Gestalt Therapy Perspective on Panic Attacks

by Gianni Francesetti

This chapter was published in a book "Gestalt Therapy in Clinical Practice. From Psychopathology to the Aesthetics of Contact" (Francesetti, Gecele, Roubal, 2013)

Panic Disorder is on the rise, and presents a particular challenge to the psychotherapist for various reasons. Firstly, it manifests itself through physical symptoms which do not initially appear to be connected with psychological or existential problems. Secondly, it can drastically affect the life of the patient, preventing him or her from fulfilling responsibilities to family and society. Then, it strikes in moments when the therapist cannot be present or support the patient. Finally, it constitutes an acute loss of autonomy for individuals who are often fiercely independent. In the present chapter, I intend to present a reading of panic disorder from the theoretical and clinical perspective of Gestalt therapy. For further reading, please see the phenomenological and clinical observations already published in Francesetti (2007). According to DSM IV, a panic attack is a precise period of intense fear or discomfort, accompanied by specific somatic or cognitive symptoms[1]. The attack begins suddenly, reaches its climax rapidly, and is often accompanied by a sense of impending doom or catastrophe and a sense of urgent need to distance oneself. Panic attacks can occur in various situations, but Panic Disorder is only diagnosed when, at least in the early stages of the condition, attacks occur unexpectedly.

[1] At least four of the following symptoms should present themselves: palpitations, pounding heart or accelerated heart rate, sweating, trembling or shaking, sensations of shortness of breath or smothering, feeling of choking, chest pain or discomfort, nausea or abdominal distress, feeling dizzy, unsteady, lightheaded or faint, derealization (feelings of unreality) or depersonalization (being detached from oneself), fear of losing control or going mad, fear of dying, paresthesias (numbness or tingling sensations) (APA, 2000).

1. Panic Attacks and the Figure/Ground Dynamic

The differences between anxiety and panic attacks are not only quantitative but also qualitative, and their recognition can further our understanding not only of panic disorder but also of its treatment. In contrast to more generalised states of anxiety, panic attacks strike suddenly, catching patients unawares. When a panic attack occurs, the patient's habitual psycho-physical and emotional landscape is abruptly and alarmingly turned on its head. Panic attacks are perceived as episodes of discontinuity within the normal continuum of experience, as can be precisely delimited temporally. Patients' accounts of panic attacks typically follow a standard format: "I was going about my normal business… when suddenly catastrophe struck…"[2]. They all share a common rhythm, whereby the normal continuum of experience undergoes an abrupt and violent fracture. What essentially happens, and what is unique to panic attacks, is a sudden falling away from beneath our feet of the "ground" upon which we assume we can "go about the normal business" of our lives. A panic attack consists in the sudden collapse of all that which sustains us, of that which is common, taken for granted, familiar, unproblematic and non-reflexive – in a word, of the ground. This ground is made up of the id and personality functions of the self (Spagnuolo Lobb, 2001a; 2001b). If every individual experience is to be understood as a figure emerging against a ground, during a panic attack the ground shatters and the figure disintegrates. A figure, as a creative synthesis of the self, can only form if a set of contacts make up and maintain the ground for long enough for the contact sequence to be completed as excitement grows until the organism withdraws. After the first panic attack, patients begin to lose faith in contacts which they usually take for granted: *"Can I trust in my body? In my sense of direction? In gravity? In the people around me? In the brakes of my car?".* The fear of further panic attacks sets in, and patients seek to steer clear of the situations in which previous attacks took place. After the first panic attack, the patient's fear of the ground subsiding means that the acquired and taken for granted contacts which normally form the ground become figure: "*Am I breathing properly? Can I see all my points of reference? Are there any familiar faces around? Will my legs still be able to carry me? Will my heart keep beating? Am I reasoning properly? Will I be able to find my way home?".* «The real world exists only in the constantly

[2] For example: "I was driving to work and stopped to queue at a traffic light. Everything seemed normal, when I was suddenly struck by a terrible sense of anxiety. I felt bottled-up, imprisoned. I had a sudden hot flush which seemed to grab me by the throat. I felt like I was suffocating and was terrified that I was going to die". Similarly: "I was chatting away quite happily with some friends when something suddenly clicked inside me and I felt locked outside the situation, as if I was experiencing it from the outside looking in. I felt lost, vertiginous and terrified".

renewed assumption of the constitutional continuity of experience» (Husserl quoted in Binswanger, 1960, p. 22 it. trans. 2006). The momentary collapse of this "constantly renewed assumption" is the key factor in panic attacks. It is immediately restored, but the abyss which has momentarily opened up is so terrible that the fear of its return blights the patient's life. «The patient undergoes an authentic and terrifying experience of being thrown out into the world unprotected (of what Heidegger calls *Geworfenheit*)» (Salonia, 2007)[3].

2. Panic Disorder and Contact Interruption

The reduction of presence through contact interruption is a key factor in the Gestalt reading of psychopathology. The habitual form of contact interruption comes to represent not only a limit to personal growth but also the very ground which supports the patient. If this form of contact interruption suddenly becomes impossible, therefore, the patient is all at once bereft of a fundamental part of the ground which generates his or her normal, safe and (neurotically) stereotypical way of getting through everyday experience. This is exactly what happens when a panic attack strikes: panic attacks occur when the habitual modalities of contact interruption are suddenly found to be lacking and when there is insufficient support in the field. Panic, therefore, is also a form of laceration, an opening out towards a new kind of contact with the environment which can not yet be sustained because the exposure to that which is new is too much for the individual to deal with, rubs too much salt into the wound of his or her personal history. From another point of view, then, we can see the fissure which opens up during a panic attack as an escape route from the stereotypical world in which the patient is living. As such, it necessitates a new form of creative adjustment.

Of the various modalities of contact interruption, we will here limit ourselves to describing one example of a patient who tended towards the retroflective style. Rossella is a 24 year old, only child, who has been suffering from panic attacks for about six months. She is a physiotherapist, who left her family home about a year ago for work reasons, but travels back to see her parents at weekends. She has been in a steady relationship for five years. "*My life's going absolutely fine. I don't understand why this terrible thing has happened to me, why it's turning everything upside down. Now I'm suddenly afraid to sleep alone, to drive on the motorway. I wouldn't even dream of going out of town to follow a course".* What strikes Rossella most of all is the

[3] As in psychotic disorders, panic attacks are experiences without ground, but in this case there is a temporary collapse of a consistent ground, while in psychosis there is a permanent lack or fragility of the ground.

change in herself: *"I've always been really independent. I remember how, as a child, the night before we had to go away on a school trip, all my schoolmates would be crying whereas I'd be absolutely fine… I'd be the one comforting them. I've always managed everything by myself, but now I suddenly need my boyfriend to hold my hand before I can go anywhere. It's unbelievable!".* Rossella had her first attack when, home alone, she began to feel unwell. *"In fact it was nothing,"* she recalls, *"but if it had turned out to be something serious, what would I have done? I didn't think of it at the time, but it started to worry me afterwards. At the time, I just felt my heartbeat going crazy and thought I was dying".* From the work go, our sessions reveal that Rossella is living against a rapidly changing, evolving and traumatic existential ground. Just before her first attack, she had left her family home, changed jobs and been involved in a serious road accident in which one of her best friends, of whom she subsequently took care, had risked losing her life. Yet this situation alone does not explain the onset of panic disorder. The key factor in Rossella's story is that her independent personal growth cannot proceed in accordance with the model of self-sufficiency which she had learnt from her family. *"I now realise that in my family it has never been possible for me to give expression to my own pain and anxiety. My mother would have panicked and my father would have ended up comforting her instead of me. I've never talked about my problems. I've always been a perfect daughter. Even now, they don't know anything about my panic attacks or my therapy. The relationship Marco (my boyfriend) and I have built up together is great because we're both really free and independent, but I'm coming to realise that I often feel lonely".*

In Rossella's life the possibility of needing someone else and of exposing her own fragility led to a crisis of the retroflective contact modality. Rossella had learnt to suppress her own needs, since her environment was unresponsive to them. She had founded her own sense of security on her ability to control her environment. Her crisis stemmed from an experience which revealed the uncontrollable nature of her own body which, as a consequence of her retroflective tendencies, had come to represent an external environment: "*And if I were ill? What would happen? How would I cope on my own?".* Rossella at this moment undergoes a terrifying realisation of her own frailty and need for others. At the point where control and self-sufficiency cease to be possible, she enters into a new and uncertain terrain, where she may find herself in need of the support of others. This is the terrain of which Rossella has always been taught to steer clear. Yet now she finds herself thrust here, she must find new techniques which will enable her to traverse this new territory: new ways of being with her own needs in the company of others, new ways of belonging which do not centre on self-sufficiency alone. It will be a therapeutic experience for Rossella to feel whole, even when she is feeling needy and

small, without being abandoned, rejected or humiliated Rossella will gradually come to restructure her personal relationships, learning to incorporate into them her own vulnerability and to accept support when she needs it. Her experience of panic attacks has taught her that there can be no autonomy without belonging, no liberty without interpersonal ties.

3. From *Oikos* to *Polis*: Panic Attacks and the Life Phases

From an epidemiological point of view, the peak period for individuals to have their first panic attack is between late adolescence and the age of thirty-five (APA, 2000). Nowadays, this is the period of the life cycle during which subjects normally break away from their birth families and acquire an increased level of independence. At present, this transition is more precarious than ever, since both the individual's roots in his or her own family and the new networks of relationships he or she is seeking to establish, are increasingly uncertain and tenuous. For this separation to take place, the birth family needs to constitute a ground which is at once stable and flexible. The new environment, "outside" the birth family, should offer points of reference to which the individual can relate. There should be new, consistent and open networks of belonging, which the subject can identify with or differentiate him or herself from. The passage from "*oikos*" (from the Greek: a space belonging to the few, to the home, to intimate friendship) to "*polis*"(from the Greek: a space belonging to the many, to the city, opening out into the world) would seem to be a key factor in the onset of panic disorder. This crucial passage involves a profound restructuring of the subject's affiliations and ground, exposing him or her to solitude and vulnerability. The new context in which the subject finds him or herself makes new and unprecedented demands, which the modalities of contact interruption learnt in the *oikos* may be insufficient to meet. Belonging is a significant element in the "ground" in which the individual puts down his or her roots, which provides sustenance and security at the most basic, fundamental level (Perls, Hefferline and Goodman, 1994). When the subject breaks away from his or her family, this ground has to be broken down and re-constructed. Its instability exposes the organism to the risk of its sudden collapse, and this leads to panic attacks. Patients suffering from panic attacks are suspended between past networks of belonging, which no longer offer any support, and future belongings which have yet to become supportive.

The post-modern difficulty in finding support in the polis is therefore particularly connected to and particularly evident during those stages of life during which individuals are in the process of abandoning their existing networks of belonging and increasing their autonomy. It appears likely that panic attacks strike at the very moment when the subject's autonomy increases

in disproportion to the support provided by his or her networks of belonging or, to put it otherwise, when the individual's movement away from the *oikos* receives insufficient support from the *polis*.

This significant alteration to the subject's networks of belonging usually take place for one of two reasons: they may either result from a loss which is independent of the subject's intentionality, or the subject may grow apart from his or her acquired networks of belonging. In the first of these two cases, it may result from a dramatic change of context (in the case of one patient, moving to another region) or from the loss of a significant affective connection (for one patient, the loss of a parent; for another, the end of a relationship). In the second case, panic attacks are a symptom of a rapid (indeed, over-rapid) evolution underway. The patient may be thrown in the face of a sudden loss of autonomy at exactly the moment when he or she was striking out for a greater degree of autonomy: "*What's happening to me? I thought I was making all the right decisions, but now all at once I feel terrible. I'm walking on egg-shells and it's terrifying".* Indeed, the onset of panic disorder very often brings with it a sudden loss of independence which the patient may see as a frustrating "regression". "*It's as if something suddenly snapped and made me regress. I can no longer do things which I used to take for granted"*. The apparent contradiction between the pull of autonomy and the need implied in seeking therapy may also be a source of confusion. We often come across introjections (typical of what Lasch (1978) describes as the "Narcissistic society" who strive for self-sufficiency): *"You've got to make it on your own", "The most important thing is to be well in yourself", "You mustn't count on anyone else".*

At this stage, it is important that the therapist remembers that our aim in helping these patients to become more autonomous is not that they become absolutely independent[4]. Instead, we wish to help them find a way to deconstruct existing networks of belonging in order to build up new ones. To push a patient towards autonomy prematurely (e.g. by encouraging them to move around unaccompanied) is to collaborate with a narcissistic trait which often exacerbates their problems. Whilst for the patient, the figure is his/her loss of autonomy and efforts to regain it, the therapist's figure should be the fragility of the patient's networks of belongings (i.e. his/her ground). While the patient may worry about the new affiliation s/he is developing with the therapist, the therapist, who sees the ground as well as the figure, can be confident that autonomy will result spontaneously from the construction of a healthy, consistent and flexible form of belonging. Autonomy feeds on belonging. The two should not be seen as being in any way opposed. Indeed, where autonomy is the figure, belonging is the ground. When dealing with patients suffering from panic attacks, it is therefore important to work on the

[4] From Latin, *ab-solutus* means untied from every bond and reference point.

dismantling and reconstruction of their networks of belonging before pushing them towards independence[5].

This consideration of the movement towards autonomy brings us to one of the key issues in patients suffering from panic attacks: solitude. The fragmentation of networks of belonging, the process of differentiation and leaving the *oikos*, all leave the individual at risk of a solitude which is not only painful but also unsustainable and terrifying. A brief clinical example may prove useful at this juncture. At a certain point in the course of her therapy, a patient called Clara began to suffer from an intense sense of anxiety and ill-being which only struck in the evenings and which sometimes led into a full-scale panic attack during which Clara was afraid she was about to die of a heart attack. In a moment of profound insight, Clara captured the central feature of this new disorder: *"I'm terrified of dying… No, that's not it… In fact, I think what I'm really terrified of is dying alone".* Clara's therapy was now geared towards dealing with her fear of death on two fronts. Firstly, she was afraid of losing people dear to her. In particular, she was very much surprised to realise that she was suffering as a result of her fear of losing her parents. This anxiety was a sign of a new elaboration of her sense of belonging to her family. Secondly, she discovered that her panic in the evenings was linked to a sense of distance from her husband, in a period of solitude and little intimacy between the couple. *"I'm not afraid of suffering a stroke at work, even if the idea comes to mind or I deliberately try to think of it. I'm scared of dying in my bedroom"*. She gradually realised that her fear was transforming itself: *"I'm increasingly less afraid that I have heart disease. Instead, I feel as if my heart is swollen from crying"*. Clara made a further important breakthrough in reaching an acute and overwhelming awareness of the solitude in which she had spent her life. At this point Clara was able to sense and articulate her fear: *"I'm so alone I'm going to die".* From this point on the fear of death was replaced as figure by the pain of solitude, and a figure thus emerged which we were able to access and elaborate upon in the course of the therapeutic relationship. Her fear was incomprehensible, devoid of history and reason, suspended like a figure with no ground. Her pain, instead, was rooted in the experiences which she was gradually recalling. Solitude and isolation are often the ground against which the fear of dying emerges so devastatingly during panic attacks. Marco, another patient suffering from panic disorder, hit the nail

[5] In another historical context the required specific support might be very different. For example, in a context characterised by secure, clear and rigid networks of belonging, it might be more important to sustain the deconstruction of affiliations and to encourage autonomy right from the beginning, without worrying about sustaining the ground of present and future belonging networks. The spirit of the "new" schools of psychotherapy in the 1950s, with their strong emphasis on the independence and self-sufficiency of the subject, can be understood from this point of view (Salonia, 1999; Francesetti, 2007).

right on the head with the following illuminating synthesis: *"A panic attack is basically an attack of acute loneliness"*.

4. Specific Support: Building up the Ground

Therapy for patients suffering from panic disorder can be divided into four distinct stages, which mark four significant moments of therapeutic passage for the patient:

1. From physical symptom to fear: the patient becomes aware that the panic attack does not represent any genuine risk of madness or death, but comes to fear the attacks in themselves;
2. From fear to solitude: solitude emerges as ground and fear is replaced by pain;
3. From solitude to belonging: the reconstruction of networks of belonging (above all through the therapeutic relationship) helps the patient to lay down new roots;
4. From belonging to separation: the patient learns to carry his/her ties of belonging within him/herself and to function separately without being alone.

These four stages do not necessarily occur in a rigid sequence. They should rather be seen as a set of recurrent and interlacing thematic strands, such as we would expect to emerge during any growth process. Let us now therefore focus our attention on some important points which the therapist should keep in mind when dealing with patients suffering from this disorder.

4.1. The Therapist's Ground

In order to cope with the impact of panic disorder, the therapist must be able to maintain his or her calm, feeling him or herself to be supported by a ground which makes it possible to deal with a relationship so strongly characterised by anxiety and the lack of support. On the one hand, he or she must be able to rely on the support provided by his or her own breathing, from the body's rootedness and comfort (we might say that, for a certain period of the therapeutic relationship, at least, the therapist has to breathe for both him/herself and for the patient). On the other, s/he must have faith in his/her own knowledge of the phenomenon and in his/her own skills and therapeutic experience. The first of these forms of support derives from the id function of the self, the second from the personality function. It is also important that the therapist receives supervision and support from a third party (Francesetti and Gecele, 2009). Another telling point, to which significant attention is rarely

paid, is that the therapist is participating in the same field as his or her patient (i.e. is in the same world during the same historical period). The therapist too encounters fragmentation, uncertainty and fear, sharing some of the patient's difficulties in building up a secure ground and secure networks of belonging. It is important for the therapist to be aware of the problematic nature of his or her own ground, firstly because this awareness enables him or her to "meet" the patient on common ground and, secondly, because it aids him or her in seeking out contextual support and relational networks which will help him or her to put down stable roots and deal with uncertainty.

4.2. Words as Ground

Patients suffering from panic attacks experience a sense of acute disorientation as a consequence of the apparently incomprehensible nature of what is happening to them. Therefore, they need support in applying a verbal definition to their experience. Sometimes, patients refer to their own symptoms as "panic attacks" right from the word go. In these cases, it is important not to automatically accept this label. The patient's hasty self-diagnosis reflects his or her need to escape from the anxiety which stems from that which is unknown and indefinite. The specific support provided by the therapeutic relationship in contexts such as these consists in dwelling on and "chewing over" the indefinite, elaborating on it together in order to reach a shared understanding based on the description and the phenomenology of the experience. Otherwise, there is a risk that the patient will once again remain isolated in the process of recognising and defining his or her own experience.

4.3. History as Ground: Recovering the Continuum of Experience

Every panic attack has a "before" and an "after," which often come to be omitted from patients' accounts because the intensity of the attack itself has dwarfed everything else. Recovering this sequence enables the patient, on one hand, to delimit and confine the experience temporally and, on the other, to recover the continuum within which this experience, often perceived as a schism, as something "other", is actually situated. Thanks to this preliminary work, which is sometimes slow and difficult, the causes which trigger the episodes gradually emerge. This, in turn, builds up the patient's faith that the panic attack is not a completely unpredictable flash of lightening against a clear sky. It comes rather to be seen as the result of experiential circumstances which formulate a pathway to panic. The recovery of the patient's awareness of

the other emotions which accompanied the terror of panic is an important step forward. The emotions will be perceived more clearly as this awareness becomes more sustainable. Often, indeed, terror is accompanied by pain, but this latter emotion will only emerge when the therapeutic relationship is mature enough to sustain the patient's anxiety and support him or her solitude.

4.4. History as Ground: Recovering the Sense of Terror

The panic experience which the patient brings with him/her into therapy is an incomprehensible event with no background. When the therapist begins to understand the patient's personal history and to meaningfully locate the disorder within that context, he or she will identify the direction in which the therapeutic process should tend and build up a ground of perceptible support for the therapeutic relationship.

The life phase of the patient and his/her changing networks of belonging provide us with a precious key for reading the symptoms in connection with the patient's life. We can thus gradually locate panic within the subject's biography, so that it becomes a figure which emerges naturally, even obviously, from his or her life experiences. A turning point in therapy is when the patient exclaims, "Now I understand that it isn't so strange that I'm suffering from panic attacks!". At this moment, panic is no longer a suspended figure, without meaning. It is instead recognised as an expression of the individual's personal history and life experience. The patient will now finally be able to recognise the symptoms of panic as representing an expression of ill-being in his/her own life, as opposed to a crisis of physical health.

4.5. The Functions of the Self: the Id and Personality Functions as Ground

Panic attacks result in the partial loss of the support provided by these two functions of the self. Part of the therapist's job consists in restoring this form of support and helping the patient to become aware of it. Panic disorder often leads to the onset of a corporeal numbness and a loss of fluidity in bodily gestures and rhythms. Sometimes the body seems to be suspended in space or trapped instead of resting on a chair. The resulting impression is that the organism feels unable to rely on any resting place, that the body is braced against the sudden collapse of its support and therefore stands guard, cautious and vigilant.

It is necessary to pay particular attention to the patient's breathing, as this is one of the fundamental bases of the organism's self-support. The breathing of patients suffering from panic attacks is lacking in fluidity, continuity, rhythm and harmony. Specific support in such cases should consist in helping the patient to achieve awareness of the way in which he or she interrupts the spontaneous flow of breathing, of feeling, and ultimately of the emotions which accompany this interruption. The therapist, especially in the first stages of therapy, has to help the patient to manage the crisis, teaching her/him how to deal with the acute anxiety. Two techniques can be helpful: first, the patient can learn how to relax when s/he is out of the psychotherapeutic room: how to breath, to maintain the grounding, to relax muscles, etc. Secondly, the therapist can suggest that the patient keep a little notebook where s/he writes all phenomena when the anxiety grows: this not only supports the patient in maintaining the connection with her/his therapist but also offers a distraction from, and therefore an interruption, in the process of increasing anxiety. Reading these notes together in the successive session offers much support to the patient and information to the therapist. In this way, the therapist takes some responsibility in the process of dealing with anxiety and this leaves the patient feeling less alone when s/he is not with her/him.

Coming now to the personality function of the self, specific support should here consist in sustaining the assimilation of experiences, and especially of those experiences which are connected to belonging and losses. In this way, the patient's life story gradually acquires meaning and continuity. It becomes a narrative which belongs, at a deep level, to the subject, a story which comes to be revitalised and inhabited. During the life phase's most crucial moments of transition, the subject's notion of "who I am" undergoes some major restructuring, moving between "who I was", "who I'm becoming" and "who I will be".

4.6. The "Next" as Ground: the Unfolding of Intentionality

The ground is made up not only of the past, but also of the future. As a perceived horizon, the future, too, provides roots and supports. The figure created in the present acquires direction not only from moving in response to stimuli and needs, but also by moving towards the creation of a form or shape – a *Gestalt*. The "next" is the point towards which the organism's intentionality moves. The unfolding of intentionality and new projects forms part of the ground in the present, to which imagination, prediction, hope, desire, expectation, possibility and dreams all contribute. The subject's personal horizon emerges as a figure against the ground formed by the perception of the

future which is shared on a social level. Representations of the future have taken on previously unheard-of contours over the last decades. As several authors have noted, we have passed from a vision of "future-promise" to one of a "future-threat" (Benasayag and Schmidt, 2006). Once again, we come up against the sum of two kinds of vulnerability: in his/her uncertainty as to the horizons of his/her own biography, characteristic of certain stages of life, the subject is afforded no support by the profound and disturbing collective scenarios prevalent at a social level. Panic can indeed be overcome, in part, through a construction or reconstruction of the future horizon and, in particular, of the future plans and networks of belonging towards which the individual is moving and which have yet to be defined, acquired or consolidated.

5. Therapeutic Belonging

The cultivation of therapeutic belonging is crucial to the treatment of panic disorder. Indeed, if we bear in mind that, as we have observed, panic disorder is the expression of an inconsistency in networks of belonging and, thus, of an insupportable solitude which is gradually revealing itself, it grows clear that an authentically and emotionally therapeutic relationship should constitute a specific remedy for this condition. Patients suffering from panic attacks undergo significant improvements if they feel that they are able to, in some sense, *keep the therapist with them*, between sessions. In order for this to happen, the patient needs to experience contact with the therapist and to assimilate this novelty. There are no short-cuts here. It would be useless (indeed, it would be downright foolish) to dilate the boundaries of therapy, passing beyond its limits. Neither is it possible to keep a safe distance without getting personally and authentically involved. It is necessary, instead, to respect, support and get across the protective mechanisms which the patient has built up in the course of his/her lifetime (modalities of contact interruption), which impede him or her from risking a new involvement. Notwithstanding this, such considerations should be particularly present when dealing with patients suffering from panic attacks: *"How do we two belong to each other? Will you take me with you? What impedes you from doing this? In what way is this place present from one meeting to another? How do you lose me? What are your feelings for me? Do you think that you disappear to me when you walk out of the door? Do I disappear to you?".* Where there was panic, therapeutic belonging will gradually emerge, weaving together a network strong enough to provide a persistent ground upon which the patient's experiences can be founded. At this point, separation should become possible.

The patient will find him/herself able to sustain presence in absence, to be alone without feeling alone.

Comment

by Nancy Amendt-Lyon

With clarity and profundity, Francesetti presents a concise description of the genesis, onset and manifestation of panic disorders according to Gestalt therapy theory. His description of four "significant moments of passage" which may occur during the therapeutic process as well as the specific supports that the practitioner must keep in mind when dealing with a patient suffering from panic disorders offer excellent orientation in this difficult field. The case vignettes chosen to bridge theory and practice are succinct and afford the reader insights into the course of the disorder.

Francesetti's contribution to Gestalt therapy theory is to be highly commended and I indeed support his perspective. Nonetheless, this review intends to initiate a discourse by highlighting and questioning certain aspects and by revisiting sections of Francesetti's chapter that were not perfectly clear to me.

In the section entitled "Panic Disorder and Contact Interruption", the author emphasizes an important supposed contradiction: «The reduction of presence through contact interruption is a key factor in the Gestalt reading of psychopathology. The habitual form of contact comes to represent not only a limit to personal growth, but also the very ground which supports the patient». Francesetti speaks of contact interruptions whereas I would prefer the term contact styles, describing the specific patterns which human beings tend to create in dealing with the exigencies of their life. Although a person's contact style reduces his or her presence, i.e. limits personal growth, this individual, habitual way of behaving with others and dealing with life's demands has become part of the very foundation which enables contact. When the individual's habitual modalities are suddenly insufficient and the field fails to provide adequate support, panic attacks ensue. This perspective is convincing, yet when Francesetti writes that a young female patient is «living against a rapidly changing, evolving and traumatic existential ground», I am unsure what "living against" implies. I wonder if she is struggling to keep up with the tempo of a world that is too hurried for her, feeling out of synch, or is she reluctant to accept certain contents of her surroundings. My tendency is to focus on the developmental crisis in the patient's life, and how she appears to very suddenly find her habitual patterns of retroflecting needs and feelings to

be inadequate and inhibiting. Her new life situation virtually forces her to realize that she has outgrown the style that suited her as a child and adolescent. The developmental crisis of a young adult leaving home to live somewhere else for the first time differs markedly from the developmental crisis that, for example, a recently widowed elderly man faces when he picks up the pieces of his life without his spouse, or a single, middle-aged woman in a demanding managerial position during times of financial duress, even if, phenomenologically speaking, they exhibit very similar symptoms.

The section entitled "From Oikos to Polis: Panic Attacks and the Life Cycle" clarifies many questions referring to developmental issues, the life cycle, and the onset of panic disorders. My concern here is that several crucial aspects of the transition from Oikos to Polis have not been thoroughly addressed, possibly because this would have gone beyond the scope of a book chapter. Reference to gender differences would have enhanced the reader's understanding of the manifold influences on the genesis, manifestation and course of this disorder. Similarly, exploring the ways that various social strata and the ethnic and religious affiliations affect panic disorders would make for fascinating future research.

Francesetti's tenet that there can be no autonomy without belonging emphasizes field theoretical, relational aspects of modern Gestalt therapy. Despite the fact that Perls, Hefferline and Goodman (1951) equated the definition of the organism with the definition of an organism/environment field, what remains in most readers' minds is Fritz Perls' dictum about moving from social support to self-support as a goal in life. Subsequent generations of Gestalt therapists introjected this aim of autarky, often taken to the point of being extremely narcissistic and self-referential, while relationships fell by the wayside. I fully embrace Francesetti's view that contemporary Gestalt therapy neither considers autonomy and belonging to be a matter of separate states of being, nor does it prefer one state to another. The concept of contact and support that Laura Perls so gracefully taught helped me to realize that the relationship, connectedness and mutuality enable growth, that the most solid psychotherapeutic work is done in small, experimental steps that can be well assimilated, and that the field must always be taken into consideration.

The section entitled "The functions of the self: the id functions and personality functions as ground" was quite illustrative in describing the id functions. To enhance the personality function of the self, I followed Francesetti's suggestion and asked a patient suffering from panic attacks to carry a notebook with her and describe situations that either enhanced or diminished feelings of panic. After many months of note-taking, she told me that she also drew little self-portraits when she jotted down what enhanced or

diminished her feelings of panic. This process resulted in what we named her "illustrated panic autobiography".

In his final section, entitled "Therapeutic belonging", Francesetti zeroes in on making the therapeutic relationship and the issue of belonging therein explicit. He does this with admirable authenticity and grace. Theoretically, he convinces me that separation should become possible if belonging has been experienced and there remains a noticeable connection with the other despite his or her absence. Once again I felt that a case example would have been illustrative here, since many therapists have been faced with the difficult situations in which it is a struggle to establish appropriate boundaries. As Gestalt practitioners know from experience, there will be patients who either despair at not presently being able to establish a sense of belonging with others outside the therapeutic context or who tend to misread the growing therapeutic contact to be an offer of "real" contact, relationship or partnership with the therapist beyond the therapeutic setting. The latter was the case with a young woman with whom I worked for about three years. About six months after we terminated psychotherapy, she called to inform me that she was doing well and carefully asked if we could meet for coffee, just to chat. Beyond informing her of the formal regulation that prohibits any social contact with former patients for at least several years, I attempted to pick up the thread of our therapeutic bond. I told her that I often thought of her and was glad that she let me know how she is, because a therapeutic relationship is such an intimate one and once it has been terminated, we therapists are left to our own imagination about our former patients. In this way I tried to convey that despite the affection that I developed for her, my social life does not voluntarily include contact with patients. This "personal space" is necessary for me to work professionally.