

‘Suspended from shaky scaffolding, we secure ourselves with our fixations.’¹ A phenomenological and Gestalt exploration of obsessive–compulsive disorder

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Abstract: This article presents an approach to obsessive–compulsive disorder based on Gestalt therapy theory, Gestalt psychology, and psychiatric phenomenology. After establishing a diagnostic framework, the experiences of clients are explored, starting from the experience of space and time, of the relationship between details and the whole, of boundaries, and of materiality. In the light of the Gestalt theory of perception, the obsessive–compulsive symptom is framed as a creative adjustment able to protect the client from much worse suffering, in a situation in which the bodily sensorial ground is permeated with terror. After describing how the obsessive–compulsive field is aesthetically actualised in therapy, a number of issues and passages are highlighted that can help therapists in their journey with the sufferers.

Keywords: obsessive–compulsive disorder, Gestalt therapy, phenomenology, Gestalt psychology, perception, psychopathology, psychopathological field, language, aesthetics.

The aim of this article is to propose an exploration of the experiences of those who suffer from obsessive–compulsive disorder (OCD), with a view to supporting clinical practitioners in providing therapy.² This exploration is based on direct clinical experience and the existing literature, and in particular makes conceptual reference to phenomenological methods (Moustakas, 1994; Spinelli, 2005; Ratcliffe, 2015; Gallagher and Zahavi, 2007) and phenomenological psychiatry (Borgna, 1989; Galimberti, 1979; Callieri, 2001), to the empirical methods of Gestalt psychology (Ash, 1995), and to the theory and practice of Gestalt therapy (Perls, Hefferline and Goodman, 1951 (hereafter PHG); Spagnuolo Lobb, 2013a; Robine, 2016; Bloom and O’Neill, 2014; Jacobs and Hycner, 2009; Francesetti, Gecele and Roubal, 2013; Vázquez Bandín, 2014). Through this approach, I hope to develop a structural³ and relational understanding of such suffering, providing a framework that can give meaning to the various experiences that clients have and relate. A field perspective will also be used to underpin therapy work with sufferers from obsessions, offering an example of Gestalt therapy analysis in psychopathology and of how phenomenological psychiatry can support this journey, building on previous work (Francesetti, 2007; 2015a; Francesetti and Gecele, 2011; Francesetti and Spagnuolo Lobb, 2013). Not many works on a Gestalt

therapy approach to OCD can be found in the literature (Morphy, 1980; Tárrega-Soler, 1997; Wheeler, 2002, p. 165; Dreitzel, 2010; Salonia, 2013). The most systematic is that of Salonia, which forms the starting point of this exploration of mine, which will then go on to propose a rather different understanding of how obsessions and compulsions take shape.

1. Some considerations on extrinsic diagnosis⁴

OCD⁵ is a frequent⁶ and serious disorder that can make life very difficult for its sufferers and the people close to them. It is characterised by two main symptoms: obsessions and compulsions. *Obsessions* are unwanted and intrusive thoughts, images, impulses or ideas that are experienced as threatening, repulsive, meaningless, obscene or blasphemous. Themes can vary and typically concern contamination, the responsibility associated with causing harm, sex, religion, violence, order, and symmetry. Three characteristics distinguish obsessions from other recurrent thoughts: they are not desired, they are incongruous with the person’s value system, and they elicit resistance in the person when attempting to eliminate them or tackle the consequences. *Compulsions* are motivated and intentional behaviours that the subject adopts in response to obsessions, in

an effort to limit the anxiety that they provoke and their catastrophic consequences. Compulsive rituals typically revolve around decontamination, control, repetition and mental acts.

Obsessive and compulsive symptoms can appear in various levels of functioning, including neurotic, borderline and psychotic functioning. Current diagnostic systems all distinguish OCD from psychotic experience, but although it is distinct, it is not all that separate or far from psychotic experience. According to some authors (Straus, 1948; Stanghellini and Ballerini, 1992), and in the model I present here, OCD can be considered close, albeit different, to psychosis; in some cases it is the bulwark that saves a person from psychotic experience. We can therefore say that OCD generally emerges at a neurotic level of organisation, but if the obsessive adjustment does not suffice to hold back the terror, we can have obsessive-compulsive symptoms in a psychotic experience. The diagnosis should also be distinguished from obsessive-compulsive personality disorder, which differs from OCD in that it is egosyntonic, i.e. the person is not troubled by his or her perfectionist, rigid, stubborn or order-seeking ways and does not seek help as a result. OCD may or may not be observed with obsessive-compulsive personality style.

2. A phenomenological analysis: the experience of the sufferer

Andrea is terrified that he might kill his two-year-old daughter or that somebody could do something awful to her. He is tormented by intrusive images of her being physically and sexually abused. He hides away all the knives and anything sharp in the house. He counts the seconds that it takes him to get to the garage and start the car after locking the door to the house – if they are not the right number, he will repeat the action until he gets it right. Then, if the licence plates he sees do not add up, using a complicated arithmetic, to a number within a certain range, he calculates a series of laborious mathematical operations to ward off the tragic consequences that could hurt his daughter.

Anna lives in a contaminated world and to protect herself she incessantly has to decontaminate her space. This means that everything that enters her home has to be washed according to specific procedures and kept in ‘quarantine’ for a certain amount of time – including herself. Her skin has become an ultra-thin sheath, increasingly exposed to contaminants. She lives in constant fear and desperation.

Cristina is no longer able to drive because the idea of running somebody over forces her constantly to stop and go back to check that she has not hit anybody. Even her job in a shop has become intolerable, as whenever somebody buys something small, Cristina is afraid that a child might swallow it and choke to death.

These thoughts have become incessant, leading her to endlessly stop and check, which relieves her anxiety, but only temporarily.

Those who suffer from a major OCD begin each and every day with a superhuman task that they will never bring to term. The battle against disorder, contamination, filth, uncertainty, harm, risk or losing control takes up all their energy without respite or end, draining them to exhaustion. In the experience of these sufferers, the world is terrifying, constantly threatening impending tragedy and catastrophe. Compulsions are the antidote, talismans that temporarily ward off the worst (Straus, 1948; Ballerini and Callieri, 1996; Muscelli and Stanghellini, 2008; von Gebattel, 1967; Stanghellini and Ballerini, 1992; Borgna, 1997). I will try to describe these experiences using four themes of particular significance in OCD: space and time; the relationship between details and the whole; the experience of boundary; and materiality.

2.1 Space and time

Space contracts. As in every experience of anxiety, it is oppressing (anxious, from the Latin *angere*, etymologically means ‘to squeeze’). The world assails those with obsessive experience from all sides, and so the person restricts space to what can be controlled and kept uncontaminated. The greater the need to control and decontaminate, the more space is restricted. Etymologically, ‘*ob-session* derives from the Latin *obsidere*, meaning *to besiege*. Thus there is a spatial implication in the original meaning of obsession. A person who is obsessed is a person who is besieged, a person who feels space is lacking, who feels that things are getting too close’ (Muscelli and Stanghellini, 2008, p. 280). The need and the strategies to achieve symmetry produce a feeling of control over space, of stopping its inexorable and chaotic closing in, of holding back the siege. Space is threatening not in the sense of it being a place where I find myself exposed to the world without protection, as in agoraphobia (Francessetti, 2007; 2013), but in the sense that it is a place where distance from things is lacking. The experience of lack of distance is the ground on which to understand the efforts of the sufferer of obsessions to create distance, as we shall see further on. The privileged use of vision, the most distancing and objectifying of all the senses, also responds to this need. Thus the subject finds himself fighting a battle of retreat, in a siege that is never brought to a conclusion, in a time that flows but without a surge, a peak and a pacification – it is a linear, uniform movement, time that flows inexorably but without reaching anything that can be punctuated by a sigh that finally puts an end to it all, allowing a new page to be turned. Time flows without becoming an *event*, generating a bodily tension that is never resolved in a

point of climax, a tension that only diminishes as the energy invested is exhausted, not because a destination at which to rest is reached. Time is not maturation, it is not a pause, and so there is no assimilation. Stopping means precipitating; there is no rest, no finishing point.

2.2 The relationship between details and the whole

Those who suffer from an obsessive disorder have nets capable of catching small fish, but which let the big fish escape. Details become figure; they are magnified and repeatedly analysed, without actually bringing any sense of accomplishment to the experience. The lack of distance leads the sufferer to magnify spatial details, which become so big as to be disgusting or dangerous.⁷ What besieges us must be pushed away, and one way to do that is to objectify it visually, turning it into an object, but one which inevitably will stand too close and thus become disgusting or dangerous. Detail prevails and comes to the fore, but the figure is never completed satisfactorily. In such experiences, it is difficult to arrive at a final gestalt that is perceived as complete and comprehensive of all the significant elements. Figures are like windmills – as they are not rooted in a ground that supports them, they become necessarily repetitive and inconclusive; *what is not completed is repeated* (cf. PHG). The lack of experience of accomplishment helps us to understand the spasmodic searching for accomplishment, which can never be achieved. It is here that the sense, which is only apparently senseless, of perfectionism emerges – *perfecto*, in the Latin, etymologically means *accomplished, complete*. It is a continuous urge towards an experience of accomplishment – this is the thirst that drives sufferers of obsessions, without ever finding relief. *Perfecto* also means *dead*, and, significantly, the way in which OCD sufferers think of suicide is as a way of putting an end to an endless battle: ‘Often, on the motorway, I think all it would take is not to turn the steering wheel on the bend. Everything would finally end, and everybody would think it was just an accident.’

2.3 The experience of boundary

Boundaries, areas, limits, thresholds, banks: these are recurring themes in the battle against closeness and contamination, in an effort to delimit degradation, putrefaction and threat. It is an endless battle against ‘evil’ in all its various forms: violence, destiny, the decay of the flesh, illness, germs and worms, danger, harm, malignant influences. But a characteristic of evil is that it cannot truly be confined. Processes of decay cannot be stopped. Germs can penetrate even the smallest cracks; violence and destiny can strike at any time. Evil is an effluvium – a fluid – that seeps through all barriers. The boundary thus needs to be

stiffened, re-marked, reinforced and thickened, but it is always fragile and full of holes. Hands are washed to eliminate the stink of evil that surrounds them, but the skin becomes ever more fragile, the barrier weakens and requires more and more cleansing, in an infinite, vicious cycle. Keeping a close eye, an obsessive eye, on every barrier is not enough; they crack and crumble, and rot. They are corrupted by the inexorable flow of time, which devours, consumes and disintegrates everything. Disgust, which some authors (Straus, 1948) consider the central experience in obsession, arises from this close encounter with materiality, which cannot be pushed away. As we saw with Swift, the lack of a broad spatial dimension, being crushed by things, makes them disgusting. The impossibility of establishing a secure boundary between oneself and the uncertainty of what might happen at any time helps us understand the phenomenology of not being able to distance and reinforce barriers in a satisfactory way. This also enables us to understand hoarding practices. ‘To eliminate’ etymologically means to thrust outside a boundary (from the Latin *e-*: ‘out’ and *limen*: ‘threshold’), but it is something that is both desired and impossible at the same time. Aggressiveness, which can sometimes lead to violence, is often an extreme attempt to raise a barrier where somebody has breached it, creating a threatening crack in the safety belt that the client is constantly building and monitoring. The fear of doing harm here does not come from a ‘repressed desire’ to harm. It is a real fear that expresses both the risk of extreme defence (when distance cannot be created and the boundary defended in any other way), and the risk of involuntarily losing control.

2.4 Materiality

In an obsessive world, things have a life. They move; they are uncontrollable and unpredictable. They are strongly characterised by what Gestalt psychologists have called ‘physiognomic qualities’ (Metzger, 1941/1971; Straus, 1948), which immediately evoke sensory and emotional experiences (see §3.1) that are usually disturbing, even to the point of being terrifying. Things are not at rest and so they elicit restlessness. Things, when you look closely at them, look at us. Things are creatures and so they, too, undergo a process of entropic decay. Matter is not a stable unit; it decays relentlessly. Things, in such experiences, are not over there, clearly separate and distanced from the onlooker, who stands in a more or less neutral position of observation. That position is coveted but never fully achieved, because things are always here; they are disturbing and cannot be pushed away. There is no clear and persistent boundary. Something is always elusive, excessive. A scratch down the side of the car, dust on the sideboard cleaned last night, a withered leaf among the geraniums, coins

handled that might have been swallowed: all vivid testimony of how much eludes our control, of an entropic battle without end, without respite, in which we can never prevail.

Sufferers of obsessions live under siege, exposed at every moment to possible harm, provoked by things or, involuntarily, by oneself. Besieged, they fight on without respite, without peace.

3. A Gestalt analysis of the experience: the meaning of obsessive–compulsive creative adjustments

The question I want to try to answer in this section is: ‘How is obsessive experience structured?’ The question is about pathogenesis, that is, how a certain type of suffering takes shape. On the basis of this analysis I hope to shed light on how this so utterly difficult way of living can nevertheless be a creative adjustment that is functional in certain situations.

3.1 Beyond the Pillars of Hercules: *Vorgestalten*, proto-self, emergent self and other chimeras

To answer this question I will base myself on a few theoretical and empirical references: to begin with, the work of Gestalt psychology on perception, following the analysis of Klaus Conrad⁸ and, in particular, the work of Metzger (1941/1971). These thinkers provided empirical evidence showing that perception is a process which, in just fractions of a second, leads to a perceptive experience in which the subject perceives himself as separate from the object, where the subject is detached both spatially and emotionally and the object possesses a clear, definite outline. This outcome of perception, which Metzger called *Endgestalt* (final gestalt) is the result of a process that arises from a very different, original perceptive moment. The perceptive forms of that initial perceptive moment are called *Vorgestalten* (pre-gestalten). With *Vorgestalten*, the perceptive experience is diffuse, undifferentiated and global. The figure has yet to stand out separately from the background; something is there, but it is an unstable, confused and indefinite presence. It is an experience of non-rest, and hence of restlessness, before a subject is distinguished clearly from an object. In this first phase, *expressive physiognomic qualities* predominate – qualities that are affectively charged, which communicate something in an immediate, pre-reflexive way. They are experienced in a passive way, as though seizing the subject, giving rise to a sense of expectation of development, of a purpose that has yet to be defined here, and if that development is delayed, tension emerges and restlessness grows. When *Endgestalten* finally emerge, *structural–material*

qualities are what predominate, characterised by a feeling of relief in perceiving a distinct figure which objectively stands out and from which the subject feels he is separate and in a position to observe with critical judgement and emotional detachment. The sensation of being passively drawn into something indistinct and disturbing ends. With *Vorgestalten*, at the origin of all perception, the experience is atmospheric and pre-dualistic, lying at the basis of our pathic life (Tellenbach, 1968/2013; Griffero, 2014; Böhme, 2010; 2017; Schmitz, 2011; Francesetti, 2015b).⁹

In this initial phase of perception, the boundaries and poles of subjectivity and objectivity are not definite and stable. This Gestalt analysis of perception is in line with the description of the emerging of the self developed by Antonio Damasio (2012).¹⁰ According to this model, based on his neurological studies, in perception the self emerges progressively, in the space of a few fractions of a second, in stages: the proto-self, the subjective self, and the autobiographical self. In the original, initial stage, the proto-self is alerted to the presence of *something*, without it being clear who it belongs to. A state of rest becomes a restlessness that cannot be attributed to me as a subject yet, because the sense of being a separate subject will only emerge at a later moment. The concept of the *emergent self*, developed by Daniel Stern (1985), also embraces this initial datum of all experience. The emergent self characterises the first few months of life of infants. At this time of childhood development, there is no definite sense of self, nor is it distinct from the world; rather it is the *emergent process* of the self that is figure. In Stern’s model, the stages we go through in development are present in every subsequent experience, in every moment for the rest of our lives. The phenomenological tradition also points to an original dimension of experience in which subject and object are yet to be differentiated, and describes the natural, naive attitude (Husserl, 1913/1931) that normally characterises perception as a product and not as an original experiential datum, although we normally pay no attention to it (Merleau-Ponty, 1945/2003; Alvim Botelho, 2016). The presence of this original experiential *momentum* is evidenced by the etymology of the words themselves: ‘We see the vestiges of this process in the words *subject* and *object*: *sub-jectum* in the Latin means cast down below, *ob-jectum* means cast out there, thus bearing evidence of their not being original essences but the product of the act of being cast into two different regions of the world’ (Francesetti, 2016a, p. 150). In a previous work, we called this moment the *pre-personal dimension* of experience (Francesetti and Spagnuolo Lobb, 2013) and took it as the cornerstone for understanding psychotic experience. In psychotic experience, the subject fails to emerge from the pre-personal dimension of *Vorgestalten*

and is left astray in a world without defined boundaries, a world that is restless and incommunicable, which engulfs him passively and from which he cannot break free. Delusion and hallucination are the creative adjustments used in this nightmare world to escape, not into a world that is shared, but at least into one that is definite.¹¹ We described this world as being *beyond the Pillars of Hercules*, a place that the Ancients believed to be beyond the known, effable world, beyond the *non plus ultra*, a world populated by monsters and chimeras, which the Pillars (in Greek rendered by the word for *boundaries*) protect us from. All of us, at the root of all of our experiences, emerge from this world. This perspective is in line with the concept of the emergent self that underpins the theory of Gestalt therapy (Phillipson, 2009; Robine, 2016; Francesetti, 2016a; Spagnuolo Lobb, 2016; Alvim Botelho, 2016; Bloom, 2016; Staemmler, 2016), where the sense of self is a process that emerges in a situation, arising as the self of the situation (PHG; Robine, 2006). Recognising the pre-dualistic origin of subjectivity is especially important because it underpins a post-Cartesian perspective (or post-Democritean, according to Schmitz, 2011) which enables us to understand suffering and its treatment from the point of view of the field (or the relationship, the situation, or the intersubjective matrix, depending on the author) and not the individual, although it is the individual who feels and expresses that suffering and calls for its transformation. This analysis of the perception process is the basis, just on another timescale, of the sequence of contact developed in PHG. The undifferentiated pathic moment is the realm of the id function of the self, from where, and on the basis of previous assimilated contacts (personality function), we continuously emerge as subjects.

3.2 The structural genesis of obsession: ceaseless Herculean leaps

The literature features various models that attempt to give meaning to how obsessions arise. In particular, there are psychodynamic models (Gabbard, 1994), behavioural and cognitive models (Beck, 1976, and subsequent developments) and even Gestalt therapy models (see references above). In PHG, obsessions are seen as thoughts that serve to remove the anxiety of excitement. The analysis that I present here will seek to build on this statement, locating the disorder in particular in relation to the neurotic and psychotic levels of organisation and understanding it in the light of perceptive processes and the emergence of the self.

The hypothesis I present in this section is *pathogenetic*; that is, it attempts to explain how the experience emerges independently of its causes, which we will seek to address later on. So let us look at a Gestalt therapy analysis of obsessive experiences.

If we correlate obsessive experience (see §2) with the genesis of perception (see §3.1), it immediately appears evident that sufferers of obsessions are *besieged in the world of Vorgestalten*, but at the same time *neither lost nor inexorably stuck there*. What we can observe is an ongoing battle to create distance, to close and conclude, to draw boundaries, raise barriers and separate. In psychotic experience, the person is stuck and lost in this world without differentiation, and acts out her drama through delusions, hallucinations, and withdrawal into the unspeakable. That does not happen here. Sufferers from obsessions fight back against the undifferentiated world by waging an endless battle to conquer a distanced, bordered and safe land. Every centimetre of ground is strenuously gained, only to be immediately and inevitably lost. Time is never a victory but an endless battle; it is not an event but an effort. In the words of a client, 'I am on a lifeboat stranded in the middle of the ocean, alone in the storm. I bail out the water, but the boat is leaky. I cannot stop. I do not sink, but for all my efforts the situation does not change. What will happen when I am too tired to continue?' While in psychotic experience the person is unable to leave behind the *Vorgestalten* and conquer a shared world, here the person makes a Herculean effort to trace out and hold on to *Endgestalten* that are clear, definite and certain – but without the *Vorgestalten* actually maturing into clear and definite figures and without being rooted in a ground. It is a leap from an immediate, pre-verbal and sensory world to a verbal, cognitive, logical/mathematical and reflexive one. Obsessions are none other than this: the capacity to create – and hold on to – definite figures which, as they are not rooted in the ground, need to be over-defined and endlessly repeated to be able to *ex-ist* (come out), *sub-sist* (remain out) and *per-sist* (endure over time). Seen in this light, the experiences and symptoms make sense, as perfectionism is an attempt to bring experience to term and reach a point of accomplishment, while bodily anaesthetisation is an attempt to push away the feeling of being seized by the atmospheric. The battle against contamination is a battle to create boundaries and define oneself. The search for symmetry, for things to add up, for order and control is an attempt to reduce the chaos of the indefinite, where anything can happen. The search for security is the search for a stable, predictable world in which to be without cares – etymologically, *secure* comes from the Latin *sine cura*, meaning 'without care' – i.e. without having to constantly work to make it subsist. Such efforts bring relief as *they are part of a battle which is not lost, although it can never be won*, like bailing out water from a leaky boat, and act out the drama the person is going through. This is a fundamental need in any psychopathological field,

because it is only by acting out suffering – actualising it in the here and now – that suffering can find a relational space in which to be transformed (Francessetti, 2015b). From this perspective, obsessive symptoms are not something to be eliminated, but the expression of a creative adjustment that saves the client from becoming lost in a psychotic world without boundaries. Here we can appreciate the contiguity, highlighted by other authors (Straus, 1948; Stanghellini and Ballerini, 1992), between obsessive and psychotic experiences. Such an approach is very different from one that considers obsessive thoughts as something wrong, as something to be confronted and overcome. Rather, such thoughts are how the client escapes from a sensorial ground that elicits only restlessness and terror. It is precisely this capacity to make the Herculean leap from the terror of the senses to, albeit temporarily, a reflexive, logical/mathematical world that can be controlled that saves the client from a much greater terror. It is, however, a leap that must be repeated at every instant: ‘Suspended from shaky scaffolding, we secure ourselves with our fixations’.

3.3 Aesthetic excess: the devil is in the detail

This analysis also helps to shed light on the sense of distance that sufferers of obsessions feel from the senses and the body. The root of feeling, in such an existence, is in fact the source of an indefinable terror that is atmospheric, boundless and unpredictable. In the words of a client, ‘I transform terror into fear every minute of every day. But my feet¹² are always immersed in terror.’ The leap out of the *Vorgestalten* is a leap from the domain of aesthetic (pathic) feeling into the cognitive, logical/mathematical and linguistic domain, where the client is left hanging in the balance between two worlds, managing not to get lost beyond the Pillars of Hercules (thus saving himself from psychosis), but unable to remain stably in the differentiated and definite world. As it is a leap that always takes him to the same spot, and not a process that takes him forward, in order to remain permanently he would have to burn his bridges definitively with the sensorial world. But if he managed to do so, a more serious form of suffering might emerge, such as, for example, a form of sociopathy.¹³ In sufferers from obsessions, desensitisation does not reach that point. What the client experiences and what generates his compulsions is a phenomenon that we can call *aesthetic excess*. Despite all her efforts, the obsessive person is not able to accomplish the leap beyond feeling, beyond an atmospheric feeling that can never fully be grasped, with which she remains in some way in contact. An atmosphere is never completely reducible to an object that can be pushed away; something always eludes us, like a fluid. Feeling can never be grasped completely or circumscribed

by language. Language and sensory feeling are incommensurable (Mazzeo, 2013). In geometry, two magnitudes or figures are incommensurable when their ratio generates a remainder. Incommensurable does not mean inexpressible; it is expressible but with a remainder. That remainder leaves an inexhaustible margin for regeneration, like approximations of infinity, such as the value of pi, which is infinite and continually regenerated after the decimal point. Language expresses sensory feeling in an approximate way, that is, with a remainder. As Lynne Jacobs has stressed,¹⁴ approximation is of value in therapy because it indicates a process of coming closer that releases people from performatively having to find the exact word and which continuously keeps the dialogue and conversation open. Language, with its subject–verb–object structure, is suited to expressing experience after subject–object separation has occurred. Universal grammar (Chomsky, 1957) serves to express *completely* the ingenuous, natural world of subjects and objects that are already separate – the world of Aristotelian logic. To express experience before that separation – beyond the Pillars of Hercules, in the world of *Vorgestalten* and the atmospheric – other languages are needed. Goodman suggests poetry (PHG, 1951; Vázquez Bandín, 2014). Or madness, the unfortunate stepsister of poetry (Clemens Brentano, quoted in Béguin, 1939). Vivid language, poetic language, which touches us and is capable of striking a bodily chord, approximates sensory experience while at the same time carrying the scent of that which remains to be said. It is a language that both hits and misses the mark, but what is missing also speaks loudly – indeed, it is what is missing that enables language to be alive, enchanted and enchanting, instead of dead and *perfecto* (Loewald, 1989; Mitchell, 2000). The atmospheric excess of sensory feeling, or aesthetic excess, is the demon that the obsessive person is unable to suppress – the things that do not add up (or leave a remainder!), the microbe that survives the antiseptic, the impulsive feeling that refuses to go away, the picture that does not hang straight, the speck of dust on the table ... the devil of obsession lies in these details, which represent the unsuppressible and saves the obsessive person from the anaesthetic of sociopathy. Approximation is intolerable for sufferers from obsession because it is a process that leaves a remainder which refuses to go away, and by doing so it does not permit completion and distance to be accomplished. This gives us additional insight into compulsive rituals as attempts to reduce and extinguish the aesthetic excess which no mathematical or linguistic logic can ever – fortunately – reduce to zero. But they only bring temporary relief. With ritual, as opposed to games, where the outcome is uncertain, we know how things will end; it is predictable and gives

a sense of control. And ritual is a culturally accepted way of keeping the atmospheric in check, giving it shape and building memory. Think of how rituals support us in times of great atmospheric valency, when they give a socially-accepted shape to individual experience while ensuring relational connection – in the case of a death, for instance, an event of excess par excellence, in which time and space unravel,¹⁵ ritual gives shape to individual experience while allowing us to remain in the shared social world. Obsessive people, however, use this adjustment without it being shared with others and hence without alleviating the solitude that underpins their terror – but without succeeding in extinguishing the aesthetic excess that ultimately ties them to the world of life.

4. In which kinds of existence does obsessive adjustment emerge?

In this section we enter epistemologically slippery ground, where the risk of reductionism is great and it must be remembered that all that we can formulate are hypotheses. Here we address the question of aetiology, or the causes of this suffering. In embarking on this road, it must be remembered that the causes of the disorder are not presently known, and this gap in our knowledge can be, paradoxically, a source of support for the therapist. Stepping into the gap with awareness helps the therapist to be open and curious and to seek a shared and unique narrative for the client which gives meaning to his suffering. Here, not knowing is the key to seeking and uniqueness.

It is always necessary, in psychopathology, to put aside the logic of simple and reductionist causality. What we generally know is that every case of suffering has its own complex and non-reducible roots. The position I take up within this complexity is based on two assumptions: first, that every case of suffering has a meaning (Borgna, 1989); and second, that suffering emerges in a relational field that is acted out in the therapeutic encounter (Francesetti, 2015b; 2016a; 2016b; Spagnuolo Lobb, 2013b).¹⁶ In psychopathology, rather than focusing on causality, which tends to lead to reductionism and generalisation, greater support can be drawn from the concept of pathways, which ensures greater emphasis on singularity, uniqueness and context. Looking at such pathways, psychodynamics has implicated fixation in the anal stage and Oedipal conflicts in the development of OCD (Gabbard, 1994; Straus, 1948). A perspective that lies closer to our own is that of intersubjective psychoanalysis, which has explored the disorder in terms of intersubjective fields (Stolorow et al., 1999). The cognitivist approach has produced much literature (Beck, 1976; Frost and Steketee, 2002; Clark, 2004) which we often depart

from as we do not agree with the perspective that obsessions are originally caused at a cognitive level; rather, from our point of view, the obsessive attachment to a thought is a creative adjustment to distance oneself from disturbing and terrifying sensory feeling.

To find our way among the pathways that lead to obsessive suffering, let us start from two phenomenal data that would appear to be evident. The first is that the emotional ground of sufferers from obsession is one of terror (Salonia, 2013; Stanghellini and Ballerini, 1992; Muscelli and Stanghellini, 2008; Calvi, 1996). The second emerges in therapy, where the client appears to be oblivious to the possibility that her terror can find relief in the relationship. She does not see relational comfort when she is afraid. Once again, Marcoaldi's insightful and terrifying poem expresses this element:

What do you think? If I hold you real tight,
will I have a better chance of escaping death's bite?
(Marcoaldi, 2008)

This question can typically emerge in an obsessive field. Obviously, the answer is 'no': a hug will not fend off *death*. But those who ask such a question clearly do not realise that a hug can fend off *the fear of death*. Sufferers of obsessions are oblivious to the calming power of a hug, of bodily closeness, of relational comfort – etymologically, *comfort* means *strong together*. Here we find a central core of this experience: the solitude of terror. The obsessive client is alone, but in a certain sense he is unaware of it because he does not realise that it does not have to be that way, as he has no experience of reference for him to be nostalgic of the other and to call out for her. Rather, as we have seen, the structure of his experience drives him to seek relief in distance, but the space to feel distant is lacking, and hence the desire for closeness, which requires a sense of distance, cannot emerge. Moreover, his experience is one of emergency – it is very hard to let go of the shaky scaffolding that saves you from the abyss to grab hold of someone's hand. It is like someone who climbs a rock face and is suspended over the void, clinging to holds without a safety rope, being invited to let go and grasp another's hand (Salonia, 2013). In such an experience, the terror and diffidence that we face are so strong that we think the other person's hand has already betrayed us, that the other is already gone. It is easy to find stories in which the relational containment that comes from affective and bodily closeness has been lacking. In the words of another client:

'I grew up through childhood in a house without walls, exposed to storms of all kinds, where bursts of unpredictable anger violently shook the house and the cold paralysed everything. It was only my solitude, curled up in a hidden corner, that enabled me to breathe as I trembled. Only my solitude gave me

comfort. I began to read through the house's immense library, one book after another, from the bottom left-hand corner onwards, in order. From general relativity to *The Charterhouse of Parma* and the works of the Marquis de Sade.⁷

Here we are outlining the possible narratives in which the other failed to provide containment when faced with terror and the uncertainty of life, but we will not go any further so as to avoid stereotyping and crystallising the experience. Instead let us stop at the two evident phenomena identified: terror and the difficulty of conceiving relational containment. These phenomena underscore an element of OCD that is rarely highlighted in the literature, which is the solitude of obsessive experiences.¹⁷ To conclude, while we are able to describe the specific way this disorder takes shape (pathogenesis, see §3), we cannot and do not want to reduce OCD to specific causes. All we can do is give the hypothesis that this form of suffering is shaped by existential experiences marked by exposure to terror, without sufficient relational containment. This lack of containment remains as a memory of the impossibility of trusting and relying on the environment. Therapy will provide a new experience where containment and trust can be felt. I do not see it as a reparative experience, since what was missed cannot be replaced: in the therapeutic moment, the realisation of the possibility of containment emerges with the pain of what was missing and this pain remains forever (albeit in different forms). But a new experience of containment that provides new possibilities for breathing and being in the world is possible.¹⁸

5. The emergent obsessive–compulsive field in the here and now of the therapy session

When we encounter a person in therapy who suffers from obsessions, together we actualise a phenomenal field¹⁹ that acts out the suffering. As I have described elsewhere, (Francessetti, 2016b; forthcoming), acting out does not imply anything artificial but specifically refers to the actualisation of a field between us and around us which is the ecstasy of the lived bodies in the present situation. What emerges is *something real* – the phenomenal field – and aesthetically perceptible as an atmosphere, an almost-entity, which is neither solely objective nor solely subjective. It is the coming out, the ex-istence, of a field that at the same time actualises the absences at the contact boundary (i.e. the suffering) and calls for presence (i.e. the potentiality for transformation and presence). The degree of presence and absence takes shape through how each of us stays at the contact boundary in the therapy session; it is the ecstasy of our bodies and of the situation. A

psychopathological field holds the absences at the contact boundary which await the presence of the other so as to transform into pain and beauty (Francessetti, 2012).

What are the features of an obsessive field? Although different for every encounter, and hence for every client, every therapist and every session, we believe there are certain features which can be found in different ways (if it is true that all obsessive suffering has a common basis of experience). The experiences I describe are an expression of the themes that circulate in the field and can be felt at times more by the client, at other times more by the therapist. They are the effect of co-creation.

In such a field, in therapy, I might feel that I have to tread very cautiously, often feeling that I am on the verge of making some mistake without really understanding why, but with the sensation that I have to control what I do carefully. I learn that some words are forbidden – *terror*, for example. Or certain gestures, such as shaking the client's hand to greet him or, sometimes, getting too close, past a certain limit. In controlling itself, my body tenses up and stiffens, my breath shortens imperceptibly. Without realising it, I lift myself slightly off the chair, raising the barycentre of my body. Sensitivity is reduced and the air becomes sterile. Sometimes, before the session, I check that the room is tidy or that the armchairs are sufficiently spaced out. I have even felt, at times, that I wished the room were bigger or I feel that the client would prefer it. I feel less in touch with my body, a bit disembodied as such. Bodily presence can almost become something disreputable, or even superfluous – 'What does the body have to do with things? We're talking about psychic suffering here, about irrepressible thoughts! I'm suspended over the void and you're telling me to breathe? Of course I'm breathing, that's not the point! How's that going to help?' Sometimes there is a sense of emergency that puts me with my back against the wall, with no way of escape, and I have the feeling that an answer is needed now, a definitive, resolute answer. At times like that space contracts and I cannot breathe. I feel under siege – what a relief it will be when the session is over! It can happen that I feel drawn to thought, to debate, to narration, to itemisation, to pure and formal logic. Time tends to flow at uniform speed, without reaching a crescendo that leads to somewhere, to some point at which I can say 'Today I've come this far!' with some sense of accomplishment. This can make bringing the therapy session to an end quite hard, as though something is missing and taking forever. The air tends to be cold and crisp, rarely ever moved by affective surges, absorbed as we are in the pursuit of something that we can never grab hold of. The clearing that every therapeutic encounter attempts to open up is never wide enough, or comfortable and

cosy, warm and substantial, hospitable and safe. It is not a resting place. What a surprise it is when I do find the space and audacity to give dignity to the stirring of my emotions, to being in touch with my soul, as it is warmed by the contact made with this person who suffers. (At this point I feel I should explain what I mean by 'soul', but this is probably the effect of the 'rising current' present in the obsessive field which as I write I am actualising.) The other may elude me – it is easy to be blinded by the details or by the urgency of the symptoms, but hard not to lose hold of the body that vibrates and suffers, that sounds out and touches the heart. At times it feels like the client is on the other side of an iron curtain; at others as though a misplaced word might pierce his soul, tearing apart the flesh. Sometimes I feel useless, even as a human being; I want to offer comfort, but it all seems too little – not because the client does not expect anything (as in a depressive field), but because I feel powerless before the reiteration of the symptom, before the urgency of the terror, before the radicalness of the questions. I try to make a difference, but often I cannot; I exhaust myself. At that point I feel a desire to step back, and maybe I do step back. And it is there that I can feel the precious value of a sentiment that slowly but surely emerges. I feel the warm pain of leaving the client alone and the client, at a certain point, can feel that the air is colder as I move away, and the terror greater. At that moment we are outside the obsessive field. Thanks to embodied presence, the terror attenuates, and we can let go, at least for an instant, the lonely, shaky scaffolding. The encounter is event, breath punctuation, the clearing a resting place.

6. Therapeutic approaches and directions

Therapy with OCD sufferers is generally difficult and frustrating for both the client and the therapist. But although the long-term outcomes can be uncertain, it is nevertheless useful. NICE provides the guidelines for the treatment of OCD.²⁰ The models of intervention most extensively reviewed, those based on behaviourist and cognitivist approaches (Abramovitz and Siqueland, 2013; Foa et al., 1999; Beck, 1976; Frost and Steketee, 2002; Clark, 2004) have been shown to help reduce the symptoms of OCD quite significantly, albeit often not definitively. The disorder, in fact, is frequently chronic in nature, alternating periods of well-being with periods when symptoms are more intense (Castonguay and Oltmanns, 2013). There is also evidence that the involvement of the family in psychoeducation or therapy can help considerably, as the mere adaptation of the surrounding environment to the ritual demanded by obsessions tends to worsen the situation. Taking

our phenomenological and Gestalt exploration as a starting point, let us look at some of the directions that can help us in therapy work. In brief and general terms, the therapeutic approach focuses on being able to feel the emergent phenomenal field in the therapy session in full, which means being present for the absences that are actualised in the field, and on grasping one's own contribution to its co-creation. This is the threshold that opens the door to change. By modulating one's presence, rather than seeking to change the client (Francesetti, 2015b; Francesetti, forthcoming), the co-created field is changed, giving rise to a new experience and thus a new memory. In the therapeutic encounter, suffering is actualised and when it reaches the contact boundary, thanks to the presence of both the therapist and client, it transforms (Francesetti, 2012; Spagnuolo Lobb, 2013a). This is a Gestalt therapy perspective on the therapeutic process that is valid with every client, regardless of his suffering. For more insight on this, reference should be made to the works cited.

But what are the themes and steps to be focused on when we find ourselves in an obsessive-compulsive field?

6.1 From the *Körper* to the *Leib*:²¹ keeping aesthetic sensitivity alive

The aesthetic dimension is the sensorial world, the root of feeling. In an obsessive field, the current present in the field constantly tends to drag us away from that dimension, and so it is important for the therapist to take care to remain in sensorial contact with her own lived body (the *Leib*). In an obsessive field, that contact can easily be lost, as the tension makes us tense up and become anaesthetised and we focus on thought. In this field the *Leib* easily becomes the *Körper*, the medicalised, anatomical and functional body, the body that does not feel and does not savour. In an emergency, the senses are roused to take in the dangers that are present; the eyes, ears and nose become alert to the environment and breathing stops in expectation of an attack. Focus is lost on aesthetic perception, on bodily, proprioceptive and atmospheric feeling, the very focus the therapist must be especially careful to maintain. It is important for breathing to remain fluid, which means keeping time and space in contact. Giving fullness to breath gives fullness to space and helps establish the right distance. Feeling the fullness of the breathing cycle as it is completed changes the uniform, linear motion of time, generating a rising and falling motion that brings a *perfecto* cycle to completion, to conclusion. Contact with one's own lived body also enables the therapist to gauge, instant by instant, the 'temperature' of contact and the actualisation of the atmospheres in the encounter. The capacity to stay in the indefinite that arises at the root of the senses, feeling

all that emerges without retreating from it, allows us to make contact with the experiences of terror which continuously fuel obsessions and keep the client and, in therapy, the therapist at a distance. Work is always, therefore, bodily, in the sense of being embodied and present in the awareness of the therapist. Sometimes, it is possible to bring this bodily work into figure, once the debasement that focusing on the body often implies is overcome and once a relationship of sufficient trust is built over time. When this is possible, the experience of bodily work is precious, as we experience the effects of distance/closeness and how it affects the experience of space, of boundaries, of their blurring and re-establishment, of the emotions that these movements elicit, and of temporality in exercises, such as the simple technique of grounding, in which the client feels fatigue and physical pain, and then relief, signalling the end (*perfecto!*) of the exercise.

6.2. From terror to containment through contact

Experiences of terror will gradually emerge in therapy – a terror for which no containment is conceived. A pure and boundless terror that can only be put in check by obsessions. A terror for which there is no concrete response. A child at around the age of two might ask her mother, ‘Will you die?’ The mother responds immediately by approaching the child with a smile and an embrace, and will usually say something about time, something like ‘But I’m not old yet!’ The child is calmed and turns her attention elsewhere. In this sequence, space is swept by a strong emotional resonance and by the body of the mother who brings the warmth of closeness; time is demarcated so as to create distance between a now that is close and a then, a then so far off that it cannot touch us (the boundary is here); the body is calmed in the arms of the mother;²² breathing returns, and the sequence of the experience is completed. Attention is free to turn elsewhere. Before a sequence of this kind, i.e. of the *com-fort* (*strong together*) of contact (not necessarily through physical contact), can emerge in therapy, a lot needs to happen first. The therapist has to have been present in experiencing the obsessive field, without retreating from it and becoming anaesthetised, and without being overwhelmed, so as gradually to become visible for the client and reliable. The client comes to ask Marcoaldi’s same question: ‘If I hold you real tight, will I have a better chance of escaping death’s bite?’ But therapy work, as I have said and will say again, is not aimed at changing the client. The questions the therapist focuses on are: ‘In the therapy session and in life, how do I deal with the existential terror provoked by the thought of my own death? And by the death of the people I love? What grounds have supported me, now and in the past, enabling me to continue

breathing when faced with these possibilities? How is all this actualised when I encounter this client?’ Asking these questions and authentically exploring one’s own experience of these issues enables us not to lose touch with our bodily and affective presence in therapy and to be able to feel that the emergence of terror will not lead us to evade therapeutic contact. From this ground, answers will emerge to the pressing questions that the client poses to the therapist (Salonia, 2013) – answers that are founded not on reassurance but on the support afforded by truth;²³ not on showing a confidence that we do not have but on contemplating the limits of life and continuing to breathe. In the example given, it would not help for the therapist to assure the client that nothing will happen; indeed, this would undermine the relationship of trust because the therapist would be stating something he cannot know. Instead, what helps is to learn, when confronted by the unpredictability of life, to keep calm together, that thanks to our presences life is sufficiently hospitable – from *hospes* (host) and not *hostis* (enemy) (Salonia, 1999). The way this happens cannot be reproduced as a technique. It is a *phronēsis* that emerges only if the therapist’s ground on these issues has been prepared (Sichera, 2001; Orange, Atwood and Stolorow, 1999; Francesetti, 2015b). An inter-corporeal relationship gradually will take the form of containment for the emergent anxiety.

6.3. From solitude to affective resonance

Being mindful of one’s sensory feeling, and capable of gathering, supporting and sustaining terror, will enable a constituent dimension of obsessive experience to emerge, which is solitude. A terrified solitude, because it is exposed to the contraction of space, the breaking of boundaries, the degradation of materiality and the absence of accomplishment. For the client, the ‘luxury’ of feeling that solitude will only be possible in the nooks, initially rare, where respite can be found from the emergency. As long as the emergency continues, any closeness will threaten the unstable boundary and the need for distance, and will not address the immediate need of finding a solution to the reasons for the terror. Nevertheless, with time a certain closeness will begin to be appreciated and to have meaning. A kinaesthetic resonance will find, with uncertainty, its way (Frank, 2016) and the therapist’s face will begin to be perceived vaguely as a healing otherness (Bloom, 2016). Quietly, almost stealthily, without being able to name it or bring it to the fore, a ground of affective presence will begin to make the difference. For this to happen, the therapist will have to call on her capacity to wait, without anticipating events and without diminishing the value of closeness – a strong pressure in the obsessive field. Even here, the therapist will ask herself, ‘How has closeness been of comfort to me? What value am I able

to give it? What supports me in my solitude?’ and it will be important to feel the sensations and sentiments that emerge from these questions. Every time the therapist brings this into the field, mostly implicitly (Stern, 2004), the field changes and will tend to help these experiences emerge in the client as well – experiences that open up an evolution in the client’s experience can be experienced by the therapist first. Through this approach, the way of being in the world can undergo a relational refoundation and the existential experiences, unspeakable but lived, which enable us to breathe and be aware and present even when faced with the uncertainty of life, can be confronted. Until ultimately sufficient relational ground is felt to understand death on the horizon of life, a passage that is necessary for life to be temporalised, space to be consistent and for time to flow (Heidegger, 1927/1962).

6.4. Pharmacological support

Pharmacological support should always be taken into consideration for this disorder as it can significantly reduce the client’s suffering. What is fundamental, however, is that it is treated as a way of reducing the intensity of the symptom and not as a way of reducing the meaning of suffering to a biochemical fluctuation, which would imply a belittlement of the client’s experience and the invalidation of his point of view, with the risk of producing iatrogenic effects. Close collaboration is therefore needed between the psychiatrist who prescribes the therapy and the psychotherapist, along with mutual respect for their fields and boundaries. Clients who suffer from OCD sometimes refuse drug treatment, especially where issues concern contamination, as taking a drug may be seen as a violation of the boundary by an intrusive foreign body. This does not exclude psychiatric advice in which the client is clearly informed of the limitations and potential of pharmacological support, where such advice clarifies, distances, and gives definite form and dignity to the client’s choice. Sometimes, before a drug is prescribed, trust in the psychotherapist needs to be built to ensure that the meaning of the client’s suffering will not be lost, even if the drugs prove effective. Appropriate drugs include, first and foremost, antidepressants, especially serotonergics, but benzodiazepines and neuroleptic drugs can also be used in specific situations.

6.5. A brief clinical example

Now I will present two brief verbatim records that help connect what I have described to concrete clinical practice. Andrea is a forty-five-year-old man, head of administration for a large company, who has been married for some years and has a two-year-old daughter. He sought therapy for major obsessive–

compulsive symptoms that heavily interfere with his life and for his terror over the possibility of harming his wife and daughter. His rituals are designed to predict and prevent accidents, misfortunes, illnesses, and possible bursts of violence. Every day, highly complicated combinatorial calculations compel him to repeat secret rituals over and over again until they all add up and the dangers are momentarily warded off. Shortly before starting therapy, he hid all the knives in the house in the cellar for fear that he could commit an irreparable act in a moment of rage. He appears extremely diffident and controlling to me, very intelligent and with an extraordinarily logical mind. His body is stiff, controlled, held back and upright. Later he would tell me that he suffers from muscle pain and tension headaches. He comes from an affluent family, with childhood experiences of abandonment and solitude, ongoing affective neglect, exposure to bursts of rage by his parents, and unpredictable departures by his mother. A cold, desolate house without walls, constantly weather-beaten and exposed to unforeseeable storms and earthquakes. The eldest son, he has a younger sister who has been diagnosed with schizophrenia, and a younger brother with addiction issues. My experience with him, especially at the start of therapy, was one of feeling tense and controlled in my actions, highly cautious and not free. I have to remind myself to keep breathing and to rest my weight on the armchair so as to be present, so as not to allow space to crumple up, as though sucked into a vacuum. The phenomenal field that we actualise is such as to make me feel powerless and cornered, with no moves possible, while he is left alone and exposed to the fear of uncontrollable events, to be managed without my support – it is an obsessive field. The key moments in therapy are moments of contact that change this co-created field. The new relational experience that is needed is one that any person with a sufficiently healthy history will obviously have in their ground: the experience of keeping calm in the face of uncertainty thanks to the presence of an affective and containing significant other.

Verbatim extract, after about eight months of therapy:

One day, Andrea described a scene to me in general terms, without going into the details, in which his two-year-old daughter is kidnapped, tortured and killed, evoking the cruel and terrible things that could happen to her without naming them. Although no specific scene is described, the atmosphere generated between us is blood-curdling.

I say to him:

Therapist: ‘The way you talk about it, more than what you actually say, makes me think that one could be terrified by these thoughts.’

Andrea: 'Yes, they're frightening.'

There is something in the way he says this that suggests a sort of side-stepping of my statement, a small movement of the head, perhaps, that gives me this impression, as though he was avoiding something. I also realise that he did not repeat the word terrifying. He seems to be evading it with the same circumspection of a feline that sniffs out and avoids a trap.

T: 'Hold on, Andrea. Are they frightening or terrifying?'

A: 'That's a word I never use.' [becoming tense and moving back]

The terror has become palpable between us. It is so strong that it weighs down on my chest; as though it were about to explode. I feel an urge to run away. I feel it is too much for both us, so I need to alleviate the tension a bit.

T: 'So you prefer the word "frightening"?' [the tension immediately relaxes a bit]

A: 'Yes, I prefer to talk about fears because they are controllable.'

T: 'Ah ...' [relieved]

Now I feel something different between us, something pleasant, but indefinite, has emerged. Perhaps it is simply the fact of not having left him alone in that tension. Then he speaks with the speed and blast of a bullet:

A: 'Instead terror is something you can't control.'

The sensation I have becomes clearer. For the first time, between the two of us, he has been able to say the word and bear it; the space between us is clear and sustaining, not sterile. There is a knowing look in his eye – he knows he has said the forbidden word and that he was able to say it thanks to the fact that he is here, and he knows that I know he knows. In that pause we savour our feeling. I feel I am with him and that we have reached somewhere.

It is a moment of special, intense contact, to be cherished, even without naming it. An understanding that changes the actualised field between us, which we both know, without saying it, we will remember – for me an experience of not feeling powerless, pressed up with my back against the wall, and for him of not being left alone with a terror sterilised of all presence. A small, shared affective journey (Stern, 2010), a grain of betweenness in a boundless solitude.

After about a year-and-a-half of therapy:

A: 'I'm sick and tired of all these controls, sums, rituals and more sums; they're growing. And what's worse is that they're an insult to my intelligence – they're such stupid things and take up loads of energy.'

T: 'They don't make sense to you?'

A: 'I'm not convinced.'

T: 'What do you mean?'

A: 'You pointed out to me that they grow when I'm afraid for the people I'm attached to, so they express my bond, perhaps even my love for them.'

T: 'Yes ...'

A: 'Reason makes me doubt all that. In the end, maybe it's all just extreme selfishness. I keep a check on everyone; I put everyone in a cage so as to set my mind at rest, but all I'm worried about is my own mind, so I'm just being selfish.'

I feel the space between us is sterile. We could discuss and debate it at length, but I feel there is no feeling at all between us.

T: 'Your reason doubts ... but what do you feel? Are you doing it for yourself or for Lisa?'

A: 'Um ... I'm not sure I can trust what I feel ... but yes, ... I'd say it's for Lisa.'

The way he says 'Lisa' sparks in me, and at the same time in him, an intense and unexpected surge of emotion; something like a sob takes us by surprise. We realise the surprise and emotion is mutual, and we are caught off guard and embarrassed by what is happening. All of a sudden, I feel his and my own existential weariness – I am well aware of the way bonds and love tie us to the pain of a loved one's loss. In this shared feeling I grasp the beauty of a new and intense contact between us, unexpected like a gift. After a brief silence I say:

T: 'I realise the great lengths you've gone to over the years to protect Lisa, the endless effort to take care of her.'

A: 'Yes ...'

Andrea looks at me, overcome with emotion. He looks away and clears his throat. There is a pause. The air is pregnant with vibration, at the limit of what is bearable for both of us. I make myself more comfortable and get a hold of my breath.

T: 'What's happening, Andrea?'

A: 'Um ... you know how I told you that some sessions are watersheds, and others are about consolidation ... well, this one's a watershed.'

T: 'I think so, too.'

We stay for an instant in that moment, a moment in which something has happened. We stop to savour it and feel its effects. We feel how it transforms our relationship and how we feel.

7. Conclusion

Our journey has taken us along the road of phenomenological and Gestalt analysis, covering: the identification of the field of investigation using extrinsic diagnosis; a phenomenological analysis of experiences; a Gestalt therapy analysis of the experience giving meaning to the creative adjustment of obsession-compulsion; the positioning of that adjustment within possible biographical and existential backgrounds; the features of an emergent obsessive-compulsive field in therapy; and finally, some elements for therapy. Along this journey I have sought to highlight how obsessive-compulsive adjustments are a specific creative approach

to dealing with terror when terror cannot dissipate in the presence of the other and how they can spare the sufferer from even greater suffering. It is my hope that this exploration of mine might support another journey, that of the therapist and the client, towards a place which our poet, once again, has captured so well:

That's right, I can't help but think:
 first we fly and then we fall—
 soaring high and then worn out,
 exhausted we return to reality.
 Only then will we be ready
 to praise the infinite
 realm of immanence
 and to accept, perhaps, the immanence
 of death—like the natural lot
 of a fruit that ripens, then falls.
 (Marcoaldi, 2015, p. 44)

Notes

1. 'Suspended from shaky scaffolding,/we secure ourselves with our/fixations. To distract/our gaze from the looming/abyss, we take refuge/in chilling automatisms,/in pathetic obsessions. / We know the burden of iniquity/that we carry on our shoulders, but/sloth, compulsion and laziness/are dull and comforting rewards/that are much more reassuring/than the dazzling and alien lights/of a world that offers no guarantees' (Marcoaldi, 2015, p. 36).
2. In order to understand this paper better, it would be useful to read my previous article 'From individual symptoms to psychopathological fields' (2015b), and 'The Field Perspective in Gestalt Therapy' (forthcoming). The present study is based on the perspective on psychopathology discussed in those works. I thank the peer referees for making me aware of how propaedeutic it can be for the reader to refer to those papers.
3. That is, an analysis that takes lived experience as its starting point to describe how a certain psychopathological experience takes shape and develops, focusing on how suffering emerges, rather than its causes (cf. Borgna, 1989).
4. For a more in-depth look at diagnosis in Gestalt therapy, and the difference between intrinsic and extrinsic diagnosis, see Francesetti and Gecele (2009); Francesetti, Gecele and Roubal (2013).
5. The DSM 5 (APA, 2013) diagnostic criteria for OCD are: a) Presence of obsessions, compulsions or both; b) The obsessions or compulsions are time-consuming or cause clinically significant distress or impairment in social, occupational, or other important areas of functioning; c) The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance or another medical condition; d) The disturbance is not better explained by the symptoms of another mental disorder. The ICD classification is not significantly different (see ICD 10, Obsessive Compulsive Disorder, F42). In order to widen the discussion of psychiatric nosography, and intrinsic and extrinsic diagnosis in Gestalt therapy, see Francesetti and Gecele (2009).
6. Around 2–3% of the adult population suffers from this disorder (Abramowitz and Siqueland, 2013, p. 194), for which the number of sufferers around the world is estimated at over 100 million people.
7. Straus (1948) highlights how the writer Jonathan Swift, who suffered from obsessions, created a character in *Gulliver's Travels* who has an inevitably large and close experience with reality, in a way that disgusts him: '[these maids of honour] would strip themselves to the skin, and put on their smocks in my presence, while I was placed on their toilet, before their naked bodies, which I am sure to me was very far from being a tempting sight, or from giving me any other emotions than those of horror and disgust' (Swift, quoted in Straus, 1948, p. 99; Italian trans. 2006).
8. Conrad was the first to define and use a method of investigation in psychopathology which he called 'Gestalt analysis' (Conrad, 1958).
9. *Pathic* means felt in the lived body and suffered. We are immediately and passively seized by the pathic, we are moved by suffering and passion; it is something *to which* we are subject (rather than *of which* we are subject). In the atmospheric, figure and background are not yet defined, but form an affectively charged tone that is diffuse in space, immediate and without clear boundaries, from which subject and object will emerge, impregnating and colouring the nascent experience, which encompasses subjects and objects in a reciprocal, circular making.
10. Cf. <<https://www.youtube.com/watch?v=8LD13O7dkHc>>
11. The first to use Metzger's work to understand psychotic experience was Klaus Conrad (1958), who laid the bases for the study of psychopathology through what he called 'Gestalt analysis'. Unfortunately, his work was not explored by later thinkers in all its potential, although today it is being reappraised by a number of authors (Alessandrini and Di Giannantonio, 2013).
12. The reference to feet is not coincidental. To 'have cold feet' is a way of saying that someone is afraid, and children, when they are frightened and do not receive bodily containment, curl up, raising their feet off the ground or holding them in their arms.
13. In this case, his desensitisation would not permit him to feel his terror and his pain any longer, and he would need the body of another person to act out the drama, the experience of another person, a victim, to make the suffering that he cannot feel emerge (Francesetti, 2012). In this way, we can understand the words of a client of mine, a person who could be dangerously violent at times, who in a moment of intense emotion said, 'I can be an angel of light or an angel of darkness. If I detach myself from my feelings, I can do anything at all and feel righteous in doing it. Nothing could stop me, except a return to my feelings and pain.'
14. Oral communication, AAGT Conference, Asilomar (CA, USA), 5th September, 2014.
15. 'The air around the deceased was irregular / with wear and tear in the net / that firmly links the here with the now' (Gualtieri, 2010, p. 50).
16. Let us clear the field of all biological aetiology. The fact that treatment using serotonergic antidepressants can alleviate the symptoms of obsession does not imply that a lack of serotonin is a cause of the disorder; if anything it may be associated with pathogenesis. Thus we are in a pathogenetic field, not an aetiological one. Drug therapy is important in clinical practice if it can alleviate symptoms, providing that it does not stop there and efforts are made to give meaning to suffering. It cannot be excluded that there may be genetic or epigenetic elements involved (Bottaccioli, 2014; Spagnuolo Lobb and Francesetti, 2015; Spector, 2012), or, more generally, biological factors at the origin of the disorder, as no clear data exists (Castonguay and Oltmanns, 2013), but in any case, the presence of biological components does not nullify the search for meaning.
17. In this respect, it is interesting to look at an observation that comes from pharmacology in clinical practice. The people who respond best to antidepressants are those who suffer from depression, panic attacks and obsessive-compulsive disorder.

From a phenomenological and Gestalt therapy point of view, the ground of these sufferers is marked by the experience of solitude (which is different in each type of suffering, see Francesetti, 2007; 2013; 2015a; Francesetti and Gecele, 2011). My suggestion is that the effect of this category of drugs is to lessen the need for the other, thus proving most effective in disorders rooted in the absence of the other. This would also help make sense of the growing consumption of antidepressants in our society, a growth that is almost exponential (Whitaker, 2010). A society that denies the legitimacy of the need for the other will inevitably give rise to disorders rooted in solitude and produce therapies that anaesthetise that need.

18. Other authors go further and maintain that compulsion and ritual are caused by the expulsion of something felt or done which ought not to have been felt or done (Salonia, 2013), or conceive the disorder as the result of introjects that compel the client to act according to a perfectionist ideal (Dreitzel, 2010; 2013). These are certainly all possibilities that we encounter in clinical practice, but from the analysis I have presented, I do not believe they constitute a structural element that can provide a common denominator for experiences of obsession.
19. For the definitions of phenomenal, phenomenological and psychopathological field, see Francesetti (forthcoming).
20. <<https://www.nice.org.uk/guidance/CG31/chapter/1-Guidance#steps-35-treatment-options-for-people-with-ocd-or-bdd>>
21. 'In the Cartesian world view, 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 (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. The *Koerper* is an entity, the *Leib* is an almost-entity' (Francesetti, 2015b; p. 9).
22. On this topic, Salonia (2013) rightly cites Grossman's splendid short story *The Hug* (2013).
23. I refer here to the relational and existential truth that is dialogically found by the therapist and client together.

References

- Abramowitz, J.S. and Siqueland, L. (2013). Obsessive-compulsive disorder. In L.G. Castonguay and T.F. Oltmanns (eds.), *Psychopathology. From science to clinical practice*. New York: Guilford Press.
- Alessandrini, M. and di Giannantonio, M. (2013). L'altro volto del mondo: la psicosi nascente secondo Karl Kraus. *Rivista sperimentale di freniatria*, CXXXVII, 3, pp. 27–45.
- Alvim Botelho, M. (2016). Id of the situation as the common ground of experience. In J.-M. Robine (ed.), *Self. A polyphony of contemporary Gestalt therapists*. St. Romain-La-Virvée: L'Exprimerie.
- American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*. Washington, DC: APA.
- Ash, M.G. (1995). *Gestalt Psychology in German Culture, 1890-1967. Holism and the quest for objectivity*. Cambridge: Cambridge University Press.
- Ballerini, A. and Callieri, B. (eds.) (1996). *Breviario di psicopatologia. La dimensione umana della sofferenza mentale*. Milano: Feltrinelli.
- Beck, A.T. (1976). *Cognitive therapy and emotional disorders*. New York: Meridian.
- Béguin, A. (1939). *L'âme romantique et le rêve*. Paris: José Corti.
- Bloom, D. (2016). The relational function of self. Self functioning of the most human plane. In J.-M. Robine (ed.), *Self. A polyphony of contemporary Gestalt therapists*. St. Romain-La-Virvée: L'Exprimerie.
- Bloom, D. and O'Neill, B. (2014). *The New York Institute for Gestalt Therapy in the 21st century. An anthology of published writings since 2000*. Peregian Beach, Australia: Ravenwood Press.
- Böhme, G. (2010). *Atmosfera, estasi, messe in scena. L'estetica come teoria generale della percezione*. Milano: Marinotti. (Original ed.: *Asthetik. Vorlesungen über Ästhetik als allgemeine Wahrnehmungslehre*. München: Wilhelm Fink Verlag, 2001.)
- Böhme, G. (2017). *The Aesthetics of Atmospheres*. New York: Routledge.
- Borgna, E. (1989). *I conflitti del conoscere*. Milano: Feltrinelli.
- Borgna, E. (1997). *Le figure dell'ansia*. Milano: Feltrinelli.
- Bottaccioli, F. (2014). *Epigenetica e psiconeuroendocrinoimmunologia*. Milano: Edra.
- Callieri, B. (2001). *Quando vince l'ombra. Problemi di psicopatologia clinica*. Roma: Edizioni Universitarie Romane.
- Calvi, L. (1996). Il fremito della carne e l'anancastico. In A. Ballerini and B. Callieri (eds.), *Breviario di psicopatologia*. Milano: Feltrinelli. (Then in: Calvi, L. (2005), *Il tempo dell'altro significato. Esercizi fenomenologici d'uno psichiatra*. Milano: Mimesis.)
- Castonguay, L.G. and Oltmanns, T.F. (eds.) (2013). *Psychopathology. From science to clinical practice*. New York: Guilford Press.
- Chomsky, N. (1957). *Syntactic Structures*. The Hague: Mouton & Co.
- Clark, D.A. (2004). *Cognitive-behavioral therapy for OCD*. New York: Guilford Press.
- Conrad, K. (1958). *Die beginnende Schizophrenie* [Incipient schizophrenia]. Stuttgart: Thieme.
- Damasio, A. (2012). *Self Comes to Mind. Constructing the Conscious Brain*. New York: Vintage.
- Dreitzel, H.P. (2010). *Gestalt and process. Clinical diagnosis in Gestalt therapy: a field guide*. Bergisch Gladbach: EHP Verlag Andreas Kohlhaage.
- Dreitzel, H.P. (2013). Comment to 'Gestalt Therapy with the phobic-obsessive-compulsive relational styles' by Giovanni Salonia. In G. Francesetti, M. Gecele and J. Roubal (eds.), *Gestalt Therapy in Clinical Practice. From Psychopathology to the Aesthetics of Contact*. Milano: FrancoAngeli; Siracusa: Istituto di Gestalt HCC Italy Publ. Co.
- Foa, E.B., Abramowitz, J.S., Franklin, M.E. and Kozak, M.J. (1999). Feared consequences, fixity of belief and treatment outcome in obsessive-compulsive disorder. *Behavior Therapy*, 30, pp. 717–724.
- Francesetti, G. (2007). *Panic attacks and post-modernity. Gestalt Therapy between clinical and social perspectives*. Milano: FrancoAngeli.
- Francesetti, G. (2012). Pain and beauty. From the psychopathology to the aesthetics of contact. *British Gestalt Journal*, 21, 2, pp. 4–18.
- Francesetti, G. (2013). Gestalt therapy perspective on panic attacks. In G. Francesetti, M. Gecele and J. Roubal (eds.), *Gestalt Therapy in Clinical Practice. From Psychopathology to the Aesthetics of Contact*. Milano: FrancoAngeli; Siracusa: Istituto di Gestalt HCC Italy Publ. Co.
- Francesetti, G. (ed.) (2015a). *Absence is the bridge between us. Gestalt therapy perspective on depressive experiences*. Siracusa: Istituto di Gestalt HCC Italy Publ. Co.
- Francesetti, G. (2015b). From individual symptoms to psychopathological fields. Towards a field perspective on clinical human suffering. *British Gestalt Journal*, 24, 1, pp. 5–19.
- Francesetti, G. (2016a). 'You cry, I feel pain.' The emerging, co-

- created self as the foundation of anthropology, psychopathology and treatment in Gestalt therapy. In J.-M. Robine (ed.), *Self. A polyphony of contemporary Gestalt therapists*. St. Romain-La-Virvée: L'Exprimerie.
- Francesetti, G. (2016b). Transmission and transformation of psychopathological fields between generations. In M. Spagnuolo Lobb, N. Levi and A. Williams (eds.), *Gestalt therapy with children. From epistemology to clinical practice*. Siracusa: Istituto di Gestalt HCC Italy Publ. Co.
- Francesetti, G. (forthcoming). The Field Perspective in Gestalt Therapy. In P. Brownell, *Theory, Practice and Research in Gestalt Therapy*. Cambridge Scholars Publishing.
- Francesetti, G. and Gecele, M. (2009). A Gestalt therapy perspective on psychopathology and diagnosis. *British Gestalt Journal*, 18, 2, pp. 5–20.
- Francesetti, G. and Gecele, M. (eds.) (2011). *L'altro irraggiungibile. La psicoterapia della Gestalt con le esperienze depressive*. Milano: FrancoAngeli.
- Francesetti, G., Gecele, M. and Roubal, J. (eds.) (2013). *Gestalt Therapy in Clinical Practice. From Psychopathology to the Aesthetics of Contact*. Milano: FrancoAngeli; Siracusa: Istituto di Gestalt HCC Italy Publ. Co.
- Francesetti, G. and Spagnuolo Lobb, M. (2013). Beyond the Pillars of Hercules. A Gestalt Therapy perspective on psychotic experiences. In G. Francesetti, M. Gecele and J. Roubal (eds.), *Gestalt Therapy in Clinical Practice. From Psychopathology to the Aesthetics of Contact*. Milano: FrancoAngeli; Siracusa: Istituto di Gestalt HCC Italy Publ. Co.
- Frank, R. (2016). Self in motion. In J.-M. Robine (ed.), *Self. A polyphony of contemporary Gestalt therapists*. St. Romain-La-Virvée: L'Exprimerie.
- Frost, R.O. and Steketee, G. (2002). *Cognitive approaches to obsessions and compulsions. Theory, assessment, and treatment*. Amsterdam: Pergamon Press – Elsevier Science.
- Gabbard, G. (1994). *Psychodynamic psychiatry in clinical practice*. Washington, DC: APA
- Galimberti, U. (1979). *Psichiatria e fenomenologia*. Milano: Feltrinelli.
- Gallagher, S. and Zahavi, D. (2007). *The phenomenological mind. An introduction to Philosophy of Mind and Cognitive Science*. London: Routledge.
- Griffero, T. (2014). *Atmospheres: Aesthetics of Emotional Spaces*. Farnham: Ashgate.
- Grossman, D. (2013). *The Hug*. New York: Overlook Press.
- Gualtieri, M. (2010). *Bestia di gioia*. Torino: Einaudi.
- Heidegger, M. (1927/1962). *Being and time*. New York: Harper & Row.
- Husserl, E. (1913/1931). *Ideas. General Introduction to Pure Phenomenology*. New York: MacMillan.
- Jacobs, L. and Hycner, R. (eds.) (2009). *Relational approaches to Gestalt therapy*. New York: Gestalt Press.
- Loewald, H.W. (1989). *Papers on psychoanalysis*. New Haven: Yale University Press.
- Marcoaldi, F. (2008). *Il tempo ormai breve*. Torino: Einaudi.
- Marcoaldi, F. (2015). *Il mondo sia lodato*. Torino: Einaudi.
- Mazzeo, M. (2013). Introduzione. In H. Tellenbach, *L'aroma del mondo. Gusto, olfatto e atmosfera*. Milano: Marinotti.
- Merleau-Ponty, M. (1945/2003). *Phenomenology of Perception: An Introduction*. New York; London: Routledge.
- Metzger, W. (1941/1971). *I fondamenti della psicologia della Gestalt*. Firenze: Giunti Barbera. (Original ed.: *Psychologie. Die Entwicklung ihrer Grundannahmen seit der Einführung des Experiments*. Darmstadt: Steinkopff Verlag, 1941.)
- Mitchell, S.A. (2000). *Relationality. From Attachment to Intersubjectivity*. Hillsdale, NJ: The Analytic Press.
- Morphy, R. (1980). An inner view of obsessional neurosis. *Gestalt Journal*, 3, 1, pp. 120–136. (French trans.: *Une vision intime de la nevrose obsessionnelle*. Bordeaux: Institut Français de Gestalt-thérapie, 1992; 2003.)
- Moustakas, C. (1994). *Phenomenology research methods*. Thousand Oaks, CA: Sage.
- Muscelli, C. and Stanghellini, G. (2008). Per un'estetica dello spazio vissuto. La modalità ossessiva. *Comprendere*, 16-17-18, pp. 279–287.
- Orange, D.M., Atwood, G.E. and Stolorow, R.D. (eds.) (1999). *Intersoggettività e lavoro clinico. Il contestualismo nella pratica psicoanalitica*. Milano: Raffaello Cortina Editore.
- Perls, F., Hefferline, R. and Goodman, P. (1951). *Gestalt Therapy. Excitement and Growth in the Human Personality*. New York: Julian Press; Highland, NY: Gestalt Journal Press, 1994.
- Philippson, P. (2009). *The emergent self. An existential-Gestalt approach*. London: Karnac Books.
- Ratcliffe, M. (2015). *Experience of depression. A study in phenomenology*. Oxford: Oxford University Press.
- Robine, J.-M. (2006). *Il rivelarsi del sé nel contatto. Studi di psicoterapia della Gestalt*. Milano: FrancoAngeli.
- Robine, J.-M. (ed.) (2016). *Self. A polyphony of contemporary Gestalt therapists*. St. Romain-La-Virvée: L'Exprimerie.
- Salonia, G. (1999). Dialogare nel tempo della frammentazione. In F. Armetta and M. Naro (eds.), *Impense adlaboravit*. Palermo: Facoltà Teologica di Sicilia.
- Salonia, G. (2013). Gestalt Therapy with the phobic-obsessive-compulsive relational styles. In G. Francesetti, M. Gecele and J. Roubal (eds.), *Gestalt Therapy in Clinical Practice. From Psychopathology to the Aesthetics of Contact*. Milano: FrancoAngeli; Siracusa: Istituto di Gestalt HCC Italy Publ. Co.
- Schmitz, H. (2011). *Nuova fenomenologia. Un'introduzione*. Milano: Marinotti.
- Sichera, A. (2001). A confronto con Gadamer. Per una epistemologia ermeneutica della Gestalt. In M. Spagnuolo Lobb (ed.), *Psicoterapia della Gestalt. Ermeneutica e clinica*. Milano: FrancoAngeli.
- Spagnuolo Lobb, M. (2013a). *The now-for-next in psychotherapy. Gestalt therapy recounted in post-modern society*. Milano: FrancoAngeli.
- Spagnuolo Lobb, M. (2013b). Developmental perspective in Gestalt therapy. The polyphonic development of domains. In G. Francesetti, M. Gecele and J. Roubal (eds.), *Gestalt Therapy in Clinical Practice. From Psychopathology to the Aesthetics of Contact*. Milano: FrancoAngeli; Siracusa: Istituto di Gestalt HCC Italy Publ. Co.
- Spagnuolo Lobb, M. (2016). Self as contact, contact as self. A contribution to ground experience in Gestalt therapy theory of self. In J.-M. Robine (ed.), *Self. A polyphony of contemporary Gestalt therapists*. St. Romain-La-Virvée: L'Exprimerie.
- Spagnuolo Lobb, M. and Francesetti, G. (2015). La normalità creativa. *PNEI Review*, 6, pp. 58–67.
- Spector, T. (2012). *Identically Different. Why We Can Change Our Genes*. London: Weidenfeld & Nicolson.
- Spinelli, E. (2005). *The interpreted world. An introduction to phenomenological psychology*. Thousand Oaks, CA: Sage.
- Staemmler, F.-M. (2016). Taking another turn. *British Gestalt Journal*, 25, 2, pp. 3–19.
- Stanghellini, G. and Ballerini, A. (1992). *Ossessione e rivelazione. Riflessione sui rapporti tra ossessività e delirio*. Torino: Bollati Boringhieri.
- Stern, D.N. (1985). *The Interpersonal World of the Infant. A View from Psychoanalysis and Developmental Psychology*. New York: Basic Books.

- Stern, D.N. (2004). *The present moment in psychotherapy and everyday life*. New York: W.W. Norton & Co.
- Stern, D.N. (2010). *Forms of vitality. Exploring dynamic experience in psychology and the arts*. New York: Oxford University Press USA.
- Stolorow, R.D., Brandchaft, B., Atwood, G.E., Fosshange, J. and Lachmann, F. (1999). *Psicopatologia intersoggettiva*. Urbino: Quattroventi.
- Straus, E. (1948). *On obsession. A clinical and methodological study*. New York: Nervous and Mental Disease Monographs 73.
- Tárrega-Soler, X. (1997). L'expérience obsessionnelle. *Cahiers de Gestalt-thérapie*, 1, pp. 73–94.
- Tellenbach, H. (1968/2013). *L'aroma del mondo. Gusto, olfatto e atmosfera*. Milano: Marinotti. (Original ed.: *Geschmack und Atmosphäre. Medien menschlichen Elementarkontaktes*. Salzburg: Otto Müller Verlag, 1968.)
- Vázquez Bandín, C. (2014). *Sin tí no puedo ser yo. Pensando según la Terapia Gestalt*. Madrid: Los Libros del CTP.
- von Gebsattel, V.E. (1967). Il mondo dell'anancastico. In E. Minkowski and V.E. von Gebsattel, *Antropologia e psicopatologia*. Milano: Bompiani.
- Wheeler, G. (2002). Compulsion and curiosity. A Gestalt approach to OCD. In G. Wheeler and M. McConville (eds.), *The heart of development. Gestalt approaches to working with children, adolescents and their worlds. Vol. I: Childhood*. Hillsdale, NJ: The Analytic Press.
- Whitaker, R. (2010). *Anatomy of an epidemic. Magic bullets, psychiatric drugs and the astonishing rise of mental illness in America*. New York: Crown Publishers.

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