ISSN: 2755-0192

Journal of Psychiatry Research Reviews & Reports

SCIENTIFIC Research and Community

Review Article

Open Access

Gestalt Therapy with Panik Attacks: Basic Relational Model (BRM), Life Cycle and Clinic in GTK

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ABSTRACT

Post-Traumatic Stress Disorder (PTSD) is a debilitating condition that often requires specialized interventions to address its multifaceted impact on emotional regulation, cognition, and interpersonal relationships. Eye Movement Desensitization and Reprocessing (EMDR) Therapy has emerged as a transformative treatment for PTSD. This literature review explores the theoretical foundations, mechanisms, clinical efficacy, and broader applications of EMDR Therapy, emphasizing its unique contributions to trauma-focused care.

Grounded in the Adaptive Information Processing (AIP) model, EMDR facilitates reprocessing fragmented traumatic memories through Bilateral Stimulation (BLS) and an eight-phase protocol, enabling patients to achieve symptom relief and adaptive memory integration. Studies demonstrate EMDR's rapid and sustained effectiveness across diverse populations, including combat veterans and individuals with intellectual disabilities. Additionally, EMDR Therapy enhances emotional regulation and recovery in social and occupational domains. Despite methodological challenges and limitations, EMDR is recognized globally as one of the first-line treatments for PTSD, with potential applications in other psychiatric and somatic conditions. This review highlights the need for continued research to refine EMDR's protocols, expand its applications, and deepen understanding of its mechanisms, ensuring broader access to this evidence-based intervention.

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Received: December 12, 2024; **Accepted:** December 18, 2024; **Published:** December 27, 2024

The article describes the study, research and clinic of Panic Attacks with a phenomenological and procedural reading, faithful to the theoretical-clinical orientation of Gestalt Therapy (GTK Institute). Panic Attacks can be considered a dramatic request for a relationship, in order to rebuild a certain constitutive belonging to every integral and full identity. In this regard, the issues concerning the phenomenology of Panic Attack in Postmodern Society will be addressed in the contribution, as well as the meaning of the symptom in relation to the patient's Life Cycle with reference to the current context and to the BRM. Study and clinical research shed light on the diagnostic aspect of panic attacks (contact interruption and bodily-relational experience in the retroflex relational style), and on the therapeutic one, taking into account the contact cycle theory, the developmental theory and the theory of the Self.

Finally, emphasis will be given to the differential diagnosis between Panic Attack and Panic Crisis, since this aspect determines the specific clinical and therapeutic intervention.

Introduction

Talking about panic attacks without considering the phenomenology of emotional bonds and relational experiences regarding postmodernity, in the actual social and cultural context we are living in, where changes happen too fast, sometimes confusingly, can be misleading and confusive, both in the diagnostic and therapeutic process [1].

In this regard, as Eugenio Gaddini recalls, the changes of our patients always have to be compared with historic changes [2].

Theoretical-Clinical and Research Aspects in Gestalt Therapy

In the founding text "Teoria e pratica della Terapia della Gestalt" (The theory and practice of Gestalt therapy"), Perls, Hefferline and Goodman establish the theoretical and clinical principles of Gestalt Therapy starting from a phenomenological epistemology, through which we can contact the deepest layers of our existence (experiences) in order to experience (full) contact in the here and now [3].

Goodman also reiterates that each theory arose from a concrete therapeutic situation; in fact, the intuition of an approach originates by the need of assigning clinical work an epistemological first place, considering it deeply and shaping the theoretical processing on it, in order to avoid the abstractness of a generalising logos and find again the entire density of a living experience, which however is connected to rationalism that specifically belongs to the therapeutic relationship [3].

The goal of each therapy should be the growth of a patient's awareness [4]. Salonia writes: "In order for a person to become aware of his own experience, it always has to be verbally expressible", and "the word always has to be a faithful copy of what happens (and has happened) in the organism" [5]. As Goodman calls to our minds in GT's founding text Teoria e pratica

della Terapia della Gestalt (The theory and practice of Gestalt therapy), the Personality-function is "a verbal copy of the Self!" [3].

Psychopathology of Panic Attacks (Panic Disorder)

Having said that, let's now try to explore the clinical description of psychopathology related to panic attacks (panic disorder).

The clinical symptomatology experienced by patients with panic attacks are mentioned for the first time in the descriptions of Jacob Da Costa in 1871, who called it the "irritable heart syndrome" [6]. This was characterized by an extreme activation of the neurovegetative and cardiorespiratory system in an acute and unexpected form in war veterans (mainly soldiers).

Scientific literature confers panic disorder a diagnostic autonomy only from 1980, with the publication of DSM-III. To the present day, the diagnosis within the handbook shared by the scientific community is based on descriptive aspects of the clinical symptomatology and the statistics on how frequently those symptoms appear (see diagnostic criteria of DSM).

DSM-5 talks about panic attacks not as a precise diagnostic category, but rather a symptomatologic constellation we can find in different pathology types, of psychological and organic nature, in particular in anxiety disorders.

The same manual defines 'panic attack' as an experience related to "a discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes.

Palpitations or tachycardia; Sweating; Trembling or shaking; Sensations of shortness of breath or smothering; Feeling of choking; Chest pain or discomfort; Nausea or abdominal distress; Feeling dizzy, unsteady, lightheaded, or faint; Derealization or depersonalization; Fear of losing control or going crazy; Fear of dying; Paraesthesia; Chills or hot flushes [7].

In order for the panic attacks to evolve into 'panic disorder', these need to keep happening for a certain period of time and with a certain regularity.

The Original Interpretation of Psychopathology of Panic Attacks in GTK (Institute of Gestalt Therapy Kairòs)

Panic attack seems to be a challenge for psychotherapists, as it is quite common to discuss cases among colleagues, in which patients suffering from this disease do not seem to benefit from the therapy; on the contrary, sometimes they seem to have 'inexplicable' relapses.

To this matter, Salonia (personal communication on June 7th/8th, 2013) has been reiterating that panic attacks have to be considered as a precise diagnostic category related to a specific relational model with retroflex style. The author argues and clarifies the difference between panic attack and panic crisis with absolute determination and scientific accuracy. The latter belong to anxiety disorders, which Salonia himself discussed about extensively in different works [8, 9].

The hermeneutic epistemology of Gestalt Therapy allows us to read the above-mentioned signs and symptoms, contextualising them within a unique and once-off story, and within a specific relationship, where the pain the patient takes to the contact boundary with the therapist is undertaken in a 'here and now' full with the most authentic bodily relational experiences.

In Gestalt Therapy, diagnosis and treatment coincide, and the non-assimilated past becomes a figure in the therapeutic setting, as Antonio Sichera recalls, in which the symptom, despite its problematicness in that context, becomes an appeal to the relationship and a dramatic request for treatment [10].

In its gravity, the panic attack unveils a sense of helplessness experienced both by patient and therapist [11]. And it will certainly not be the verbal categories that do justice to the suffering of the patient, nor the words detached from the body experience, which in particular do not find spontaneous expression or contextualization within a process of awareness [2,8,12,13].

Psychopathology and Basic Relational Model (BRM)

This said, psychopathology always has to be read within a specific social and cultural context. Indeed, "assuming relationality (in its declination of methods of the being-with) as key to an understanding of the complexity of the individual-society relationship, the Basic Relational Model (BRM) [is processed] with a key of the relationship between cultural contexts and psychotherapy" [2].

With this theorizing, Salonia describes the differences between BRM/WE, which favours membership and is figured in dangerous situations, where a push to survival is requested, and BRM/I, which prefers subjectivity and self-fulfilment. We can say that panic attacks are to be allocated to a typical relational style of a society that corresponds to the BRM/I.

The New Theoretical Prospective in Gestalt Therapy: Research and Theoretical Reinterpretations in GTK

A basic point in the diagnostic (and treatment-related) process in Gestalt Therapy is the theoretical corpus on the functions of the Self.

In this regards, we will shortly outline the Theory of the Self in Gestalt Therapy, and in particular the recent researches (Salonia, Sichera, Conte, Orlando and others) conducted by the Institute of Gestalt Therapy h.c.c. Kairòs, as essential guide, together with the theory of contact and the developmentary one, for every diagnostic and therapeutic orientation that wants to be connoted with scientificity, therefore able to replicate the results expected and previously obtained in clinical research. Goodman states that the Self in Gestalt basically is a function of the relationship between Organism and Environment [3]. The Self is the organism in contact and features, among other connotations, three important substructures that usually are described as follows: Id-function, (the body from which the movement towards something emerges: 'What do I feel'), the Ego-function (to accept or alienate what emerges: 'What do I want'), the Personality-function (assimilation after contact: 'What I have become') [5].

The theory of the contact cycle refers to the process that determines the times and modes of the organism-environment relationship; such process, in its physiological and pathological aspects, allows us to identify the 'how' in a bodily-relational process, whether the individual reaches the other or not, and therefore 'when' and 'how' the person interrupts the process of contact (psychopathology) with the environment.

Lastly, a short comment on the developmental theory: 'The guiding light' of the diagnostic process. Without it, it would be impossible to understand a past that is living and present in the here and now

in the contact experiences. In fact, the methods of the being-with, accomplished by the individual from a bodily relational viewpoint, refer to significant figures that took care of him. To this matter, Salonia's developmental theory is enlightening, "from We to 'I-You'" and the following theorizing with his studies on "Oedipus after Freud" and on the "primary triangle" (co-parenting as expression of the Personality-function of the Self) [14].

Research in Clinical Practice

Genesis of the "retroflex relational model" in patients with panic attacks

In clinical work, both in the diagnostic process and during therapy with patients affected by panic disorder, a developmental history characterized by 'disturbed family schemes' comes out.

Co-parenting is negatively conditioned by an unequal 'marital relationship' that is "experienced with obsessive contrast or dependence (one up – one down). The child allies him with the parent of the opposite sex and is against the parent of the same sex" [15]. The child is forced to sacrifice parts of itself, so to be like the mother wants it to be, catering to the mother, being special in her eyes; the child is therefore asked - implicitly or not - to take on 'adultifying' behaviors; "The fact of feeling big in a small body is the origin of retroflex mode" [15]. In order to feel special in the eyes of the parent of opposite sex, the child had to give up the experience of being welcomed and supported in his need of being little. This precise experience didn't allow the child to abandon itself to the environment with spontaneity and faith, enacting retroflection as a contact interruption. "The control of its parts the mother believes to be bad/mean causes the scission that Winnicott calls 'true self' and 'false self', which in Gestalt Therapy is the 'retroflection'", seen as mode of interruption of the contact process in panic attacks [15,16].

Valeria Conte very thoroughly describes such relational model in different works and articles. As regards the "retroflex narcissist", she writes that unlike the "confluent narcissist" and the "autistic narcissist", which connect their weakness and vulnerability to missed experiences and therefore require introjections, the 'retroflex' instead "fear introjection as cancellation of their own personality" [15]. Indeed, introjection in therapy could also refer to the clarification of roles (therapist-patient) within the setting. A patient with narcissistic relational mode encounters difficulties in defining himself a person in need of help (disorder of the Personality function of the Self) in a therapeutic relationship (since he doesn't trust the environment O>A). He has an extreme inability of relying on someone and asking: he undergoes a real 'connection phobia'.

In light of the above, we can state with scientific accuracy that the person suffering from panic attacks interrupts the contact process in retroflection.

As for panic disorder, the patients undergo a collapse of the existential grounding (Personality function of the Self). Due to the loss of that 'fake autonomy' and 'self-confidence', the need for a significant and authentic connection that has always been searched for and never experiences, even though in a 'latent and symptomatic' form, arises in the person with retroflex relational mode. This allows the patient to access therapeutic relationships with an 'implicit' and very clear definition of the roles connected to the request for help. At this stage, compared to the previous stages, in which weak and almost insignificant connections used to accompany his experience, the patient only searches for a few connections, which are significant and which he can rely on (therapist, doctor, wife, brother, parents, etc.).

Differential Diagnosis: Panic Attack or Panic Crisis?

At this point, we can get to the heart of the differential diagnosis regarding panic disorder. First of all, it has to made clear that panic can be considered physiological in some circumstances, when referred to a real danger the patient is suddenly approaching. This can trigger the natural 'fight or flight' mechanism in the person, which makes him paralyse in front of the real and unexpected danger. Such mechanism can be considered as conservative and specific.

On the other hand, the pathological pain, or panic crisis, arises through an abnormal reaction of psychophysiological nature, with peaks of acute anxiety, that are incoherent with the risk or danger referred to the situation. This is typical of anxious and insecure persons [17].

Instead, panic attack refers to an experience of acute anxiety with neurophysiological activation and of the neurovegetative and vagus system (see above mentioned diagnostic criteria DSM-5), which unexpectedly and suddenly arises within an ordinary or usual situation. It is a typical situation that could affect people with an apparently "autonomous" style, which are very efficient in life and quite affectless [18,19].

Therapy

In light of the above, let's now focus on the diametrically opposed treatments related to panic crisis and panic attack - panic disorder (see chart 2).

Therapy with patients affected by panic crisis will deal with processes and interruptions connected to the anxiety of separation. Therefore, strength and autonomy will be supported in the person, so that he or she can contact the environment with spontaneity and self-confidence.

On the contrary, therapy with patients affected by panic disorder moves in direction of the Personality function of the Self. "In fact, each interruption in the contact cycle/pulling back from the contact recalls a history of primary relationships, in which the individual went through and learnt - from a verbal and corporeal point of view - disordered experiences of the Personality function […]. Describing the family schemes and letting them emerge from the background, in which an interruption mode was learnt, is an efficient therapeutic procedure that is coherent the phenomenological matrix of Gestalt Therapy" [20].

Goal of the therapy will be to go through the anguish bound to belonging, favouring and supporting a healthy confluence.

In the therapeutic relationship, differentiating the relationship in its asymmetric dimension becomes crucial. Where there is a 'You' the patient can rely on without feeling discredited and in which he can find himself.

Obviously, as for what is described with regards to the abnormal reaction that the body undergoes during a panic attack, the work on the Id-function of the Self will be the key in therapy, starting from the breath up to the experiences felt in the body as tensions, expressions of blocks of the relationship with the other. To this matter, Goodman talks about the "Self that concentrates". A good therapeutic practice with patients affected by panic disorder is use concentration techniques on the body. So, the patient can recover those experiences that have always been denied and retroflected, but belong to him.

Working on retroflection within the therapeutic path will help the patient, who is supported by the therapist, to rely on the environment and on himself, overcoming the blocks bound to his own bodily-relational experiences, which did not allow to contact the other and rely on them in time.

Therapy can be considered concluded in so far as, from a Personality-function perspective, the patient will go through a co-centrality in feeling unique, but with the others. From an Id-function perspective, he will perceive the feeling to live within his own body and the awareness that the emerging needs are integrated in the schemes of the being-with, with responsibility. As for the contact cycle, the patient will be able to turning himself in to the finally contact, and to see the other as a resource, rather than an obstacle [21].

Final Consideration

In such way, therapy will be able to offer the patient suffering from panic disorder a new and intact personality. Through the new schemes of "being with" learnt in the relationship with the therapist, he is able to reach the fullness he has always wanted and 'finally' found.

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