The Power of “Moving on” - a Gestalt Therapy Approach to Trauma Treatment

by Ivana Vidakovic

The new millennium started with high distress from natural and man-made disasters. Trauma affects the wholeness of the person; its physical, emotional, behavioural, cognitive, social and spiritual functioning. Still, most people will not suffer long term trauma reactions, depending on their personal characteristics, life experience and support available in the aftermath, as well as the nature and consequences of the trauma itself. However, some traumas surpass the range of human capability to process and to assign meaning to the experiences.

1. Diagnostic Considerations

Trauma related psychiatric disorders\(^1\) are, according to some authors, controversial diagnoses: the etiological factor of the disorder is recognized outside the individual, in the external traumatic stressful event (Yehuda & McFearlane, 1995; McNally, 2004), while many symptoms are not specific only to this diagnosis (Campbell & Lorandos, 2010). Additional ambiguity in the diagnosis is related to the high comorbidity of PTSD with mood disorders, other anxiety disorders, substance abuse and somatoform disorders (Kulka et al., 1990; Orsillo et al., 1996).

The phenomenon of traumatic stress reactions has been described much earlier, even outside medical literature (van der Kolk, 2007), yet only recently was post-traumatic-stress-disorder (PTSD) recognized as a diagnosis and introduced in DSM III edition (APA, 1980).

\(^1\) A part of Post-traumatic stress disorder (PTSD) described in DSM IV and DSM IV-TR (APA, 1994; 2000), and ICD-10 ( WHO, 1992), the other trauma related disorders are: Acute stress disorder (APA, 1994; 2000) or Acute stress reaction (WHO, 1992), as time-limited reactions to trauma (less than a month, usually 1-3 days) with symptoms overlapping with those for PTSD, but with a greater number of dissociative symptoms. In the literature we could also find references on Complex PTSD or Disorders of Extreme Stress Not Otherwise Specified - DESNOS (van der Kolk et al., 1996; Herman, 1997; van der Kolk, 2001) that refer to the severe and long lasting personality changes (in people traumatized at an early age, or with a history of prolonged interpersonal trauma). DESNOS is not recognised as a distinct diagnosis in DSM-IV, but could correspond to the description of an Enduring personality change after catastrophic experience in ICD-10 (WHO, 1992).
According to DSM IV² (APA, 1994) “PTSD follows a traumatic stress event in which the person has experienced, witnessed, or been confronted with an event that involved actual death or death threatening situations or serious injury to oneself or others" (criterion A1) and "the person’s response involved intense fear, helplessness, or horror" (criterion A2). In order to meet criteria for a diagnosis of PTSD, the individual must present symptoms from three distinct clusters: persistent re-experiencing of a traumatic event, avoidance of stimuli associated with trauma and numbing of general responsiveness, and increased arousal (criteria B, C, D), for at least 1 month (criterion E), in a way that causes clinically significant distress or clinically significant impairment in social, occupational or other important areas of everyday functioning (criterion F).

2. The process diagnostic and relational considerations

In diagnosis and therapy Gestaltists always refer to the relational experience in the “here and now”. Before referring to that aspect of the dynamic Gestalt diagnoses here, we will describe what we can observe in a person with PTSD in process diagnostic terms.

Too strong and inflexible or fluid and non-existant personal boundaries - both extremes can be noticed in the contact with people after trauma, that could lead them to social isolation or inability to self-protect and the risk of multiple victimizations.

The basic contact functions (eye contact, voice, hearing, touch/posture/movement) are often changed after trauma, and suspended in their aim to reach and be reached by others. Furthermore, perceptive, emotional and cognitive processes (sensory integration, emotional reactivity and regulation, mental processing and memory) are distorted, and significant shifts occur in judgement and Self evaluation. (Janoff-Bulman & Frantz, 1997).

² For upcoming DSMV the following changes are foreseen: criterion A1 will be expanded to include extreme or repeated exposure to aversive details of traumatic events, while criterion A2 that requires a peritraumatic reaction of intense fear will be excluded. The potential diagnostic symptoms for PTSD will be expanded and organized around four clusters: intrusion, avoidance, negative alterations in cognitions and mood, and changes in arousal and reactivity (Friedman, Resick, Bryant, & Brewin, 2011; APA, 2012). PTSD will be moved from Anxiety disorders and assigned to the new category of "Disorders associated with trauma and stress". (Friedman, Resick, Bryant, Strain, Horowitz & Spiegel, 2011; APA, 2012).
The dynamic of figure/ground is interrupted. Trauma, as the figure, becomes so compelling that the context is lost. The attention is narrowed and the traumatised person is not able to widen the perceptual field to allow other aspects of life to become figural. (Avery, 1999).

All self-functions are under a cloud: Id functions (“I need”, “I am aware of...”) are suppressed, the person has restricted needs and interests, Ego function (“I choose”, “I act...”) is lost in an inability to cope with trauma, continuity of Personality function (“I am...”) has disappeared, the person as he/she used to be no longer exists, the new experiences are not integrated and a new persona has not yet arisen after the life-changing event.

The contact cycle is stuck in demobilisation from traumatic experience, and further interrupted by desensitization (emptiness, numbing) and/or deflections (negation, avoidance, projections, etc.).

Trauma also affects self-representation and interpersonal experiences; and it is always present in the field and in the client-therapist relation. We can observe people suffering from trauma as agitated or withdrawn and inhibited, with overwhelming and mixed emotions, or sometimes with a blocked emotional response, fragmented and generally less available for contact in the here and now. As a part of the field and the relational diagnostic process, the therapist is also active in the co-creation of the phenomenological experience in the interpersonal relating that indicates the post-traumatic reactions or PTSD. The relational dimension in the therapy refers to the capacity for contact, relationship, trust and intimacy, but also to the projections, transference and counter-transference in the client-therapist interpersonal experience. The therapist has to be alert to them since they could bring trauma elements into the here and now and make them available for exploration. The common relational issues in therapy with trauma clients are stability/instability, trust/mistrust and power/helplessness. It is a delicate and challenging task to meet the client in his/her post-traumatic existence and to co-create a stable and trusting relationship that can allow the client to feel grounded, and to accept getting in touch with painful emotions in order to regain his/her wholeness.

3. Gestalt model of trauma and PTSD and its application

The trauma seen as “uncompleted situations from the past” and “fixed perceptions” was first described by gestalt founders (Perls, Hefferline, & Goodman, 1951). Later, many gestalt authors referred to these roots to explain trauma as unfinished experiences, fixed gestalts, and inability to disengage, that interfere with novel experiences (Polster & Polster, 1973; Zinker, 1978; Serok, 1985).
Trauma has been considered broadly as an adverse event or “rather a traumatic series of more or less frustrating and dangerous moments” (Perls, Hefferline & Goodman, 1951) and the phenomenology of post-traumatic reactions in intrusion, avoidance, numbing, and hyper-arousal, have been recognized and described: “Uncompleted situations from the past, accompanied by unexpressed feelings never fully experienced or discharged... they obstruct our present-centered awareness and authentic contact with others” (Perls, Hefferline & Goodman, 1951). “Uncompleted directions do seek completion and when they become powerful enough, the individual is beset with preoccupation, compulsive behavior, wariness, oppressive energy and much self-defeating activity” (Polster & Polster, 1973). “...the tension of the feeling and the dangerous explosiveness of the response gradually heighten, and the inhibition of these is habitually strengthened until, in the interest of economy, feeling and response are blotted out...”, “Avoidance is the means individuals use to prevent themselves from completing “Unfinished Business”... Avoidance exists for good and sufficient reason, and hence the task is to become aware of the reasons for its existence” (Perls, Hefferline & Goodman, 1951).

Addressing “uncompleted past situations” for closure, by “returning to the old business or relating to parallel circumstances in the present” (Polster & Polster, 1973) and “engaging in many ways besides the verbal” (Perls, Hefferline & Goodman, 1951), is recommended for re-establishing a capacity for contact with Self, others, and the environment in the “here and now”.

Developing further the gestalt knowledge on trauma, Melnick and Nevis suggested that PTSD is a manifestation of the difficulties in demobilization, as the final stage of the cycle of experience, and an individual’s inability to absorb and digest an unhealthy experience in order to achieve disengagement (Melnick & Nevis, 1992; 1997a; 1997b; 1998). If the experience is too charged to be easily absorbed, the old figure remains un-integrated and has a perpetually distorting effect on the current and future experience of the individual (Melnick & Nevis, 1997). Therapy should start with enabling the client to turn away from the traumatic figure. Taking the client slowly through a process of assimilation, emotions will be discharged simultaneously with the development of the ability to cope and deal with them. Encountering the void is the most difficult phase but, when completed, leads to acknowledgement of the emergence of something new about the self (Melnick & Nevis 1992; 1998).

Some further advances in the gestalt approach to trauma treatment have been developed more recently. Butollo has written about post-traumatic
development of Self, with loss of empathy and reactive narcissism as two possibilities for reactions of the traumatized Self (Butollo, Kruesmann & Hagl, 2000). He presented a therapeutic process through the phases of Safety (Feeling safety, Establishing therapeutic relationship, Learning techniques of relaxation, breathing, Differential work with symptoms, Facing avoidance, Activation of social support resources), Stability (Overcoming insecurity, Self-acceptance, Self-reflections in contact with others), Confrontation (Activation and protection of Self-boundaries, Cognitive and emotional processing of trauma) and Integration (Acceptance of what happened, Acceptance of Change, I-Thou dialogue with trauma).

In his reconsideration of PTSD from Gestalt perspectives Cohen (2002; 2003) explained the trauma symptoms as two-dimensional polarities: a continuum from extreme arousal and agitation to low arousal and numbness; and a continuum from over involvement (re-experience, flashbacks and rumination) to total avoidance of stimuli related to the trauma experience. He argues that gestalt could be the treatment of choice for trauma, seeing integral approaches in gestalt psychotherapy in phenomenology and I-Thou dialogues as effective therapeutic components in trauma treatment.

The gestalt approach to trauma treatment achieved greater visibility in recent years (Avery, 1999; Fodor, 2002; Cohen, 2002, 2003, Hardie, 2004). Several articles and case studies that have been published demonstrate how gestalt therapy works with clients who suffer from a variety of trauma, i.e. abused children, adult survivors of child abuse, war victims and refugees, war-veterans, helping professionals: counselors, social services staff, traumatized flight attendants, etc. (Crump, 1984; Serok, 1985; Crump, 1984; Sluckin, Weller & Highton, 1989; Kepner, 1995; Butollo, Kruesmann &Hagl, 2000; Pollard et al., 2002; Coen, 2003; Gilbert, 2006; Pack, 2008).

4. Trauma treatment

Different approaches to trauma treatment often include verbal and emotional expressions, behavioral overcoming and cognitive re-processing of the traumatic event with its consequences. Most manuals for the treatment of PTSD recommend trauma focused therapy and exposure as a major tool for treating PTSD patients (Foa, Keane & Matthew, 2000; National Institute for Clinical Excellence, 2005). Exposure-based therapies engage clients in systematically confronting the object(s) of their fears and distress within a therapeutic framework in order to regain control of
overwhelming emotions. Relaxation and breathing techniques for lowering physical tensions and hyper-arousal are widely used in trauma treatment protocols. Cognitive Behavioral Therapy works with cognitive restructuring, targeting clients’ upsetting thoughts and interpretations of the trauma and its effect on their lives. (Resick, & Calhoun, 2001). Some of the new developments in trauma treatment are presented within Narrative Exposure Therapy (Neuner et al., 2004; Neuner et al., 2008) and Emotion-Focused Therapy for Trauma (Paivio & Leone, 2010). Eye Movement Desensitization and Reprocessing combines exposure, relaxation technique and cognitive restructuring with an alternation between frames of the trauma image for stimulation of mental processing (Shapiro, 1995). EMDR has been widely accepted and used by therapists of different orientations, including Gestalt therapists. (Ginger, 2010)

4. I Gestalt Trauma treatment

Gestalt therapists have a particular focus on relational aspects in the treatment of trauma, working with dialogical interventions to strengthen the ability for contact, and helping the client to finish unresolved traumatic experience in a dialogical way (Butollo, 2010). With its holistic approach Gestalt considers and treats the wholeness of a person affected by trauma. The phenomenological method used in Gestalt leads to the slow, minute-by-minute process of examining the original experience and recognition of interruptions in the process of assimilation and disengagement. The phenomenological stance in the here and now offers the possibility of distancing from the overwhelming past experiences and focusing the healing process on the present moment and all resources and supportive elements existing in the Self and its environment at the present time. The contact between therapist and patient is important to enable patients to withstand the trauma processing; the relationship and process are more valuable than content and techniques. The I-Thou dialogue, with presence, inclusion, and confirmation, is a method, but also a desired achievement in the therapy. For clients who suffer from PTSD it is a challenging but also a healing experience. Awareness and acceptance, inclusion and dialogue as a basis for the approach in work with trauma affected people can be supported by useful specific Gestalt interventions like experimenting; empty chair or two-chair work, working with the “here and now”, reassuring “I statements”, etc. Other interventions commonly integrated in a Gestalt approach are dream work and visualization, bodywork, breathing exercises, relaxation, and meditation, rituals, therapeutic writing, etc. These simple curative skills can
help trauma survivors to become re-grounded, re-centred and get back to the inherent wisdom of the organism to return balance and wholeness, and live more peaceful lives.

The healing happens in the process between two (or more) persons – client(s) and therapist. Every client has his/her own unique experience, each relationship and therapy is different. Still we will try to present here some occurrences and milestones often seen in the Gestalt trauma treatment.

4.1.1. Reestablishing self-regulation and boundaries of traumatized Self

The natural ability for self-regulation and reaching homeostasis is lost, and the therapist has to encourage the client to increase self-care and healthy habits (nutrition, sleep, walk). At the beginning, but also during the therapy whenever the traumatic figure is too prominent, it is important that the client re-establishes self-control and a sense of safety in the “here and now” moment. The therapist supports the client to tolerate sensations, tensions and emotions by directing and focusing attention to the present moment; this helps in introducing distance from an overwhelming past experience. Respecting client’s boundaries and willingness is also important in the therapeutic relationship, to avoid slipping into the parallel process with previous victimization. The therapist encourages the client to be an active participant; able to follow and choose what may happen in the course of therapy.

4.1.2. Reestablishing Self and context awareness and contact functions

If the person has reacted during and after trauma with a strong dissociation of sensations and affects, the split of the “observing self” and the “experiencing self” could last a long time, causing disconnections from the context, and restricting clients from feeling sensations and emotions. This could be reduced by helping the person to enact and recover Self-awareness. The therapist could suggest some specific interventions as life-assuring “I statements” (“I am safe, I survived”, „I am here and I’m alive”), as well as simple exercises for raising awareness of the body with its sensations and feelings. Breathing, relaxation and meditation helps clients to lower hyper-arousal, while some physical activities or exercises could release blocked trauma energy. Bringing the traumatized client back in contact with his/her body is a delicate and long-lasting part of the therapy if the trauma involved physical or sexual maltreatment. Still, the important
part of trauma therapy is to realize how trauma is still represented in the body and to externalize it. (Kepner, 1995).

4.1.3. Re-approaching trauma – working with avoidance and intrusions

Working on the client's traumatic experiences often requires re-approaching or re-enacting the original situation and allowing the associated affect to be experienced and expressed. Trauma victims find it difficult to stand the recurrent and disturbing recollections of the event, including perceptions, images, thoughts or dreams. Self-calming (relaxation and visualization techniques – a safe place, feeling the ground and the roots...) and systematic controlled exposure (setting a 10 minutes each day in which the person will recall or allow trauma memories) with an attitude of “acceptance and let it go” (mindfulness) can enable trauma survivors to regain control over intrusive contents.

The Gestalt experiment can be engaged as an exposure technique to the trauma-related stimuli: the client is guided to approach a particular traumatic situation again: to revisit the scene and re-experience it - retelling the details of the traumatic event, sensations and emotions as if it were happening in the present. With support from the therapist, the client encounters an impasse or the trauma content and emotions that he/she is avoiding. The therapist is involved, reassuring the client to endure and go through the experience, offering awareness of the here and now moment where the survivor’s Self in relationship with the therapist is present, safe and alive. The client is helped to reach closure and to gradually disengage from the experience.

Throughout the process, the client is constantly encouraged to practice awareness, inclusion and dialogue. Still, we should always be aware of the high risk of re-traumatisation, particularly in applying exposure techniques without building sufficient support for the traumatized person to endure a new approach to the trauma.

4.1.4. Coping with overwhelming negative emotions and thoughts – building capacity for acceptance

Apart from the sadness and grief for the real or symbolic losses, shame, guilt, and anger, together with feelings of failure, “what if” rumination and other self-defeating thoughts and adverse emotions are emotions commonly experienced by people after a severe trauma. The expression and processing of authentic emotions is supported. Instead of denying, blaming, overtaking or displacing responsibility for one’s experience, the individual is
encouraged to accept thoughts, feelings, and actions in the past and present, as parts of the Self and its limitations. Working on the capacity for acceptance helps the client to accept the changes, deal with the consequences and re-build a life with dignity and quality in the given circumstances. Specific Gestalt dialogical interventions are helpful here: “empty chair” as a chance to directly voice anger, or “two chairs” for “top dog-under dog” dialogue when the client is overwhelmed with guilt and self—accusation.

4.1.5. Re-building a social support system and involvement in interpersonal relationships
The interpersonal support, from family, friends and a wider social network, the feelings of belonging and love, prove to have tremendous healing potential. Still, trauma affects relationships and clients often bring to treatment issues related to the disturbance in interpersonal functioning: regulation of emotions, attachment and intimacy. They are often frightened by their emotions or numbness, and try to protect important relationships, withdrawing from contact. The specific interpersonal dynamic related to trauma often appears in therapy too and the therapist has to be alert to his/her own experience in the relationship. When the client turns away from the trauma elaboration and looks for an experience where his/her new assumption might be tested and evaluated the relationship with the therapist becomes important; boundaries and trust are tested and expectations and demands can be elevated. It is important to remain stable, safe and in a clear setting with the presence of the therapist as a human-being with realistic and limited abilities. In a transference and counter-transference dynamic, client and therapist can exchange the trauma related content that remains beyond the words and out of awareness. Trying new assumptions in relationship and accepting another person with his/her strength but also limitations reassures self-acceptance.

4.1.6 Transformation of meanings, trauma disengagement, integration and completion
Before being available for trauma disengagement, integration and completion clients need to re-establish a cognitive support system. Their basic assumptions about the world and oneself are challenged, particularly those regarding personal worth, trust and safety. The task of therapy is also to reconstruct fundamental personal beliefs and to revive positive thinking; to restore a system of values and beliefs, and help clients to regain hope,
faith, and a perspective on the future. Gestalt psychotherapy with its emphasis on meaning making and spiritual holding (Polster & Polster, 1977) helps clients to reframe the narrative, reinterpret the event and search for new meanings relating to “the ground that provides a stability that the current moment itself cannot provide and perspective to reach beyond the immediate context for dialogue with something that is beyond the most immediate figure “(Jacobs, 2003).
Reframing helps the client reach a new perspective beyond the individual experience; client and therapist are looking for a context and a frame that can give a universal perspective and new meaning to the personal traumatic experience. Therapeutic writing and other artistic expression can help to integrate the trauma experience into life-flow, and to reconnect the past, present and future. Completion and integration are achieved when life before and after the trauma are perceived as parts of a meaningful continuum, rather than as fragmented, disconnected segments (Alon & Levine Bar -Yoseph, 1994).

4. 2. Individual and Group Treatment

Most of the interventions described above could be used both in an individual and a group setting. The choice of individual or group treatment is usually a matter of convenience. However, the following observations should be taken into consideration before including people with severe trauma in group therapeutic work. An individual setting is recommended for people with severe trauma, for revelation and initial work on the trauma. It provides a safer environment and more private contact, with better prospects for re-establishing attachment and intimacy. The group context can be an important addition to the individual therapy, where the client can validate his experience again in a relatively safe situation. The group should be developed enough to be able to contain the traumatic content and related emotions and still stay whole and coherent. Sharing strong traumatic experiences at the beginning of the group during the first few sessions can be counter-productive; the group as a unit can be overwhelmed by the traumatic narrative in a similar way as the traumatised person.

5. Individual and Collective in Trauma

The unaddressed and unhealed trauma can be re-enacted through acting-in (alcoholism, substance abuse, depression, work-holism, physical ailment, suicide, etc) or acting-out (aggressive behavior, repetitive conflicts, high-
risk behavior, domestic or interpersonal violence, etc.) and can cause individuals to hurt themselves or others, intentionally or not. “Pain that is not transformed is transferred” (Rohr, cited in Yoder, 2005). Trans-generational transmissions of the trauma have been described, particularly after massive and extreme traumatic events as Holocaust (Yehuda et al. 2005; Sorscher & Cohen, 1997). Trauma affects not only those directly involved in trauma but also their family, friends and, on larger scale, their communities. There are always strong social, cultural and political dimensions in defining and treating trauma that the therapist should be aware of (Scott, 1990; Yoder, 2005; Vidaković, 2009; 2011; Jankovic et al. 2010; Perera-Diltz, Laux & Toman, 2012). A Gestalt therapy includes a field perspective and offers a culturally sensitive approach to PTSD diagnosis and treatment (Chang, 2005; Perera-Diltz, Laux & Toman, 2012).

6. Existential Perspective in Trauma Healing and Post Traumatic Growth

After successful therapy the client will not only be symptom free but also able to acknowledge a gain from the traumatic experience (Melnick & Nevis 1992; 1998). People can not only survive trauma, they can also experience growth as a result of dealing with life’s struggle (Calhoun & Tedeschi, 2006; Gilbert, 2006). Post-traumatic growth includes positive transformative dimensions, appreciation of life, shift in priorities, deepening of spiritual life, fostering positive attitudes and emotions. (Hobfoll, et al. 2007; Grubaugh & Resick, 2007). Continuous transformation occurs both during the trauma and in the post-trauma coping period; it is a process and not just an outcome (Linley & Joseph, 2002).

As a therapist we have to believe in our clients and their capacity to overcome trauma and adversity in life. Still it is important to be realistic and honest, to act within the frame of a professional therapeutic relationship, and to recognize that for some of the severely traumatised clients even limited gains are appreciated. Otherwise we are at greater risk of “burn out” and “compassion fatigue”.

From our experience with war-affected clients we can also recognize enormous human potential for endurance and creative adaptation through adversities. A lot can be learned from those people who manage to survive severe trauma, move on afterwards and re-build their lives: “Going through the deep losses, I have learned to embrace the gift of life”, “I am struggling to provide for daily living, but in a way am now more present in my life than before”, “I appreciate everyday life with my family, small things, my grandchildren smiling or crying, freshness in the air and sunrise”. “I still
believe that good is prevailing in human nature, I have no enemies and I am at peace with my God.” The resilience and post-traumatic growth of those people can be recognized through the new spiritual dimensions they have reached and their ability to pass on wisdom to others. The post-traumatic growth continues also in the therapy, and it happens, both for the client and the therapist, through a deep human interaction.

7. Case studies

Case study 1. The client was a man in his sixties who was captured during the war, imprisoned for eight months and physically and psychologically tortured. Within the diagnostic session he reported intensive post-traumatic symptoms: he had difficulty falling and staying asleep, intrusive upsetting images; often feeling exhausted, tense and easily startled. He started the therapy, coming regularly and talking mostly about a lack of interpersonal contact and enjoyment in his life. He lost interest in meeting people and had no willingness to work, which caused him to feel guilt and inadequacy and reinforced his restlessness. He felt unable to be close to his family; he socialized only with ex-detainees, believing that only they can truly understand him. In a way he seemed to be preoccupied with the suffering in the present while the trauma stayed out of reach of our exchange in the therapy. Only after referring to that could we understand how he was “holding himself on safe ground”, being unsure that the therapist, a young female, could understand a terrifying experience of war. His realisation of how he held himself back to protect the other person from his deepest fears and horrors brought a new breakthrough in the course of the therapy. He started to share some of his trauma memories by speaking about the period when he was detained and completely isolated. He did not know anything about his daughter and wife; they remained alone in the war territory and the perpetrators threatened to find and kill them. Among the perpetrators were his pre-war neighbors who knew him and his family, which made his experience of torture and fear for the family even worse. In the dialogue that he created with the perpetrator through the two-chair technique he was able to confront and let the trauma experience go, demonstrating not only his capacity to endure and survive, but also to recall a positive experience where other people helped him to survive. After acknowledging his efforts to protect others even in his isolation, he was encouraged to go further by re-approaching people and re-establishing contacts with his family, particularly his daughter and new-born grandchildren, and to open himself to emotional exchange, without being
afraid that he would damage his beloved with everything that he is carrying
and coping with.

Case study 2. A young woman, in her early thirties, has been involved in
group therapy for more than a year. She was a refugee, living with her
mother and two brothers in a collective centre. In the group, she was very
serious, reserved and rarely involved in the spontaneous exchange. In the
second year of therapy, she gained enough trust in the group to be able to
speak about herself. She has been thinking of going back to faculty; before
the war she studied to become a teacher. War destroyed her plans for the
future, her house and a relationship with a boy from the neighborhood. She
received a lot of empathy and support from the group for her bravery and
fortitude; the group encouraged her to go on with her life. After this
opening, she started to attend less regularly, missing several group
meetings and avoiding any deeper contact. When she was offered an
individual session with the therapist, she revealed that she had had an
outburst of emotions and intrusive dreams, struggling between feelings of
shame and a desire to reveal her deepest experience within the group. She
was about to share her suffering from being sexually abused during the war,
but she was worried how the others would react. Her Self image was
polarized between a strong and brave part, able to cope with all adversities
that came with the war, and an unprotected and powerless part of the Self,
unable to resist and protect herself when sexual violence occurred. We
worked on her traumatic experience in an individual setting intensively for
six months, mostly dealing with her feelings of guilt, powerlessness and
shame. She went over and over the fragmented memories, and she felt
frozen, just as if the trauma was happening in the present. We went back to
see how desensitization and dissociation helped her at the moment of
trauma; she recalled the memories of looking at herself from above, feeling
nothing, “like watching a movie”. The therapist followed her, supporting
her perseverance but also her hesitation, reminding her of the present
moment and of eye-contact as safe places in the “here and now” that she
could refer to. It was important to provide space for processing,
maintaining boundaries but respecting her autonomy. She was repeatedly
reminded that she had the possibility of choosing when to stop, restoring in
that way her sense of control over her experience. However, for a long
period of time, she was overwhelmed with powerlessness. The change-
point for her was when she was able to recall some particular self-
protective efforts and movements that she made during and immediately
after the traumatic event, and to recognize this as evidence of personal
endurance and strength even in the most adverse moments. She regained
reliance and trust in herself. Gradually, some emotions and body sensations related to the traumatic event appeared, and she was increasingly able to tolerate them. The trust in the relationship was strengthened and it was easier to be in contact and to share emotions; she was able to reach and receive support from the other person. Ever since the traumatic events took place she has always been alone with her experience; now she felt accepted, understood, and reinforced. She was ready to join the group. Since then, a lot of work has been done in the group context on emotional processing and the reconstruction of self-esteem. The long journey is still in front of her. Ability for full contact, interpersonal trust and intimacy are seen as a desired destination.

Bibliography


Hardie, S. (2004) Literature Review surveys Gestalt therapy and related literature on the treatment of Post Traumatic Stress Disorder *Gestalt! Vo. 8 ; No. 1*


Scott, W. J. (1990) PTSD in DSM-III: A Case in the Politics of Diagnosis and Disease in *Social Problems Vol.* 37, No. 3
Vidaković, I. (2011) *After the war and conflicts in the Western Balkans*. Presentation on the conference: Social, political and cultural relationships as therapy’s ground: EAGT, EMA & EIUC, 12.-14.October, Venice, Italy
WHO (1992) The ICD-10 *Classification of Mental and Behavioural Disorders*. Clinical description and diagnostic guidelines