The Field Perspective in Clinical Practice:

Towards a Theory of Therapeutic Phronēsis

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Introduction

The concept of field has been used in psychotherapy in a variety of ways by different authors, but also in a variety of ways by the same authors at different times. Without clarifying the meaning of the term, the risk is of creating a Babylonian confusion in which it is often unclear what we are talking about (Staemmler, 2005). The aim of this chapter is not to propose a universal definition of the concept, but to offer -

taking into consideration the complexity of the matter - a theoretical framework that is sufficiently clear and to illustrate its consequences for clinical practice.

In the previous edition of this book (Brownell, 2008) the chapter on the field perspective in Gestalt therapy was prepared by Gaffney and O'Neill. There the authors described the field concept in all its complexity and highlighted the differences among the main conceptions in use (in particular, Lewin's and Perls, Hefferline & Goodman's)[1], presenting the consequences of the perspective in clinical practice and offering a number of precious examples of therapy. In this chapter, I build on that excellent discussion and on the work of other authors who have developed these concepts (Latner, 1983; Yontef, 1984; Parlett, 1991, 2005; Wheeler, 2000; Cavaleri, 2001, 2003; Yontef, 2002; Kennedy, 2003; Robine, 2004; Jacobs, 2005; Staemmler, 2005; O'Neill, 2008; Wollants, 2008; Jacobs and Hycner, 2009; Bloom, 2011, 2016, 2017; Spagnuolo Lobb, 2013; Day, 2016; Philippson, 2017b). In the background lie other conceptions of field from other models, in particular from psychoanalysis, where the field concept today is attracting growing interest (Stolorow, Brandchaft and Atwood; 1994; Orange, Atwood and Stolorow, 1997; Baranger, 2005; Baranger and Baranger, 2008; Stern, 2010; Neri, 2016; Ferro, 2016), and from other approaches (Tolman, 1959; Pribram, 1971; Combs, 1999).

Here I draw on this literature to propose a phenomenal, phenomenological, and psychopathological field perspective and strategy to underpin a specific conception of human suffering and of therapy in practice. This field perspective does not offer a technique that can be reproduced as a behaviour or a procedure, but proposes an approach to therapy to help steer the therapeutic act as it emerges in the specific situation. Therapeutic effectiveness is based on the here-and-now unfolding of the

[1] See Lewin (1952) and Perls, Hefferline and Goodman (1951).

therapeutic alliance and on intersubjective phenomena rather than on manualized techniques (Duncan, Miller, Wampold and Hubble, 2010; Day, 2016). A field 'strategy' is not *tekhnē* (i.e., the repetition of specific behaviours to achieve a purpose), but rather *phronēsis*[2]: the capacity to steer a path given the potentiality and limitations of the present situation (Orange, Atwood and Stolorow, 1999; Sichera, 2001). The *phronēsis* of this field perspective supports an orientation and an intervention which, although emerging anew in any given situation, unfold along a line of approach that can be identified as specific and as such can be considered for the purposes of research, too. So, the field perspective is not a theory of a technique, but a theory of phronēsis. The view I present builds on the field concept in psychotherapy in general, and not only in Gestalt Therapy, and seeks to develop the concept of the organism/environment field introduced by Perls (1942) and Perls, Hefferline and Goodman (1951). This perspective helps us understand therapy work in a radically relational light.

Common Elements of Field Theories

Different field perspectives are found in psychotherapy, as well as in Gestalt therapy, revealing deep-rooted theoretical differences that underpin clinical practices that can be quite divergent. A common ground from a Gestalt therapy perspective can be described by the five principles of field theory identified by Malcom Parlett (1991, pp. 3-6):

[2] While *tekhnē* is the reproduction of actions to produce an object as identical as possible to a prototype (like a craftsman producing terracotta cups), *phronēsis* is the capacity to act in accordance with the current situation, which is never exactly the same, thus requiring creativity and the capacity to grasp all the significant aspects present. In phronesis lies the artistic nature of therapy.

Organisation

Everything is interconnected and the meaning derives from the total situation. Properties of things are defined by their context of use, by a wider organisation of overall meaning.

Contemporaneity

The constellation of influences in the present field explains present behaviours. No particular special causal status is accorded to events in the past nor a special status as "goals" is accorded to future events, though they are both part of the experiential field in the present. "The psychological past and the psychological future are simultaneous parts of the psychological field at a given time": the interest of the therapist is in how past or future events are part of the present actuality of the present field.

Singularity

Each situation is unique, each set of circumstances and each person is unique. Generalisations are quite unavoidable, but they can lead to *a priori* structuring of reality perceived which can easily lead in turn to finding in the present what one is looking for. Concentrating on similarities can lead one to lose sight of the specificities of the actual situation: we should be able to keep a unique perspective.

Changing Process

The field is in flux, each experience is provisional, we cannot twice have an exactly identical experience (cf. Heraclitus: "No man ever steps in the same river twice"). Nothing is fixed and static in an absolute way; reality unfolds in ways which can never be fully predicted.

Possible Relevance

Everything in the field is part of the total organisation and is potentially meaningful, though it may seem irrelevant. Gestalt therapy is interested in the obvious, in rendering afresh what has become automatic or is being taken for granted or regarded as of no relevance. The range of possible relevance is not restricted to some parts of the total field, we have to be open to the present configuration of the field, without a fixed criterion of what is relevant.

These principles form a horizon on which the various field theories found in psychotherapy and in Gestalt therapy can be situated. They form the basis for a variety of perspectives, one of which is the perspective of the phenomenal field, the phenomenological field, and the psychopathological field, which I present here.

The Phenomenal Field as a *Half Entity*: A Radical Phenomenological Perspective

> *"A particular question eventually becomes unavoidable. Is 'the field' ultimately just a metaphor, a useful derived concept and framework that can be used to explain what is difficult to explain? Or is 'something*

there' in the form of an explicit energy field in the 'space between'?" (Parlett, 2005, p. 60).

The foundational text of Gestalt therapy (Perls, Hefferline and Goodman, 1951) speaks only and specifically of the organism/environment field. Through this concept, the founders rejected the reductionist perspective of viewing the organism without considering its environment to adopt a perspective that takes into account interaction between the two. Interaction is continuous, indispensable, and indissoluble, and underpins the shift from a view centred on the individual to a view centred on the interactions between the organism and environment. All the various Gestalt therapy authors would appear to agree on this, but it is at this point that their perspectives diverge. Some authors (Robine, 2008) hold that at any specific time, everyone has a specific organism/environment field, just as everyone has their own visual field, consisting of the horizon of all that they can see, or their own affective field, consisting of the horizon of all that is relevant to them affectively at that moment. Thus, each person's field is different and dependent on the present situation (and hence different in every situation). Other Gestalt therapy authors have proposed another conception of field, which has been called the 'phenomenological field', which is co-created in the encounter (Cavaleri, 2003; Spagnuolo Lobb, 2013; Francesetti, 2015a). This concept allows us to focus on the *emergent experiential quid* of the encounter, that something which is experienced in the situation.

For a clearer theoretical understanding, and basing myself also on the work of other authors (Crocker, 2009; Bloom, 2009), I believe it is necessary to distinguish between the phenomenal field and the phenomenological field.

The Phenomenal Field[3]

By "phenomenal field" I mean the horizon within which emergent experiential phenomena are generated in the encounter. It can be considered as *the horizon of all possible forms*, constituting the *possibilities* (in this field many different forms of experience can emerge) and *limitations* (in this field not all forms of experience can emerge). It is *a region of space-time in which a force produces an effect* (Maxwell)[4]. The phenomenal field is generated by all that is relevant and extends into space and time *as far as it can produce a difference in experience* – these are its boundaries. It is affected not just by what can be perceived by the five senses, but also by past memories and future expectations. For instance, the presence of a loved one or of a person we fear in the room next door affects our present experience, such as our state of mind while reading a book, even though the senses do not directly perceive anything. The field is not perceived through the differentiated perception of the five senses, but through sensations that are synaesthetic and essentially undifferentiated, with a strong kinaesthetic element that is protopathic rather than epicritic. The perception of clear and defined objects is, in fact, only one way of perceiving and generally the result of the perceptive processes. The flow of time, for example, is certainly felt, although it is not perceived by any specific sensory organ, nor can it be identified with a specific object of perception. Or the sinister atmosphere of the onset of psychosis, which is felt in the air, without being associated with any defined object that can be described. It is grasped through an aesthetic awareness, which is sensorial but not yet related to any sort of

[3] Parts of the following are taken from Francesetti (2015a).

[4] Cf. the concept of magnetic field introduced in the 1840s by Maxwell and Faraday: "the region where a particular condition prevails, especially one in which a force or influence is effective regardless of the presence of a material medium" (*The New Oxford Dictionary of English*, 1998, p. 680).

object constituted in a definite way. The phenomenal field is something that emerges *between* us and *around* us in our encounter. We could also say that the field is *how* Kantian transcendentals manifest themselves, representing at the same time the conditions of possibility and limitation – it is how time, space, boundaries, and the sense and way of being become manifest in the here and now, making certain forms of experience possible and others not (see also Bloom's chapter in this book). For instance, in a depressive field time slows down, and every experiential phenomenon is coloured and shaped by that slow down. This perspective sheds light on psychopathological phenomena not only in the therapy room, but on a much broader social level, as well. Without going into depth on the matter, an example is to think of what happened in Zimbardo's Stanford Prison Experiment (Zimbardo, 2008), where the participants were taken by something that they themselves had co-created, but which was *much powerful than them*, a force present in that space-time which gave shape to their experience and led them to exert a level of violence that none of the participants – outside of that field – would have used, such that Zimbardo was compelled to suspend the experiment.

Although perceived as 'real', a phenomenal field does not exist in the same way *external* objects do. It is not an object. It does not have the physical perceptual characteristics of a chair, for instance. But nor can it be reduced to a mere subjective, *internal* experience. Rather, in some way it is perceived unfolding *between and around* subjects; it engages them, influences them and in turn is influenced by them. Thus we find ourselves dealing with a region of existence that defies a Cartesian and positivistic description of the world based on its reduction to subjects and objects – such a world view does not conceive the existence of phenomenal fields and hence cannot contemplate them. Another philosophical ground is needed to understand experiential phenomena when we regard them as expressions of the field. The phenomenological

tradition (Husserl, 1913; Heidegger, 1953; Merleau-Ponty, 1945; Zahavi, 2015) provides this ground. Some inputs from the New Phenomenology, as theorised by Hermann Schmitz, can also be interesting: in particular he describes a class of entities that exist in this third dimension. For this author, ever since Democritus (5th century BC), Western culture has progressively scotomised and denied this dimension, splitting the external world (of Euclidean geometry) from the internal realm (the intrapsychic) and locating experience within the subject, and objects in the world. The Cartesian method of doubt (Descartes, 1998), which admits only 'clear and distinct ideas' and casts out anything overshadowed by doubt, is a method that systematically eliminates almost-entities from its world view[5]. Such scepticism has sterilised and done away with the 'half-way world', disenchanting the world (Weber, 2004). According to the work of Gernot Bohme on aesthetics (2010; 2017), every perception starts out as an atmosphere[6]. Such atmospheres constitute the perceptive *prius* of every figure of experience. A depressive field actualised in a group, for instance, is palpable and perceptible by the participants as an atmosphere. Someone who walks into the room will feel its presence; she may be contaminated by it, or may react to it, or may notice a discrepancy between the atmosphere encountered and her own frame of mind, if in a good mood. The field exists as an almost-entity, ephemerally present among the participants[7]. In contrast with objects, almost-entities do not perdure continuously in

[5] Cartesian dualism obviously served an evolutionary purpose at a time when casting out all that was shadowy meant casting off the yoke of the Medieval world, paving the way towards the light of reason, the individual, science and technology.

[6] It is important to underline that Bohme's understanding of atmosphere is very different from Schmitz's. For the first author an atmosphere is a perceptive phenomenon in the process of perception itself, for the second the atmospheres exist in the world independently from the subject. Here I am clearly referring to Bohme's conception of atmospheres as perceptive phenomena without any independence from the subjects' presence.

[7] This concept is also significant for our understanding of corporeity. In the Cartesian worldview, the body is reduced to a machine, separate from the world and from the psyche – it is the *Koerper*, as German thinkers have called it, the anatomical-functioning body of medicine

time; they can appear and disappear, continuously changing, and can be seen as the way how we perceive the processes. Secondly, they are surfaceless and are poured out spatially. A chair perdures in time – if my chair is not in the room, it makes sense to ask where it is; and it has clear-cut, geometrical surfaces which I can touch. Phenomenal fields can instead be described as almost-entities. They exist between and around the subject and object and cannot be reduced to either of them; perceptively they come before them. Each of us retains and actualises in different situations psychopathological fields – our own modes of presence of absence. These fields give rise to the specific atmosphere that each of us evokes at a given moment, in an immediate – preverbal and prereflective - way.

Such a perspective restores dignity to emergent phenomena, re-opening the gates to the enchantment[8] of the 'half-way world' – a world that Western society has all but consigned to oblivion (although traces remain in language), squeezing almost-entities into the ranks of external things (*ob-jectus*) or internal experience (*sub-jectus*). But experiential phenomena (implying indivisibly the lived body and the phenomenal field) are almost-entities that constantly vibrate in the *in-between*.

From this point of view, to answer Parlett's question at the beginning of this section, the field is not just a metaphor, but *something* which produces effects and that perceptively exists.

(or the athletic or cosmetic body of the consumer society). The lived body (or felt body) – the *Leib* in German (sharing the same etymological root as *love* and *life*) – is the body that we experience in being alive and in contact with the world (Husserl, 1913; Merleau-Ponty, 1945). The *Koerper* is an object; the *Leib* is an almost-entity. The difference can be understood effectively through a simple experiment. Place your hand near another person without actually touching them; at a certain point you will feel a change in the mutual experience: you are not touching the person's *Koerper* (which ends at the surface of the skin), but their *Leib* (which exists beyond the skin, in the space-time between and around bodies).

[8] Max Weber spoke of positivist science's disenchantment of the world (see Weber, 2004).

The phenomenal field is the *ecstasy* of the present situation, that includes the lived bodies that come into play in the situation. We can also add that the field that is actualised is not static, but changing and tends towards a certain type of contact in the encounter. That tendency is the fruit of the intentionality for contact. What happens tends towards the actualisation of the potentiality for contact, or, in Gestalt therapy terms, the potentiality for encounter with nourishing novelty. Intentionality for contact is a tendency that is rooted in the id and personality functions of the situation and which becomes intention when it is taken up by the ego function of the self. It is the emergence of intercorporeal feeling (id function), which is such given the situation and roles[9] (personality function of the self). The relationship between the field and the subjects is hermeneutically and endlessly circular – we constitute the field in the present situation and the field emerges and constitutes us; it is actualised and gives shape to our experience. Within the range of possibilities for contact, the field that emerges is the unique synthesis of the histories of the client and the therapist, and the situation that brings them together; it is the result of a creative act that actualises the encounter of their histories and evolves with it. Thus the field is a dimension that is neither subjective nor objective, a dimension that is the foundation from where subject and object emerge and become distinguishable. At the root of experience, where the figure/ground dynamic in which experience is generated dawns, the subjective and objective have yet to be distinguished.

To recap, under the perspective that I present, what are the characteristics of a phenomenal field?

Is it subjective or objective? A phenomenal field is the ongoing outcome of the

[9] There cannot be, for example, an intentionality for sexual relationship in the therapeutic encounter, as the therapeutic encounter, by constitution, is not equal.

process of co-creation that is rooted in a dimension that is prior to the definition of the subject, and as such it is a phenomenon that is not only subjective. At any given moment, there are not as many phenomenal fields as there are subjects, but one shared field emerges. That field is perceived subjectively in different ways by each person, and these different perceptions modify the field, therefore neither is it solely objective. In this way, the phenomenal field cannot be reduced to being either subjective or objective alone

Does it have extension and duration? The field is a process that extends across space to the point that it produces a difference in perception, and hence experience, without having clearly surfaces. It endures in time[10] and changes, something which happens continuously in a more or less perceptible way, while still supporting a certain experience. Here we are speaking of lived time and space, as described in the phenomenological tradition, and hence not the chronological time or Euclidean space of an external observer.

Is it material? The phenomenal field is not material, it is not a 'thing'. Nevertheless, its existence is real and perceptible in time and space. It cannot be reduced to or described within the Cartesian dichotomy of the *res cogitans* and the *res extensa*, which carved an abyss between the subjectivity situated *inside* us and objects situated *outside* us. It may be considered an *almost-entity*, i.e., an entity diffuse in space and without temporal persistence, just like music is, for instance, or the climate sensed in a situation. It is not matter, however, but an atmosphere that is felt as emotionally charged and hence able to be situated in the dimension of perception.

How do we perceive it? It can be perceived *aesthetically* through the senses, at

[10] The duration of the present moment, and hence the minimum permanence of the field, is more or less five seconds (Stern, 2004; Tschascher, 2013; 2017).

the sensorial root of experience where the subject and object emerge (but are not yet entirely separated) and the senses work in a synaesthetic way, where perception is undifferentiated and affectively charged (Metzger's *Vorgestalten*, 1941).

What is its relationship with the situation? The situation is the set of conditions (i.e., limitations and potentialities) present here and now which are actualised in the field as experience, taking on form and pulsating life. The phenomenal field is the *ecstasy* of the situation, just as music is the ecstasy of the vibrating strings of a harp; it is the coming out of the potentialities and limitations (i.e., length and tension of the strings) in play in the situation, which actualise the specific perceptive field.

Is it generated or does it generate corporeality? The phenomenal field is generated by the bodies in play in the situation, but at the same time it circularly generates their specific corporeality in the specific situation. It is an example of a hermeneutic circle which cannot be escaped, like Escher's hands, which reciprocally draw each other.

Does it have a direction? Yes, the field is moved and transformed by the intentionalities for contact within the limits and potentiality of the situation itself. It tends to transform towards the *now for next*. The field emerges from the restlessness of intentionalities, it is not at rest but in tendency.

The Phenomenological Field

The phenomenological field is the result of a kind of "phenomenological conversion" (Husserl, 1913), of the capacity to look upon phenomena that emerge with curiosity and seek their sense and intentionality. It requires a shift from the immediate perception/action that emerges as the phenomenal field, and is generated by curiosity

and a feeling of wonder about what is happening (Bloom, 2009). As Eugen Fink (1933), Husserl's collaborator, says, *wonder about the world* is the best definition of the phenomenological attitude. The *phenomenal* field is suffered, in the sense that it seizes us and we are *subject-to* what emerges. It is *pathos (i.e., suffered)* and hence it is the actualisation of what comes into play. The *phenomenological* field is the result of a shift, implying the movement from being *subject-to* to being *subject-of*. It is an enhancement of freedom. It is not a *meta*-position as it is not above or outside the phenomenal field, but at the same time it is a position from which we can take notice, with curiosity and wonder, of what is happening to us, between us and around us. It is an enhancement of freedom while dwelling the phenomenal field, i.e. in the ecstasy of the situation. The therapist puts his corporeality into play to let the potentialities of the encounter emerge and takes an actively curious approach, which enables him to notice what emerges and consider it to be interesting, thereby occupying the in-between (from the Latin, *inter-esse*, *being-in-between*). A clear example that can help distinguish these two perceptual experiences is that of bipolar experience, where the depressive and manic phenomenal fields are very different, even opposite, yet the phenomenological field can be the same, in the sense that the two phenomenal fields are the expression of the same impossibility of reaching the other (Francesetti, 2011; 2015b). Phenomenal fields emerge at every instant of our experience, but the shift involved in expanding one's presence to look with curiosity upon how our experience emerges and to occupy it so as to sustain its potentialities is specific to the therapy situation. It is as though by sitting down opposite a client we co-create a world, and this happens at every moment of our experience. However, the specific task of therapy is to take notice and take care of how we constitute that world and dwell in it. The setting is the specific device that supports the therapist to do so: without a clear setting the therapist suffers the

phenomenal field and risks to just identify with it and repeat the old story with the illusion to change it. Through this shift of conversion, the therapist's perception moves from the phenomenal field to a phenomenological field.

The Field Perspective Revolution in Clinical Practice: Psychopathological Fields

If we take these to be the characteristics of a phenomenal field and understand psychopathology as absence at the contact-boundary[11] (Francesetti and Gecele, 2009; Francesetti, 2011; 2012; 2014), it follows that a psychopathological field is a phenomenal field in which there is an absence at the contact-boundary: it is a field in which suffering is present as an absence. Absence is a presence that does not irradiate, that is mute, that moves away, that does not arrive at the contact-boundary. It is the experience of not fully existing for the other or that the other does not fully exist for me. The *degree of fullness* is not absolute from the situation and cannot be measured by comparing it to an external scale, but it is the result of the potentialities and of the intentionalities for contact of the present situation.

Therefore, I take the object of psychopathology to be the field, not the individual. This shifts the epistemological ground of psychopathology itself, in the definition, understanding and treatment of suffering. Thus, I assert that it is not in the client that we locate suffering, but rather we regard it as an emergent phenomenon at the contact-boundary. Accordingly, if psychopathology is an absence at the boundary and the boundary is a co-created phenomenon, there can be no psychopathology of the isolated individual or mind. Being *of the field* (Robine, 2016), the therapist does not

[11] In psychopathology, suffering is not pain but absence. Desensitisation or anaesthesia at the contact-boundary prevents presence in full (Francesetti, 2012, 2014). For example, the pain of grief is not psychopathological because it is a presence; the absence of pain in sociopathy or the absence of joy in neurosis are instead psychopathological phenomena.

'work on the client', but in the field and on the field that is actualised between the therapist and client. Given that this field is co-created, the therapist works primarily on himself and on modulating his presence and absence at the contact-boundary.

Let us consider the example of depressive suffering (Francesetti, 2015b). If we say that the client *is depressed*, we lose sight of the fundamental fact that he is also not depressed[12], and our perception of him becomes crystallised, objectifying him and reducing input to therapy. We might, therefore, choose to say that the client *is suffering from depression*, but this reifies depression, turning it into an abstracted thing, extraneous to the person and his history, and thus offering no help in giving sense to his suffering. In reality, such approaches are not even sufficient for the correct use of drug treatment as they do not support the search for meaning, something which the client always needs. Alternatively, we can say that the client is having *a depressive experience*. This does not reduce the client to the suffering itself and opens up possibilities to explore and give meaning to the experience, but it ultimately still remains within an individualistic frame of reference. In a radically relational frame of reference, we can instead say that in the encounter with this client a *depressive field* is actualised. This places the depressive phenomenon in a relational frame of reference, bringing to the fore the co-creation of the experience, activating the search for meaning within the therapy context and immediately helping the therapist to feel part of and within a psychopathological field. In this sense, Gestalt psychotherapy is *deconstructive*. The crystallised symptom is progressively deconstructed so as to bring out the relational field and its suffering, which in becoming actualised makes movement and transformation possible.

[12] To cite Minkowski, it is important to grasp the extent to which a patient is schizophrenic, but it is just as important to grasp the extent to which she is not (Minkowski, 1927).

In this way, a depressive psychopathological field, to continue with our example, can be considered the actualisation of a phenomenal field in which the client and the therapist experience a hopeless sense of defeat in their attempt to reach the other. This defeat, and the helplessness it provokes, imbues the field in various ways, giving rise to experiences that are typical and recognisable by both the client and the therapist (Francesetti, 2011, 2015b; Roubal, 2007, 2014). The situation is no longer one where 'the therapist encounters a depressed client', but rather, '*this* depressive field is actualised between the therapist and the client' – a field that is different with different clients, different with different therapists and different with the same client in different moments (Robine, 2004; Francesetti, 2011, 2015b; Spagnuolo Lobb, 2013). Similarly, panic disorder, and a certain kind of hypochondria, arise in a phenomenal field in which denied solitude (Francesetti, 2007) is present. Or a schizophrenic delusion arises in a field in which the differentiation between subject and object has not emerged sufficiently, the relational boundaries are blurred and the experience rests beyond the Pillars of Hercules (Francesetti and Spagnuolo Lobb, 2013). Focusing on the psychopathological field reveals how suffering is actualised in reality, in the here and now, co-created at the contact-boundary, in the *in-between* and around the therapeutic relationship, and how it is experienced by the client and the therapist. Compared to a psychopathology of the isolated individual, to see psychopathology as a phenomenon of relational suffering that becomes real and alive in the therapeutic encounter can be revolutionary. It might be objected that the client is depressed even outside the therapy room and hence her depression does not emerge in the therapy setting. But the argument seems not valid to me: the fact that the client is depressed before and after the therapy session serves to show that she brings and actualises a depressive field in the different contexts she encounters, perhaps even in all of them. Of course, we could use an

extrinsic diagnosis and label her a patient suffering from depression. But this does not change the perspective that *during the session the depressive field is co-created every time* and that the way it is actualised is specific and different in different situations and, as may be the case, with different therapists. The field perspective enables the therapist to move from the question 'What can I do for such a depressed client?' to 'How are we depressing together right now?' (Roubal, 2007; Francesetti and Roubal, 2013). It is precisely the element of co-creation that gives the therapist margin for therapy, as minimal as it can sometimes be. Since the therapist himself is part of the id and the personality of the situation (Robine, 2004), he will always be able to effect a choice (ego function) that is rooted in the here and now of the situation and is an expression of the intentionalities at play in the field. Such a perspective also presents psychopathology with two new tasks: to describe the specific way the *Gestaltung*[13] unfolds for different types of suffering; and to describe the specific phenomenal and aesthetic aspects (Bloom, 2003) of the different psychopathological fields actualised. Work on the first task is exemplified by studies on panic disorder (Francesetti, 2007), depression (Francesetti, 2011; 2015b), schizophrenic psychoses (Francesetti and Spagnuolo Lobb, 2013), obsessive-compulsive disorder (Francesetti, forthcoming) and other disorders (Francesetti, Gecele and Roubal, 2013). The second task has largely yet to be explored in a systematic way.

A Field Perspective in Clinical Practice: HARP As the Unity of the Therapeutic Act

[13] *Gestaltung* is the process by which a Gestalt is formed; it is the emergence of a figure from a background, and hence the becoming and defining of a figure of experience.

Sadness is contagious,

my love, and from this we see

that we have joined hearts

and are one, but appear as two.

And so I

inseminate joy

in this thing that does not consist

but yet exists and keeps us both tied.

It is I

who puts in

the joy.

(M. Gualtieri, *Bestia di Gioia*, 127)

Thus we have posited our theoretical premises. As soon as the therapist and client sit down and face one another, a phenomenal field is actualised in the situation of the therapy setting, which tends to actualise the potentialities for contact in play. In this co-created field, the therapist may have very different experiences, which in general can be distinguished as attunement and resonance. From these two experiential phenomena, the therapeutic act in a field perspective lies in the modulation of the therapist's own presence, abandoning any attempt to change the client, and all the paradoxes and performance anxiety that it entails (Beisser, 1970). This perspective is in line with what Myriam and Erving Polster (1976) proposed when they underlined the need that the therapist modulates his way to be in contact according with the client’s possibilities and limitations.

I shall call the experiential unity of the therapeutic act "HARP" – Human Attunement, Resonance and Presence.

Attunement

Attunement phenomena[14] have been widely described in philosophy (Stein, 1989), phenomenology (Merleau-Ponty, 1945), infant research (Stern, 1985; 2010), neurosciences (Gallese, 2006a, 2006b; Gallese, Eagle and Migone, 2007; Rizzolatti and Sinigaglia, 2008), and in psychotherapy (Rogers, 1951; Bandler and Grinder, 1975; Erickson, Rossi and Rossi, 1976; Yontef, 1993; 2002; Schore, 1994; Thompson, 2001; Siegel, 2012; Tschascher et al, 2013; 2017). Generally speaking, it is the therapist's experience of feeling *on the same wavelength* as the client, of having similar or even the same feelings. The discovery of *mirror neurons* (Rizzolatti and Craighero, 2004; Rizzolatti and Sinigaglia, 2006) has shed light on the neural bases underpinning the ability to experience a situation in the same way, regardless of whether it happens to me or to somebody else. Attunement is an event of great therapeutic value in and of itself, as it is a central phenomenon in the process of acknowledging the client and contributes to the validation of his experience. Attunement is distinct from confluence, where a figure does not emerge from a ground or where the boundaries between the organism and the environment cannot be perceived. With attunement, a clear figure emerges and the boundaries between me and the other are also clearly defined, in the sense that it is clear that I feel what you are feeling and that you feel that I feel what you are feeling. Attunement, in different situations, helps the client validate the feeling that his

[14] I think that the concept of attunement that I present here corresponds, or is very close, to Yontef's concept of "inclusion" from Buber (Yontef, 1993; 2002), however I prefer the term attunement as it is used in a range of other studies, in particular in infant research and neuroscience.

experiences are real, and thus to feel he is not crazy, and to feel the dignity of his experience, to feel understood, to feel he is not alone, to feel that it is possible to encounter the other through his suffering. These are, therefore, therapeutic phenomena which are fundamental and essential for the processes of meeting, containment, change and growth. As shown by infant research and clinical studies, attunement is not a static phenomenon, but is extremely mobile and mutual. It is a process in continuous movement. The mobility of experience requires a process of continuous adjustment, which never stands still. An example of this is our eyes. When we look somebody in the eyes, our eyes are never still – looking is not a static phenomenon, but a continuous movement of reciprocal adjustment of direction, focus, eyelid movement, of looking away for a fraction of second to then catch the other's gaze again, before losing it once more. Besides being continuously mobile, attunement also alternates with moments in which attunement is lost, or interrupted, and is then restored, moments when attunement is lost and then found again, through a new attunement. Rupture and restoration of attunement would appear to be crucial therapeutic phenomena (Ornstein, 1974; Colli and Lingiardi, 2007). It is this process of continuous adjustment and attunement, and not a static, uninterrupted attunement, which characterises healthy human relationships, including the therapeutic relationship. The shifts present in attunement enable, in Gestalt therapy terms, the ongoing perception of boundaries which would otherwise be lost through the natural adaptation of the senses, if contact were static.

Resonance

Resonance is a concept coming from the physics, and in particular physics of music[15]. In this context, resonance phenomena refer to the therapist's feelings which emerge in the therapy setting[16] (or before or after the session) but are not similar or identical to those of the client – indeed, they can be very different. For example, a client may feel a deep sense of sadness or desperation, while the therapist may be bored, or frightened, or even annoyed. Even the client, on her part, will experience resonance phenomena in the presence of the therapist. Resonance phenomena are bodily, sensory experiences which are essentially undifferentiated in their origin; synaesthetic – before than kinaesthetic - resonances that are not configured in definite objects. Often they are unexplainable bodily sensations and feelings that do not immediately make sense, but may then take the shape of images or memories, fleeting fantasies, words of poetry or melodies, tactile sensations or localised bodily pain, emotions, feelings, etc. To grasp them, the therapist needs to be sensitive to them by focusing on what can be called the aesthetic dimension, a sensorial world without clearly defined objects of perception, and to slow time down just enough to grasp the fleeting, or at times more persistent, emergence and touch of these emergent sensory phenomena. Often the therapist perceives resonances as disturbing and unexplainable sensations, feelings or thoughts; she can feel guilty about them and try to avoid them or put them aside. But they are incredibly precious elements of the co-created phenomenal field – from otherwise rejected stones, in a field strategy they become the cornerstones[17]. A resonance is often perceived as something out of place that can elicit wonder, it is an '*atopon*': "Gadamer

[15] Two systems which are *entraining* each other into a shared rhythm of oscillations in such a way that together they form an overarching synchronized system whose oscillations are regulated by its own order parameter (Fuchs and Koch, 2014).

[16] Resonance phenomena are present in all human relationships, however here we will focus solely on their relevance in therapy.

[17] "The stone the builders rejected has become the cornerstone" (*Psalm* 118, 22).

reminds us that the Greeks had a word for that which brings understanding to a standstill. This word was *atopon*, which in reality means 'that which cannot be fitted into the categories of expectation in our understanding and which therefore causes us to be suspicious of it'" (Costa, 2014, 356).

These are fundamental phenomena, first recognised by psychoanalysis as transference and counter-transference, on which a vast literature exists – too vast to be covered here. From a field perspective, however, resonance phenomena are not experiences which the client projects and situates in the therapist, or which the therapist projects and situates in the client (how experiences pass from one person to the other is a tricky theoretical problem for psychoanalysts, see Stolorow *et al*., 1999; Eagle, 2011; for a critique of the concept of projection see Jacobs, 2012). Gestalt therapy's theory of self (in line with phenomenology and contemporary neurosciences) considers subjects as co-emerging from the present situation; they are co-creating together (Francesetti, 2016). Our way of being, i.e., the ecstasy of our corporeality, co-creates the phenomenal field and the experiential phenomena that the client and the therapist experience. What we have is not two separate individuals who influence each other through their encounter, but the emergence in the here and now of two subjectivities that co-shape each other[18] and take this specific form. Resonance is the *epiphany*, or the unfolding, of this co-creation. Moreover, resonance phenomena are not the mere re-proposal of past scenarios, but how the potentialities of the field take sensible form here and now. Suffering takes shape depending on the potentiality for transformation that the situation offers. The client is not just narrowly building his experience as he has learned to do in the past, implying that the therapist should help widen his sights. Rather, he brings a

[18] Staemmler (2016) has called this relational perspective "strong relationality"; see also Francesetti (2012; 2015a).

legacy that is trying to ex-sist here and now in order to reach the other and be transformed. This is a teleological perspective: cherishing pain and suffering has a meaning and it is not just a learned and rigid way of reacting and behaving. *Suffering* means "to bear" (from the Latin *fero*, to bear) and the client bears the pain that in this specific encounter can potentially be felt, recognised and transformed (Francesetti, 2012).

Resonance phenomena have been treated in very different ways over the history of psychotherapy and have attracted plenty of interest in the current literature (Howard, Orlinsky and Hill, 1969; Brody and Farber, 1998; Roubal and Rihacek, 2014; Wolf, Goldfried and Muran, 2013a; 2013b; Gazzillo *et al*., 2015). Early psychoanalysis treated them as interferences to be cleaned up, although later they were seen as the gateway to interpretative analysis, while more recent developments would have the therapist's resonances placed at the disposal – implicitly or explicitly – of the client (Stolorow *et al*., 1999; Eagle, 2011; Boston Change Process Study Group, 2010). In humanistic experiential therapies, including Gestalt therapy, resonance has been used as a central tool through *self-disclosure*, where the therapist shares her own experience. Resonance phenomena are therefore precious in that they are singular events, unique to the moment and to the particular client – a true epiphany of mutual co-creation. But they are also mysterious, because at the immediate moment they emerge, the therapist *is moved* but does not understand either where they come from or what they mean. It should be remembered that self-disclosure is not in and of itself therapeutic – indeed, it can be dangerously re-traumatising. If performed without there being sufficient ground to support it, it can cause harm by re-traumatising and invalidating the client's experience. The direct and crude expression, for instance, of the fear felt by the therapist in a

psychotic field or of desperation in a highly depressive field, or of irritation in a hysterical field can greatly worsen the client's suffering[19].

The crucial question is, therefore, what to make of resonance in a field perspective.

Presence: From the Phenomenal to the Phenomenological Field

We said that resonance, in a field perspective, is the epiphany of the co-creation process. It is, therefore, something that the therapist feels, but which does not belong to the therapist alone. It emerges from the process of co-creation and belongs to the field, and only makes sense when considering the field. It is the most precious sign of the field that we constitute and the themes that circulate within it, between the client and the therapist. Themes are the typical contents of the co-created field and they steer us in identifying the field we are experiencing. The relevant relational themes have been recently described by Lynne Jacobs (2017), who calls them *Enduring Relational Themes (ERTs)* and proposes them as a way to understand transference phenomena in the Gestalt Therapy theoretical frame. I fully agree with Jacobs that ERTs emerge as co-created phenomena in contact processes; indeed they do not belong only to the client. I also agree they should not be considered projections (both for the clinical risks and theoretical inconsistency) and that they are potentialities that lead to relational novelty and transformation (see also Philippson, 2002).

In the view I am proposing here I want in particular to describe two specific processes. First, that themes *circulate* in the co-created phenomenal field; this implies

[19] Consider that research shows that the condition of around 8% of patients in therapy deteriorates (Hansen, Lambert and Forman, 2003).

that they can be felt and enacted both by the client and/or by the therapist. Secondly, through the themes, suffering emerges in the here and now and moves towards the *transformation* of absence in pain and of pain in beauty (Francesetti, 2012). Resonances are the way we can sense and feel the themes. To recognise them is a crucial part of the therapeutic process, since one of the main risks is to attribute the theme only to the client. When the therapist recognizes it, s/he modulates her/his presence and – by doing so – s/he changes the field. Let us look at some clinical examples to illustrate how the modulation of the therapist's presence can be a central element of therapy based on the field perspective.

First Clinical Example: Co-Creating a Narcissistic Field

One issue that can be highly present in a therapeutic encounter is that of disregard and shame. The therapist may feel disregarded and ignored and this can be very unpleasant. He may feel he has to do something to be taken notice of, something, perhaps, to prove he is professionally competent, as it would seem that the client shows very little regard or esteem for him. If he simply perceives and reacts to the resonance, he may start doing something to show that he is indeed competent – he might think of all the articles he has authored, for instance, and perhaps even cite a few. At a certain point he might feel that he does not want the client to know certain things about his life as he would feel ashamed of them and, without realising it, he avoids them entirely. The client, for instance, may frequent only people of a certain social standing while the therapist comes from a much more humble background, something he would rather the client did not know. Slowly but surely, without even realising it, the therapist manages to assert himself in this way in the encounter and feels more at ease – luckily the session

is going better and better in his view. But then, to his surprise, the client ends the session saying he feels annoyed and that, in the end, therapy will not help. The risk for the therapist is that he may feel wounded by the comment and attribute it to the client's narcissism, because 'like a typical narcissist he is unable to accept what the therapist offers'. In this way he does not see how he himself has contributed to the emerging of these phenomena and is unable to appreciate the legitimacy and truth of the client's experience. What the therapist does is attribute the suffering to the client alone and identify with a theme in the field, that of regard/disregard. He fails to place what he feels in the context of a ground in which to make sense of it and instead identifies with what he feels and acts it out without realising that it is the outcome of a co-creation process.

An alternative is that the therapist becomes aware of what he experiences without identifying with it. To do this, he needs to be curious about what he is feeling – "I feel ignored, disregarded, ashamed… how hard it is right now to bring up my background and feel its worth… perhaps these are themes that are circulating between us." The shift here is to value what we feel and to place ourselves on much broader terrain from which to perceive what we feel with a sense of curiosity. Perhaps the therapist can find in that terrain a strength that comes from his humbleness, the strength to feel his worth without denying his limitations, or concealing them. If this happens, the therapist will have modulated his presence, enabling the tolerability and value of limitation to emerge in the field, thereby changing the field itself. If this happens, if the therapist modulates his presence, having limits will no longer be prohibited or denied. We could say that the field I have described has narcissistic elements. If the therapist identifies with the themes of disregard, he will contribute to co-creating it; instead, if he manages to make sense of his experience and let the legitimacy and tolerability of

limitation emerge, the field will be a little less narcissistic and will open up space for the possibility for what is not always valued positively to have dignity and the right to exist.

Second Clinical Example: Co-Creating a Depressive Field

A therapist sees a client suffering from severe depression and she is sometimes very worried, at times irritated and annoyed, because nothing changes. She feels the client is not making enough effort in therapy and with recent appointments found herself hoping right up to the last minute that the client would not turn up and decide to go to another therapist. The shift of modulating the therapist's presence, from a field perspective, enables her to ask herself, "How am I, the therapist, co-creating this experience? How am I letting my body freeze up and not breathe? How am I losing my hold on life? How are we depressing together (Roubal, 2007) and how I am myself getting depressed?" (Francesetti and Roubal, 2013; Francesetti, 2015b; Roubal and Rihacek, 2014). These questions shift the focus from what the client does to what the therapist herself does. By becoming aware of how she is influencing the field, the therapist can regain the freedom to breathe or feel once again the throbbing weight of her body, or notice that a butterfly has landed on the window and remember that spring is coming, or recall a poem by Mary Oliver (2004): "And now I will tell you the truth. Everything in the world comes". This would modify the therapist's presence and the atmosphere of the session would lighten up, enabling a greater receptiveness on the part of the therapist to emerge. The specific sequence of experiences in a depressive field has been explored and described by Roubal and Rihacek (2014) as a 'depressive co-experiencing trajectory'. Their research findings fit perfectly with the HARP model presented here: therapists experience attunement (and contagion by depression),

resonances (i.e., distance from the client), and finally they modulate their presence by focusing on what is happening in the therapeutic relationship. This last move, made possible when they become aware of what is emerging as a co-created phenomenon, allows the therapists to feel that something meaningful, helpful, and relieving is emerging and changing the experience of both the therapist and the client.

Third Clinical Example: Co-Creating an Hysterical Field

A theme that may circulate in a field is that of authenticity/inauthenticity. It is easy for the therapist to feel irritation over a suffering that the client evidently and openly shows, but that the therapist is unable to feel, with a consequent tendency to judge the client as not being authentic and be annoyed by this. If the therapist does not recognize the theme and is unable to look at it and disassociate from it, the risk of re-traumatizing the client is high. The shift in therapy is to broaden the ground of experience and for the therapist to ask herself how she herself is co-creating this theme, how authentic she really is being. Is she really expressing what she feels? Maybe not. Maybe she is torn between expressing the irritation she feels and the fear that this may re-traumatise the client by representing yet another rejection, for which she finds herself in a position in which what she expresses is not what she feels, which means she herself is not being authentic. If she realises this, she can understand her contribution to the co-creation of the field and - by paying more attention to what she feels in feeling this - she can realise more still, such as *the pain of not feeling the pain* of the person suffering in front of her. In this way she can feel real pain and find the words to say authentically

that *she feels the pain of not feeling the pain of the other person*. If she manages to do this, she will be fully and authentically present and this will change the emerging field.

These examples help describe a shift that changes the perspective in therapy, by realising that *in the here and now* the therapist suffers and creates the co-created phenomenal field just as much as the client suffers and creates it. The focus of the therapy act is therefore on the quality of one's presence, rather than on changing the client.

Therapist's Competences for Working with the HARP Model

I now present the competences implied when working with the HARP model. In this description they become a sequence of different and explicit steps, but they constitute a fluid and implicit flow. For each of them I will provide a short description, draft the experience of the therapist, and offer some short clinical examples from the three fields presented above. The phenomena that I describe are quite typical of the fields used here as examples, but, of course, in a session different feelings will emerge according to the specificities of the therapist, of the client and of the situation. Nevertheless, it is usually possible to recognize some features of a field where a specific suffering emerges.

Modulating the therapist's presence therefore requires:

- **Openness and willingness to experience attunement and resonance phenomena**: the therapist is able to slow down and focus on the aesthetic dimension, i.e., on what she feels, what the client feels, what she feels is

emerging in the between[20] *without dismissing any element* of her experience. This is at the level of the phenomenal field. In order to be able to dwell in this native dimension of the experience, the therapist needs to developed a specific aesthetic sensibility (Francesetti, 2012; 2015a). Clinical vignettes:

- **With Tony**: "I feel I'm not a good enough therapist for Tony, he is so brilliant and has achieved so many important goals in his life! I need to do something more or I should hide part of who I am in order to appear ok. I feel disregarded and I feel the unpleasant pressure of 'having to be something more."
- **With Jim**: "I oscillate between feeling depressed and reacting to it: when I am sitting with Jim, I feel a heaviness, a terrible tiredness... or sometimes I simply feel dumb, sleepy, empty, falling down... then I take my distance from Jim, I can't stand this anymore, I don't want to fall into such a black hole! When I'm with him time slows down, the space in the between becomes wider, darker and more burdensome; I feel anguish, impotence and then the wish to fly away."
- **With Rose**: "With Rose I feel annoyed, bored, disturbed, irritated, even though she clearly shows her suffering. Sometimes I feel attracted by Rose's manifestations of suffering, so colourful, even though something not completely real or authentic is suspended in the air... She doesn't seem authentic!."

- **Curiosity about the therapist's own resonances and a willingness to let them be**, **without attributing them in advance to the client alone or to oneself alone**: the therapist ask herself "What's happening to me? That's strange, I

[20] On these three focuses of feeling during training processes, see Philippson (2017a).

really can't understand why, but I feel this way." Throughout her awareness, the therapist does not identify with the phenomena of attunement and resonance: this is the shift from the phenomenal field to the phenomenological field. Clinical vignettes:

  - **With Tony**: "I am aware of this feeling of being dismissed or not being good enough and I just wonder about this, without reacting in order to be better than who I am."
  - **With Jim**: "I am aware of my own oscillations, my feelings of being depressed and then reacting against it, I am tempted to dismiss them or to feel guilty because of them... it's interesting."
  - **With Rose**: "I am aware of my resonances of rejection or attraction, I notice the sense of something not completely authentic and I wonder what is happening to me and to us."

- **Tolerance of the uncertainty** that such an approach entails (Staemmler, 1997; 2006), **accepting that we do not know the direction the therapy process is taking**: the therapist feels sensations and feelings or images come to her and she does not know why, she cannot give any immediate meaning to them, so she offers and gives time to the process by tolerating the uncertainty. Clinical vignettes:
  - **With Tony**: "I would like to be a better therapist, more on the ball, I don't know what it means, could it be a theme circulating in the field that we are co-creating?'
  - **With Jim**: "I try to cope with this deep lack of energy and interest, without knowing where it emerges from — am I too tired after seeing so many clients? Am I distancing myself from the themes that Jim is bringing about

his relationship problem? Yesterday evening I had a harsh discussion with my partner... Is this a way to perceive and co-create a depressive field?

  - **With Rose**: "I don't know what to do... Should I share my feelings or not? If not, am I being authentic or not? I don't know... yet.'

- **Expanding attention so as to feel what emerges from the background, from the fringes of the resonances:** the therapist is still feeling and waiting, in the hope that something else will still arise… The question is: "What does the therapist feel in feeling what she feels?" Clinical vignettes:
  - **With Tony**: "I now feel an almost imperceptible sadness, coming out from somewhere...just a slight movement in the background of my feelings..."
  - **With Jim**: "I feel that space and time change when sitting with Jim, I feel an anguish when I focus on the space between us, I feel impotent and my body becomes paralyzed... but by being interested in these feelings I start to feel something different'
  - **With Rose**: "I start to feel some pain, a feeling of loneliness perhaps... yes, I feel alone and it's strange because Rose seems so present to me...'
- **Grasping what emerges and looking for its meaning in accordance with the emerging intentionality for contact**. The therapist asks herself:"What does this mean for me? For my client? For us? For the situation we find ourselves in? What theme is emerging? What landscape we are in? Where is it taking us?" Clinical vignettes:
  - **With Tony**: "Yes, I feel sad...I feel a sadness for my feelings of not being good enough, for the effort required in my life to try to be who I am not..."

- **With Jim**: “I would like to be able to feel that I’m alive while sitting with Jim, just this... and feel the possibility of moving, I feel this wish...it reminds me of my moments of deep depression...”
- **With Rose**: “Yes, I feel loneliness, as if I have no chance to really be reached by Rose or to reach her. I can’t really feel her pain... is this a theme circulating between us?’

- **Using this awareness to modulate the therapist’s presence, how she stays in the situation, revealing or not explicitly revealing, depending on the situation, what she feels**. Before expressing what she feels, the therapist should assess whether she has grasped the resonances’ meaning or, if she has not, whether the client, therapeutic relationship and situation can cope with and make use of that input. If she decides to share something of her sensations, feelings and thoughts, she has to convey them to the client when she feels that this will support the contact between them. The *‘how’* she expresses is a sign of the increasing presence and existence of both the therapist and the client. A criterium that I propose in order to decide whether to express the resonance or not is the following: *the therapist should not express her resonance until she perceives only it*. In order to express the resonances she has to grasp some background around them, to feel that she feels curiosity towards them and that she is not completely identified with them. Usually, the more the client is severely suffering, the more the resonances are strong, the more it is difficult not to be identified with them and the more the risk of re-traumatisation is high. Clinical vignettes:
  - **With Tony**: “I now feel the profound need to be who I am, to give dignity to my person, to my history, even to my stupidity and to my limitations. This

gives me a sense of dignity, integrity and freedom, of humbleness and strength at the same time. Tony now looks different to my eyes: I can feel his effort, endless effort, of being 'something more'... I feel sad for this and a feeling of tenderness emerges in my body. I can now stay here and I could say, with a soft voice, tenderly and looking straight into his eyes: ' Tony, I'm impressed by how many important things you have done in your life... And I also see how much work and effort you have done for all of this. Aren't you tired sometimes?'"

- **With Jim**: "Yes, we are co-creating a depressive field... let me allow myself to expand my chest and inhale, just inhale... I feel better, I can see Jim more clearly, with some colour... I'd like to bridge the space in between, but I don't know how to do this. But I feel better, this willingness is already a relief. Now I can breathe and stay here and I could say, with warm words emerging from my experience of deep darkness: 'Jim, I feel the heaviness of what you're bringing, and I feel the impotence, too. I feel a wish to overcome it, but I don't know how, I can't yet. But I can stay and breathe with you, and maybe you can breathe with me..'"
- **With Rose**: "I now feel the real pain of not really feeling Rose's pain. What loneliness! And what a relief in feeling this real feeling! Now I can stay here, with her, I feel that somewhere I am meeting her, and I could firmly say: ' Rose, I see your pain, the pain in your story, and I can feel how alone you have been with it, how difficult is to be reached there... I feel pain now, while saying this to you'. And real tears can come out in my eyes."

Conclusion: Lending the Therapist's Flesh to the Client

At the level of the phenomenal field, both the client and the therapist are responsible for what they feel. But the therapist is responsible for shifting from the phenomenal field to the phenomenological field and modulating her presence to support the intentionality for contact underway, and not just reproduce the phenomenal field that is actualised. In this, the therapeutic relationship is not an equal relationship.

To use the words of Jean-Luc Marion (2003), the therapist lends her flesh to actualise and feel the suffering of the client. The body of the other was absent in the client's experience since the other was not there to welcome and transform her/his pain. The pain precipitated in the client's body, the *Leib* became *Körper*, the palpitating atmospheric emotion became a clot. The therapist's flesh is now called to receive this cherished pain in order to allow the transformative process of the meeting to happen. Psychopathological suffering is psycho*patho*logical precisely because it precipitates into the client's flesh without the possibility of it being felt as an affective and emotional experience *in the in-between*, with the support of the other's presence. There is not freedom here: what is suffered is *pathòs*, passively felt. The symptom is the memory of the other's absence and a grain of the potentiality of encounter. It is absence in that it is the memory and evidence of the absent other. It is absence in that it is a silent presence that does not resonate. It is the presence of an absence that wants to ex-sist, i.e., to come out, and to play the melody that it cherishes – the therapist is the embodied instrument that resonates with the melody. Human beings are loyal to their pain and bear it (i.e., they suffer) in the form of a symptom, which is a creative way of bearing pain without succumbing to it (Borgna, 2005). When the other – the therapist – becomes present in therapy, he lends his flesh to the client's pain and that pain can reach the contact-boundary. When this happens, the therapist grasps the face of the

other and there is a sense that something important is happening and the fundamental sentiment that emerges is tenderness (Lévinas, 1987). Here, time becomes event (Maldiney, 1991); the novelty is co-created and met, the potentialities for contact are fully expressed, according to the possibilities and limitations of the present situation. The HARP model is a way to allow the psychopathological field to be co-created (the absence becomes present), to let the suffering emerge (the pain arrives at the contact boundary) and the transformation happen (the intentionality for contact unfolds); the therapist does not identify with the circulating themes: she lends her flesh in order to let what is suffered exist in the here and now (she is reached by the suffering) and by relying on her aesthetic sensitivity she modulates her presence and supports the intentionality for contact. She pumps into the situation new aesthetic elements and so a new freedom springs up.

How suffering emerges in therapy follows aesthetic rules and opens the way to easing and joy – the cup that holds suffering is the same that holds joy (Gibran, 1923). It is a human way of bearing pain until it is transformed at the contact-boundary and new freedom is gained. It is the transformation of absence in pain and of pain in beauty (Francesetti, 2012; 2015b). Human beings work like musical instruments that harmonise – they pluck the strings of their hearts to play in unison[21]. Like two harps, when one sounds, the other resonates. This is why from a field perspective the unity of the therapeutic act can be called HARP[22] – Human[23] Attunement, Resonance and Presence. Its unity comes from the emergence of feelings of attunement and resonance which lead the therapist to modulate his presence to sustain the expression of the potentiality for

[21] Translator's note: "Cuore" – "heart" in Italian – derives etymologically from the Latin *cor*, which gives us both "cuore" (heart) and "corde" (cords/strings) in Italian. Unfortunately, this could not be rendered in the English.

[22] I dedicate this appellation to my daughter Chiara, harper and psychologist.

[23] I thank Joyce Sciberras for having suggested to add the 'H' from 'Human'. As suggested by Alison Clare the 'H' could also refer to 'Heart'.

contact present in the situation. This perspective helps us understand how *suffering* is the *bearing* (from the Latin *fero*) of an absence which in therapy becomes presence, and which thanks to the presence of the therapist transforms into potentiality for contact. And so, in emerging beauty.

As a consequence, not only does the client change. The transformation of the cherished pain is a transformation of the legacy of a history that creatively changes the present situation. And the therapist changes, too. And with them, the fabric of the world and of life changes.

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