic stress.	Theoretical/conceptual paper; clinical examples from trauma-exposed populations.	Theoretical model development with narrative literature review.	Intervention: Dance/movement therapy (DMT). Duration: Not specified. Comparator: None. Outcomes: PTSD; somatic regulation; embodiment; integration.	Proposes a model articulating how movement intervention addresses physiological, emotional, and relational dimensions of trauma. Core elements: rhythm, grounding, and co-regulation — parallel to Gestalt concepts of contact, support, and therapeutic relationship.

Table 1 *(continued).* Charting Table of Included Studies — Body-Oriented Interventions for Trauma (n = 47).
Systematic Review: Body Oriented Gestalt Trauma Therapy (MS_306)
Data charted according to JBI Manual for Evidence Synthesis (Aromataris & Munn, 2020). Studies ordered by year of publication within each intervention category.

AUTHOR(S)	YEAR	COUNTRY	AIMS / PURPOSE	POPULATION & SAMPLE SIZE	METHODOLOGY	INTERVENTION / DURATION / COMPARATOR / OUTCOME MEASURES	KEY FINDINGS
Dance Movement Therapy *(continued)*							
Koch, Riege, Tisborn, Biondo, Martin & Beelmann [20]	2019	Germany	Update meta-analytic evidence on effects of dance movement therapy and dance on health-related psychological outcomes, including trauma subgroup.	Mixed clinical and non-clinical populations across included RCTs; trauma, depression, schizophrenia, dementia subgroups represented.	Systematic review and meta-analysis.	Intervention: Dance movement therapy (various modalities). Duration: Variable across included studies. Comparator: Waitlist, TAU, active control. Outcomes: PTSD; depression; anxiety; quality of life; social functioning.	Significant effects for DMT on depression and quality of life in pooled analysis. Trauma subgroup analyses reported. Publication bias possible. Heterogeneity high across included studies.
Tomaszewski, Belot, Essadek, Onumba-Bessonnet & Clesse [32]	2023	France	Systematically review the impact of dance therapy on adults with psychological trauma.	Adults with trauma-related symptoms or diagnosed PTSD; mixed trauma types and clinical settings across included studies.	Systematic review (narrative synthesis).	Intervention: Dance therapy/dance movement therapy. Duration: Variable across included studies. Comparator: Waitlist, TAU, active control (varies). Outcomes: PTSD symptoms; dissociation; avoidance.	DMT associated with improvements in psychological and physiological symptoms of trauma exposure, particularly avoidance and dissociative phenomena. Evidence base promising but metho-dological quality variable across studies.
Body- and Movement-Oriented Interventions (Meta-analytic findings)							
Scheffers, Hatzmann, Blankesteijn et al. [35]	2019	Netherlands	Systematically review and meta-analyse body- and movement-oriented interventions (BMOIs) for PTSD.	Adults with PTSD; 22 studies included (12 RCTs, 3 non-randomized controlled studies, 7 single-group studies).	Systematic review and meta-analysis.	Intervention: Body- and movement-oriented interventions (BMOIs; yoga, DMT, body-oriented psychotherapy). Duration: Variable across included studies. Comparator: Waitlist, TAU, active control. Outcomes: PTSD; depression; anxiety; somatic symptoms.	Moderate overall effect size (g = 0.57) for BMOIs *vs* control conditions, with heterogeneity across intervention types. BMOIs operate via 'bottom-up approach' addressing prefrontal–sub-cortical dysregulation in PTSD. Theoretical rationale aligns with Gestalt principle of change through immediate experience.
Interoception and Body Awareness							
Leech, Stapleton & Patching [29]	2024	Australia	Map the literature on interoceptive awareness and PTSD; identify measurement approaches and gaps in evidence.	Adults with PTSD or trauma exposure; 28 studies included in the scoping review.	Scoping review (JBI framework); narrative synthesis.	Intervention: Various body-oriented and mindfulness-based approaches. Duration: Variable. Comparator: Variable. Outcomes: Interoceptive awareness (MAIA); PTSD symptoms; affect regulation.	MAIA is the most consistently used interoception measure. MAIA differe-ntiates between anxious hypervigilance (maladaptive) and adaptive, mindful awareness — a distinction clinically relevant to Gestalt therapy's differentiation of awareness from rumination. Interoceptive dysfunction central to PTSD.

Note. CAPS = Clinician-Administered PTSD Scale; DES = Dissociative Experiences Scale; BDI = Beck Depression Inventory; MAIA = Multidimensional Assessment of Interoceptive Awareness; TCTSY = Trauma Center Trauma-Sensitive Yoga; SE = Somatic Experiencing; DMT = dance movement therapy; TAU = treatment as usual; RCT = randomized controlled trial; PTSD = post-traumatic stress disorder; DSM-IV = Diagnostic and Statistical Manual of Mental Disorders, 4th edition. Data verified against study citations as reported in the manuscript (MS_306). Where specific sample sizes, durations, or comparators are not reported in the manuscript text, the corresponding cell is marked '–' to avoid inference beyond documented sources. The 16 studies shown are those described in detail in the manuscript and are representative of the 47 sources included in the full review.

Continued

The mechanisms of trauma-sensitive yoga align with Gestalt concepts of awareness and here-and-now experiencing. Yoga practice cultivates interoceptive awareness, which research has shown to be disrupted in trauma survivors [11, 29]. By facilitating reconnection with bodily experience in a safe context, yoga addresses the dissociative responses characteristic of traumatic stress while building affect tolerance and self-regulation.

Sensorimotor Psychotherapy

Sensorimotor psychotherapy, developed by Pat Ogden [16], integrates somatic awareness with psychodynamic and cognitive approaches. The method emphasizes working within the 'window of tolerance,' tracking somatic experience, and facilitating completion of truncated defensive responses.

Classen et al [30] conducted a pilot RCT of a body-oriented group therapy adapted from sensorimotor psychotherapy with 32 women with complex trauma histories. The Trauma Body Group (TBG) demonstrated significant improvements in body awareness, anxiety, and soothing receptivity compared with the waitlist control group. Effects were maintained at the six-month follow-up, providing preliminary evidence of the approach's efficacy in complex trauma.

Gene-Cos et al [31] examined sensorimotor psychotherapy group treatment for complex PTSD, reporting positive outcomes in reducing traumatic symptoms and improving affect regulation. The study highlighted the importance of the group setting in providing opportunities for relational healing alongside somatic processing.

Sensorimotor psychotherapy's attention to body experience, resources, and completion of defensive actions reflects Gestalt therapy's emphasis on awareness, support, and contact. The Gestalt concept of 'unfinished business' finds parallel expression in sensorimotor work with truncated fight-flight-freeze responses stored in the body.

Dance Movement Therapy

Dance movement therapy (DMT) offers a creative arts approach to body-oriented trauma treatment. Tomaszewski et al [32] conducted a systematic review of DMT for adults with psychological trauma, finding evidence that DMT may improve both psychological and physiological symptoms associated with trauma exposure, particularly avoidance and dissociative phenomena.

Levine and Land [33] performed a meta-synthesis of qualitative findings on DMT for trauma, identifying key themes including embodied processing, creative expression, and relational connection within the therapeutic context. The synthesis suggested that DMT provides unique opportunities for nonverbal expression of traumatic experience that may complement verbal processing.

Dieterich-Hartwell [34] proposed a reference model for DMT in trauma treatment, articulating how movement intervention addresses the physiological, emotional, and relational dimensions of traumatic stress. The model emphasized rhythm, grounding, and co-regulation as core therapeutic elements – concepts with clear parallels to Gestalt therapy's attention to contact, support, and the therapeutic relationship.

Body-Movement-Oriented Interventions: Meta-Analytic Findings

Scheffers et al [35] conducted a comprehensive systematic review and meta-analysis of body- and movement-oriented interventions (BMOIs) for PTSD, including 22 studies (12 RCTs, 3 non-randomized controlled studies, and 7 single-group studies). The meta-analysis found a moderate overall effect size ($g = 0.57$) for BMOIs compared to control conditions, with heterogeneity across intervention types.

Importantly, the review noted that BMOIs provide a 'bottom-up approach' addressing the inability of the prefrontal cortex to modulate lower brain areas in traumatized individuals [35, 8]. This theoretical rationale aligns with the Gestalt principle that meaningful change emerges from immediate experience rather than cognitive insight alone.

Niles et al [36] provided a systematic overview of complementary and integrative interventions for PTSD, finding promising evidence across multiple body-oriented modalities while calling for continued methodological rigor in research designs. The authors emphasized the potential value of body-oriented approaches for patients who do not respond adequately to standard cognitive-behavioral treatments.

Theoretical Framework: Gestalt Principles in Body-Oriented Trauma Therapy

Awareness as Core Therapeutic Mechanism

The Gestalt concept of awareness (Gewahrsein) represents the foundational therapeutic mechanism linking body-oriented approaches. In Gestalt therapy, awareness is understood as the capacity for full contact with ongoing experience, such as bodily sensations, emotions, thoughts, and environmental stimuli, without deflection or avoidance [5, 7]. This phenomenological stance toward experience parallels the interoceptive awareness cultivated in body-oriented trauma therapies.

Neuroimaging research has demonstrated that mindfulness-based and interoceptive interventions influence brain activation and connectivity within networks associated with self-referential processing and emotion regulation [37, 38]. Specifically, these interventions appear to enhance insular cortex function, the primary neural substrate of interoception, while modulating amygdala reactivity and strengthening prefrontal regulatory capacity [39].

The scoping review by Leech et al [29] on interoceptive awareness and PTSD identified the Multidimensional Assessment of Interoceptive Awareness (MAIA) as the most consistent measure used in research, noting that this instrument differentiates between anxious hypervigilance toward body sensations and adaptive, mindful awareness – a distinction clinically relevant to Gestalt therapy's differentiation of awareness from rumination or projection.

Contact and the Therapeutic Relationship

Gestalt therapy conceptualizes healthy functioning through the lens of the 'contact cycle', the rhythmic process of engagement and withdrawal at the organism-environment boundary [5]. Traumatic experience interrupts this cycle, resulting in fixed gestalten or 'unfinished business' that maintains symptomatic patterns. Body-oriented therapies address these interruptions through attention to somatic holding patterns, breathing restrictions, and postural configurations that embody contact disturbances.

The polyvagal theory provides neurophysiological grounding for understanding contact disturbances. Porges [9, 10] describes how the social engagement system, mediated by the ventral vagal complex, supports affiliative contact, while sympathetic activation and dorsal vagal shutdown represent phylogenetically older defensive states that interfere with social connection. Therapeutic interventions that facilitate ventral vagal engagement may thus restore the neurophysiological basis for relational contact.

Haeyen [40] applied polyvagal theory to arts therapies for trauma, demonstrating how creative modalities can facilitate shifts in autonomic state through neuroception, which is the unconscious detection of safety or threat. The therapeutic relationship itself becomes a vehicle for co-regulation, with the therapist's regulated presence supporting the client's capacity for ventral vagal engagement and expanded contact functioning.

Organismic Self-Regulation

The Gestalt principle of organismic self-regulation posits that organisms possess innate wisdom for adaptive response when environmental support permits awareness and choice [5, 7]. Trauma disrupts self-regulation through overwhelming activation that exceeds integrative capacity, resulting in dysregulated autonomic patterns, dissociative responses, and symptomatic behaviors that represent incomplete self-protective efforts.

Somatic Experiencing explicitly targets the restoration of self-regulation through the titration of traumatic activation, pendulation between activated and resourced states, and the completion of interrupted defensive responses [14, 15]. These techniques align with the Gestalt emphasis on supporting organismic capacity rather than imposing external solutions, facilitating the emergence of new integrative responses from within the client's experiencing.

Research on heart rate variability (HRV), an index of autonomic flexibility, has demonstrated that body-oriented interventions can enhance self-regulatory capacity at the physiological level [41]. Higher HRV reflects greater vagal tone and more adaptive stress responding, suggesting that body-oriented therapies may restore the biological substrate of organismic self-regulation compromised by trauma.

Field Theory and Embodied Context

Gestalt therapy's field theory emphasizes the inseparability of organism and environment, understanding experience as emergent from the dynamic interplay of multiple factors in the phenomenal field [5]. This perspective finds support in contemporary embodied cognition research, which demonstrates that mental processes are shaped by bodily states and environmental affordances rather than occurring in isolation within an abstract cognitive system [42].

For trauma treatment, field theory implies attention to the multiple systems affecting the traumatized individual. The PNEI (psychoneuroendocrinoimmunology) framework provides a scientific model of these interconnections, demonstrating bidirectional communication among psychological experience, neural activity, endocrine function, and immune response [43, 44]. Traumatic stress affects all these systems simultaneously, suggesting the need for integrative interventions that address the whole organism-environment field.

Neurobiological Mechanisms

Interoception and the Insular Cortex

Interoception, the sensing, processing, and integration of internal bodily signals, is a primary mechanism by which body-oriented therapies exert therapeutic effects. The insular cortex, particularly the anterior insula, serves as the neural hub for interoceptive processing, integrating visceral signals with emotional and cognitive information [11, 39].

Fani et al [13] reviewed neurophysiological research on interoceptive disruptions in trauma-exposed populations, finding evidence for altered pain perception, interoceptive acuity, and physiological responses following trauma. Neuroimaging studies have demonstrated functional changes in the insula and related regions (anterior cingulate cortex, amygdala) in PTSD, reflecting dysregulated interoceptive processing [39, 45].

Bobou et al [46] conducted a systematic review of psychological interventions for interoception in mental health disorders, finding that interoception-based interventions (IBIs) demonstrated efficacy in 64.5% of RCTs reviewed, with particularly promising results for PTSD. The review identified body-oriented approaches, including mindfulness-based interventions, yoga, and somatic therapies, as effective modalities for enhancing interoceptive function.

Autonomic Regulation and Polyvagal Pathways

The polyvagal theory [9, 10] provides a comprehensive neurophysiological model for understanding autonomic dysfunction in trauma and the mechanisms of body-oriented intervention. The theory describes a hierarchical organization of autonomic responses, with the phylogenetically newest ventral vagal system supporting social engagement, the sympathetic system mediating mobilization for fight-or-flight, and the dorsal vagal system enabling immobilization as a last-resort defense.

Traumatic experiences, particularly those involving life threat or inescapable stress, can result in chronic dysregulation of this hierarchy, with individuals becoming 'stuck' in defensive states that interfere with social connection and adaptive functioning [10]. Body-oriented therapies aim to facilitate neural pathway recruitment that supports ventral vagal engagement, utilizing elements such as safety cues, rhythmic activity, social presence, and sensory grounding.

Research on vagal nerve stimulation and vagal tone enhancement has provided support for targeting the vagal system in trauma treatment. Studies have demonstrated that interventions enhancing vagal function, including breathing practices, yoga, and meditation, can improve emotional regulation, reduce anxiety and depression, and decrease PTSD symptoms [41,47].

PNEI Integration: HPA Axis and Inflammatory Processes

The hypothalamic-pituitary-adrenal (HPA) axis represents a central mechanism linking psychological stress to physiological dysfunction. Chronic trauma exposure results in HPA axis dysregulation, characterized by altered cortisol patterns and impaired stress responsivity [43, 48]. Research has demonstrated that the timing of trauma exposure during development affects the nature of HPA dysfunction, with early-life trauma associated with distinct patterns compared to adult-onset trauma [49].

Inflammatory processes have emerged as another key mechanism linking trauma

to mental and physical health outcomes. Dell'Oste et al [50] conducted a systematic review, finding elevated pro-inflammatory cytokines (IL-1β, IL-6, TNF-α) in individuals with PTSD compared to healthy controls. This low-grade inflammation may contribute to both psychiatric symptoms and the somatic co-morbidities common in trauma survivors.

Body-oriented interventions may influence PNEI systems through multiple pathways. Yoga and meditation have demonstrated effects on cortisol regulation and inflammatory markers [51, 52], while movement-based interventions appear to modulate immune function and reduce systemic inflammation [53]. These physiological effects suggest mechanisms through which body-oriented therapies address the somatic sequelae of trauma beyond psychological symptom reduction.

Clinical Applications and Integration

Assessment of Body-Oriented Functioning

Clinical application of body-oriented Gestalt therapy requires assessment of clients' interoceptive functioning, autonomic regulation patterns, and body awareness capacities. The Multidimensional Assessment of Interoceptive Awareness (MAIA-2) provides a validated self-report measure of eight dimensions of interoceptive awareness, including Noticing, Not-Distracting, Not-Worrying, Attention Regulation, Emotional Awareness, Self-Regulation, Body Listening, and Trusting [54].

Assessment of autonomic functioning can include both objective measures (heart rate variability monitoring, skin conductance) and subjective tracking of activation levels using tools such as the Subjective Units of Disturbance Scale (SUDS) or window of tolerance mapping. Gestalt therapists may additionally assess contact functions, boundary awareness, and patterns of creative adjustment to trauma through phenomenological observation and dialogic inquiry.

Window of Tolerance and Titration

The concept of the 'window of tolerance,' developed by Siegel [55], has become central to body-oriented trauma therapy. This optimal zone of arousal permits integrative processing; activation beyond the window (hyperarousal) or below it (hypoarousal) interferes with the cognitive-emotional integration necessary for trauma resolution. Body-oriented approaches utilize this framework to guide intervention pacing and support clients' self-regulation.

Titration, the gradual, carefully dosed exposure to traumatic material, represents a key technical element across body-oriented modalities. Unlike exposure-based therapies that aim for sustained confrontation with traumatic stimuli, somatic approaches emphasize approaching trauma incrementally, using pendulation between activation and resource states to expand integrative capacity [14, 15]. This approach aligns with Gestalt therapy's emphasis on support and the ethical imperative to avoid retraumatization.

Integration with Established Trauma Treatments

Body-oriented approaches can be integrated with established trauma treatments, including EMDR (Eye Movement Desensitization and Reprocessing) and cognitive processing therapy. EMDR incorporates bilateral stimulation that may have somatic effects beyond cognitive restructuring [56, 57], while cognitive approaches can be enhanced by attention to bodily correlates of beliefs and schemas.

De Jongh et al [57] provided an updated review of EMDR efficacy, noting large effect sizes (d = 1.88) for PTSD treatment in recent controlled trials. The authors highlighted that EMDR, while primarily cognitive in orientation, incorporates elements of bilateral stimulation that may activate body-based processing mechanisms, suggesting potential synergies with explicitly body-oriented approaches.

Butollo et al [58] compared Dialogical Exposure Therapy (an approach incorporating Gestalt principles) with Cognitive Processing Therapy for PTSD treatment. Results demonstrated comparable efficacy between approaches, supporting the viability of dialogical, phenomenologically-oriented treatments as alternatives to standard cognitive-behavioral interventions.

DISCUSSION

Summary of Evidence

The findings of this systematic review support several conclusions: (1) Body-oriented interventions demonstrate promising effica-

cy for PTSD and trauma-related symptoms, with effect sizes comparable to established treatments; (2) Common mechanisms across modalities include enhanced interoceptive awareness, autonomic regulation, and completion of interrupted defensive responses; (3) Gestalt therapy principles of awareness, contact, and organismic self-regulation provide a coherent theoretical framework for understanding these mechanisms.

The strongest evidence base exists for trauma-sensitive yoga (d = 1.07 in van der Kolk et al [18]) and Somatic Experiencing (d = 0.94-1.26 in Brom et al [25]), though both approaches require additional RCTs with active comparison conditions. Sensorimotor psychotherapy and dance movement therapy show preliminary support primarily from pilot studies and qualitative research, warranting larger-scale controlled investigations.

Theoretical Integration

The integration of Gestalt therapy with contemporary neuroscience offers a comprehensive framework for body-oriented trauma treatment. The Gestalt emphasis on phenomenological awareness finds support in interoception research that demonstrates the importance of attending to internal bodily states for emotional regulation [11, 29]. The concept of organismic self-regulation aligns with polyvagal theory's emphasis on restoring flexible autonomic functioning [9, 10]. Field theory anticipates the PNEI model of bidirectional psychophysiological interaction [43, 44].

This theoretical convergence suggests that Gestalt therapy's historical emphasis on the unity of mind and body anticipated neuroscientific methods capable of elucidating the mechanisms underlying therapeutic change. The synthesis presented here positions body-oriented Gestalt therapy as a scientifically grounded approach that honors both phenomenological experience and biological process.

Limitations and Future Directions

Several limitations qualify the conclusions of this review. First, the heterogeneity of interventions, populations, and outcome measures across studies precluded formal meta-analysis for many comparisons. Second, many included studies had methodological limitations, including small sample sizes, lack of active comparison conditions, and high dropout rates. Third, the search was restricted to English and Italian language publications, potentially missing relevant research in other languages [59].

Future research priorities include: (1) Large-scale RCTs comparing body-oriented approaches to established treatments and active control conditions; (2) Dismantling studies identifying specific effective elements within multicomponent interventions; (3) Mechanistic neuroimaging studies examining neural correlates of body-oriented therapy; (4) Development of standardized protocols and fidelity measures for body-oriented interventions; (5) Investigation of moderators and predictors of treatment response to guide client-intervention matching [60].

Additionally, research examining the integration of body-oriented approaches with traditional Gestalt therapy practice would clarify how these modalities can be combined effectively. Investigation of training requirements and competencies for body-oriented trauma therapy would support the dissemination of evidence-based practices.

CONCLUSIONS

Body-oriented Gestalt trauma therapy represents a theoretically coherent and empirically promising approach to treating traumatic stress. The integration of Gestalt therapy's phenomenological foundations with contemporary neuroscience provides a comprehensive framework addressing psychological, neurological, and physiological dimensions of trauma simultaneously.

The evidence reviewed supports the efficacy of body-oriented interventions, including Somatic Experiencing, trauma-sensitive yoga, sensorimotor psychotherapy, and dance movement therapy (Table 2). Common therapeutic mechanisms enhanced interoceptive awareness, autonomic regulation through polyvagal pathways, and completion of interrupted defensive responses, aligning with Gestalt principles of awareness, contact, and organismic self-regulation.

For clinicians, this synthesis supports integrating body-oriented techniques within a Gestalt framework, attending to clients' somatic experience, autonomic states, and bodily resources alongside cognitive and emotional processing. The emphasis on titration and the window of tolerance provides ethical guidelines for trauma work that minimize the risk of retraumatization.

Table 2. Comparative overview of body-oriented trauma interventions: entry points, bodily targets, and mechanisms of action.

INTERVENTION MODALITY	PRIMARY THERAPEUTIC ENTRY POINT	CORE BODILY TARGET	DOMINANT MECHANISM OF ACTION
TRAUMA-SENSITIVE YOGA	Structured movement and breath	Interoceptive awareness	Autonomic regulation and embodied self-regulation
SOMATIC EXPERIENCING	Tracking internal sensations	Defensive response completion	Bottom-up modulation of arousal and procedural memory
SENSORIMOTOR PSYCHOTHERAPY	Somatic awareness integrated with verbal processing	Body-based emotional regulation	Integration of somatic cues with cognitive-affective meaning
DANCE MOVEMENT THERAPY	Expressive and relational movement	Embodied emotional expression	Sensorimotor integration and affective regulation
BODY PSYCHOTHERAPY APPROACHES	Posture, tension, bodily experience	Somatic-affective patterns	Regulation of implicit bodily memory and affect

Note: While these interventions differ in structure and technique, they converge on enhancing bodily awareness and regulating psychophysiological processes disrupted in PTSD.

As the evidence base continues to develop, body-oriented Gestalt therapy is well-positioned to contribute meaningfully to the treatment of trauma, offering approaches that honor both the scientific understanding of traumatic stress and the phenomenological richness of human experiencing.

Authors' Contribution

Chiara Scognamiglio and Enrico Moretto contributed equally to the conception, design, literature search, data extraction, and writing of this manuscript. Both authors reviewed and approved the final version.

Conflict of Interest

The authors declare no conflict of interest.

Data Availability

This article is a systematic review based on previously published studies. No new data were collected or generated. All sources are cited in the reference list and publicly available through the respective journals.

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AI Use Disclosure

Artificial intelligence tools were used in the preparation of this manuscript. Specifically, Claude (Anthropic), a large language model-based chatbot, was employed to assist with the English translation of the manuscript and the formatting of tables. The intellectual content, critical analysis, and conclusions remain entirely the work of the authors, who take full responsibility for the accuracy and integrity of the published work.

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Caso clinico

Psicoterapia della Gestalt integrata e trattamento in età evolutiva: un caso clinico

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ABSTRACT

Introduzione: Il presente lavoro si propone di evidenziare l'efficacia dell'approccio gestaltico integrato nell'ambito dell'età evolutiva, facendo riferimento all'integrazione tra l'approccio umanistico esistenziale, la Gestalt play therapy, l'approccio cognitivo-comportamentale, l'analisi transazionale e la teoria dell'attaccamento.

L'approccio gestaltico integrato in età evolutiva si basa sull'assunto che il bambino, come l'adulto, possiede un potenziale autoregolativo e una tendenza naturale all'integrazione e alla crescita, a condizione che possa esprimere liberamente le proprie emozioni in un "ambiente sicuro" e nella relazione con una "base sicura".

L'esigenza di superare i confini delle singole scuole di pensiero risulta fondamentale per costruire percorsi terapeutici flessibili che possano rispondere pienamente ai bisogni del bambino e/o dell'adolescente, unendo l'atteggiamento congruente ed empatico del terapeuta, il lavoro esperienziale sul presente, la lettura dei copioni relazionali e la riparazione dei legami affettivi primari.

Caso Clinico: Dopo una breve panoramica teorica, il presente lavoro si propone di mostrare l'efficacia dell'approccio gestaltico integrato in ambito evolutivo, attraverso la presentazione di un caso clinico che permette di evidenziare, qualitativamente e fenomenologicamente, come l'integrazione tra l'accettazione incondizionata dell'approccio umanistico esistenziale, l'utilizzo del gioco e delle tecniche espressive e sensoriali che prendono spunto dalla Gestalt play therapy, le strategie mutuate dall'approccio cognitivo comportamentale, il lavoro sui "permessi, le ingiunzioni e le spinte" in analisi transazionale e il senso di protezione e di sicurezza relazionale sperimentato attraverso la relazione terapeutica, possa contribuire a un miglioramento significativo nella comunicazione verbale e nella consapevolezza emotiva nel trattamento dell'età evolutiva.

Conclusioni: I risultati di tale lavoro suggeriscono l'efficacia dell'approccio gestaltico integrato in età evolutiva, le varie fasi di intervento e l'evoluzione del processo psicoterapico nella presa in carico di un caso clinico specifico che mette in evidenza l'importanza del compito terapeutico relazionale con i bambini e del sostegno genitoriale come fattori imprescindibili che influenzano l'esito della terapia, considerando sempre l'individuo all'interno del campo fenomenologico.

Parole chiave

Psicoterapia della Gestalt integrata, Approccio umanistico esistenziale, Gestalt play therapy, Analisi transazionale, Approccio cognitivo comportamentale, Teorie dell'attaccamento, Età evolutiva, Caso clinico.

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ABSTRACT IN ENGLISH

Background: This paper aims to highlight the effectiveness of the Integrated Gestalt Approach in the field of developmental age, with reference to the integration between the Humanistic-Existential Approach, Gestalt Play Therapy, the Cognitive-Behavioral Approach, Transactional Analysis (TA), and Attachment Theory.

The Integrated Gestalt Approach in developmental age is based on the assumption that the child, like the adult, possesses a self-regulatory potential and a natural tendency toward integration and growth, provided they are allowed to freely express their emotions in a "safe environment" and within a relationship characterized by a "secure base."

The need to go beyond the boundaries of individual schools of thought is fundamental for building flexible therapeutic pathways that can fully respond to the needs of the child and/or adolescent. This integration unites the therapist's congruent and empathic attitude, experiential work in the here-and-now, the reading of relational scripts, and the repair of primary affective bonds.

Case Report: After a brief theoretical overview, this paper aims to demonstrate the effectiveness of the Integrated Gestalt Approach in developmental settings by presenting a clinical case. This case allows for a qualitative and phenomenological illustration of how the integration of unconditional acceptance from the Humanistic-Existential Approach, the use of play and expressive/sensory techniques drawn from Gestalt Play Therapy, strategies borrowed from the Cognitive-Behavioral Approach, work on "permissions, injunctions, and drivers" in Transactional Analysis, and the sense of protection and relational safety experienced within the therapeutic relationship can contribute to significant improvement in verbal communication and emotional awareness in child psychotherapy.

Conclusions: The results of this work suggest the effectiveness of the Integrated Gestalt Approach in developmental age, describing the various phases of intervention and the evolution of the psychotherapeutic process in the treatment of a specific clinical case. The case highlights the importance of the relational therapeutic task with children and the support of the parental couple as essential factors that influence the outcome of therapy, always considering the individual within the phenomenological field.

Keywords

Integrated Gestalt psychotherapy, Humanistic-existential approach, Gestalt play therapy, Transactional analysis, Cognitive-behavioral approach, Attachment theory, Developmental age, Clinical case.

INTRODUZIONE

Integrare diversi approcci di psicoterapia in età evolutiva è utile per rispondere in modo mirato e personalizzato alla complessità dei bisogni del bambino e della sua famiglia. Il funzionamento cognitivo, emotivo, relazionale e corporeo del bambino è in continua evoluzione e spesso le problematiche si esprimono in modo multifattoriale (comportamentale, emotivo, somatico, relazionale). Per questo motivo, nessun modello teorico da solo è sempre sufficiente [1].

Ogni bambino è unico, alcuni rispondono bene agli strumenti cognitivi; altri hanno bisogno di lavorare sul corpo o sulla relazione. L'integrazione consente di costruire un intervento su misura, personalizzando il trattamento. I bambini, infatti, si sviluppano sul piano cognitivo, affettivo, motorio e relazionale e, per non limitare l'efficacia del trattamento, è importante lavorare su tutti gli assi di sviluppo, favorendo una crescita armonica. In età evolutiva, l'intervento psicoterapeutico non può prescindere dal coinvolgimento dei genitori e spesso è necessario integrare la psicoterapia del bambino con parent training e, in alcuni casi, offrire spazi di sostegno alla genitorialità o di terapia familiare [2].

I vantaggi dell'integrazione riguardano una maggiore adattabilità clinica ai bisogni reali, una riduzione della frammentazione nei percorsi terapeutici, una maggiore efficacia e durata del cambiamento e favoriscono una visione globale e sistemica del bambino [3].

La Terapia Della Gestalt In Età Evolutiva

La psicoterapia della Gestalt è un approccio relazionale ed esperienziale che si adatta con sensibilità e creatività al mondo interno e ai bisogni dell'età evolutiva. Fondata da Fritz Perls, Laura Perls e Paul Goodman, la Gestalt è stata poi adattata al lavoro con bambini e adolescenti da vari autori, tra cui Violet Oaklander, che ha dato un contributo fondamentale.

La psicoterapia della Gestalt per bambini e adolescenti è un approccio che mette al centro l'esperienza nel "qui e ora", favorisce l'espressione autentica del sé, utilizza il gioco, il disegno,

il movimento e il linguaggio simbolico come strumenti terapeutici e punta a sviluppare consapevolezza, contatto e responsabilità [4].

I principi chiave della psicoterapia della Gestalt si fondano sul "qui e ora", che concentra l'attenzione sul presente, su come il bambino sente e vive l'esperienza attraverso diversi livelli (corporeo, sensoriale, immaginativo, cognitivo, verbale, emotivo), funzioni di contatto (guardare, toccare, ascoltare, assaggiare, annusare) e su come si comporta nel momento presente. Il concetto di contatto e confine individua il modo in cui il bambino entra in relazione con l'altro, con l'ambiente e con se stesso, quindi come regola i confini del sé. La consapevolezza è intesa come potente strumento per aiutare il bambino a diventare pienamente consapevole di ciò che sente, agisce e pensa, avviandolo alla padronanza e alla responsabilità nell'ambiente in cui è inserito [5]. L'espressione creativa, attraverso il gioco, diviene uno strumento cardine della psicoterapia, e il disegno e le narrazioni consentono all'esperienza emotiva di prendere forma ed esprimersi.

Il terapeuta della Gestalt è una figura autentica, empatica e presente, che accoglie senza giudizio, costruisce un campo relazionale sicuro, sostiene l'autoesplorazione del bambino, valorizza le risorse individuali e la spontaneità [6].

Il ciclo del contatto è un concetto centrale nella psicoterapia della Gestalt. Descrive come entriamo in relazione con l'ambiente per soddisfare un bisogno. Attraverso una sequenza dinamica di fasi, la persona prende coscienza di ciò che sente, agisce per soddisfarlo e poi si ritira una volta completata l'esperienza [7].

Capire il ciclo del contatto è fondamentale per lavorare con i bambini, perché ci permette di osservare dove e come si interrompe l'esperienza: blocchi emotivi, evitamenti e sintomi possono infatti essere segnali di un ciclo interrotto [4].

Le fasi del ciclo del contatto sono:

1. SENSIBILIZZAZIONE (Pre-contatto)
   Il bisogno comincia a emergere, spesso in modo vago o inconscio.
   "Sento qualcosa, ma non so bene cosa."
   Es: un bambino inizia a muoversi agitato, ma non sa dire se ha fame, è annoiato o arrabbiato.
2. CONSAPEVOLEZZA
   Il bisogno diventa chiaro: "So cosa sento, cosa voglio."
   "Ho fame" / "Mi sento solo" / "Voglio giocare con qualcuno."
3. MOBILITAZIONE DELL'ENERGIA (avvio al contatto)
   La persona attiva le proprie risorse per soddisfare il bisogno.
   Si mette in moto un'intenzione, una direzione.
   Es: il bambino si avvicina a un compagno per proporre un gioco.
4. AZIONE/CONTATTO (contatto pieno)
   È il punto massimo dell'esperienza: c'è un incontro reale tra bisogno e ambiente.
   Il contatto può essere con un oggetto, una persona, un'idea.
   È qui che avviene il cambiamento o la soddisfazione del bisogno.
   Es: il bambino inizia a giocare e si sente accolto.
5. ASSIMILAZIONE (Post-contatto)
   La persona integra l'esperienza, ne trae senso, apprendimento.
   È la fase del rilassamento, della riflessione o del piacere.
   Es: il bambino si sente soddisfatto e torna tranquillo.
6. RITIRO
   Il ciclo si chiude. Il bisogno è stato soddisfatto e si torna in uno stato neutro o di quiete.
   "Mi sento in pace" [8].

Nel lavoro clinico si osservano spesso interruzioni del ciclo, che generano disagio o sintomi. Se l'interruzione avviene nella fase di sensibilizzazione, il bambino è disconnesso dai suoi bisogni; nella fase di consapevolezza il bambino non sa bene cosa prova, non trova le parole e spesso somatizza i sintomi; nella fase di mobilitazione, il bambino si blocca, si chiude, si ritira, attraverso l'evitamento o il "congelamento"; nella fase di azione/contatto, c'è paura del giudizio, ansia sociale, aggressività; nella fase di assimilazione, il bambino non riesce ad elaborare l'esperienza a causa di traumi e confusione; infine, se avviene un'interruzione nella fase del ritiro, il bambino rimane attivato, ipercoinvolto o in allarme non riuscendo a chiudere serenamente l'incontro.

Il ciclo del contatto è una bussola clinica che permette di osservare le dinamiche del bambino nel gioco, nel linguaggio, nel comportamento. Aiuta a capire dove si interrompe l'esperienza e dove intervenire (es. favorendo la consapevolezza, il contenimento, l'azione creativa). Supporta il terapeuta nel creare uno spazio di contatto sicuro, dove il bambino possa portare a termine le esperienze bloccate [9].

La crescita del bambino, secondo una visione gestaltica, avviene all'interno della relazione al confine-contatto con l'altro. Lo sviluppo infantile si articola intorno alla maturazione e all'organizzazione delle capacità

dell'individuo di entrare in un contatto sano e nutriente con le figure di riferimento e con l'ambiente. Il bambino, dalle esperienze relazionali primarie, apprende come "esserci con l'altro" attraverso il gioco, l'esplorazione e l'interazione corpo a corpo con le proprie figure genitoriali.

Questa fase non solo lo aiuterà ad abitare il proprio corpo con spontaneità, ma contribuirà anche a costituire quelle competenze di base, evolutivamente più complesse e funzionali, che vanno integrandosi tra loro più o meno armonicamente [9].

Se le relazioni primarie falliscono e il bambino sente che i propri bisogni non sono sufficientemente soddisfatti dai caregivers, ciò genera in lui diverse tipologie di sofferenza e di disagio, poiché l'ambiente non contribuisce al giusto sostegno rispetto allo sviluppo e all'evoluzione del bambino, il quale sarà destinato a perdere la propria autenticità, spontaneità e creatività.

Nella prospettiva gestaltica, la creatività è considerata un'espressione diretta dell'essere umano e, soprattutto, del bambino; è un modo naturale di relazionarsi con il mondo esterno e di attribuire significato alle esperienze della vita [4]. Un'attenta osservazione delle espressioni corporee, dei comportamenti, dei copioni e degli stili relazionali e comunicativi dei bambini e/o degli adolescenti consente di far emergere, nel setting terapeutico, quelle parti del sé vere e autentiche che necessitano, possibilmente, di un processo di integrazione oltre che di espressione. Allo stesso tempo, quando ci si trova bloccati o limitati nella propria espressione creativa, ciò può indicare una mancanza di integrazione o di consapevolezza delle parti del proprio sé [10].

Approcci Integrati alla Psicoterapia Gestalt in Età Evolutiva

Questo articolo si propone di evidenziare l'efficacia di un approccio gestaltico integrato, considerando i principi e gli strumenti dell'approccio umanistico esistenziale, della gestalt play therapy, dell'approccio cognitivo-comportamentale, dell'analisi transazionale e della teoria dell'attaccamento nel trattamento di soggetti in età evolutiva. Alla base di questa integrazione proposta, c'è una cornice relazionale che mette al centro la sicurezza affettiva e la regolazione emotiva; un processo di continua co-regolazione nel campo, fondamentale per accogliere il bambino nella sua globalità corporea, affettiva e simbolica e accompagnarlo in un percorso che gli consenta di dare senso e voce al suo vissuto interno, espresso più nel gioco e nel corpo che con le parole [11].

L'integrazione avviene tra i seguenti approcci:

- l'Approccio umanistico esistenziale, che si traduce in un insieme di pratiche educative e terapeutiche che mettono il minore al centro del proprio processo di crescita;
- la Gestalt play therapy, che offre un impianto esperienziale, fenomenologico e creativo, centrato sul "qui e ora" e sull'espressione autentica del sé;
- l'approccio cognitivo-comportamentale, che propone strumenti e strategie per trattamenti individualizzati e focalizzati;
- l'analisi transazionale, che fornisce una lettura chiara delle dinamiche interne ed esterne attraverso gli stati dell'Io e i copioni di vita;
- la teoria dell'attaccamento, che porta attenzione alla dimensione relazionale primaria e alla necessità di offrire esperienze correttive attraverso la sintonizzazione emotiva.

Con queste coordinate, il piano di lavoro integra fasi di processo terapeutico, utili al raggiungimento degli obiettivi.

In una fase iniziale caratterizzata da accoglienza, osservazione fenomenologica e costruzione del legame, l'attenzione è rivolta alla costruzione dell'alleanza con il minore e i genitori. Attraverso il gioco libero, il disegno, la narrazione simbolica e l'osservazione della relazione caregiver-bambino, si raccolgono elementi utili per comprendere lo stile di attaccamento, la regolazione emotiva, le spinte e le ingiunzioni ricevute, nonché i messaggi impliciti che contribuiscono alla formazione del copione di vita.

Allo stesso tempo, il terapeuta inizia a costruire una relazione sicura, una base affettiva da cui il bambino può esplorare il mondo interno ed esterno attraverso il gioco e la narrazione. Con la costruzione dell'alleanza terapeutica con il bambino e la famiglia e l'osservazione fenomenologica, è possibile individuare gli obiettivi da raggiungere, proponendo anche strategie comportamentali personalizzate alla famiglia e mettendole in atto in prima persona nel setting, per osservare come il bambino le accoglie nella relazione.

Attraverso questo elaborato, ci si propone di evidenziare l'efficacia dell'approccio gestaltico integrato, con riferimento alla descrizione qualitativa e fenomenologica delle varie fasi che hanno caratterizzato l'evoluzione

di un caso clinico specifico di una bambina con diagnosi di mutismo selettivo. Attraverso il compito terapeutico relazionale con la minore, l'accettazione incondizionata di quest'ultima, l'osservazione dei copioni messi in atto associati alle spinte e alle ingiunzioni interiorizzate, attraverso l'osservazione degli stili relazionali e comunicativi e il sostegno alla coppia genitoriale, si è giunti a un esito positivo del processo psicoterapico, in cui sono stati utilizzati strumenti terapeutici espressivi come il gioco, il disegno, la sensorialità, il movimento e strategie cognitivo comportamentali per supportare la famiglia e gli operatori nella presa in carico.

Tali strumenti, in età evolutiva, sono mezzi di comunicazione privilegiati per entrare in contatto con i bambini e, attraverso di essi, i bambini hanno la possibilità di condividere e esprimere il proprio sentire, le proprie emozioni e i propri bisogni, riuscendo così a narrarsi e a sperimentarsi, accogliendo e integrando le varie parti del proprio sé [12].

Il trattamento dei soggetti in età evolutiva, secondo l'approccio gestaltico integrato, tende a delineare alcuni momenti specifici e fondamentali, seguendo il ciclo del contatto, tra i quali: la fase di pre-contatto, con osservazione e valutazione iniziale; la fase di avvio al contatto, in cui l'alleanza terapeutica si avvia alla costruzione, il bambino percepisce il setting come un luogo sicuro in cui esprimersi e la relazione con il terapeuta diviene esclusiva perché autentica; la fase dell'intervento, che corrisponde al "contatto pieno" con il minore e il supporto alla famiglia; la fase finale, di post-contatto, con la ristrutturazione dell'intervento in base agli obiettivi raggiunti o di chiusura del percorso [8].

Approccio Umanistico Esistenziale

L'approccio umanistico-esistenziale di Carl Rogers, uno dei fondatori della psicologia umanistica, si fonda sull'idea che ogni individuo possieda un potenziale innato di crescita, autodeterminazione e autorealizzazione [13]. Quando questo approccio viene applicato all'età evolutiva (infanzia e adolescenza), assume caratteristiche specifiche legate allo sviluppo della personalità, dell'autostima e delle relazioni con le figure di riferimento [11].

I principi chiave dell'approccio di Rogers consistono nella tendenza attualizzante, che vede in ogni essere umano una forza interiore che lo guida verso la realizzazione del proprio potenziale; nella congruenza, che esorta il terapeuta verso l'autenticità e la coerenza nei rapporti con il bambino, che a sua volta può sperimentare nella relazione con il terapeuta la possibilità di sentirsi accolto e amato incondizionatamente per quello che è e non per quello che fa e, infine, l'empatia, cioè la capacità di comprendere profondamente il vissuto dell'altro senza giudicare [13].

Nell'ambito dello sviluppo, l'approccio di Rogers si traduce in pratiche educative e terapeutiche che mettono il bambino al centro del processo di crescita; la relazione educativa è centrata sul bambino; l'adulto, quindi il genitore o educatore/insegnante, assume il ruolo di facilitatore della crescita. Si valorizza l'esperienza soggettiva del bambino e l'apprendimento avviene in un clima di fiducia e di accettazione.

Fondamentale risulta il lavoro in terapia sullo sviluppo dell'autostima, in quanto i bambini sviluppano un concetto positivo di sé quando si sentono ascoltati e compresi e in tal senso, l'autostima non nasce dal giudizio esterno, ma dalla consapevolezza interiore del proprio valore.

Una relazione basata sull'empatia e sull'accettazione favorisce lo sviluppo di una personalità integrata e autonoma. Il bambino, così, impara a conoscere, ad accogliere e a rispettare i propri bisogni, i propri sentimenti e le varie parti del proprio sé [11].

Principi Della Gestalt Play Therapy

La Gestalt Play Therapy è un modello terapeutico psicologico di intervento con bambini e adolescenti, di grande potenza ed efficacia, sviluppato da Violet Oaklander negli anni '70; questo approccio consente un'espressione efficace del proprio sé. La Gestalt Play Therapy può essere applicata a tutte le età e utilizzata in molti contesti differenti [14].

Il modello, infatti, contempla una vastissima varietà di strumenti artistici a disposizione del terapeuta, tra i più usati: il disegno, le fantasie guidate, i burattini e i pupazzi, l'argilla, la vasca della sabbia, il collage, le carte proiettive. Grazie a tutti questi "media" il terapeuta può incontrare il bambino in un gioco creativo in grado di far emergere le emozioni e i vissuti dentro di lui che risultano bloccati. Il lavoro di espressione emotiva si articola nell'aiutare il bambino a capire quale emozione sta provando, nel qui e ora, e a imparare ad esprimerla attraverso canali espressivi che risultino per lui modi efficaci e luoghi sicuri.

L'obiettivo è aiutare il bambino a sviluppare un senso del sé più forte; i sintomi e le risposte affettive e comportamentali che attirano l'attenzione dell'adulto sono spesso le evidenze dell'interruzione del contatto con l'esperienza di crescita, in termini funzionali, e con lo sviluppo psico-emotivo e relazionale [14].

Il compito del terapeuta è supportare la spinta del bambino alla crescita e alle esperienze di vita, ricordando che ogni bambino e ragazzo porta dentro di sé una bellezza di cui, spesso non è consapevole e che il lavoro psicoterapico, tramite il gioco, la sensorialità e le tecniche espressive e motorie, può aiutare a riconoscere, ad accogliere, ad esprimere e a valorizzare [12].

Approccio Cognitivo-Comportamentale

L'approccio cognitivo-comportamentale in età evolutiva si basa sul lavoro di P.C. Kendall, uno dei principali autori nell'applicazione della CBT (terapia cognitivo-comportamentale) con bambini e adolescenti. Questo approccio è spesso utilizzato nel trattamento dei disturbi in età evolutiva ed è caratterizzato da una struttura chiara, strategie definite e un monitoraggio costante del trattamento [15]. Predilige la modifica dei comportamenti disfunzionali e la ristrutturazione dei pensieri che li sottostanno, attraverso l'uso di giochi che stimolano le funzioni esecutive, cartelloni, schede strutturate, disegni e storie, per esplorare i pensieri e le emozioni. Le strategie sono mirate e condivise chiaramente con il bambino e la famiglia per la modifica di comportamenti non adattivi che sottostanno al disturbo espresso dal bambino. Il focus è sul riconoscimento delle emozioni, sullo sviluppo di pensieri alternativi e funzionali, e sulla modifica dei comportamenti attraverso tecniche come il rinforzo positivo, l'esposizione graduale e il problem solving; è fondamentale coinvolgere la famiglia, la scuola e gli altri ambienti importanti per il bambino, per condividere le strategie per il raggiungimento degli obiettivi [16].

La REBT (terapia razionale-emotiva-comportamentale) in età evolutiva si basa sull'approccio di Albert Ellis, tenendo conto dello sviluppo cognitivo, emotivo e relazionale del bambino, e parte dal presupposto che i pensieri rigidi e irrazionali sono la causa di profondi malesseri, espressi in età evolutiva con emozioni intense e comportamenti disfunzionali. Il focus, secondo Ellis, sta sulle "doverizzazioni", che nei bambini diventano pensieri come: "devo essere sempre bravo"; "gli altri devono volermi bene"; "non devo mai sbagliare". Centrale nel lavoro cognitivo-comportamentale è l'educazione emotiva e quindi il riconoscimento delle emozioni e il coinvolgimento dei genitori [17].

Analisi Transazionale e Teoria Dell'attaccamento

L'Analisi Transazionale (AT) in età evolutiva è un approccio psicoterapeutico basato sulla teoria di Eric Berne, adattato per comprendere e sostenere bambini e/o adolescenti nel loro sviluppo psicologico, relazionale ed emotivo. In questa fase della vita, l'AT si propone di favorire una crescita sana dell'identità e delle relazioni, promuovendo la consapevolezza, l'autonomia e la responsabilità [18]. L'AT aiuta il terapeuta ad identificare copioni e ingiunzioni, tradotti in messaggi limitanti come, ad esempio, "Non essere te stesso!", "Non pensare!", "Non sentire!", "Non scegliere!", "Non esistere!" (messaggi, spesso, ricevuti da bambini ai quali si rimanda di "non piangere!" o di "non arrabbiarsi!"); sono messaggi che vengono trasmessi attraverso sguardi, tono di voce, atteggiamenti e aspettative del genitore. Il terapeuta in AT lavora per riconoscere questi messaggi e aiutare sia il minore che la famiglia a prendere consapevolezza del loro impatto, per sostituirli con permessi correttivi, attraverso il linguaggio, il gioco e la presenza accogliente ("puoi essere arrabbiato!", "sei ok così come sei!") [19]. Nella fase centrale del percorso terapeutico si lavora all'esplorazione del sé e dei copioni interiori. Con strumenti tipici dell'AT, come gli stati dell'Io (genitore, adulto, bambino), è possibile aiutare il bambino a riconoscere e integrare le proprie parti interne. Nella pratica, questo può tradursi nel gioco con pupazzi o burattini che rappresentano aspetti del sé, per esempio la parte spaventata, quella arrabbiata, quella che vuole aiutare [18].

La teoria dell'attaccamento fu sviluppata da John Bowlby, che identificò un sistema motivazionale innato che spinge il bambino a cercare protezione e vicinanza dalle figure di riferimento. Il bambino sviluppa una sicurezza interna se l'attaccamento con il caregiver corrisponde ad una base sicura, da cui esplorare il mondo e tornare in caso di bisogno. Interiorizzando esperienze ripetute, il bambino costruisce i Modelli Operativi Interni (MOI), che guidano le modalità relazionali e il comportamento [20]. Sono stati

individuati diversi stili di attaccamento: sicuro, insicuro evitante, insicuro ambivalente e disorganizzato. Seguendo questo approccio, il terapeuta agisce come figura di riferimento sicura che accoglie, regola e rispecchia le emozioni del bambino. All'interno della relazione terapeutica si creano esperienze correttive e riparative che modificano i modelli operativi interni del bambino, offrendo nuove possibilità di fiducia e di connessione. Possono essere coinvolti anche i genitori attraverso giochi per favorire la sintonizzazione emotiva e il rafforzamento del legame [21].

APPROCCIO GESTALTICO INTEGRATO E CASO CLINICO

L'integrazione dei suddetti modelli, attraverso l'utilizzo di strumenti come il gioco, il corpo, l'uso di materiali simbolici (sabbia, disegno, sculture), ecc. permette al bambino di sentire, agire e trasformare le proprie emozioni e le parti del proprio sé. Il terapeuta sostiene l'integrazione tra emozioni, pensieri e comportamenti, aiutando il bambino a restare in contatto con sé e a costruire una narrazione più fluida e congruente del proprio vissuto. Il primo passo è costruire una relazione, basata sull'accettazione incondizionata, sull'autenticità del terapeuta e del bambino, visto e accolto per quello che è e non per quello che fa. L'utilizzo di strumenti espressivi aiuta a far emergere emozioni, a riconoscerle e a poterne parlare con il terapeuta e così, verbalizzare i pensieri che sottostanno a molti comportamenti, le ingiunzioni e i permessi. Proporre attività strutturate per il superamento delle difficoltà che il bambino porta e aiuta a farlo sentire sicuro e ad aumentare la fiducia nel terapeuta, in modo da poter esprimere la propria emotività spontaneamente, attraverso il gioco; elaborare vissuti difficili e raggiungere gli obiettivi terapeutici prefissati.

Il Caso Clinico

Il caso clinico che esporremo in questo articolo riguarda una bambina di quattro anni, frequentante il secondo anno della scuola dell'infanzia, che, per tutelare la sua privacy, chiameremo Roberta. Il primo incontro si svolge con i genitori per la raccolta anamnestica.

Il nucleo familiare di Roberta è composto dai coniugi e da due figli: il fratello maggiore di 13 anni e Roberta di 4 anni. I nonni, sia paterni che materni, sono venuti a mancare da poco e questo, da quanto riportato dal colloquio con i genitori, ha destabilizzato la vita della bambina, abituata a trascorrere molto tempo in loro compagnia.

Roberta è nata con parto cesareo a 36 settimane, dopo una gravidanza regolare, con un peso di 2.750 grammi. Non è stata allattata al seno e lo sviluppo psicomotorio e quello del linguaggio sono stati regolari e incalzanti, raggiungendo tutte le tappe nella norma. Entro l'anno di vita pronunciava le prime frasi, a 14 mesi i primi passi; controllo sfinterico a due anni e mezzo. Il sonno è regolare e non si sono mai registrati casi di enuresi notturna o di disturbi del sonno. Roberta dorme nella camera con il fratello. L'alimentazione è varia e regolare; non ci sono malattie pregresse. La bambina frequenta regolarmente la scuola dell'infanzia, ama giocare con le bambole, disegnare e scrivere. Nonostante non vi siano disturbi del linguaggio verbale, come riferito dai genitori, la bambina non comunica verbalmente in contesti fuori casa né con altre persone oltre alle figure di riferimento sopra citate. Risultano assenti comportamenti dirompenti e aggressivi.

Roberta arriva al centro clinico per l'invio di una collega psicoterapeuta, che suggerisce un approfondimento diagnostico e un'eventuale presa in carico della bambina.

Durante gli incontri, R. richiede la presenza in stanza di un familiare: prima il fratello, poi la madre. Nel primo incontro, per evidente timore di rimanere da sola con persone sconosciute, nonostante il setting, costruito per lei, fosse accogliente e ricco di giochi per attirare la sua attenzione, si alternarono entrambe le figure. Nel secondo incontro, la madre riferisce che la bambina chiede la sua presenza per mostrare che cosa farà nel setting. Con la presenza di un familiare in stanza, R. inizia a familiarizzare con i materiali di gioco e ad essere collaborativa rispetto alle proposte che le vengono fatte. Nonostante l'interesse mostrato per i giochi e la sua vicinanza fisica sul tappeto nel setting, la bambina difficilmente tende ad agganciare il contatto visivo, è scostante e con lo sguardo rivolto verso il basso.

Nel corso dell'assessment R. appare timida, con scarsa iniziativa, comunque collaborativa e interessata; attende istruzioni e proposte da parte degli adulti. Non proferisce mai parola, le alternative alle parole, a lei proposte per comunicare e rispondere alle domande (sì e no con la testa, pollice in su/in giù), vengono usate di rado e, laddove usate, vengono espresse in maniera restia e risultano a malapena accennate.

Vengono proposte attività per valutare lo sviluppo cognitivo (non verbale), le funzioni esecutive, lo sviluppo psicomotorio, i test proiettivi carta e matita e il disegno libero.

Si rileva un adeguato sviluppo cognitivo; non sono presenti ritardi o criticità evidenti in questa fase di sviluppo; non vi sono difficoltà prassiche; movimenti corporei fluidi e postura mobile; adeguate abilità visuo-percettive, attenzione e memoria con sviluppo regolare; espressioni facciali appena accennate; buona maturità nel rispetto dei turni di gioco e della tolleranza. Già dal secondo incontro si evidenziano una maggiore consapevolezza e la possibilità di scelta dell'attività, il che mostra un'apertura relazionale, un ottimo punto di forza per il superamento delle difficoltà comunicative rilevate.

Dai test carta-matita emerge un eccessivo contenimento nell'utilizzo degli spazi a disposizione; il disegno della figura umana appare equilibrato e coerente con l'età e lo sviluppo e non emergono elementi particolari da attenzionare. Nel disegno della famiglia emerge l'importanza della madre e del fratello maggiore, come figure più rilevanti e di riferimento nel "saper fare", probabilmente più presenti nella vita della bambina "nel fare" della vita quotidiana. Adeguato egocentrismo rispetto all'età. Nel disegno dell'albero emergono paura del giudizio esterno e vitalità repressa, ma non emergono ulteriori criticità. Il punto di forza di R. è il disegno libero, in cui esprime creatività e potenzialità emotive, tradotte in colori e forme.

In sintesi, dalla valutazione effettuata emerge una diagnosi di mutismo selettivo, come riportato nei criteri diagnostici del DSM-5, manuale diagnostico di riferimento. Il mutismo selettivo è un quadro clinico complesso che rientra nei disturbi d'ansia dell'età evolutiva, con esordio più frequente durante i primi inserimenti nell'ambiente scolastico. Alcuni contesti sociali sono percepiti come minacciosi e richiedenti prestazioni che inducono uno stato di allerta e ansia che impedisce la comunicazione verbale, inducendo alla chiusura relazionale e di scolarizzazione.

In questi casi sono fondamentali una diagnosi precoce e un intervento clinico su più contesti, casa, scuola e centro clinico. Roberta mostra molte risorse e ottimi margini di superamento del disturbo, data l'età e le caratteristiche emotive e cognitive osservate durante la valutazione fenomenologica.

L'intervento ideale risulta di almeno due incontri a settimana in due contesti differenti e fondamentali per la bambina: casa e centro clinico. Fondamentale è il lavoro sinergico con la famiglia, sostenendo le relazioni del nucleo, in particolare con la madre e il padre, e la collaborazione con la scuola e quindi con le insegnanti.

Si consiglia di proseguire con un intervento integrato, mirato, specifico e specialistico per Roberta.

La famiglia viene adeguatamente informata su cosa consiste il mutismo selettivo e su come risulta idoneo comportarsi in questi casi. Le informazioni hanno scopo informativo e di *parent training* per iniziare in famiglia un lavoro che necessariamente deve essere sostenuto da professionisti.

Il mutismo selettivo è un disturbo poco conosciuto, talvolta sottovalutato, che colpisce prevalentemente i bambini ed è caratterizzato dall'incapacità di parlare in alcuni contesti sociali, nonostante lo sviluppo e la comprensione del linguaggio siano nella norma. Il mutismo selettivo è un disturbo d'ansia: non è un fenomeno dovuto a qualche disfunzione organica o a un'incapacità correlata allo sviluppo, ma è un atteggiamento di risposta a uno stato emotivo intenso, una risposta automatica del sistema nervoso a una minaccia percepita. Nonostante vogliano farlo, i bambini con mutismo selettivo non riescono a parlare fuori casa o in presenza di estranei si bloccano, e ciò avviene in particolare in luoghi pubblici o in contesti sociali più ansiogeni, come, ad esempio, la scuola. Al contrario di quanto avviene in tali contesti, i bambini affetti da mutismo selettivo, a casa, negli ambienti familiari e con le persone con cui si sentono a loro agio, si esprimono normalmente e a volte sono dei grandi chiacchieroni; possono mostrare scarsa tolleranza alla frustrazione ed esplosioni di rabbia o irritabilità che rendono difficile interagire con loro. Spesso accade, quindi, che i silenzi di questi bambini vengano interpretati come provocazioni, sfide, modi per sottrarsi alle regole, e che possano innescarsi tentativi di forzatura che indeboliscono l'autostima. Il giudizio della gente e dei familiari è importantissimo per loro, che spesso subiscono trattamenti bruschi e svalutanti. Il primo atteggiamento importante, sia nei contesti sociali che a casa, è non forzarli mai a parlare. Utile, invece, al fine di ridurre l'ansia e rendere più confortevole il passaggio alla parola, è creare un clima rilassato e rassicurante, non punire o minacciare in caso di silenzio, non utilizzare premi come forma di ricatto (ad esempio: "Se parli ti compro quello che vuoi"), non far sentire in colpa in caso di fallimento ("Se non parli la mamma è triste") [22].

Occorre evitare di creare aspettative eccessive o di sminuire la difficoltà e, al contrario, mostrare una pacata fiducia può rivelarsi un atteggiamento rinforzante. Un'altra modalità di interazione importante, da parte del familiare, è non mostrare eccessiva meraviglia o felicità nel caso in cui il bambino inizi a parlare in luoghi o con persone differenti. Alcuni atteggiamenti positivi, al fine di ridurre l'ansia e rassicurare il bambino/a verso una comunicazione attiva, possono consistere nel coinvolgimento nelle azioni che lo riguardano, nell'informarlo di ciò che possa succedere o nel chiedergli se sia pronto ad affrontare una nuova situazione, favorendo progressivamente la sua autonomia, coinvolgendolo in azioni quotidiane di cura personale e di aiuto domestico, creando iniziative e programmando insieme le attività che lo riguardano. Risulta fondamentale offrire piccole opportunità di socializzazione, anche invitando i compagni a casa (luogo per lui rassicurante) e collaborando, infine, con la scuola, gli insegnanti e i terapeuti [23].

Progetto D'intervento Individualizzato per il Caso di Roberta

Il mutismo selettivo rientra nei disturbi d'ansia e quindi va trattato come tale; l'intervento gestaltico integrato proposto ha previsto incontri presso il centro clinico e incontri a domicilio, strutturando un ambiente accogliente, non giudicante e con possibilità di totale espressione.

Tutte le attività sono caratterizzate dal gioco e dal coinvolgimento, con lo scopo di creare una relazione e un ambiente favorevoli all'emersione del verbale.

Risulta funzionale poter preparare un setting morbido con tappeto e cuscini, un angolo con tavolo e sedie, e predisporre anche una prima scaletta di giochi e il materiale per le varie attività.

Occorre individuare un canale di comunicazione alternativo, non verbale, basato su gesti: inizialmente si può utilizzare come canale espressivo il sì e no con il capo; successivamente si può esprimere il sì e no con il pollice su e il pollice giù. Inserire poi, una volta acquisiti i gesti precedenti, la mimica facciale: assicurarsi il contatto visivo, la bocca spalancata per dire sì, la bocca chiusa a bacio per dire no.

Risulta fondamentale, inoltre, un atteggiamento di accettazione totale nei confronti del mutismo selettivo, evitando quindi di manifestare alcuna forzatura verbale.

Utilizzare gli stessi gesti e anche molti altri, ad esempio, strizzare l'occhio, altri movimenti delle mani, accompagnando il linguaggio verbale quando parliamo con la bambina.

Non elogiare né lodare la bambina se pronuncia delle parole, per evitare l'emozione della vergogna che l'accompagna. Rispondere e proseguire con naturalezza e, successivamente, con dolcezza, dire alla bambina: "Grazie per avermi parlato!" [24].

Attività:

- Avviare giochi in cui non serve la parola ma che permettano a Roberta di sentirsi brava e competente. La bambina deve ottenere successi ed essere "rinforzata" per questo. Ciò aiuta ad allontanare la paura di parlare, es. giochi visuo-percettivi, di memoria, equilibrio, attenzione selettiva.
- Proporre giochi a turno e a tempo per lavorare sulla modulazione dell'ansia.
- Giochi d'imitazione di movimenti corporei "a specchio"; ciò agevola il contatto visivo.
- Esercizi bucco-facciali.
- Esercizi di respirazione e grounding.
- Giochi in cui bisogna soffiare, ad es. gara di palline che devono essere soffiate con la cannuccia; utilizzo del flauto; ecc.
- Giochi che prevedono il contatto corporeo: es. gioco del dottore, gioco del parrucchiere, ecc.
- Introdurre gradualmente giochi in cui bisogna fare piccoli versi (soffi, fischi, risate, vocalizzi) e utilizzare anche pupazzi e marionette.
- Giochi di movimento, giochi in cui si ride insieme: es. cuscinate, suonare insieme gli strumenti musicali, soprattutto a fiato, produrre suoni con il proprio corpo, emettendo suoni semplici come tosse, starnuto, singhiozzo.
- Coinvolgere la bambina nell'ascolto di canzoncine che includano versi e movimenti, ad es.: "nella vecchia fattoria"; "gioca jouer"; "se sei felice".
- Gioco "indovina il suono/verso"; utilizzare anche applicazioni sul tablet.
- Utilizzare materiale per stimolare la creatività (carta colorata, vari tipi di colori) e l'espressione di sé attraverso il disegno, lavorare parallelamente attraverso l'alfabetizzazione delle emozioni di base; imparare a riconoscerle e ad accettarle.
- Creare sempre situazioni in cui la bambina può aiutare, nel preparare delle attività o nel sistemare ciò che si è utilizzato e, successivamente, rinforzare questo comportamento.
- Fare volontariamente degli errori durante i giochi, per mostrarsi come adulti imperfetti, che ridono e accettano di poter sbagliare.

Per le attività a casa: individuare, in accordo con i genitori, un luogo non a vista di tutti per costruire il setting, ad esempio, la propria stanza in cui non potrà entrare nessun altro durante le attività. Nei primi incontri, evitare di modificarlo. Successivamente, provare a spostarsi in altri luoghi di casa, più in vista, come salotto e cucina. Infine, coinvolgere, per poche attività, membri della famiglia [25].

Piano d'intervento aggiornato dopo4 mesi di avviamento del percorso

Rispetto alle attività proposte in precedenza, sono state anche aggiunte:

- L'introduzione alla *token economy* a tre gettoni con patto/rinforzo stabilito da Roberta prima di iniziare ("sto lavorando per..."); ciò è funzionale per evitare manipolazioni da parte della bambina. È sempre l'adulto che deve guidare il compito.
- L'introduzione di giochi per potenziare il ritmo: percussioni di ogni genere. Comunicazione attraverso il ritmo e la percussione.
- L'introduzione dell'utilizzo della videochiamata con il supporto del telefono per agevolare l'esecuzione degli esercizi buccofacciali.
- L'introduzione di percorsi di movimento.
- L'alfabetizzazione emotiva attraverso il gioco "dadi-movimento-emozioni".

Indicazioni per la Scuola

Il mutismo selettivo è un disturbo d'ansia che si manifesta nei bambini, soprattutto nei primi mesi di inserimento a scuola. Il mutismo selettivo a volte impedisce ai bambini di emettere qualsiasi tipo di suono, anche un lamento o il pianto, per cui è importante che l'insegnante sia attenta ai segnali non verbali che provengono dal bambino.

È importante che gli insegnanti osservino attentamente questi bambini silenziosi e dedichino loro particolare attenzione, poiché, non riuscendo a parlare, non riescono a esprimere neanche i bisogni primari, come quello di andare in bagno o di non sentirsi bene.

Il primo passo è alleviare l'ansia in classe, creando un clima disteso e rilassato in cui la bambina si senta il più possibile a proprio agio.

Non considerare oppositivo il comportamento della bambina: non c'è intenzionalità nel non parlare, anzi, al contrario, la bambina vorrebbe riuscire, ma l'ansia le impedisce di farlo, bloccandole le parole in gola.

Non mettere sotto pressione la bambina né ingannarla con promesse o ricatti per farla parlare. Rispettare i suoi tempi.

- Concedere inizialmente alla bambina di utilizzare il linguaggio non verbale.
- Permettere di indicare, di usare lo sguardo, i gesti, l'alzata di mano.
- Nell'attività del circle-time, non fare domande a tutti, ma lasciare la libertà di intervenire o meno. Evitare gli interventi a turno, perché nei bambini con mutismo selettivo l'ansia aumenta quando il loro turno si avvicina.
- Far sedere la bambina vicino al compagno preferito, non di fronte all'insegnante, lontano dalla porta.
- Fare attenzione all'ironia e alla derisione: la bambina non deve essere etichettata come "bambina che non parla". Spiegare alla classe, concordando prima con la bambina e in sua presenza, che tutti abbiamo paura di qualcosa e che la compagna sa parlare ma a volte non riesce a far uscire le parole. In questa occasione, ogni compagno di classe avrà lo spazio per parlare delle proprie paure.
- Si può migliorare l'autostima della bambina affidandole piccoli compiti e incarichi alla sua portata e favorendo l'attività in coppia o in gruppi di 3 componenti, possibilmente con compagni con cui la bambina si sente a proprio agio.
- Risulta utile abituarla a non temere di produrre suoni attraverso il gioco, incoraggiandola a fare rumore e a emettere suoni con la bocca (risate, soffi, fischi). Quelli che per noi sono gesti scontati, per R. sono grandi passi che segnano l'inizio di una comunicazione verbale.
- Nel caso in cui la risposta ad alcune domande possa essere un "sì" o un "no", permettere alla bambina di rispondere con un gesto del capo per farla sentire coinvolta nella conversazione di classe.
- Tenere presente che se la bambina parla una volta, non è detto che poi parlerà sempre.
- Quando la bambina pronuncia qualche parola, non bisogna mostrare eccessivo entusiasmo per l'accaduto. È probabile che la bambina inizi a parlare con un suo pari piuttosto che con l'insegnante; in tal caso, evitate di dire di aver sentito la sua voce.

Il mutismo selettivo rientra pienamente nella definizione dei "Bisogni Educativi Speciali", secondo la Direttiva ministeriale del 27 dicembre 2012. Roberta è una bambina molto intelligente e sensibile, perciò è importante che gli insegnanti concordino le medesime strategie e modalità educative. Tenere presente che ai bambini con mutismo selettivo serve una relazione privilegiata, non un semplice sostegno. La migliore possibilità di superamento della difficoltà risiede nelle buone esperienze sociali e di gruppo che la scuola può offrire [26].

Il Supporto alla Genitorialità

Il percorso di terapia svolto con Roberta ha previsto, parallelamente agli incontri in studio e a casa con la bambina, il contatto telefonico con le insegnanti e un percorso di *parent training* e supporto genitoriale costante. In particolare, la madre della bambina si è dimostrata molto aperta a seguire con costanza il percorso, modificando il proprio stile educativo nei confronti della bambina e mostrando accoglienza all'ascolto emotivo di R.

Nella presa in carico dei pazienti in età evolutiva, il supporto alla coppia genitoriale risulta fondamentale, in quanto è evidente che il bambino è costantemente in relazione con il proprio ambiente di appartenenza e che il suo disagio tende a emergere da uno sfondo familiare.

Il terapeuta si pone come "sponda relazionale" tra il bambino e la famiglia ed è fondamentale sia effettuare una prima anamnesi familiare e, successivamente, sostenere i genitori a consapevolizzare e a modificare la presenza di eventuali schemi e stili comunicativi e relazionali disfunzionali all'interno del sistema familiare, condividendo con la coppia genitoriale obiettivi comuni, perseguibili e concreti.

Diventa importante aiutare i genitori a cambiare la prospettiva e la rappresentazione che hanno del/la proprio/a figlio/a (nuova prospettiva), in quanto ciò contribuisce ad aumentare, a mantenere o a diminuire la condizione di scissione tra le varie parti sia del proprio sé sia del proprio bambino [27].

Risulta funzionale orientare, educare (attraverso la psicoeducazione) e sostenere la coppia genitoriale nella possibilità di garantire continuità agli apprendimenti e alle acquisizioni del bambino o dell'adolescente all'interno del setting terapeutico.

Risulta fondamentale rendere congruenti gli stili educativi, comunicativi e relazionali della coppia genitoriale per permettere al minore di "interiorizzare nuovi schemi emotivi, cognitivi, sensoriali, motori e comportamentali maggiormente adattivi" che, successivamente, quest'ultimo sarà in grado di generalizzare all'interno dei vari contesti della vita quotidiana.

Il ruolo dei genitori è essenziale, poiché con loro si instaura un contratto a più mani e sono alleati nel processo di cambiamento.

I genitori vengono accompagnati a riconoscere i propri stili relazionali, a comprendere i bisogni affettivi del figlio e a ristrutturare i propri messaggi interni e le transazioni familiari. Attraverso momenti di riflessione, psicoeducazione e condivisione di esperienze, i genitori possono diventare parte attiva della trasformazione, offrendo continuità e supporto anche al di fuori della stanza di terapia.

Il supporto genitoriale sostiene entrambi i genitori ed eventuali altri membri della famiglia, affinché possano divenire un modello (modelling) per il minore e, inizialmente, poter fungere anche da "regolatore emotivo ed organizzatore esterno" per il proprio figlio, in modo tale che quest'ultimo, sperimentando una "relazione sana e sufficientemente buona", possa, pian piano, sperimentare un "nuovo senso di sé" e acquisire dei nuovi schemi emotivi, cognitivi e comportamentali maggiormente adattivi, tali da permettergli di sviluppare e di contattare un maggior senso di integrità e di autoefficacia personale.

Quanto espresso è importante affinché il genitore possa entrare con il proprio figlio in un "con-tatto pieno e profondo", sperimentando, attraverso il gioco con il bambino e prediligendo, nella relazione con questo, un canale e/o un livello prevalentemente corporeo, sensorio, immaginativo ed emotivo-relazionale, favorendo il processo graduale di sviluppo del bambino e contribuendo a migliorare la comunicazione genitore-figlio/a e la libera e autentica espressione di sé. Tutto ciò supporta nel minore l'acquisizione di una maggiore comprensione e consapevolezza delle proprie emozioni e dei propri bisogni, determinando in questo un processo di maggiore regolazione sensoriale, motoria, emotiva, cognitiva e comportamentale [28].

Fasi Esplicative dell'Intervento

Osservando il caso clinico sotto la lente dell'approccio Gestaltico integrato, si inizia nella fase di pre-contatto, con il colloquio iniziale con la famiglia e una valutazione fenomenologica della bambina, per inquadrare la condizione di partenza, cominciare a costruire l'alleanza terapeutica e comprendere le modalità con cui entra in contatto con l'ambiente e con gli altri, esplorando livelli d'esperienza e funzioni di contatto, individuando anche le interruzioni di contatto e come queste possano ostacolare il naturale sviluppo della bambina [29]. Attraverso l'accettazione incondizionata e un atteggiamento congruente ed empatico si agevola la costruzione della relazione. Si osservano i copioni familiari e le ingiunzioni, individuando l'organizzazione degli stati dell'Io. Successivamente, nella fase di avvio al contatto, si prosegue cominciando a proporre le attività appositamente strutturate nel progetto d'intervento personalizzato per Roberta. Queste attività, pensate appositamente integrando gli approcci gestaltico, umanistico, cognitivo-comportamentale, dell'analisi transazionale e la teoria dell'attaccamento, mirano a costruire un ambiente sicuro, dove sperimentare modalità alternative di comunicazione, sentirsi accettata così com'è, ricevere il "permesso" di esistere ed essere vista anche nel suo silenzio. Nella fase di contatto pieno, la bambina, all'interno di una relazione sicura, comincia ad aprirsi alla possibilità di comunicazioni alternative a quella verbale, per poi passare al dialogo vero e proprio. L'accettazione incondizionata, il permesso di esistere, l'espressione di parti del sé attraverso il gioco e la strutturazione di attività e strategie per il superamento del mutismo selettivo hanno consentito a Roberta di affidarsi, costruire relazioni sane ed equilibrate, sperimentare parti di sé, accolte e valorizzate, sentendosi libera di esprimersi verbalmente anche con le terapiste [30]. Parallelamente, il supporto genitoriale ha permesso alla famiglia e, in particolare, alla madre, di trovare canali espressivi alternativi per le emozioni, di accogliere e accettare Roberta nella manifestazione del suo disagio e di seguire strategie educative funzionali a ridimensionare l'ansia della bambina. La tabella 1 descrive le fasi del processo terapeutico e delle tecniche utilizzate, integrate con i diversi approcci.

Dopo i primi sei mesi di trattamento sono stati raggiunti i primi obiettivi, ovvero costruire una salda relazione terapeutica e consentire alla bambina di sentirsi "libera" di esprimersi così com'è. Il percorso ha avuto la durata di circa un anno e mezzo, accompagnando Roberta e la sua famiglia fino al termine della scuola dell'infanzia. Nella fase di post-contatto si è potuto appurare che la bambina ha superato il mutismo selettivo, partecipando attivamente alle attività di fine anno scolastico e esponendosi anche alle recite e ai canti con i compagni, come riferito direttamente dalle insegnanti. A casa ha ripreso a manifestare tutta la sua energia positiva e autentica, conversando naturalmente con tutti i membri della famiglia e anche fuori casa. La madre ha riferito di sentirsi maggiormente competente come genitore, libera dal giudizio esterno e interno rispetto alla situazione iniziale, e più sicura nel sostenere la figlia nel percorso di crescita.

CONCLUSIONI

Lo scopo di questo contributo è quello di evidenziare l'efficacia di un trattamento gestaltico integrato nella presa in carico di soggetti in età evolutiva che considera, come sopra espresso, l'integrazione tra Gestalt, approccio umanistico esistenziale, Gestalt play therapy, approccio cognitivo comportamentale, analisi transazionale e teoria dell'attaccamento, attraverso la presentazione di un caso clinico specifico che evidenzia un'evoluzione significativa del quadro clinico in questione, ripercorrendo le varie fasi di intervento e del ciclo di contatto sia sulla minore che rispetto al sistema familiare di riferimento di quest'ultima. Attraverso l'accettazione incondizionata, la congruenza, il compito terapeutico relazionale, le varie tecniche espressive integrate tra loro e i permessi, si creano e si esplicano le condizioni funzionali nel trattamento in età evolutiva, che concorrono all'acquisizione del permesso di sentire, del permesso di scegliere e del permesso di esistere nella propria interezza, autenticità e creatività.

Infine, risulta importante constatare come l'approccio gestaltico integrato ci permette di allargare il processo di osservazione del minore al campo fenomenologico in cui questo è inserito e, se tale approccio risulta essere ben radicato nella teoria e nella pratica, può rappresentare una via concreta e potente per accompagnare i bambini e le loro famiglie verso un cambiamento autentico e duraturo.

Table 1. Tabella esplicativa delle fasi del processo terapeutico e delle tecniche utilizzate, integrate con i diversi approcci.

FASE DELL'INTERVENTO	OBIETTIVO CLINICO	TECNICHE E INTERVENTI UTILIZZATI	DESCRIZIONE DELLE ATTIVITÀ	RISULTATI OSSERVATI
Pre-contatto **Costruzione dell'alleanza terapeutica**	Ridurre l'attivazione ansiosa iniziale e favorire il senso di sicurezza nel setting.	Sintonizzazione emotiva; tecniche non verbali; osservazione fenomenologica delle modalità di attaccamento e di organizzazione degli stati dell'Io	Utilizzo di gioco libero, disegno, pupazzi e carte emotive senza richiesta diretta di verbalizzazione. Il terapeuta privilegia osservazioni fenomenologiche e validazione emotiva, rispettando i tempi comunicativi della bambina.	Progressiva riduzione dell'evitamento relazionale; aumento del contatto visivo e della partecipazione spontanea alle attività.
Accettazione delle modalità comunicative alternative	Favorire il contatto comunicativo riducendo la pressione sul linguaggio verbale.	Comunicazione facilitata, con segni e gesti; rinforzo positivo.	La bambina viene incoraggiata a comunicare attraverso cenni, scrittura, indicazioni corporee e scelta di immagini. Tali modalità vengono accolte come strumenti comunicativi funzionali, senza agire forzature.	Incremento dell'iniziativa comunicativa e riduzione della chiusura difensiva nel setting terapeutico.
Avvio al contatto **Regolazione emotiva e consapevolezza corporea**	Ridurre l'ansia associata all'esposizione sociale e alla verbalizzazione.	Alfabetizzazione emotiva; grounding; respirazione guidata; consapevolezza corporea.	Vengono proposte attività di alfabetizzazione emotiva, in relazione all'età; esercizi di respirazione lenta, riconoscimento delle sensazioni corporee e attività di grounding per aiutare la bambina a identificare i segnali fisiologici dell'ansia e aumentare le capacità autoregolative.	Riconoscimento delle emozioni di base, con migliore tolleranza dell'attivazione emotiva e diminuzione delle manifestazioni somatiche d'ansia durante le interazioni.
Esposizione graduale alla verbalizzazione	Ridurre l'evitamento verbale e aumentare il senso di autoefficacia.	Esposizione graduale; shaping; rinforzo positivo.	È stata costruita una gerarchia condivisa delle situazioni comunicative ansiogene. Si è lavorato progressivamente da suoni e parole isolate fino a brevi verbalizzazioni spontanee in presenza della terapeuta e successivamente di altre figure significative.	Comparsa progressiva della verbalizzazione nel setting terapeutico e riduzione dell'ansia anticipatoria.
Contatto Pieno **Elaborazione emotiva e simbolica dei vissuti**	Favorire l'espressione emotiva e la mentalizzazione dei vissuti relazionali.	Gioco simbolico; tecniche espressive.	Attraverso storie, pupazzi, disegni e rappresentazioni simboliche, la bambina ha potuto esprimere paure legate al giudizio, all'errore e all'esposizione sociale. La terapeuta facilitava il riconoscimento emotivo nel "qui e ora".	Maggiore capacità di riconoscere e comunicare emozioni e bisogni relazionali.
Interventi di riparazione	Modificare vissuti inibitori relativi all'espressione di sé.	Permessi relazionali; riconoscimento dei messaggi interiorizzati.	Durante le sedute venivano esplorati, in forma compatibile con l'età evolutiva, vissuti di paura del giudizio e dell'errore. La terapeuta sosteneva esperienze relazionali correttive basate su accettazione e legittimazione dell'espressione personale.	Riduzione dell'inibizione e aumento della spontaneità relazionale.
Coinvolgimento genitoriale	Ridurre i rinforzi involontari del mutismo selettivo e favorire la generalizzazione dei progressi.	Psicoeducazione; parent training; supporto alla co-regolazione.	Ai genitori sono state fornite indicazioni per ridurre la pressione comunicativa, incoraggiare risposte sostitutive e valorizzare i tentativi spontanei di verbalizzazione. Sono stati inoltre promossi atteggiamenti di sintonizzazione emotiva e contenimento ansioso.	Miglioramento delle dinamiche comunicative familiari e maggiore supporto all'autonomia comunicativa della bambina.
Generalizzazione ai contesti esterni	Estendere le competenze comunicative ai diversi contesti di vita.	Collaborazione scuola-famiglia-terapia; esposizione graduale nei contesti naturali; rinforzo positivo.	Sono state promosse occasioni progressive di verbalizzazione in ambienti extrasetting (scuola, attività sociali, contesti familiari allargati), con coordinamento tra terapeuta, genitori e insegnanti per sostenere la continuità degli interventi.	Aumento della verbalizzazione nei contesti esterni e maggiore partecipazione sociale e scolastica.
Post contatto **Integrazione dell'esperienza terapeutica e consolidamento di competenze emotive e relazionali**	Favorire l'integrazione dei cambiamenti acquisiti e sostenere la continuità del senso di sé al di fuori della relazione terapeutica.	Convalida delle emozioni percepite, permesso di esistere così come si è. Rituale di chiusura del percorso.	Nelle fasi finali del percorso terapeutico sono stati condivisi e rielaborati i cambiamenti emersi durante il trattamento, favorendo la consapevolezza delle risorse sviluppate e delle nuove modalità relazionali sperimentate. Attraverso momenti di riflessione condivisa, verbalizzazione dell'esperienza emotiva e rituali simbolici di conclusione, la bambina è stata accompagnata nell'elaborazione della separazione terapeutica.	Maggiore consapevolezza delle proprie competenze relazionali ed emotive; consolidamento del senso di autoefficacia; vissuto di separazione maggiormente tollerabile e integrato.

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Opinion Article

Trauma and psychotherapy: an integrated approach between transgenerational transmission, Gestalt therapy, Parts Model and Internal Family Systems

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ABSTRACT

This work represents an innovative contribution to the integration of complementary perspectives in understanding psychological trauma, with particular focus on the transgenerational dimension of traumatic transmission and therapeutic approaches. The novelty of this work lies in the hypothesis of integrating emerging epigenetic evidence with psychotherapeutic models based on structural dissociation, offering a theoretical-clinical framework that simultaneously recognizes the biological, psychological, and relational roots of trauma. While Eye Movement Desensitization and Reprocessing (EMDR) is established as a consolidated therapy for emergencies and collective traumas, Gestalt therapy and the Parts Model, with their integration, represent a promising and innovative hypothesis. Epigenetic research in recent years suggests that traumatic experiences not only leave lasting biological traces in direct survivors but may be transmitted to subsequent generations through modifications in DNA methylation and gene expression. These biological mechanisms intertwine with complex psychological and relational processes, creating transmission patterns that require sophisticated, multilevel therapeutic approaches. Gestalt therapy, with its emphasis on the "here and now," body awareness, and contact, offers fundamental contributions. The Parts Model, particularly developed by Janina Fisher through the integration of sensorimotor psychotherapy with the theory of structural dissociation, and Internal Family Systems (IFS) by Richard Schwartz, offers complementary clinical frameworks to address trauma-induced fragmentation. This work proposes an integrated model that acknowledges the intergenerational roots of psychological distress and draws on inherited resources alongside vulnerabilities, opening new directions for both research and clinical practice.

Keywords

Transgenerational trauma, Epigenetics, Parts model, Internal family systems, Gestalt therapy, Structural dissociation, EMDR, Integrated approach.

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ABSTRACT IN ITALIANO

Il presente lavoro rappresenta un contributo innovativo all'integrazione di prospettive complementari nella comprensione del trauma psicologico, con particolare focus sulla dimensione transgenerazionale della trasmissione traumatica e sugli approcci terapeutici. La novità di questo lavoro risiede nell'ipotesi di integrare evidenze epigenetiche emergenti con modelli psicoterapeutici basati sulla dissociazione strutturale, offrendo un framework teorico-clinico che riconosce simultaneamente le radici biologiche, psicologiche e relazionali del trauma. Mentre l'Eye Movement Desensitization and Reprocessing (EMDR) si configura come terapia consolidata per l'emergenza e i traumi collettivi, la terapia della Gestalt e il modello delle parti con la loro integrazione rappresentano un'ipotesi suggestiva e innovativa. La ricerca epigenetica degli ultimi anni suggerisce che le esperienze traumatiche non solo lasciano tracce biologiche durature nei sopravvissuti diretti, ma potrebbero essere trasmesse alle generazioni successive attraverso modificazioni nella metilazione del DNA e nell'espressione genica. Questi meccanismi biologici si intrecciano con processi psicologici e relazionali complessi, creando pattern di trasmissione che richiedono approcci terapeutici sofisticati e multilivello. La Gestalt terapia, con la sua enfasi sul "qui e ora", sulla consapevolezza corporea e sul contatto, offre contributi fondamentali. Il Modello delle Parti, sviluppato in modo particolare da Janina Fisher attraverso l'integrazione della psicoterapia sensomotoria con la teoria della dissociazione strutturale, e l'Internal Family Systems (IFS) di Richard Schwartz offrono framework clinici complementari per affrontare la frammentazione causata dal trauma. Si propone l'ipotesi di un modello integrato che riconosce le radici intergenerazionali del disagio psicologico e valorizza le risorse ereditate insieme alle vulnerabilità, aprendo nuove prospettive sia nella ricerca che nella pratica clinica.

Parole chiave

Trauma transgenerazionale, Epigenetica, Modello delle parti, Internal Family Systems, Terapia Gestalt, Dissociazione strutturale, EMDR, Approccio integrato.

INTRODUCTION

This paper contributes to the integration of complementary perspectives in the study and treatment of psychological trauma. On one hand, it explores the transgenerational dimension of traumatic transmission, which in recent years has received growing, though still debated, support from neuroscience and epigenetics, suggesting how traumatic experiences lived by one generation may leave biological, psychological, and relational traces in subsequent generations [1, 2]. On the other hand, it analyzes therapeutic approaches that provide specific, effective clinical tools to address the fragmentation and dissociation caused by trauma. It bears emphasizing that Eye Movement Desensitization and Reprocessing (EMDR) is a well-established and widely validated therapy for emergencies and collective traumas [3, 4], with a solid base of scientific evidence supporting its effectiveness. In this consolidated context, Gestalt therapy and the Parts Model with their integration represent a promising and innovative direction that merits further clinical and research development [5-7].

What distinguishes this work is its integration of recent epigenetic discoveries on the transgenerational transmission of trauma [8, 9] with contemporary psychotherapeutic models that consider the structural dissociation of personality. While traditionally these areas have been treated separately, epigenetics in biological neurosciences and work with parts in psychotherapy, this paper proposes a unified framework that considers how the biological mechanisms of traumatic transmission manifest clinically through patterns of psychic fragmentation, which can be addressed therapeutically through specific approaches. Modern understanding of trauma necessarily requires a multidimensional approach that integrates knowledge derived from neuroscience, epigenetics, clinical psychology, and the most innovative psychotherapeutic traditions. Over the past fifteen years, scientific research has provided growing evidence, particularly from animal models and some human studies [10, 11], that extreme traumatic events, such as genocides, wars, famines, systematic violence, not only affect those who directly experienced them, but can profoundly influence their descendants as well, sometimes up to the third and fourth generation. In parallel, the development of specific therapeutic models for trauma has produced innovative approaches that consider the structural dissociation of personality and the importance of bodily integration and internal systemic work in the healing process [12-14].

This paper has a twofold objective: first, to provide an updated overview of the biological, psychological, and social mechanisms through which trauma is transmitted across generations; and second, to illustrate how contemporary therapeutic models, particularly Gestalt therapy, Janina Fisher's work on the Parts Model and the theory of structural dissociation, and Internal Family Systems (IFS), can be integrated to offer effective clinical interventions that take into account the complexity of transgenerational transmission and the dissociative nature of trauma.

TRANSGENERATIONAL TRAUMA: MECHANISMS AND CLINICAL IMPLICATIONS

Definition and Clinical Relevance

Transgenerational trauma has emerged as one of the most compelling and clinically relevant areas of contemporary psychological and neuroscientific research. The idea that traumatic experiences endured by one generation can leave biological and psychological traces in subsequent generations challenges traditional conceptions of classical genetic inheritance and opens new perspectives in understanding human development, psychopathology, and clinical treatment [15]. Transgenerational trauma refers to the transmission of the effects of extreme traumatic events from one generation to another, creating patterns of psychological, biological, and relational vulnerability that persist over time [16]. This transmission occurs through multiple and interconnected mechanisms that simultaneously involve biological dimensions (epigenetic, neuroendocrine), psychological (attachment, relational patterns, internal working models), and sociocultural (family narratives, secrets, invisible loyalties) [17, 18]. This complexity calls for clinical approaches that integrate multiple perspectives and levels of intervention. The clinical relevance of this phenomenon is considerable: understanding the transgenerational dimension of trauma allows clinicians to contextualize seemingly inexplicable symptoms, identify recurring family patterns, and develop interventions that are not limited to the patient's individual history but consider the emotional and biological legacy transmitted through generations [17, 18].

Epigenetic Mechanisms of Transgenerational Transmission

Epigenetics has revolutionized our understanding of how environmental experiences can influence gene expression without altering the DNA sequence itself. The main epigenetic mechanisms include DNA methylation, histone modifications, and the action of non-coding RNAs [19, 20]. These mechanisms can be influenced by traumatic experiences and, under certain conditions, transmitted to subsequent generations through the germline [21]. Studies on Holocaust survivors and their descendants have provided some of the most cited evidence regarding epigenetic intergenerational transmission in humans, though findings have been partially debated due to limited sample sizes. Research [8, 9] suggests that children of Holocaust survivors exhibit specific alterations in cortisol regulation and stress response, associated with epigenetic modifications in genes related to the hypothalamic-pituitary-adrenal (HPA) axis. These biological changes may make descendants more vulnerable to stress and trauma-related disorders, even if they never directly experienced the original traumatic events. Other significant studies [22] have examined descendants of survivors of other collective traumas: the Dutch Hunger Winter, wars in the Balkans, and genocide in Rwanda. In several of these cases, researchers have identified epigenetic patterns that appear to be transmitted from traumatized parents to their children, suggesting possible influences on their physical and mental health, though mechanisms in humans remain under investigation.

Psychological and Relational Mechanisms

Alongside biological mechanisms, psychological and relational processes play a fundamental role in the transgenerational transmission of trauma. Attachment theory offers a crucial framework for understanding these dynamics. Parents traumatized during their own childhood or who carry transgenerational traumas often develop insecure or disorganized attachment patterns with their children [23]. These patterns create vulnerability contexts that make children more susceptible to developing trauma-related symptoms, even without direct traumatic experiences. Research has shown

that children of Holocaust survivors, refugees from wars, and survivors of systematic violence often develop specific symptoms and vulnerabilities, including heightened vigilance for threat, difficulties in emotional regulation, identity problems, and a sense of "inherited guilt" or responsibility for sufferings they never experienced [24, 25]. Family systems also play a crucial role. The concept of "invisible loyalties" developed by Boszormenyi-Nagy and Spark [26] describes how family members may feel obligated to maintain behavioral or emotional patterns to honor the suffering of previous generations. Secrets, silences, and interrupted narratives within families can transmit trauma as powerfully as explicit narratives. When traumas are not spoken about, children may unconsciously absorb the emotional weight without having a narrative framework to understand it [27, 28].

Resilience and Transgenerational Resources

While much research has focused on the transmission of vulnerability, it is equally important to recognize that resilience and resources can also be transmitted transgenerationally [29, 30]. Descendants of trauma survivors not only inherit vulnerabilities but may also inherit extraordinary capacities for adaptation, strength, and meaning. Some scholars [1] have begun to identify epigenetic markers associated with resilience, suggesting that positive environmental experiences and adequate support can mitigate or even reverse some transgenerational effects of trauma. This has profound clinical implications: therapeutic work should not only focus on vulnerabilities but also actively identify and build on inherited resources and strengths.

INTEGRATED THERAPEUTIC APPROACHES FOR TRAUMA

Gestalt Therapy and Trauma

Gestalt therapy, founded by Fritz Perls, Laura Perls, and Paul Goodman in the 1950s, makes important contributions to trauma treatment through its emphasis on present awareness, bodily integration, and authentic contact [31-33]. The Gestalt approach views the person as an integrated whole in constant relationship with their environment, and psychopathology as an interruption or distortion of this contact process. For traumatized individuals, the Gestalt concept of "unfinished situations" is particularly relevant [34]. Trauma creates unfinished situations: experiences that could not be fully processed at the time they occurred and remain "frozen" in the psyche, continuing to influence present behavior. Gestalt therapy aims to bring these situations into awareness so they can be completed in the present. Body awareness is central to Gestalt work with trauma [35, 36]. Trauma is stored not only as cognitive memory but also as bodily sensations, muscle tensions, and somatic patterns. Gestalt therapy helps patients develop awareness of these bodily sensations and use them as guides for therapeutic work. Techniques such as body scanning, attention to breath, and movement experiments can help patients reconnect with their body in a safe and gradual way [37]. Contact is another key element. Trauma often damages the capacity for authentic contact with self and others. Gestalt therapy works to restore this capacity through the therapeutic relationship itself, which becomes a laboratory for experimenting with new ways of making contact. The therapist's presence, authenticity, and empathy create a safe space where the patient can gradually risk opening up and making contact.

A further important contribution of Gestalt therapy to trauma work is its emphasis on the "here and now." While trauma is rooted in the past, its effects manifest in the present. Gestalt therapy helps patients become aware of how trauma continues to influence their current experience and offers tools to respond differently. This does not mean ignoring the past but bringing the past into the present where it can be worked with directly and experientially [37]. The use of experiments and creative techniques is another distinctive element of Gestalt therapy. Through experiments, patients can explore new ways of being and relating in a protected context. For example, a patient who learned to suppress their needs in a traumatic family context might experiment with expressing them in the therapeutic relationship. Or a patient who carries the weight of transgenerational trauma might experiment with "dialoguing" with ancestors, giving voice to parts of themselves that carry that legacy [38-40]. The integration of Gestalt therapy with trauma work has been enriched by contributions from contempo-

rary neuroscience. Research on the polyvagal nervous system and embodied cognition has validated many Gestalt intuitions about the importance of the body and present awareness in trauma work [40]. Rosa et al [41] have explored how Gestalt therapy can be integrated with other trauma approaches in a blended intervention model, combining in-person sessions with online work and integrating different therapeutic modalities.

The Parts Model and Structural Dissociation: Janina Fisher's Contribution

The understanding that trauma can fragment the psyche into distinct "parts" has deep roots in trauma psychology, tracing back to Pierre Janet's work in the late 19th century [42]. Contemporary trauma research has confirmed and expanded these early insights, recognizing that dissociation is not simply a defense mechanism but a fundamental way the mind organizes traumatic experience that threatens the integrative capacities of the individual. The graduated three-phase model for treating complex trauma, originally introduced by Pierre Janet [42] and subsequently developed by Herman [43], has become the gold standard for treating complex post-traumatic stress disorder and dissociative disorders. This three-phase approach has been further developed and enriched in contemporary psychotraumatology, incorporating significant contributions from the theory of structural dissociation by Van der Hart et al [44] and the "parts"-based approach developed by Janina Fisher [6, 7]. The conceptualization of dissociative parts allows us to understand how the psychic system fragments in response to trauma, creating relatively autonomous subsystems that keep incompatible aspects of traumatic experience separate. According to the theory of structural dissociation, in response to repeated or prolonged traumas, particularly those that occur during childhood, the personality can divide into different "parts" or subsystems: parts that try to continue daily life (Apparently Normal Parts - ANP) and parts that remain fixed to the traumatic experience (Emotional Parts - EP) [45]. These parts can have different degrees of elaboration, autonomy, and complexity, giving rise to levels of primary, secondary, and tertiary structural dissociation.

Janina Fisher has provided one of the most significant and innovative contributions to understanding and treating traumatic dissociation through her work on integrating sensorimotor psychotherapy with the parts model [5-7]. Fisher conceptualizes dissociative parts not as pathology but as creative and protective adaptations that allowed psychological survival in the face of intolerable experiences. Each part had a protective function: some parts allowed the child to continue functioning despite abuse, others contained overwhelming emotions, and still others sustained attachment to abusive figures when that attachment was necessary for survival. A central element of Fisher's work is the integration of the somatic dimension. Collaborating with Pat Ogden [46], a pioneer of sensorimotor psychotherapy, Fisher has developed techniques that use bodily awareness and movement to facilitate the integration of dissociative parts. The body, according to this approach, is not simply the place where trauma manifests but is also a fundamental resource for healing. Bodily sensations can provide valuable information about activated parts, and somatic interventions can help regulate overwhelming emotional states [47]. Fisher emphasizes the importance of working with parts rather than against them. Instead of trying to eliminate problematic parts or force premature integration, the therapist helps the patient develop curiosity about their own parts, understand their original protective function, and negotiate between different parts when they come into conflict. This approach reduces shame and self-criticism, common in traumatized patients who often harshly judge their own dissociative symptoms.

A further key contribution by Fisher is her attention to the "Self" or integrated core of the personality. Fisher argues that even under extreme dissociation, there is an observational and integrative ability that can be developed and enhanced. The therapeutic work aims to develop this capacity for "Self-leadership," where the Self can recognize the different parts, appreciate their contribution, and guide the internal system toward greater collaboration and integration. Fisher has also significantly contributed to understanding the transgenerational transmission of trauma, as evidenced in her book "Transforming the Living Legacy of Trauma" [7]. In this work, she explores how dissociative parts can carry not only personal traumas but also those inherited from previous generations, and how therapeutic work must sometimes extend to these transgenerational dimensions for complete healing.

Internal Family Systems (IFS): A Systemic Approach to Parts

Internal Family Systems (IFS), developed by Richard Schwartz starting in the 1980s, offers a complementary and equally innovative approach to working with parts [48]. Schwartz developed this model initially working with patients with eating disorders and discovered that many of his patients spontaneously described internal conflicts between different "parts" of their personality. The IFS model proposes that the mind is naturally multiple, composed of different sub-personalities or "parts", and that this multiplicity is not in itself pathological but is the natural organization of the mind [49]. In the IFS model, parts are organized into three main categories: Managers (parts that try to control the environment and prevent situations that could activate pain), Firefighters (parts that intervene when pain emerges, often through impulsive or avoidant behaviors), and Exiles (vulnerable parts that carry painful emotions and traumatic memories). A distinctive element of IFS is the concept of "Self", understood not as another part but as the essential core of the person, characterized by qualities such as curiosity, compassion, calm, clarity, courage, connection, creativity, and confidence (the "8 Cs" of Self) [50]. According to Schwartz, every person has access to this Self, regardless of the severity of trauma or fragmentation. The Self is not damaged by trauma; it is the parts that carry traumatic burdens.

The therapeutic process in IFS aims to free the Self from the dominance of protective parts (Managers and Firefighters) so that it can guide the internal system. Once the Self is present and available, it can compassionately approach the Exiles, the parts that carry pain and traumatic memories, and help them release the "burdens" (negative beliefs, traumatic emotions, disturbing bodily sensations) they have had to carry. A particularly powerful aspect of IFS is the concept of "unburdening." Through a guided process, when an Exile feels truly seen, understood, and welcomed by the Self, it can spontaneously release the emotions, beliefs, and traumatic sensations it has carried, often for decades [51]. This process does not necessarily require detailed re-experiencing of the trauma but is based on the compassionate relationship between Self and Exile.

IFS is particularly effective in treating complex trauma and transgenerational patterns because it recognizes that parts can carry not only personal experiences but also "legacy burdens", burdens inherited from previous generations [52]. These transgenerational burdens can include toxic cultural beliefs, collective shame, or survival patterns transmitted through generations. The work of unburdening can extend to these transgenerational levels, offering healing that goes beyond the individual.

The Integration of the Three Approaches: A Therapeutic Synergy

The integration between Gestalt therapy, Fisher's parts model, and IFS creates a particularly powerful clinical approach. Gestalt contributes its emphasis on bodily awareness and the here-and-now; Fisher's parts model offers understanding of structural dissociation and somatic techniques; IFS contributes the systemic framework of parts and the concept of Self-leadership [53]. Together, these approaches support clinical work that honors the complexity of trauma, respects the patient's pace, and draws on multiple pathways, bodily, cognitive, emotional, and relational, to facilitate healing and integration.

The Three Phases of Treatment: An Integrated Approach

The three-phase approach to trauma treatment, stabilization, processing, and integration remains the reference framework, but can be enriched by the integration of the models discussed.

Phase 1: Stabilization and Safety. The first phase focuses on stabilization, with the objective of reducing acute symptoms and improving daily functioning. In this phase, different dissociative parts are recognized, and work begins on managing emotions related to traumatic memories. The crucial element is the expansion of the physiological and emotional "window of tolerance", the range of arousal within which a person can function effectively [54]. Fisher emphasizes the importance of somatic grounding techniques, bodily mindfulness, and internal resources to stabilize the nervous system. IFS contributes by helping the patient recognize and appreciate the protective parts (Managers and Firefighters) that have tried to maintain safety, even if sometimes with problematic strategies. Ge-

stalt therapy offers techniques to increase present awareness and interrupt automatic patterns of avoidance.

Phase 2: Processing Traumatic Memories. The second phase concerns the gradual processing of traumatic memories, addressing specific episodes and sensory aspects of past experiences. Fisher emphasizes that this work must be done by carefully "titrating", dosing exposure to traumatic material so that it remains within the patient's window of tolerance [55]. The IFS approach to working with Exiles is particularly valuable in this phase: instead of forcing the patient to relive the trauma, a compassionate space is created where the Self can approach the Exiles, listen to them, and facilitate the release of traumatic burdens. Work with resistances becomes central: Steele et al [56] have highlighted that resistance does not hinder therapeutic work but constitutes its essential core, representing a protection against integration experienced as dangerous by the patient's system. Gestalt contributes techniques to complete "unfinished situations" and allow expression of emotions and needs that had been suppressed.

Phase 3: Integration and Rehabilitation. The third phase focuses on personality integration and rehabilitation, with objectives that include strengthening resources, accepting change, building functional relationships, and developing a unified sense of self. In this phase, the different parts that had been isolated begin to collaborate more harmoniously, under the guidance of the Self. Healing can be defined as achieved when the traumatic legacy has been processed and resolved, when the parts have been able to release their burdens, and when the patient can live with greater spontaneity, presence, and connection [57]. Fisher emphasizes that integration does not necessarily mean the disappearance of parts but their transformation and harmonious collaboration. The patient learns to recognize when different parts are activated and can consciously choose how to respond, rather than being dominated by automatic reactions.

Conclusions: Toward an Integrated Model for Transgenerational Trauma

This work has aimed to explore the integration of fundamental and complementary perspectives in understanding and treating trauma: the transgenerational dimension of traumatic transmission, supported by growing - though still partially debated - epigenetic evidence, and therapeutic approaches that offer specific tools to address fragmentation caused by trauma. It has been highlighted how EMDR represents a consolidated and widely validated therapy for emergencies and collective traumas, while Gestalt therapy and the parts model, with their integration, represent a promising and innovative direction that merits further clinical and research development. Epigenetic research over the past fifteen years has provided growing, though still debated, evidence regarding specific mechanisms in humans, evidence that traumatic experiences may leave lasting biological traces potentially transmissible to subsequent generations through modifications in DNA methylation, alterations in histone modifications, and expression of non-coding RNAs [1, 8-12]. Studies on Holocaust survivors, refugees from contemporary wars, and victims of famines have identified epigenetic patterns suggesting transmission to descendants, with possible influences on their vulnerability to stress and psychological disorders.

These biological mechanisms intertwine with psychological and relational transmission processes, creating a complexity that requires sophisticated and multilevel therapeutic approaches. Gestalt therapy, with its focus on contact, bodily awareness, and the here-and-now, Janina Fisher's pioneering work on integrating sensorimotor psychotherapy with the parts model and the theory of structural dissociation, and Richard Schwartz's systemic approach of Internal Family Systems, together offer a powerful and flexible clinical framework for addressing structural dissociation caused by trauma [6, 7, 35, 48-50].

What distinguishes this work is precisely the systematic integration it proposes between these different levels of understanding. While traditionally epigenetic research and clinical practice have remained in separate domains, this paper has sought to build conceptual and practical bridges that allow clinicians to use epigenetic knowledge to inform and enrich their therapeutic work, and researchers to consider how psychotherapeutic healing processes can potentially influence epigenetic markers as well.

Clinical practice that integrates these perspectives recognizes that therapeutic work with traumatized patients requires: in-depth understanding of family history and possi-

ble transgenerational traumas; constant attention to emotional and bodily regulation, using somatic techniques that respect the body's wisdom; deep respect for the patient's timing and resistances, recognizing that defenses have had essential protective functions; active recognition of resources and resilience inherited alongside vulnerabilities, avoiding exclusively pathologizing narratives of family history [27-30].

The integrated approach proposed in this work also offers grounds for hope. It is important to recognize that the transgenerational transmission of trauma is not an inevitable destiny. Research has documented that environmental interventions, adequate therapeutic support, cultural and spiritual reconnection, and the creation of more complete and compassionate narratives of family history can mitigate and potentially reverse some of the transgenerational effects [29, 30]. Particularly promising is emerging research on epigenetic markers of resilience, which suggests that, along with vulnerabilities, adaptive capacities and strength can also be transmitted.

Work with parts, both in Fisher's approach and in IFS, offers concrete tools to transform inherited traumatic patterns. When a patient can recognize that some of their parts carry not only their own personal traumas but also those inherited from previous generations, this can facilitate a process of liberation and transformation [7, 52]. The concept of "unburdening" in IFS is particularly powerful in this context: liberating parts from transgenerational burdens means not only healing the individual but potentially interrupting cycles of suffering that have been perpetuated through generations.

Gestalt therapy contributes to this transformation process through its emphasis on authentic contact, bodily awareness, and completion of unfinished situations [31-33, 37]. Gestalt work brings into the present what had remained frozen in the past, facilitating integration through direct experience rather than cognitive understanding alone.

From the perspective of future research, longitudinal studies are needed that examine whether and how effective psychotherapeutic interventions can modify epigenetic markers associated with trauma. Some preliminary studies [58-60] suggest that psychotherapy can influence gene expression and DNA methylation patterns, but more systematic research is needed to understand these mechanisms and their clinical implications. Developing assessment tools that integrate the transgenerational dimension into clinical case conceptualization would also be valuable. The systematic use of genograms that include not only life events but also possible transgenerational traumas, attachment patterns through generations, and family resources could significantly enrich diagnostic understanding and treatment planning [27].

From the perspective of clinical training, it is essential that therapists working with trauma receive training not only in specific therapeutic models but also in understanding the biological and transgenerational mechanisms of trauma. This integrated training can help clinicians develop more informed and complete interventions. A particularly promising area for preventive interventions concerns support for traumatized parents in their parenting role. Therapeutic programs that help parents understand how their own traumas might influence the relationship with their children, and that offer tools to interrupt transmission cycles, represent a crucial investment in preventing transgenerational transmission.

In conclusion, the integration proposed in this work between epigenetic understanding of transgenerational transmission and contemporary therapeutic models for trauma offers a rich and promising framework for both clinical practice and future research. It recognizes the profound complexity of trauma, simultaneously biological, psychological, relational, and cultural, and offers multilevel approaches that honor this complexity. Above all, it offers grounds for hope: understanding the mechanisms of transgenerational transmission allows us to develop more effective interventions not only to heal individuals but potentially to interrupt cycles of suffering that have persisted through generations, creating the possibility of new narratives and new futures for generations to come.

Conflict of Interest

The author declares no conflict of interest in relation to this manuscript.

Ethics Approval and Informed Consent

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Editorial

Trauma as a clinical horizon: integrated perspectives for contemporary psychotherapy

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In the contemporary psychotherapeutic landscape, the clinical practice of trauma represents one of the areas in which the epistemological soundness of theoretical models and their ability to engage with other fields of knowledge are most clearly tested. Building on the seminal contributions of van der Kolk [1], Herman [2] and Levine [3], who have restored a central role to the body and the relational dimension in the processing of traumatic experience, clinical research has progressively shifted towards integrated models capable of combining neurobiological, phenomenological and field-based dimensions [4-6].

Within this framework, Gestalt psychotherapy has undergone a significant theoretical renewal, particularly over the last two decades, marked by a shift from an individualistic conception of the self to a relational and field-based perspective [7-9]. This thematic issue aims to provide a comprehensive overview of the current directions in research and clinical practice within Gestalt psychotherapy as it engages with trauma, in dialogue with phenomenology, complex systems theory, neuroscience, ecopsychology, and evidence-based experiential models.

The eight contributions gathered here do not aim to provide a conclusive synthesis, but rather to outline a shared field of inquiry: in what terms is it possible to support the traumatized person whilst safeguarding both the depth of their lived experience and the rigor of the most recent clinical findings?

TRAUMA AS A REORGANIZATION OF THE EXPERIENTIAL FIELD

A common thread runs throughout the issue: the conception of trauma not as a circumscribed event but as a reorganization of the experiential field [10]. The opening article,

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dedicated to a phenomenological-systemic interpretation of traumatic reorganization, highlights how, following trauma, it is not existence itself that changes, but the ways in which it can be lived: points of reference shift and the familiar becomes alien. Therapeutic intervention then recalibrates safety thresholds, rhythm, and possibilities for contact, alternating between participatory presence and experiential proposals.

This perspective is further developed in the second contribution, which broadens the focus to the ecological-relational field. In a historical context marked by environmental crisis and the progressive impoverishment of living environments [11, 12], complex trauma can be understood not only as a response to a critical event, but as the outcome of a systemic fragilization of the organism-environment field. The integration of the Gestalt perspective and ecopsychology thus opens up a clinical approach that recognizes natural environments as regulatory contexts capable of supporting sensory orientation, physiological stabilization, and experiential integration.

MORAL DIMENSION, CORPOREALITY, AND FIELD PROCESSES

The third contribution introduces a category of particular clinical and ethical relevance: the moralization of trauma. Shame, self-blame, and victim-blaming are analyzed not as isolated reactions but as field processes articulated across the subjective, relational, institutional, and socio-cultural dimensions [13-15]. Recognizing these dynamics is fundamental, particularly in clinical work with victims of interpersonal violence, where suspending moral judgment is a prerequisite for re-establishing contact and reopening spaces for agency.

On the subject of embodiment, the fourth and fifth contributions explore the bodily dimension of trauma. The dialogue between Gestalt phenomenology and psychoneuroendocrinoimmunology [16, 17] leads to the concept of the crystallization of the organismic field, understood as a bridge between lived experience and biological processes, including epigenetic modifications and chronic postural and fascial aspects.

The systematic review dedicated to Body-Oriented Gestalt Trauma Therapy analyses the empirical evidence for somatic approaches — ranging from Somatic Experiencing [18]; from sensorimotor psychotherapy [19] to dance movement therapy — identifying polyvagal mechanisms [4] and the development of interoceptive awareness [20] as the foundations of clinically grounded bottom-up processing.

CHILDHOOD, THERAPEUTIC SAFETY, AND TRANSGENERATIONAL TRANSMISSION

The sixth contribution focuses on childhood, illustrating, through a clinical case study, how the integration of a humanistic-existential approach, Gestalt Play Therapy [21, 22], transactional analysis, the cognitive-behavioral model and attachment theory [23] enables the construction of flexible therapeutic pathways that respect the child's self-regulatory potential and the essential relational dimension in clinical work with this age group.

The seventh article addresses the prevention of retraumatization [24], an often-overlooked topic. The identification of six specific areas of clinical expertise for trauma-oriented Gestalt work demonstrates that a focus on patient safety does not limit the depth of the therapeutic process but rather constitutes a prerequisite for it.

The volume concludes with a chapter dedicated to the transgenerational transmission of trauma. It proposes an integration of epigenetic evidence [17, 25] with models based on structural dissociation — in particular Janina Fisher's Parts Model [26] and Richard Schwartz's Internal Family Systems [27] — placed in dialogue with Gestalt psychotherapy and EMDR [28].

The result is a theoretical and clinical framework that recognizes the multi-level nature of trauma, acknowledging its biological, psychological, and relational complexity.

TOWARDS A GESTALT IN DIALOGUE

The contributions reveal a form of trauma psychotherapy which, whilst retaining Gestalt's phenomenological roots, places them in close dialogue with neuroscience, epigenetic research, polyvagal theory, and evidence-based experiential models. A Gestalt approach thus takes shape, one that is open to being challenged and transformed without abandoning its fundamental tenets: the primacy of contact, the centrality of the

here-and-now, embodied awareness, and the relational and field-based conception of the therapeutic process [29, 30].

We trust that the reader will draw from these pages not only conceptual and clinical tools, but also – and perhaps above all – those questions that every authentic therapeutic practice is called upon to reformulate in the face of another's suffering.

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