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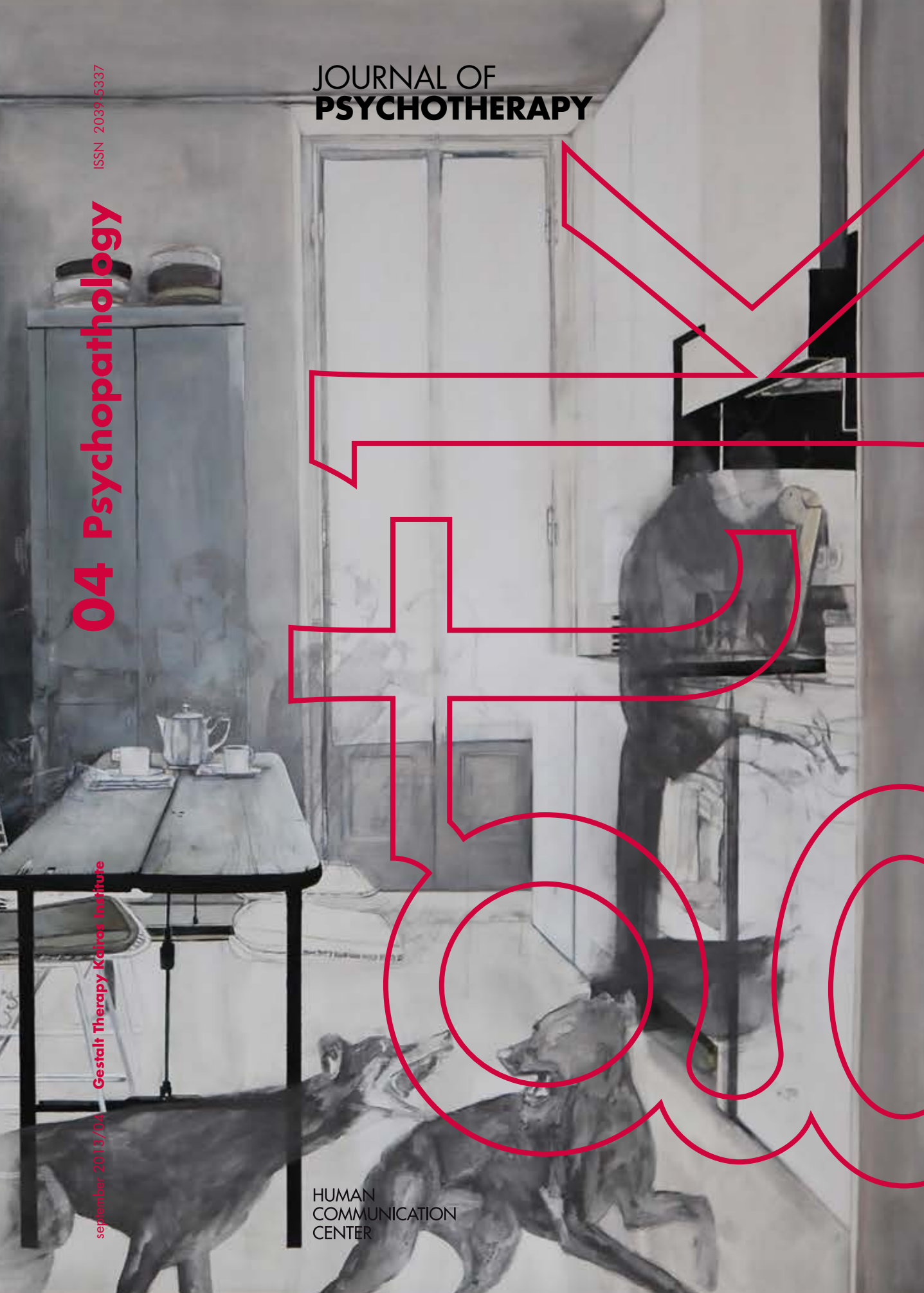

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THE MOON IS MADE OF CHEESE EXERCISES OF GESTALTIC TRANSLATION OF BORDERLINE LANGUAGE

Giovanni Salonia

1. A foreword like a dedication. Isadore From's[1] teaching

Every borderline's precocious experience is the denial of the possibility of experience itself: «Don't say this», «Don't think this». Since psychoanalytic technique is quite similar, it turns out to be intolerable for borderlines. Without telling lies, in Gestalt Therapy, it is possible to confirm the patient's experience and, unless it is dangerous, never intervene by saying: «You don't have to think about this» or «Don't say so». A child could say, for example: «The moon is made of cheese», a somehow extremely poetic statement. However, an anxious mother could respond: «You're wrong». Well, even a good Gestalt therapist knows that the moon is not made of cheese, but would not say to a borderline: «Yes the moon is made of cheese», but rather «They are both yellow». And that is it.

1 Isadore From (1918-1994) was one of the most esteemed didacts and therapists of the group of the seven founders (together with Fritz Perls, Laura Polster, Paul Goodman and others) of Gestalt Therapy. He did not write much: cfr. *Requiem for Gestalt*, in «Quaderni di Gestalt» (directors and founders Giovanni Salonia & Margherita Spagnuolo Lobb), I, 1, 1985, 22-32; together with V. Miller the introduction of the 1994 edition of the text *Gestalt Therapy* by F. Perls, R. Hefferline and P. Goodman; an interview given to E. Rosenfeld on *Storia orale della psicoterapia della Gestalt* published in 1987 in «Quaderni di Gestalt», III, 5, 11-36. Among texts written on him, we remember: G. Salonia (1994), *La forza della debolezza*, in «Quaderni di Gestalt», X, 18/19, 53-57; A. Sichera (1994), *Per una rilettura di 'Requiem for Gestalt'*, in «Quaderni di Gestalt», X, 18/19, 81-90; B. Muller, *Il contributo di Isadore From alla teoria e alla pratica della Gestalt terapia*, in «Quaderni di Gestalt», VIII, 15, 7-24; H. Cole (1994), *In ricordo di Isadore From*, in «Quaderni di Gestalt», X, 18/19, 5-20; M. Spagnuolo Lobb (1994), *Da figlia a madre*, in «Quaderni di Gestalt», X, 18/19, 45-52. Since 1981 and up to some years before his death, he taught in various HCC Gestalt Institute departments (Syracuse, Venice, Rome).

Be very careful with borderlines. Never tell them they are wrong; instead, listen to their experience of the world.
If you observe the history of these patients, in their early years, they listened to the language used by the key people in their lives which sometimes negated their experience. They may have done it to protect them, but by doing it in this way, they confused them by creating conditions of disorder. Therefore, as therapists you should not allow history to repeat itself; you do not have make things happen which have already happened. I do not care about truth in front of borderline patients. What interests me is protecting their experience, what they say they experience. If a borderline patient said to me: «You look sad», I would not simply respond, «I'm not sad» (I could do it with patients that are not borderline, highlighting the fact that it could be a projection), but I would add: «I'm very tired today». I would not negate what he told me, but I would not tell a lie: only in this way do I protect his experience[2].

This contribution ideally arises from Isadore From's withering, very smart intuition. Like a determining hermeneutic figure of Gestalt Therapy (GT) approach with borderline patients (bd pt)[3]. Without discrediting («What you say is wrong») without lying («What you say is true»), the therapist supports his patient and makes the intimate coherence of a statement emerge, which seems strange at first glance. Let's proceed with our itinerary from this paradigmatic and poetic example and from some precious teachings on the topic by From[4].

2 The text is an authentic translation of a seminary held by Isadore From in Venice, from 29/1 to 1/12 1990, at the HCC Gestalt Institute.
3 The term 'borderline patient' is used for practical reasons; however, it does not intend to label, but rather indicate a specific relational modality.
4 Every time I cite Isadore From, I remember that dinner in southern France, where I told him (almost joking menacingly) – he was still reticent to publish about Gestalt – that I would publish many seminaries he had held under his name. He looked at me with his warm, sharp and clever eyes and responded with precision, something along the lines of: «You cannot write 'What From said', but 'What I understood from From's lessons'». Remembering this fine precision each time I refer to what… I understood from his

GT can give the world of therapy an original, approaching method of interpretation and clinical intervention even in the most difficult conditions and the extremest psychic disorders.

However, to me, starting with From also means expressing a sincere gratitude towards him as he was the one that first adopted GT at work with serious patients. As he knew and often reiterated, GT can give the world of therapy an original, approaching method of interpretation and clinical intervention even in the most difficult conditions and the extremest psychic disorders. In this sense, the bipartition of my work will try to respond to two requirements: to clarify, to a certain extent, hermeneutic basics and gestaltic therapy with some of the most difficult and emblematic patients of our times; and to connect (and question) the 'gestaltic way' with some of the most successful and well known suggestions (from Gabbard to Kernberg, from empathy to mentalisation) in the diagnosis and treatment with bd pt, in order to first of all verify a diversity and distance that also signifies a serene, respectful and decisive dissent in real therapeutic language.

2. The gestaltic method: translating borderline language

In my messy pockets
I search for words never learnt
And only see wrong words,
Confused, intrusive, tangled
I go back or I am absorbed
by a reiterated deceit
And so I feel myself thrown into the world
In which I lose and confuse myself
I hang onto the other to understand
What happens to me, if I can feel.
Annalisa Iaculo[5]

Their words and behaviour may appear confusing, strange, accusing, but always include fragments of truth and coherence, from which one necessarily has to start.

The Archimedean point of gestaltic clinical work with bd pt is the certainty that their words and behaviour may appear confusing, strange, accusing, but always include fragments of truth and

ideas is a duty and pleasure to me.

5 A. Iaculo (2013), *Border-line*, in «GTK Journal of psychotherapy», 3, 61-63.

coherence, from which one necessarily has to start, in order to trace the patient's experience. Such a gestaltic model could be called a 'translation of borderline language'. It is about avoiding the cognitive or emotional colonisation of bd pt, going back from his words – respected, even if totally idiographic – to the related experience. The use of the word 'translation' is not innocuous or accidental, but hermeneutically characterised. 'To translate'[6] means giving the bd pt's statements a dignified language. Indeed, in translation, both languages involved require and receive equal dignity. A translator cannot approach source and target language presuming implicit hierarchies of value.
It is a considerable aspect. In fact, in therapy with bd pt, you often try to impose a language – the therapist' one – considering the borderline language as 'wrong' rather than 'foreign'. However, only if you know both languages appropriately, can you provide a correct translation. Indeed, each translation has to distinguish the rich shades and sensitivity that a language owns. Defining the present gestaltic working model with bd pt as a 'translation of borderline language' actually means to acquire the epistemology of translation as a therapeutic task. From such a perspective, the therapist is aware of the fact that you can learn a lot from a bd pt: the therapy will turn into an interesting and, to a certain extent, a fascinating trip towards the exploration of secret (but determining) trends of the human heart. The insuppressible and obstinate research for clarity and diversity from the bd pt's side will help the therapist to become conscious of his incoherence, clearer in his treatment relations and more precise in the use of his language.

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The insuppressible and obstinate research for clarity and diversity from the bd pt's side will help the therapist to become conscious of his incoherence, clearer in his treatment relations and more precise in the use of his language.

6 For a new hermeneutics of 'translating' not any longer based on '*sources-oriented*' and '*target-oriented*' theories, but on the metaphor of the hotel, that is linguistic hospitality, basic text is A. Berman (1984), *L'epreuve de l'étranger*, Gallimard, Paris. Also cfr.: M.J. Iglesias (2013), *L'esperienza della traduzione. Verso un'ermeneutica dell'ospitalità e della reciprocità*, in «Nuova Umanità», XXXV, 206, 177-192. Translating means reconfiguring both source and target language… correlating them: cfr. C. Hagège (1989) (ed. or. 1985), *L'uomo di parole*, Einaudi, Torino, quoted in S. Fontana, A. Zuccalà (2011), *Tra segni e parole: Impatto linguistico, sociolinguistico e culturale dell'interpretariato lingua dei segni/lingua vocale*, in «Rivista di Psicolinguistica applicata», XI, 3, 67-78.

In the therapeutic path, it is essential to focus on the stage and passage, in which the subject experienced or decoded the experience in a socially incomprehensible way.

Let us go back to the translation process. Etymologically, 'to translate' (*trans-duco*) means 'to lead', 'to carry across', 'to cross'. In gestaltic clinics, to translate means going through the bd pt's verbal and non-verbal communication, in order to identify the point where disorder was formed. In From's example, the therapist finds the connection (surely idiographic and artistic!) that the patient established to put together moon and cheese: the colour yellow. The confusion in this example–happens at the stage where the subject organises his perception of reality: his association criterion is different from the one of common semantics – but no less logical or coherent. In the therapeutic path, it is essential to focus on the stage and passage, in which the subject experienced or decoded the experience in a socially incomprehensible way.

GT offers a clear and interesting description of this process in two interpretations: the theory of the contact cycle (elucidation of the stages where the Organism meets the Environment) and the theory of the Self (the spaces of the experience where confusion happened: the Id-function, or the body and/or the personality-function, so in other words, the narration)[7]. Identifying the confusion in these phases and in these levels will allow the patient's words to be traced back to a type of source-text. In this line of work, the Gestalt therapist is guided by questions such as: «What relational experience is the patient living?», «What difficulties is he facing in the experience, in understanding and telling us about the experience?», «How are his 'strange' words connected to such experience?», «What is happening between us, therapist and patient, in our contact border?».

One day, Claudio, a patient, says to me as soon as he sits down: «Giovanni, I get the impression that you are mad at me today». I did not seem to feel such emotion, and thus I responded: «I don't seem to feel this emotion, but if you say so, I want to listen to myself better. Give me some time to think about it». I

7 Cfr. F. Perls, R. Hefferline, P. Goodman (1997) (ed. or. 1994), *Teoria e pratica della Terapia della Gestalt*, Astrolabio, Roma; G. Salonia (1989), *Tempi e modi di contatto,* in «Quaderni di Gestalt», V, 8/9, 55-64; G. Salonia (2012), *Theory of self and the liquid society. Rewriting the Personality-function in Gestalt Therapy,* in «GTK Journal of psychotherapy», 3, 29-57.

ponder on it and say to him: «I don't find anything against you in myself, but if you say so, such anger must be somewhere». A moment of silence and I add: «Maybe knowing when you've seen it and on which part of my body can help us. Try to remember». The patient: «I saw anger in your eyes». I ask: «When?». And he says, after a while: «Here you are, I remember it! Your eyes were angry when you opened the door». That day, the secretary was not there and I went to open the door. I respond: «Let me think... ». At a certain point, everything became clear: «You're right – I say to him – when I opened the door, my eyes were furious, but not with you. I was reading a letter about a colleague which made me furious and when I opened the door, my eyes were still in that emotional wave». «Thank Goodness – concludes Claudio – I'm not mad!».

At the time that my patient ends the interaction exclaiming «Thank Goodness, I'm not mad!», he opens a gaping hole in the efforts he performs, telling himself and us about his experience without being misunderstood or seen as mad. If we had not found the reason for his feelings together, if we had not found a concrete explanation for my anger, even in that case I could have said to him: «You are telling me the that you sense anger in me towards you. I cannot see this and we cannot find a concrete explanation for this. If you say so, then it must be true in some shape or form. Let's continue. Should you sense the same emotion or a similar one again, we will talk about it again: we will find out what it refers to...». It is obvious: respect and confidence in the truth of the bd pt's words do not intend to naively exclude the possibility that the patient could project his own experience onto the therapist. It becomes clearer and clearer how the GT's identifying clinical factor with bd pt is to make perceptive misrepresentation processes emerge, starting with fragments of truth – as From insisted – that are present in the patient's statement and are incorporated in the twist of feelings, experiences and language. Sustaining, from a gestaltic point of view, that the patient has (a) reason for what he states, reveals the certainty (coherent with the theory of phenomenological communication) that the bd pt always and in any case wants to talk about the relational experience that he lives, and that he is unfortunately unable to understand and recount.

The GT's identifying clinical factor with bd pt is to make perceptive misrepresentation processes emerge, starting with fragments of truth – as From insisted – that are present in the patient's statement and are incorporated in the twist of feelings, experiences and language.

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3. The imprinting of borderline confusion

3.1 Contribution of neurosciences

As neuropsychological sciences have confirmed[8], the development of an experience involves three levels (motor skills, the emotional and the cognitive sense), which in neuropsychology have been described as 'triune brain' by MacLean: «A brain with a brain within a brain»[9]. In the matter in question, the 'reptilian brain', the first one that developed according to an evolutional viewpoint, controls the *arousal*, the organisms' homeostasis, sexual impulses and is connected to the motor skills and the level of information processing, including impulses related to voluntary movements. Linked to the emotional process, the 'paleomammalian brain' or 'limbic system' present in all mammals, surrounds the reptilian brain and mediates emotions, memory, some social behaviours and learning[10]. Different types of knowledge originate from each of these brains[11]. The reptilian brain produces «innate behavioural knowledge: the tendency to carry out instinctive actions and habits linked to primitive survival needs»[12]. The limbic system is linked to «emotional knowledge: subjective feelings and emotional reactions to world events»[13]. Instead, the neocortex generates «declar-

8 Cfr. Wilber's notion of hierarchic processing of information, which describes evolutional and functional hierarchy between three levels of experience organisation: cognitive, emotional and motoric sense. Cfr. K. Wilber (1996), *A brief history of everything*, Shambhala, Boston. In relation of neuroscience, also cfr. A. Damasio (1999), *The Feeling of What Happens: Body and Emotion in the Making of Consciousness*, Harcourt, NY.

9 P.D. MacLean (1985), *Brain evolution relating to family, play and the separation call*, in «Archives of General Psychiatry», 42/4, 405-417.

10 Cfr. L. Cozolino (2002), *The neuroscience of psychotherapy: Building and rebuilding the human brain*, Norton, New York.

11 Cfr. P. Ogden, K. Minton, C. Pain (2006), *Trauma and the body. A sensorimotor approach to psychotherapy*, Norton & Company, New York - London.

12 J. Panksepp (1998), *Affective Neuroscience: The Foundations of Human and Animal Emotions*, Oxford University Press, New York, 43.

13 Ibid.

ative knowledge [...] propositional information about the world»[14]. Indeed, the clinical work of GT tends to analyse the development process of Gestalt (a sort of Gestalt-analysis) to identify where borderline confusion is placed: it is a phenomenological-relational work, which reduces and does not intensify the patient's confusion, avoiding any reference to *frames of reference* not related to his communication contents. The specific nature (and correlated severity) of any borderline disorder is established with the level of confusion in the patient. With this path, the therapist will understand (verbal and non-verbal) messages, which were first labelled as 'strange' and have now become only 'unknown', thus require a translator. I believe that understanding how borderline confusions happen and are structured along the patients' evolutional learning paths is an essential, but not sufficient, pre-understanding to approaching a bd pt without any therapeutic prejudice.

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3.2. Evolutional theory and psychopathology

In order to understand a bd pt's vocabulary and grammar, you need to go back to those imprinting processes, where the child is confused and/or misled without being aware of it. The evolutional stage[15] in which this dysfunction happens is when he starts to become aware of experiences (sensations, perceptions, emotions, and intercorporeal feelings), his own ones and those of others, and of the words used when telling himself about and recounting such experiences. By describing confusion times and levels, it will then be possible to identify appropriate therapeutic paths for the different ways from which the borderline disorder arises.

In order to understand a bd pt's vocabulary and grammar, you need to go back to those imprinting processes, where the child is confused and/or misled without being aware of it.

14 Ibid.

15 Cfr., in relation, G. Salonia (2013), *Gestalt Therapy and Developmental Theories*, in G. Francesetti, M. Gecele, J. Roubal (eds.), *Gestalt Therapy in Clinical Practice*, Franco Angeli, Milano, 235-249.

3.2.1 Borderline confusion in the sensory-motor register (Id-function)

Pathologically serious are those traumatic confusions that are produced in the stages where the child awakes to awareness and are placed at the level of corporeal sensations (Id-function of the Self).

Pathologically serious are those traumatic confusions that are produced in the stages where the child awakes to awareness and are placed at the level of corporeal sensations (Id-function of the Self). A mother starts to kiss her daughter on the face, then on the neck, in a crescendo that displays her affection more and more intensely and viscously, turning the kisses into bites. Despite the daughter's verbal and nonverbal signals, the mother does not desist and continues sometimes using tender, and sometimes aggressive words. The daughter's body is overwhelmed with opposite sensations at the same time (warmth, affection, invasion, violence, annoyance). Confusion is inscribed in her body: each time she is kissed, mixtures of contrasting sensations and emotions will appear in this child's body, which will produce confusion and disorientation. Another example: early in the morning, a father goes into his eleven-year-old daughter's room, who is sleeping, speaking to her in an aggressive and confusing voice, saying vulgar words expressed with this terrible question: «What are you dreaming about? You are a tart! You belong to me!». A violent and mad intrusion that confuses and destroys the corporeal spontaneity of sleeping, dreaming and awakening in the girl. A lot of clinical work is required to restore such seriously destroyed spontaneity.

The most serious experience of traumatic confusion is certainly incest.

However, the most serious experience of traumatic confusion is certainly incest[16]. In the variety of ways that this crime happens, from a clinical point of view, it is necessary to consider that the

16 On abuse cfr. J. Kepner (1995), *Healing tasks: Psychoterapy with adult survivors of child-hood abuse*, Jossey-Bass, San Francisco; P. Ogden, K. Minton, C. Pain (2006), *Trauma and the body. A sensorimotorial approach to psychotherapy*, cit.; M. Stupiggia (2007), *Il corpo violato. Un approccio psicocorporeo al trauma dell'abuso*, La Meridiana, Molfetta (BA). Touching, on incest, depositions of E. Aster: cfr. E. Aster (2011), The recovered body. Writings and images of a therapy, in «GTK Journal of psychotherapy», 2, 75-78; E. Aster (2011), *I can't write it…*, in «GTK Journal of psychotherapy», 2, 79-81. Also cfr. E. Amenta (2011), *Re-reading 'the re-discovered body' Interview with Maurizio Stupiggia*, in «GTK Journal of psychotherapy», 3, 65-71 and the forum for sexual abuse of the GTK Institute edited by doctor E. Amenta: www.gestaltherapy.it.

harm involves the Id-function of the Self (sensorial-motor level) decisively, if the abuse happened at a premature age, when a girl does not have the means to give this experience a name yet, since her body is overwhelmed and confused by contradictory and incoherent excitement and emotions (pleasure, warmth, pain, violence, bewilderment, proximity, passiveness, powerlessness and so on). When the body will feel sexual sensations and stimulations at any level in the future, it will at the same time and in the same corporeal space feel other emotions in an extricable way, such as uneasiness, violence, need, disgust, anger, with a deep sense of confusion and sensory as well as behavioural loss.

In the experience forming stage, the intrusive educational style can create confusion, and even different levels of severity (examples: «Go to bed, don't you know that you are tired», «Eat, you are hungry», «Cover yourself, it's cold», «I know what is happening to you now» and comparable), which interrupt spontaneity in the physiological process to go through and learn corporeal, emotional and relational experiences from life. As if the names of emotions were learnt without experiencing them, as if that *nomina nuda tenemus*[17] was acheived, which from time to time takes on different meanings. Even the educational style that verbally anticipates the paths and names of an experience that the child is starting to live and that has not yet reached its own form, seems confusing. Such confused *timing* imposes an external direction pre-established to sensations still in the early stages, which the child starts to feel, and so prevent the pre-learning-experience of those processes that follow when an emotion has to take form (for example: even 'light irritation' will be called 'rage'). Conte summarises «Hence, the child has been prematurely hyper defined [...] with a false and deceptive kind of empathy that does not allow him to learn the right name of his feelings. The child's experience has been interrupted by establishing a difficulty

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17 As we know, the original text was: «*Stat Roma pristina nomine, nomina nuda tenemus*», which then became 'rose' and celebrated by U. Eco.

in the symbolisation process and in the significance of the experience. [...] This misleading anticipation of experience offered by the parent in place of a respectful support of differences and a child's regular experiences becomes a scam. As a consequence, the child grows up with confusing experiences»[18].

3.2.2. To whom do the experiences belong?

A second level of induced confusion does not actually concern the processes of formation of the experience, but their belonging, their assignment.

A second level of induced confusion does not actually concern the processes of formation of the experience, but their belonging, their assignment. If the child asks his mother if she is sad and the mother – not aware she is experiencing and showing this kind of emotion – responds in an intrusive way «What are you saying: me, sad? I am happy. You are the one that's sad»; or if the mother responds to her child, who says she is sad «Come on, don't say that. I'm the one that's sad», the child remains disoriented with reference to identification and the correct distribution of experiences.
Another situation: Anna, eight years old, is annoyed by her father's caresses that she feels are, albeit not disturbing, but inappropriate. When she shows her annoyance, she is told that she is at fault, because she has strange thoughts: the father is not aware of the corporeal borders between himself and his daughter and attributes it to a mistaken emotion. The girl gets confused, because she does not know whether to allocate the 'inappropriate' experience to her father's behaviour or to her own reaction. When she attends the therapy, she talks about her confusion, about the fact that she feels hurt when she feels unpleasant reactions in relation to the behaviour of others. In order to rediscover the limpidity in relationships with others, she will need to learn that it is her body and that nobody has the right to touch her without her permission.

18 V. Conte (2010), *The borderline patient: an insistent, anguished demand for clarit. Interview to Valeria Conte ed. by Rosa Grazia Romano*, in «GTK Journal of psychotherapy», 1, 63-77.

3.2.3. A third level of borderline confusion: names of the experiences (Personality-function of the Self)

Another form of confusion that can be caused in children has to do with incorrect names given to the emotions they experience or see in the body of others. Confusion has been caused at the moment when the Personality-function[19] comes out and the learned words do not correspond to or distort the experience one goes through. In a training group, at the end of a project, Anna shows that she is relaxed and tranquil. I ask her: «How do you feel?». And she replies: «I feel anxious». The participants and I are surprised: her answer seems to be too discordant with what her body communicates and with the work we have done. So, I ask her to explain to me in more detail what she feels in her body, which sensations she perceives, and above all, where the perception of anxiety comes from. She responds: «I feel my body vibrating. I feel energy flowing through me. I want to move my body… I feel anxious!». «If that word did not exist – I ask her – what would you say?». Surprised, she tells me: «Is this not anxiety?». Then she tells me that each time she feels the desire to move her body, she remembers her mother saying in similar circumstances: «What is wrong with you? Why are you so nervous? Why don't you stand still?». In such a situation, experience has been formed and has been seen as one's own, but the name given is 'wrong' (according to a shared vocabulary). Wrong names of experience refer to the cognitive and narrative experience level, which GT defines as Personality-function of the Self. As shown, from a clinical point of view, it is necessary to make a differential analysis of confusion types and levels: distinguishing if it concerns the ID-function (formation of experience in sensations and emotions) or the Personality-function (telling oneself or recollecting an experience).
This analysis becomes particularly necessary in incestuous situations: indeed, the severity is qualitatively different to when a

Another form of confusion that can be caused in children has to do with incorrect names given to the emotions they experience or see in the body of others. Confusion has been caused at the moment when the Personality-function1 comes out and the learned words do not correspond to or distort the experience one goes through.

From a clinical point of view, it is necessary to make a differential analysis of confusion types and levels: distinguishing if it concerns the ID-function (formation of experience in sensations and emotions) or the Personality-function (telling oneself or recollecting an experience).

19 On the Personality-function of the Self, cfr. G. Salonia (2012), *Theory of self and the liquid society. Rewriting the Personality-function in Gestalt Therapy*, cit.

girl clearly distinguishes what happens – the violation of her body and related reactions – but she does not know if she has the right to say it, how to say it, if she is responsible as well, if they will believe her, if it is right to create other problems between parents or at home. In such a situation, confusion refers to the words used to define, understand and retell the experience, which the girl has, however, clearly undergone.

Using wrong names to define one's own experiences does not only create confusion at a cognitive and narrative level, but also harms other levels of the experiential-relational world.

Using wrong names to define one's own experiences does not only create confusion at a cognitive and narrative level, but also harms other levels of the experiential-relational world.

For children, in fact, learning to talk does not only consist of finding words to be filed in their memories and then mechanically repeated with their lips, but it coincides with the growth of linguistic ability that progresses with age and practice. The words children learn not only increase their information, but also prepare their intellect to understand with higher alacrity what they have not yet heard, to clarify what they have already heard a long time ago and only understood half of it or not at all, and to tidy up the world[20].

This confusion can also refer to the names of the emotions of others. Angelo answers the phone and his aunt asks if she can speak to his mother. At the end of the conversation, he asks: «Mum, aunty was speaking strangely. What is up with her?». His mother – lying (the aunt was in hospital because her husband had had a heart attack) – responds: «She was just a bit tired». The son replies: «Well, she did not seem tired to me, but very worried». Age allowed the boy to learn the right words in identifying an emotion through the tone of a voice.

If children do not learn the correct names to identify the experiences of others, they are doomed to have confusing and conflicting relationships: if they wrongly learn to define a 'sad' face with an expression of disgust instead, this would give rise to misunderstandings and disagreements that nobody would understand the reason for at that moment in time. It is the repetition of similar situations that creates, in the long term, the definition of 'strange' that characterises the borderline.

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20 W. von Humboldt (1989) (ed. or. 1988), *Scritti sul linguaggio*, Guida, Napoli, 51-52.

3.2.4. The 'double bind' theory

A widely studied scam has been the one defined as the 'double bind' theory in literature. The mother gives two T-shirts to her son: a red and a white one. When she sees her son with the red T-shirt, she cries out: «You don't like the white one». And vice versa in the case of the white T-shirt.
In other words, 'double bind'[21] is a situation in which the communication between two individuals connected by an emotionally relevant relationship shows an inconsistency between the level of clear conversation (verbal) and the one of meta-communication (nonverbal: gestures, attitudes, tone of voice, etc.). However, in order to have a double bind, the situation has to be like this: the recipient of the message shall not have the chance to decide which of the two levels is valid, nor to make the incongruence explicit. Bateson's[22] example is the mother, who sees her son again after a long period of time, because he has been in care due to mental illness. As a fond gesture, the son tries to embrace his mother, who freezes; at this point, the son pulls back, and the mother says: «You don't have to be afraid of showing your feelings».
At an implicit communication level (freezing), the mother expresses rejection against the son's fond gesture, while at an explicit communication level (the sentence said immediately after), she denies being responsible for the estrangement: it is the son who is stopped in expressing his feelings. They make him feel guilty, and he is unable to respond.
Referring to his studies on learning levels, Bateson suggests that the cause of schizophrenia is the chronic exposition to double bind family situations.
In reality, the Palo Alto school has already responded extensively to similar theories, for example in the *Pragmatics of Human Communication*,[23] where it is clear on the one hand

21 C.E. Sluzki, D.C. Ransom (1979), *Il doppio legame*, Astrolabio, Roma.
22 Cfr. G. Bateson (1976) (ed. or. 1972), *Verso un'ecologia della mente*, Adelphi, Milano.
23 P. Watzlawick, J.H. Beavin, D.D. Jackson (1971) (ed. or. 1967), *Pragmatica della comunicazione umana*, Astrolabio, Roma.

with lucid simplicity that, even if most people are subjected to double bind experiences in their lives, these are «isolated and spurious [...] A different situation is shown, when one is exposed to double bind for a long time and gets used to it gradually and expects it, with particular attention to childhood, where children have few defences and think, which leads them to establish that such communication happens all over the world»[24]. On the other hand, in keeping with a model that distances itself from the identification and theorisation of a single cause (linear causality), in favour of multifactorial causes and effects that retroact (circular causality), Watzlawick and his colleagues explain «the double bind does not cause schizophrenia. All that can be said is that where the double bind has become a predominant communication model [...] it is evident that the behaviour of this individual meets the diagnostic criteria of schizophrenia»[25].

3.2.5. The strange separation of the borderline: ambivalence between autonomy and dependence

The primary relational method of borderlines is determined by the presence of a confluent, warm and intrusive parental figure that does not tolerate a child's diversity.

The primary relational method of borderlines is determined by the presence of a confluent, warm and intrusive parental figure that does not tolerate a child's diversity. In particular, the figure is distressed by the fact that her child can have perceptions and experiences that are different from her's. The difference made by GT between experiences and behaviours modifies the theory on Mahler's[26] and other authors' onset of borderline disease. Indeed, Mahler's theory refers to the manifestation of the borderline disease. In-

The difference made by GT between experiences and behaviours modifies the theory on Mahler's and other authors'.

24 Ivi, 203.
25 Ivi, 204.
26 Cfr. M.S. Mahler, F. Pine, A. Bergman (1978) (ed. or. 1975), *La nascita psicologica del bambino*, Bollati Boringhieri, Torino; G. Salonia (2013), *Gestalt Therapy and Developmental Theories*, cit. Also cfr. M.S. Mahler, L.J. Kaplan (1977), *Developmental Aspects in the Assessment of Narcissistic and So-called Borderline Personalities*, in P.L. Hartocollis (ed.), *Borderline Personality Disorder: the Concept, the Syndrome, the Patient*, International Universities Press, New York, 71-85.

stead, the perceptive borderline structure was formed in the primary confluence stage that opens to introjection (around the 5th or 6th month). In the stages of confluence with the mother, children do not experience misunderstandings and confusion, because the mother – who represents their whole world – is confused as well. Only at the stage where they distance themselves from the mother by walking, giving rise to their own adventure in the world, will these first difficulties emerge more and more evidently: they will neither be able to understand the others, nor have the feeling that they can be understood. When happy, they will describe themselves as nervous, they will turn to a sad person as if he/she was happy and will explain in detail why they are different in ways not usually shared: step by step, they will be perceived and slightly perceive themselves as 'strange', starting to deposit experiences of aggression, anger and confusion. It is useful to bear in mind that, while you can confuse the names of concrete things, you can be denied immediately (if a child calls the 'table' bread, he is experimenting by mistaking the term used), it is rather complicated to experiment with denial and identify mistakes in the world of corporeal and relational experiences (if a child calls his own vivacity 'anxiety', he cannot compare the mistaken name). These features make the child's separation path towards his mother complex. It is true that from a certain point of view, the parental figure and the child split in a primary borderline relationship, but they actually remain unified in the confusion that combined them as far as sensations, perceptive structures, emotions and words are concerned. A specific ambivalence is developed in the patient, so the more he approaches the other and feels warmth (his own and the warmth of others), the more he gets confused and does not know what he wants. If he walks away and distances himself, then his confusion decreases but his sense of solitude increases. In practice, a borderline acquires a differentiation of identity, not of experiences. His relational scheme can be defined like this: «I know who I am and who you are, but I don't know to whom the experiences belong». We will see that the typical difficulties (strangeness) of bd pt come from such confusion.

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3.2.6. Gestaltic collocation of the relational borderline method

Hermeneutics collocation of borderline confusion in the theory of the Self[27], or better in the Id-function or Personality-function, has a clear clinical consequence. For example, if the therapist shakes the patient's hand, and the latter pulls back immediately, saying that he feels embarrassed, the first clinical intervention will be to verify in which function this embarrassment is positioned. This means asking the patient if he feels embarrassment in the hand, the body or if it is connected to certain thoughts (you don't do it, it's not fair and similar). Differentiating confusion by positioning it in the body or narration is a required, irreplaceable presupposition for the following clinical work. The confusion concerning the Id-function requires a long and delicate intervention, a slow process of progressive clarification of the range of contradictory and disordered sensations emerging altogether.

Differentiating confusion by positioning it in the body or narration is a required, irreplaceable presupposition for the following clinical work.

As for the contact cycle theory[28], the therapist has to consider that the bd pt starts every experience in a confusing *Stimmung*, because he does not have any adequate semantic tools to decipher and recollect his experiences and the ones of others. When the requirement/figure emerges from his confused background, he is inevitably confused. In fact, as it gradually takes form, he amasses more confusing elements, instead of clarifying them. At this point, it is important to separate the borderline confusion with the one of neurotic or psychotic[29]. Indeed, borderline confusion is more intimate:

the therapist has to consider that the bd pt starts every experience in a confusing Stimmung, because he does not have any adequate semantic tools to decipher and recollect his experiences and the ones of others.

27 Cfr. F. Perls, R. Hefferline, P. Goodman (1997) (ed. or. 1994), *Teoria e pratica della Terapia della Gestalt*, cit.; G. Salonia (2012), *Theory of self and the liquid society. Rewriting the Personality-function in Gestalt Therapy*, cit.

28 Cfr. Hefferline, P. Goodman (1997) (ed. or. 1994), *Teoria e pratica della Terapia della Gestalt*, cit.; G. Salonia (1989), *Tempi e modi di contatto*, in «Quaderni di Gestalt», V, 8/9, 55-64.

29 I do not think that one can speak about borderline confusion in the situation described by Dreitzel, where the child is confused by the diversity between father and mother. I do not agree with this definition: «From the point of view of Gestalt therapy, we must first be aware that borderline experiencing derives from schizoid and narcissistic modes of experiencing, in changing constellations»,

in a certain sense, the patient is conscious of what he is doing, but is not able to distinguish confused sensations, or better still, he tells them with words right for him, but wrong for the others. The bd pt's disorder is not a lack of awareness of what happens to him, which is typical of the neurotic, and not the psychotic's lack of identity, but rather the lack of clarity about what is happening in his intrapersonal and interpersonal world. Because the bd pt's confusion is placed right at the beginning of the formation of the experience, from a contact cycle point of view (in other words, the stage where the relational experience block occurs) his troubles lie in the pre-contact phase.

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4. Therapeutic paths

In a certain sense, the therapeutic work has to retrace the passages of the development process of experience the bd pt undergoes, in order to grasp the cores of confusion. A phenomenological-gestaltic methodology, respectful of the patient's perceptions (even if complicated), allows the therapist to enter into his account and to translate it in common language. Every other intervention that bypasses this preliminary path proves to be ineffective and maybe even iatrogenic: like an intervention whereby two partners are in conflict, because they do not realise that although they are using the same language, they are assigning different meanings. If one person states that an hour is a very long time and the other instead maintains that it is a very short time, the two will be in (quite useless!) conflict, until it emerges that they have different reference backgrounds (the first one may compare hours with minutes, the second one hours with years!).

A phenomenological-gestaltic methodology, respectful of the patient's perceptions (even if complicated), allows the therapist to enter into his account

in H.P. Dreitzel (2010), *Gestalt and Process. Clinical Diagnosis in Gestalt Therapy. A Field Guide*, EHP Verlag Andreas Kohlhage, Bergisch Gladbach, 116.

4.1. Hermeneutical horizons

4.1.1. The horizon of clarity rather than awareness

Such assumptions explain the reason why some approaches, such as not taking care when identifying precisely and respecting the patient's experiences, are ineffective and maybe harmful. Indeed, it is epistemological and clinical nonsense in the treatment of a bd pt:

- Intensifying the patient's level of emotion (their confusion would be increased);
- Suggesting interpretations (this would create anguish, because it would repeat an archaic scheme where the parental figure states: «Don't trust what you hear, because it's not true, it means something that you don't know»);
- Exploring past experiences in the search of the meaning of the actual disorder (would enhance the confusion of the present experience);
- Working in view of an *insight* (this would be a signal for a wrong diagnosis: the bd pt is not missing awareness, but clarity);
- Verbalising the emotional content (this would sound like limiting and defining the patient's experiences);
- Showing the patient his inability to 'represent himself within mental systems referring to himself or to others' (such intervention – which reveals a precise disturbance of the therapist – ignores the rule in which you can open yourself to the world of the other, only after you have created clarity in his own world);
- Coming into the escalation of 'who is right' (non-therapeutic intervention, since it would turn the relationship into an equal one and repeat the conflicts that created the bd disease).

The therapist has to totally rely on the patient's affirmations, even if they sound incomprehensible and very strange: once explained, they reveal intimate and coherent truths. Many behaviours are actually clarified in this path of translation from strangeness to *imprinting*-experience.
In other words, you can affirm that in therapy with bd pt, the therapist is asked for a surplus of awareness that facilitates the processes of clarity (rather than of awareness) in the patient.

and to translate it in common language. Every other intervention that bypasses this preliminary path proves to be ineffective and maybe even iatrogenic.

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4.1.2. Horizon of cordiality rather than warmth

In the growth of the bd pt, confusion or cheating happened in the stage of confluence with the maternal figure; the bd pt has been cheated on in a warm relationship, he believed the maternal warmth, enjoyed it and then discovered that he had believed wrong information. Like a child finding out that the milk was off (which makes his stomach hurt) only after he drunk it. When he realises that what he has learnt from his maternal figure does not correspond to his interior world, he feels molested by such intrusion, so much so that an implacable anguish is aroused in him. His interior will develop a sort of fracture between truth and warmth: he will persistently search for the truth and develop a sense of intolerability of the relational warmth.

Phobia of warmth is another feature that characterises the bd pt: since he has experienced being cheated on from the point of view of affective warmth, he enters into anguish and confusion when he feels warmth in affective relationships.

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If possible (and giving him such a chance is therapeutic), he has to distance himself, because he risks being sucked up in psychotic fusion, losing his identity, not being able to distinguish what he wants compared to what others want. Differentiating the borderline from the narcissist distancing can be useful: from a behavioural point of view, it is the same movement, but whilst the borderline distances himself in order to understand what he wants, because he is confused in relational warmth, the narcissist distances himself and retroflects for fear of being scarified in a possessive confluence.

But whilst the borderline distances himself in order to understand what he wants, because he is confused in relational warmth, the narcissist distances himself and retroflects for fear of being scarified in a possessive confluence

The fight between autonomy and dependence can be understood in this relational *frame*. For example, a distinctive feature of the bd pt is to come to sessions irregularly. From was very clear on this point: Let the bd pt decide on the rhythm of the sessions. What others define 'irregularity' is a self-regulated system to him. When the patient feels affective warmth in a relationship, at the same time he perceives an intensification of confusion: he needs to keep his distance and spend some time alone in order to understand what really interests him and what is instead induced.

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After sessions where I experienced a very fluid understanding with the patient, she seemed distant and aloof during our following session, as if she had forgotten the previous one. How-

ever, the meaning is very clear: the previous sessions' warmth was perceived as excessive and had confused her. Now she wanted to be on her own, in order to find some clarity. This relational style descends into an alternation of 'I cannot live with you' and 'I cannot live without you' in the affective experience of a bd pt.
For this reason, cordiality is the required emotional climate in treatment with a bd pt. It is necessary for the therapist to avoid any invitation to closer proximity or any expression of warmth. For example, it is good to use the formal form to address the patient rather than being on first name terms. For a bd pt, clarity is more important than reception.

some time alone in order to understand what really interests him and what is instead induced.

For a bd pt, clarity is more important than reception.

4.1.3. Horizon of climate/background rather than figure

The therapist's attention has to aim at creating a climate of trust. The purpose of therapy with a bd pt is not to unveil something unconscious or to arrive at some particularly illuminating and determined *insight*. On the contrary, a single session sometimes seems to produce no results. In fact, the purpose of therapy is to create a trusting and protective climate for the patient in the medium and long term, since confusion has to be cleared up gradually. In other words, the principle that therapeutic work must focus on the personality-function[30], or the therapist-patient relationship first, has a determining mean-

The principle that therapeutic work must focus on the personality-function, or the therapist-patient relationship first, has a determining meaning for the bd pt, given that he was actually hurt in trusting his significant primary figures. In this sense you need to work on the background rather than focus only on the figure.

30 I do not agree with Muller's statement – cfr. B. Muller (2013), *Comment* to G. Salonia, *From the greatness of the image to the fullness of contact. Thoughts on Gestalt Therapy and narcissistic experiences*, in G. Francesetti, M. Gecele, J. Roubal (eds.), *Gestalt Therapy in clinical practice. From psychopathology to the aesthetics of contact*, Franco Angeli, Milano, 643-659 – that you can indifferently work on the Id-function or on the personality-function without priority. If I ask a narcissist «What do you feel?» I will get this response, before he even defines himself a 'patient': «What should I feel?». The attention to Personality-function is priority and represents the therapy's background for efficient therapeutic work. Cfr. G. Salonia (2013), *From the greatness of the image to the fullness of contact. Thoughts on Gestalt Therapy and narcissistic experiences*, cit.

ing for the bd pt, given that he was actually hurt in trusting his significant primary figures. In this sense, it is evident that you need to work on the background rather than focus only on the figure. In my experience, a sign that a '*fit*' climate for the therapy has been created – where the patient does not have to defend himself, because he does not feel threatened by any kind of misunderstanding – is the progressive relaxation in the way he sits during the session. Working with a reasonably serious patient, I remember that a sign for the fact that the therapeutic process was going on, in spite of everything, when progress seemed to be very slow, was the much more relaxed and tranquil way the patient sat down in the armchair.

4.2. Translation exercise of borderline language

Bd pt behaviour in everyday life, explained in psychopathology manuals, is described in the DSMV[31] with a hint of 'strangeness' and almost 'incomprehensibility'. The manual cites: idealisation-devaluation, vicinity-distance, obsession, viscosity, control, manipulation, promiscuity, hallucination, dependence, incoherence, confusion, uncontrollable anger. This target-quality of characterised strangeness is so specific that it assumes a diagnostic value to distinguish bd from psychotics and neurotics.

Bd pt behaviour in everyday life, explained in psychopathology manuals, is described in the DSMV with a hint of 'strangeness' and almost 'incomprehensibility'

When reading (or translating) 'strange' bd words and behaviours, various psychotherapy models can be separated. For example, Gabbard writes: «[Borderlines] often attach themselves to their perception just as to an absolute fact, rather than seeing it as one of various, possible alternatives»[32]. This 'attachment of patients to their perception' loses its pathologic

When reading (or translating) 'strange' bd words and behaviours, various psychotherapy models can be separated.

31 Cfr. AA.VV. (2013), *DSM-5. Diagnostic and statistical manual of mental disorders*, American Psychiatric Publishing, Raffaello Cortina, Milano. For an up to date gestaltic key of the DSM-5 pages on borderline personality diseases, cfr. the considerable work of G. Gionfriddo, *La trama relazionale borderline: lettura gestaltica dei criteri tra corpo e parola, spazio e tempo*, Postgraduate School, HCC Kairos Gestalt Institute, academic year 2012-2013.

32 Cfr. G.O. Gabbard (2006), *Mente, cervello e disturbi di personalità*, in «Psicoterapie e Scienze Umane», X, 1, 9-24.

connotation if you read it as the unique certainty the bd pt hangs on, avoiding feeling overwhelmed by psychotic confusion (he experienced this at the beginning of his story and is afraid of repeating it again with the therapist!).
For GT, the 'strange' behaviours of the bd pt come from a relational experience he does not manage to understand, to tell himself or others, because of missing common instruments, or better still, different from the common ones. Words and behaviours of a bd pt are a real language to communicate his experiences, as well as corporeal and relational meanings (sensations, emotions, perceptions) that the subject experiences in his being-in-the-present-of-a-relationship. In the register of experiences, our identity takes form and you can experience real relationships. Diagnostic and gestaltic psychopathology establish the patient's (and therapist's) corporeal-relational experiences as a place of psychic disorder, and therefore of treatment. Separating behaviours from experiences is the guiding light that permeates and guides clinical work.
Elena, a bd pt, also presented the symptom of alcohol dependence. When her parents, unsatisfied by the slow recovery, sent her to therapeutic heavy drinker groups, the symptom got worse: treating dependence (from alcohol or other) without considering that bd pt experiences are very different from the ones of heavy drinkers, only created confusion and damage in the patient. Translating bd pt' behaviours (or their language) into common language of experiences is, for GT, a starting point and end point of clinical work.
It is acknowledged that the actual *Stimmung* of a bd pt is confusion. Besides noticing little clarity within one's own emotional world, they feel confused in a relationship with others: they feel out of place[33], unable to understand and be understood, though speaking the same language that the others do. They are not aware (and neither are those who interact with them) and unable to use an idiographic corporeal-cognitive vocabu-

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33 Cfr. in relation to the excellent work of A. Amato, *Il mondo è fuor di squadra. Che maledetto dispetto esser nato per rimetterlo in sesto! (Amleto). Gestalt Therapy e stile relazionale borderline*, Postgraduate School, HCC Kairos Gestalt Institute, academic year 2011-2012.

Since they live in an intricate net of confusion (what happens to them is interpreted as fragments and misunderstandings), their relational lives often register an intertwining of confusing situations.

lary, which makes them incomprehensible to others and the others incomprehensible to them. Their interactions are continuously seen as disastrous and produce (additional/secondary) experiences of aggression and failure, with the risk of strange or dangerous behaviours. Since they live in an intricate net of confusion (what happens to them is interpreted as fragments and misunderstandings), their relational lives often register an intertwining of confusing situations. At this point, it is obvious that as soon as they perceive confusing or manipulative communications from others – thanks to their strong awareness of misleading elements, although subtle – they feel like going insane, not being able to give a mane to the disorder and anxiety they feel. And in order to appease the unbearable anguish, they can use auto or hetero damaging behaviours (*acting out*).

4.2.1. From 'strange' behaviours to corporeal-relational experiences

– A borderline patient does not accept apologies

When I admitted to Giada that I had finished our previous session abruptly and apologised by offering her my reasons, I was surprised by her negative reaction and her intensifying irritation. I apologised again, explaining my reasons again (I did not have any negative feelings towards her), but her anger levels did not decrease; on the contrary, they seemed to get worse. I removed the predicted, useless thought 'borderlines are really strange' and tried to understand Giada's logic. At a certain point, I realised the slightly hidden manipulation in my excuse. Giada was right: as a first step, I wanted to calm her down by apologising. I thought of a partner that asks for forgiveness after having been unfaithful and expects the other to stop being furious about it.

Just when she managed to understand and express her anger to me, she felt – and rightly so! – that it was a way to calm or diffuse her anger levels (e.g. from the series: 'You can be angry, but not too much, unless I allow it'). Her behaviour (not accepting my apologies) revealed my unconscious attempt of manipulation ('Don't leave me feeling the embarrassment of be-

ing accused for long', 'Stop being angry with me at once'). I learnt from her to say to pts: «You are right. Tell me about your anger in full. If you want, I will also tell you the reasons for my behaviour». The therapist needs to realise that those who need clarification go haywire if compelled to put together opposite reasons. Putting together two emotions of an opposite sign is a very complex, emotional process for a person with a confusing *Stimmung* and who is trying to express one emotion at a time with clarity. When, six months after, in quite a similar situation, I suggested to Giada to hold the legitimacy of her anger together and my possible reasons in her heart, she learnt to express her reasons and to also include mine in a clear and assertive way.

– Borderline patients do not tolerate any mistakes

A bd pt operates what is called a 'borderline split' to protect himself from further confusion: the world is either black or white, with unavoidable, seesawing passages from moments of idealisation to stages of disqualification. From taught that therapists sometimes can split the process that for bd pts is a quick passage (*shift*) from the Id-function to the personality function instead. It is well known that bd pt are unable to tolerate mistakes (and sometimes even one simple mistake) even in therapists. And often a mistake of the idealised person becomes unbearable for the bd pt: the mistake becomes so intolerable that he chooses the passage from idealisation to denigration. Here is a description in verses of this kind of experience lived from within:

And now that you meet and cross me
Now a devil, now a god
I paint you with white, with black
And if my god dresses in black
I dirty the whole world with anger[34]

Those who are very anxious and confused are not able to support further, unclear messages from the outside and are instead calmed down by clear and univocal messages. The bd pt feels

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34 Annalisa Iaculo's (cit.) poem accompanies us along the process.

The bd pt feels like going crazy when he receives confusing messages that he is unable to decipher. He prefers, by far, to be in a situation of clear pain (caused by others and even by himself) rather than be in an ambiguous situation.

Even the possible mistake of the therapist can be recovered as a moment of growth, as long as the latter does not stand up for himself, does not apologise, is able to respect the patients' experience and the time he needs to put together confusion and anger, anger and understanding (black and white).

The patient cannot be opened up to other inputs, if he has not cleared his interior world first.

like going crazy when he receives confusing messages that he is unable to decipher. He prefers, by far, to be in a situation of clear pain (caused by others and even by himself) rather than be in an ambiguous situation. A patient told me that, when she was in conflict with her partner, she felt like going crazy after moments of great vicinity and she had to go back to brutally clear situations, in order to calm herself down: either the warmth of a beer or the physical relation with a guy she despised. The bd pt can only hold one emotion: it is easier for him to tolerate a negative emotion rather than put together and hold two emotions of opposite value. If you keep in mind this dynamic, even the possible mistake of the therapist can be recovered as a moment of growth, as long as the latter does not stand up for himself, does not apologise, is able to respect the patients' experience and the time he needs to put together confusion and anger, anger and understanding (black and white).

– The bd pt does not listen to the therapist

In the same dynamic, or better, the same logic, another demanding feature – is part of the bd pt – and that is the phobia of introjection, or the inability and unavailability to listen (even to what the therapist says during a session). Such modality causes problems in the therapy, but has to be deeply respected and supported. The patient cannot be opened up to other inputs, if he has not cleared his interior world first. He protects himself against increasing confusion with regards to the relationship.
The therapist shall never push the patient in a direction that the other does not feel as his own. In front of such perceptive differences with the patients, the therapist has to search for an increase of his own awareness, considering that the one who is confused does not tolerate other information, but first of all wants help in clarifying the confusion in himself. Essential principle of the therapy with bd pt: the therapist has to increase in clarity. The insuppressible need for clarity and truth of the bd pt becomes the direction for his growth: the borderline's experiences will restore the sense and coherence of his words and behaviours.

– The bd pt is obstinately attached to detail

When a contrast of opinions with the bd pt emerges, the latter, to defend his thesis, puts forward one or more details that

he repeats obstinately. The obsessive attachment to detail and inferences (sometimes even arbitrary) can cause annoyance in the therapist, but corresponds to the logic of whom, being cheated, manipulated or confused in the past, needs to continuously verify truthfulness in the words of others. It is known – as an old saying cites – that god or the devil are hidden in detail. The research and fixation on detail reveal a scepticism in words. In the bd's mind and body, these kinds of thoughts are present and active: 'Who knows if what he is telling me is true', 'I can't relapse by trusting again', 'Let's check in detail the truthfulness of what he is saying to me', 'If I find something that confirms my suspicions, I'm calm: I know how to protect myself… and I'm not going to be cheated on again!'.

– The bd pt has the phobia to be defined, even if positively

One of the ways of intervention that the bd pt perceives as violent is sensing the definition of himself.

I don't look for excuses, I don't want torts
Everything seems like a scam to me
I can neither hear nor tell myself
But I won't allow you to define me
If what I say seems unusual to you
Don't pay attention to it, it's my alphabet
Confused, senseless, incoherent

Each time they are defined by others, bd pts fear a new scam. Besides the risk that the definition could be wrong, each definition has a limit and a pretension. Even a compliment ('You are very kind') can cause unpredictable reactions, since it can be perceived (in reason!) as subtle manipulation: 'I tell you that you are kind with the hope that you continue to be so'.
It is interesting to note how, in an ironic way or by fate, even the names of those patients are defined and remain in a limbo of non-definition. 'Border-line' or: at the border, neither psychotic nor neurotic, undefined. Each label (heavy drinker, depressed, dependent and others) added to borderlines, turns into a diagnostic and therapeutic mistake.

– The bd pt has his own verbal language

The obsessive attachment to detail and inferences (sometimes even arbitrary) corresponds to the logic of whom, being cheated, manipulated or confused in the past, needs to continuously verify truthfulness in the words of others.

One of the ways of intervention that the bd pt perceives as violent is sensing the definition of himself.

Even the names of those patients are defined and remain in a limbo of non-definition. 'Border-line' or: at the border, neither psychotic nor neurotic, undefined. Each label (heavy drinker, depressed, dependent and others) added to borderlines, turns into a diagnostic and therapeutic mistake.

The borderline verbal language is intriguing. In a supervision group for professionals of a CTA, we had discussed their guests' language (serious patients), distinguishing the psychotic language from the borderline one. An operator objects: «I share the importance of trying to understand the patients' language, but sometimes they become unbearable… they keep on repeating the same sentence like a broken record». The co-therapist asks her to give an example: «While I was accompanying a guest to town – the operator says – he repeated the same hammering complaint during the whole trip: 'Why don't women stay at home instead of going to work?' There was no reason that could calm him down. Really unbearable». The co-therapist asks: «How were you doing that morning? How was your driving?». «The day started badly. His complaints made it even worse. I was really nervous even in my driving». Raising smiles among participants, the colleague says: «Don't you think he wanted to say: drive more calmly?». She gives the others a smile and understands how important it is to help the patient with clarity, but the operator needs to achieve more awareness. The first step of a therapist is the path from external dialogue to internal dialogue[35]. It is very useful to bear in mind the rules of transformational[36] grammar, which allows the deep structures of language to emerge, going through distortions, such as generalisation, nominalisation and cancellation.

The first step of a therapist is the path from external dialogue to internal dialogue

– The relational… *acting out* of a bd pt

Considering such a relational background, you can also understand the *acting out* that represents a serious risk of therapy with bd pt. They are gestures, which aim to calm anxiety, the explosive sense of craziness when there is no accessible

35 H. Franta, G. Salonia (1979), *Comunicazione Interpersonale*, LAS, Roma; G. Salonia, C. Di Cicco (1982), *Dialogo interno e Dialogo esterno: contributo per un'integrazione della Terapia Cognitiva con la Comunicazione Interpersonale*, in «Formazione Psichiatrica», 1, 179-194; R. Bandler, J. Grinderr (1981), *La struttura della magia,* Astrolabio, Roma.

36 On generative grammar cfr. N. Chomsky (1968), *Language and Mind*, New York, 24.

emergency exit: you feel cheated, you cannot come out of it and you are unable to express the furore imploding inside. You come to extreme violence, if you feel that you cannot move away from the scam: feeling like going crazy because someone important to you makes you feel crazy, incites a violent rage, a sometimes uncontrollable fury. If *acting out* happens in therapy, it can refer to the relationship between bd pt and therapist, who has become a significant person to him. It is self-harming gestures that happen when the experience of exploding is connected to guilt ('I am bad') and the person in the *up* position is inacceptable or irreplaceable (a borderline attempt suicide has particular connotations and requires interventions that are very different compared to neurotic or psychotic). When these features are missing, the explosion will be hetero-direct. In both violent gestures, therapeutic work that tries to let the core of the confusion emerge, causing explosive anguish, is crucial.

A borderline attempt suicide has particular connotations and requires interventions that are very different compared to neurotic or psychotic.

At seven ò clock in the morning, my mobile phone rings. It is Luisa, who is telling me in an agitated and controlled voice that she is slashing her wrists. We talk. I verify the non-seriousness of her gesture. She slowly calms down. Afterwards, once I have cheered her up, I hang up and wonder what I could have done in my last session (of this therapy that started a couple of months ago) that had confused and annoyed Luisa. Suddenly I realised: I made a mistake. I had to leave the room for some time and I gave Luisa my mobile phone without specifying that this was not an affective gesture of vicinity (in those days, only a few had mobile phones and you gave your number only to family and those people close to you), but a working requirement, because the mobile phone was my office number, given that I was always out of the office. How does a girl, who receives such an intimate gesture, explain this to herself? If she doubts the therapist's competence (she talks well of him and sees him for a long time), she can only think badly of herself ('What did I do?'). Confusion becomes explosive and she calms down with a gesture that hurts me and allows me a 'medical' use of the phone.

5. Learning from a borderline patient

5.1. Secret knots in relationships

The gestaltic approach of 'translation' turns therapy with borderlines into an intriguing experience, which explores and enlightens hidden and decisive meanders of human relationships, giving word to pain and disorders in uncommon languages. One of the qualities that struck me the first time I saw From working had been the essential, clear and rigorous use of his words: not one in excess, not one out of line. I jokingly said: «You seem to have the delicacy and precision required by a micro-surgeon». Hereafter, I was under the impression that he gained such mastery by using specific words in working with bd pt. The two coordinates of borderline experience: intimate confusion (in the making of the relationship and narration) and swindle (from the most intrusive to the less invasive one) are present, in different levels and registers, in all relationships, and represent the elements of frailty and violence. Working from a gestaltic point of view with bd pt makes the therapist's language become clearer and clearer, less ambiguous, and sensitive to grey areas, ambivalences, implicit backgrounds. For example, the implicit, egocentric apologises. The ambiguities of therapy, intended as an attempt to colonise the patient's world, impose one's own semantic and perceptive schemes to help him. Subtle and hidden violence in defining the other also positively avoids calling oneself into question in front of the patient's disorder… Training to translate borderline language entails a learning of clarity, of places and anxieties where swindles are hidden.

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Training to translate borderline language entails a learning of clarity, of places and anxieties where swindles are hidden.

5.2. How to live in a borderline society

When Adolph Stern[37] introduced the diagnostic category of 'borderlines' for non-psychotic and non-neurotic patients in classical psychiatry in 1938, he could not foresee that such a

37 A. Stern (1938), *Psychoanalytic investigation of and therapy in the borderline group neuroses*, in «Psychoanalytic Quarterly», 7, 467-489.

diagnosis would have been extended so much, that it has become one of the most common ones today. From diagnosis of socialised psychotics, it turned into trash-diagnosis (or rubbish) for all marginal pathologies that were hard to diagnose as for that name or seriousness. It was as if the awareness suddenly aroused the personal and relational borderline style that was present in a lot of psychic pain and not only in serious cases[38]. So much so that we talk about a transition of society from narcissism – explosion of subjectivity and image – to borderline society, meant as an extension of confusing relationships, a phobia of listening, and of a suspicion as relational premise[39]. In other words, if the comparison was between subjectivity and alterity, between two grammars ('Only my point of view is valid') in a narcissistic context, in borderline society we face a decline of subjectivity[40] and grammar. If autoreferentiality caused a relationship crisis in narcissistic society, in borderline society then relationships are missing, because you are not only uninterested, but also show an inability to dialogue and compare means. Family therapy is, in this sense, a litmus test: if in the past you went to sessions where partners exploded in an aggressive rage and then you went to those where narcissistic modes of relationships prevented you opening yourself to alterity, then over the last ten years a new relational disorder has arisen, which can be formulated as follows: «We don't

If the comparison was between subjectivity and alterity, between two grammars in a narcissistic context, in borderline society we face a decline of subjectivity1 and grammar.

38 Literature is vast. Cfr. for a review L. Cancrini (2006), *L'oceano borderline*, Raffaello Cortina, Milano. In gestaltic world, even with different value, cfr. among others N. Janssen, *Therapie von Borderline-Störungen*. In R. Fuhr, M. Sreckovic, M. Gremmler-Fuhr (Hsrg.) (1999), *Handbuch der Gestalttherapie*, Hogrefe, Göttingen, 767-786; E. Greenberg, (1999), *Love, Admiration or Safety. A System of Gestalt Diagnosis of Borderline, Narcissistic and Schizoid Adaptations that Focuses on What Is Figure for the Client*, in «Studies in Gestalt Therapy», 8, 52-64; M. Spagnuolo Lobb (2013), *Borderline. The Wound of the Boundary*, in G. Francesetti, M. Gecele, J. Roubal (eds.), *Gestalt Therapy in Clinical Practice*, Franco Angeli, Milano, 609-639.

39 For the importance of a social contextuality of any relational form and for the different declinations of the Basic Relational Model (MRB), cfr. G. Salonia (2013), *Psicopatologia e contesti culturali*, in G. Salonia, V. Conte, P. Argentino, *Devo sapere subito se sono vivo, Saggi di Psicopatologia Gestaltica,* Il Pozzo di Giacobbe, Trapani, 17-32.

40 G. Vattimo (1981), *Al di là del soggetto*, Feltrinelli, Milano.

The experience of therapeutic work with bd pt can offer prospects to recover opportunities of encounters and relational bonds in borderline society.

Their strangeness, when not quietened by descriptive or interpretative diagnostics, helps us to understand how coexistence is possible, when the comparison of diversity does not take place on the 'right or wrong', sanity or madness' axis, but the one of translation.

talk, we don't understand each other, as if we were speaking two different languages. We seem to go crazy when we listen to each other». It is the icon of relational disorder from a social viewpoint: unable to understand the other, and therefore not even yourself.

The experience of therapeutic work with bd pt can offer prospects to recover opportunities of encounters and relational bonds in borderline society.

– Borderline patients offer a precious contribution to the understanding of chaos of human relationships in postmodernity. Their strangeness, when not quietened by descriptive or interpretative diagnostics, helps us to understand how coexistence is possible, when the comparison of diversity does not take place on the 'right or wrong', sanity or madness' axis, but the one of translation. Giving every language dignity. Not renouncing dialogue, but renouncing the obsession to understand the other [41] that is controlling him. Learning to coexist without understanding each other, but in respect of the different languages. Therefore, dialogue that shall invent new conditions: translating the language of the other without discrediting him (in stages of conflict) and without confirming to him by telling him a lie (in neurotic confluence), but recognising the fragment of truth that he is the bearer of.
– Willing to reconsider one's own language with the rigour (a sort of Ockham razor) of who is aware of ambiguity, manipulations, implicit confusions not only in the polysemy of words, but also in the variety of implicit backgrounds. Recognising that the confusing fragment in one's own language opens itself to suggestive spaces of sharing and encounter.
– In the period of narcissist society, spaces have been created, in order to give word to everybody. You went from fighting for legality to fighting for legitimacy: from respecting/not respecting law to the questions 'Who are you to give orders?'[42]. Authoritativeness can become a borderline

41 Cfr. G. Salonia (1999), *Dialogare nel tempo della frammentazione*, in F. Armetta, M. Naro (eds.), *Impense adlaboravit. Scritti in onore del Card. Salvatore Pappalardo*, Pontificia Facoltà Teologica di Sicilia - S. Giovanni Evangelista, Palermo, 571-585.

42 In relation to cfr. G. Agamben (2013), *Il mistero del male.*

alternative (and thus confusing) to authority. Authority cannot be legitimated by authoritativeness: the first one is linked to objectivity of a context, the second one subject to the precariousness of a subjective judgement. In order to step out of Scilla's subjectivity and Cariddi's institution, maybe a common rewriting of communicative rules of logic is needed – as the attendance of a bd pt teaches. The bd pt's obstinate research for truth and clarity suggests that the integrity of a rigorous communication logic can be a meeting path. Democracy avoids the drift of fragmentation; not with nostalgic comebacks to indisputable authority or recourse to frail and questionable authoritativeness, but maybe by facing the task of rewriting the rules of dia-logic[43] starting with the peculiarity of each language, translated and shared.

The bd pt's obstinate research for truth and clarity suggests that the integrity of a rigorous communication logic can be a meeting path.

6. Gestalt Therapy and other approaches

The hermeneutic translation model, with its serene, careful and never prejudiced potential to the implicit research in borderline language, seemed to be the most coherent with the theoretical prerequisites of Gestalt Therapy so far; all focus, in their approach, on the seriousness of the therapist-patient relationship, on the authentic *man to man* comparison, on the need for a radical acceptance of the surface and therefore of the other's words and gestures in the setting, without shortcuts, without any presumed interpretations given, which turn the patient in principle into a 'subordinate' (very different from considering him in need of treatment in a clear distinction of roles). We have seen how such a firm choice entails a sort of 'conversion' of the therapist to listen and the paritary consideration of the existence of the other. But not only that. The consequences of this setting leapt out very clearly. It was about putting the therapist in the inconvenient but intriguing position of 'translator', who dedicates himself completely to clarification, aiming to return

the need for a radical acceptance of the surface and therefore of the other's words and gestures in the setting, without shortcuts, without any presumed interpretations given, which turn the patient in principle into a 'subordinate

Benedetto XVI e la fine dei tempi, Laterza, Bari.

43 A contribution to start thinking with logic again is: P. Cantù (2011), *E qui casca l'asino. Errori di ragionamento nel dibattito pubblico*, Bollati Boringhieri, Torino.

to the other language, trying to catch the spirit through grey areas, focusing on detail, educating his gaze and wording to acute understanding and infinite discovery of the 'thing' hidden in the other language, who turns it into a different way of telling the world about himself in the incomprehensible context of a common substance. Now it is time to introduce to the dialogue this suggestion with some of the current and most influential approaches in the field of therapy with bd pt, in order to clarify the position and difficulty of one's own view, by renouncing a fruitless contrast of models in principle and rather putting the different settings on probation and delving into the heart of therapeutic languages, or in the concreteness of verbatim offered by the authors. It is obviously not about expressing valuable judgments, but only about undertaking a prolific and concise debate in the common research of a key in front of a form of disorder that is emblematic of our times and therefore of our own lives. However, it is worth starting by giving a brief history. You need to operate from comparisons, in order to catch the identifying factor of every psychotherapy model.

Now it is time to introduce to the dialogue this suggestion with some of the current and most influential approaches in the field of therapy with bd pt.

It is obviously not about expressing valuable judgments, but only about undertaking a prolific and concise debate in the common research of a key in front of a form of disorder that is emblematic of our times and therefore of our own lives.

6.1. In principle. Freud's misunderstanding

«One fine day – Freud narrates – I had clear evidence that what I suspected corresponded to truth: one of my quietest patients, with whom I got excellent results in hypnosis, one day put her arms around my neck, as soon as she woke up from a hypnotic sleep, as I relieved her from her pain, relating her painful attack to the reasons that provoked it. The unexpected entrance of a servant spared us embarrassing clarification, but we renounced with a tacit agreement to continue the hypnotic treatment from that moment on. I had enough wisdom to avoid ascribing such an event to my personal irresistibility and therefore reckoned that I had finally understood the nature of the mystic element (*Mystich*) that acted beyond hypnosis; I needed to renounce hypnosis, in order to eliminate or at least isolate it».[44]

44 S. Freud (1989), *Autobiografia*, in *Opere*, vol. X, Bollati Boringhieri, Torino.

As we know, this 'embarrassing' episode was at the origin of the invention of transfer and its correlations (theory of the patient that seduces and counter-transfers as a possible response from the therapist's side). Besides stopping hypnosis, a third person (the father) was introduced into analytic therapy as not present, but as the real addressee of the seductive embrace. Such stratagem was necessary to avoid therapy failure (which would have happened, if the therapist had responded to the embrace or interrupted his sessions). Two logical mistakes are implicit in this story: the patient's point of view is missing (the tacit agreement does not guarantee reciprocity) and a seductive intention (erotic and paritary) is assigned to the patient's embrace. Freud's comment («I had enough wisdom to avoid ascribing such an event to my personal irresistibility») shows honesty on one hand, but on the other hand confirms his embarrassment and related misunderstanding of the patient's gesture.

If the therapist had read the patient's gestures as asymmetric from a gestaltic point of view (the context required it), he might have welcomed and reciprocated it: in fact, in an asymmetric context – like the one of therapy and hypnosis – the patient's embrace only expresses the, maybe clumsy, attempt of a physical, affectionate contact with a man that is taking care of her and does not have (cannot have) paritary seductive intentions. Indeed, seduction represents – the 'Stockholm syndrome'[45] proves it further – one of the many ways to protect oneself from fear and from the refusal of those who are in the *up* position. A therapist ascribing erotic-paritary intentionality to a patient would show a precise disorder in his Personality-function of the Self, since he would place himself in another context (paritary partner). Paradoxically, as GT sustains, if the patient's embrace had been welcomed in an asymmetric way and possibly returned, the therapy would (finally!) have made considerable progress. According to GT, the task of the therapy is concluding the interruptions of corporeal-relational experiences which create psychic disorder: the welcomed patient would have taken the road of completion of a relational gesture that, being inter-

Indeed, seduction represents one of the many ways to protect oneself from fear and from the refusal of those who are in the up position. A therapist ascribing erotic-paritary intentionality to a patient would show a precise disorder in his Personality-function of the Self

According to GT, the task of the therapy is concluding the interruptions of corporeal-relational experiences which create psychic disorder.

45 For a critical story of transfer in the analytic perspective cfr. A. Carotenuto (1986), *La colomba di Kant*, Bompiani, Milano.

rupted, then created many psychic and relational disorders, since that patient – it is good to remember – did not want to embrace her father, but actually the therapist, the man that was taking care of her 'paternally' in that precise context. The desire to embrace him was completely spontaneous, even if recalled from and by the corporeal memory of an activated but blocked (or interrupted) movement towards her father. After having embraced the therapist, the patient could possibly also have gone to her father and embraced him: like another experience, on the register of fullness and no longer on the one of integrity. When the therapist backs out of the patient's embrace, defining it as seductive (and therefore symmetric), he reiterates the experience that had been interrupted between father and daughter, and makes the therapeutic path[46]

When the therapist backs out of the patient's embrace, defining it as seductive (and therefore symmetric), he reiterates the experience that had been interrupted between father and daughter, and makes the therapeutic path1 more complicated and maybe confused.

46 See: H.S. Krutzenbichler, H. Essers (1993), *Se l'amore in sé non è peccato... Sul desiderio dell'analista*, Raffaello Cortina, Milano. The story this book tells of the various abuses of psychoanalysis should be reinterpreted within the framework of 'disfunction of the therapist's personality-function', which loses the asymmetric dimension of therapeutic relation. In this perspective, two theoretical and clinical points are implicit. Firstly, the interruptions of relational gestures in early childhood cause corporeal and emotional anxieties that determine relational blocking: cfr. G. Salonia, *L'Anxiety come interruzione nella Gestalt Therapy*, in G. Salonia, V. Conte, P. Argentino (2013), *Devo sapere subito se sono vivo. Saggi di Psicopatologia Gestaltica*, Il Pozzo di Giacobbe, Trapani, 33-53. Secondly, as a principle of emotional self-regulation, the child – like the patient – does not perceive the need for erotic-paritary experiences in asymmetric contexts: any possible perceptions in this sense are 'in the place of' other emotions. In relation, cfr. G. Salonia (2012), *Theory of self and the liquid society. Rewriting the Personality-function in Gestalt Therapy*, cit. In GT hermeneutics, the patient feels a corporeal impulse to express affection and thankfulness towards the therapist. However, image and body will be blocked if her affective gesture has been interrupted as a child. At this point, it is as if the patient wanted to try the interrupted gesture with her therapist. Only with this interpretation does a therapeutic intervention makes sense. Cfr. G. Salonia (1992) (or. ed. 1989), *From We to I-Thou: A Contribution to an Evolutive Theory of Contact*, in «Studies in Gestalt Therapy», 1, 31-42; G. Salonia (2013), *Gestalt Therapy and Developmental Theories*, cit.; G. Salonia (2008), *La psicoterapia della Gestalt e il lavoro sul corpo. Per una rilettura del fitness*, in S. Vero, *Il corpo disabitato. Semiologia, fenomenologia e psicopatologia del fitness,* Franco Angeli, Milano; G. Salonia (2013), *Oedipus after Freud. From the law of the father to the law*

The story shows very well the open possibility of therapists turning their disorders into pathology labels applied to patients. And this is a misunderstanding (or manipulation) risk that is presented most of the time in the work with bd pt.

more complicated and maybe confused: indeed, once again, an affective push of the daughter/patient was seen as wrong due to the fear or embarrassment of the person that was taking care of her.
What do I mean? Irrespective of the fact that the patient was maybe not part of a borderline diagnosis, I believe that the story shows very well the open possibility of therapists turning their disorders into pathology labels applied to patients. And this is a misunderstanding (or manipulation) risk that is presented most of the time in the work with bd pt.

6.2. The therapist in the heart of the session: Gabbard's example

«Ms. A was a 28-year-old patient with borderline personality disorder in dynamic psychotherapy. About 6 months into the process, an apparently minor event in the therapy session triggered a major reaction in Ms. A. With about 5 minutes left of the therapy session, Ms. A was talking about having visited her family during the Thanksgiving holidays. She felt unimportant to her father because he seemed much more interested in her brother's activities than in hers. In the course of this discussion, I looked at the clock on my wall because I knew the time was running out and I wanted to see if I had time to make an observation about her assumption regarding her father's feelings about her. Ms. A stopped talking and looked at the floor. I asked her what was wrong. After a few seconds of silence, she burst into tears and said, "You can't wait for me to get out of your office! I'm sorry if I'm boring you! I've known for a long time that you can't stand me, and you just do this for the money. I'll leave now if you want me to." I was taken aback and replied, somewhat defensively, that I was simply monitoring the time because I wanted to be sure I had time to say something before the session was over. Ms. A replied by saying, "Nice try to get out of it. You think I'm going to believe that?" Escalating in my defensiveness, I stated emphatically, "Whether

of relationship, in G. Salonia, A. Sichera, V. Conte, *For Oedipus a New Family Gestalt,* in «GTK books», 2, 13-48.

you believe it or not, that's the truth." Ms. A was adamant: "I saw what I saw." Placing her hand firmly on the wooden table next to her chair, she raised her voice: "It's like you're telling me that this table is not made out of wood!". Feeling as misunderstood as she was, I continued: "All I'm saying is this: it's possible that I looked at the clock for reasons other than the ones you attribute to me – just like you may make assumptions about your Dad". Ms. A became even more insistent in response to my efforts to offer other possibilities: "Now you're trying to say I didn't see what I saw! At least you could admit it!"».

It is a very instructive conversation. Gabbard comments: « One of the greatest challenges for a psychotherapist is managing this almost delusional conviction of some patients with borderline personality disorder […] I became a potentially malevolent and persecuting object for that patient; she became the victim; and a hypervigilant, anxious and humbled affective state had cemented the Self with the object. In this feeling of terror, you cannot think or reflect. Ms. A's intense accusations even eroded my ability to think»[47].

The point is: was it really just perceptive distortion of the patient, or was it something authentic, something deeply and truly involved in Ms. A's disease and words, who called the therapist to a fruitful exercise of 'translation' of a language deserving consideration and paritary? Was the interruption of therapy the fruit of a patient's delirium or of missed benefit of hermeneutics of translation from the therapist's side?

A Gestalt therapist would have said, for example: «Ms A., you are right in a certain sense. While you were talking to me, I was actually thinking of formulating an interesting comment which I could have used to reply to your words. I am sorry. I believe I missed some interesting things you were telling me… Maybe once again something happened between us that used to happen at home when you did not feel appreciated by your father…». In a gestaltic perspective, the effort is to find common ground, the humus that makes a translation possible and that detracts the other from a sense (lethal to him) of authoritative disconfirmation of experiences.

In a gestaltic perspective, the effort is to find common ground, the humus that makes a translation possible and that detracts the other from a sense (lethal to him) of authoritative disconfirmation of experiences.

47 G.O. Gabbard (2006), *Mente, cervello e disturbi di personalità*, cit.

6.3. GT and method of Fonagy's mentalization

«Patient: Yesterday, I had a bad anger crisis…
Therapist: What happened?
Patient: I argued with my mother.
Therapist: Tell me…
Patient: Nothing, as always… We agreed that she would wake me up to go shopping, but I woke up on my own and she was gone. As soon as she came back, I said all sorts of things to her, yelling at her that she was not interested in me, as usual.
Therapist: Why did your mother not wake you up?
Patient: As I've already mentioned, she is not interested in me!
Therapist: And what if she only wanted you to have a rest, given that, if I remember well, this has been a very difficult week for you?
Patient: No, doctor, I know my mother better than you do, sometimes she is mean! I'm sure she did it on purpose!»[48].
Even in this punctual verbatim of Fonagy's approach, any effort of translation is missing. The therapist even presumes she knows the patient's family reality better than the patient herself, denying the possibility of existence to his perspective of the world of intimate relationships. Indeed, here the therapist's comment: «In this communicative exchange, the patient's conviction to be in the right is clear, blocking any possibility to be involved in a Socratic dispute. We can conclude by saying that the patient slides into an 'excess of reality'»[49] in this operation.
If read from a gestaltic perspective, such verbatim seems to highlight how the therapist not only validates, but also (unconsciously!) reiterates a manipulating and confusing relational style, which is summarised in the statement: 'I don't keep a pact (waking you up in time) for your own good!'. The therapist denies the patient's experience here, imposes her perceptive inference (reading the mother's mind): hence, the thera-

The therapist denies the patient's experience here, imposes her perceptive inference.

48 E. Prunetti, F. Mansutti (2013), *La terapia basata sulla mentalizzazione (MBT) – caratteristiche distintive*, Franco Angeli, Milano; P. Fonagy (1991), *Thinking about Thinking: Some Clinical and Theoretical Considerations in the Treatment of a Borderline Patient*, in «International Journal of Psychoanalysis», 72, 1-18.
49 Ibid.

peutic intervention seems to validate the mother's confusion who, beyond all (more or less valid) motivations, 'cheats' her daughter by not meeting the agreement.
A Gestalt therapist would have said: «You are really enraged: the fact that your mother does not respect a pact makes you furious. How can you not feel hurt by this? Even if she did it for your own good, to let you rest, it would be a lack of agreement from your mother's side…I believe you! You feel angry and confused».

6.4. The question of listening in a conversation with Kernberg

In order to complete the picture, let us turn our attention to an account taken from another essential author in borderline treatment – Kernberg[50]. It is a very instructive case, given that, despite unconsciously, two approaching types are put side by side: one, apparently passive according to the therapist, very close to a translation attitude that helps and releases the patient; the other one, far more active and orthodox, which, however, seems to be unable to guarantee results.
«Miss N was a lawyer in her early thirties, presenting borderline personality organization with predominant obsessive and schizoid features. I saw her in psychoanalytic psychotherapy three times a week, for more than five years… in the midst of my interpreting Miss N's fears of sexual longings for me as father (because they were forbidden by her internal mother), a relatively sudden deterioration occurred, and over a period of several weeks she seemed to regress to what had characterized the early stages of her treatment.

50 O.F. Kernberg (1984), *Severe Personality Disorders: Psychotherapeutic Strategies*, Yale University Press, New Haven - London. I underlined the text. Such verbatim is part of a research on confrontations among verbatim that is going to be published. I thank doctor A. Macaluso for this contribution. In relation, also cfr. J.F. Clarkin, F.E. Yeomans, O.F. Kernberg (2000) (ed. or. 1999), *Psicoterapia delle personalità borderline*, Raffaello Cortina Editore, Milano; O.F. Kernberg (1967), *Borderline Personality Organization*, in «Journal of the American Psychoanalytic Association», 15, 641-685.

At one point, Miss N let me know that she wanted me to say only perfect and precise things that would immediately and clearly reflect how she was feeling and would reassure her that I was really with her. Otherwise, I should say nothing but listen patiently to her attacks on me. At times, it became virtually impossible for me to say a word because Miss N would ínterrupt me and distort almost everything I was saying. I fmally did sit back for several sessions, listening to her lengthy attacks on me while attempting to gain more understanding of the situation.

I now limited myself to pointing out that I understood her great need for me to <say the right things, to reassure her, to give her indications that I understood her almost without her having to say anything. Also, I pointed out that I understood that she was terribly afraid that anything I might say was an attempt to overpower, dominate, or brainwash her. After such an intervention, Miss N would sit back as if expecting me to say more, but I did not. Then she would smile, which I privately interpreted as her acknowledgment that I was not attempting to control her or say anything beyond my acknowledgment of this immediate situation.

I must stress that in the early stages of this development I had intended to interpret the patient's attitude as an effort to control me omnipotently and as a reflection of her identification with the attitucle of her sadistically perceived mother (her superego) toward herself (represented by me). But at this stage, any such efforts at interpretation exacerbated the situation and avere not at all helpful (in contrast to similar interventions that had been very helpful months earlier). Surprisingly, after several weeks of my doing nothing beyond verbalizing the immediate relationship between us as I saw it, Miss N felt better, was reassured, and again had very positive and sexual feelings toward me. However, my efforts to investigate the relationship between these two types of sessions – those in which she could not accept anything from me and had to take over and those in which she seemed more positive but afraicl.of her sexual feelings – again led to stalernate.

After a few more weeks, I finally formulated the interpretation that she was enacting two alternate relations with me: one in which I was like a warrn, receptive, understanding, and not-controlling mother and another in which I was again a father figure, sexually tempting and dangerous. Miss N now said that when I interpreted her behavior she saw me as harsh, mascu-

line, invasive; when I sat back and just listened to her she saw me as soft, feminine, somewhat depressed, and somehow very soothing. She said that when she felt I understood her in that way – as a soothing, feminine, depressed person – she could, later on, listen to me, although I then de the "made by mistake" of again becoming a masculine and controlling figure»[51].
So, the reiterated interpretation deteriorates the therapeutic relationship with the bd pt, given that it tends to assert a model on the patients words and emotions. Noticing how the therapist is the one that has major difficulties in changing is intriguing: «I finally did sit back» (how much does a patient have to fight to make herself heard!). Turned healthy, but theoretically unconscious. Indeed, later on the therapist states: «Surprisingly, after several weeks of my doing nothing beyond verbalizing the immediate relationship between us as I saw it, Miss N felt better». The adverb 'surprisingly'[52] seems to instil doubt that the therapist behaved how the patient requested (avoiding interpreting and only pondering) without understanding the deep reasons for that apparently imposed choice. The patient asked for equal dignity, listening and 'translation'. This is the road that leads to an 'inexplicable' improvement.

The reiterated interpretation deteriorates the therapeutic relationship with the bd pt.

How much does a patient have to fight to make herself heard!

6. 5. The limits of empathic response with borderline patients

A therapist asks for supervision for the fact that she feels discouraged in the work with a patient, who continuously protests

51 O.F. Kernberg (1984), *Severe Personality Disorders: Psychotherapeutic Strategies*, cit., 128-130.

52 It is interesting how there are moments in a therapist's experience, where he becomes aware of the fact that his method could be modified and he perceive embarrassment. I studied this phenomenon in Horney: «... I think it is important to avoid overestimating emotional experience, as if such experience was the only thing that counts in analysis. I don't think it's right». Shortly before that, she said: «If such self-perception, such self-acceptance is so important, then we should maybe change good part of the therapy». Cfr. K. Horney (1988) (ed. or. 1987), *Le ultime lezioni*, Astrolabio, Roma, 89. In relation, also cfr. G. Salonia (1990), *Karen Horney e Friederick Perls: dalla psicoanalisi interpersonale alla terapia del contatto*, in «Quaderni di Gestalt», VI, 10/11, 35-41, 40.

her interventions, even when she limits herself to respond in an empathic way. I ask her to give me some examples of interaction in the session.

Patient:

– My mother is sweet, but always misunderstands what I say. She makes me say things I do not think.

Therapist:

– You feel misunderstood by your mother.

Patient:

– What does that have to do with anything? It is well known that mothers are not able to understand their children.

Therapist:

– You do not feel understood by your mother.

Patient:

– It is not like this. What confusion!

After having carefully listened, my comment is: «Let us start from the point of view that the patient is not an opponent, but precise. Secondly, the bd pt refuses empathic answers, because he perceives them as definitions. And he learnt in his story to perceive the definitions of his emotions and meanings as a way of having power over him and to limit his experiences. Rereading the text that way, you realise that the therapist is using the manipulation the patient fears, since she omitted some precious statements of the patient in her empathic responses, such as: 'sweet mother', 'mothers don't understand their children'. Therefore, I suggest a different hermeneutics, of the kind: «You feel confused when a mother is tender, but you don't feel understood anyway. Any mother does not understand her children… it is very confusing. They love, but they don't feel understood…».

It is not about repeating, and maybe telling lies, and not about disconfirming by interpreting, but relying on the risk of the relationship, in order to give background and consistency to the fragments of truth of the 'divergent' language of the other, not asking for normalisation, but creative restitution. In other words, as the last analysis, poetry.

This last example highlights the fact that translating does not mean emphatically reaffirming, but establishing a common understanding of space within that no-man's-land, where each translator ventures in his effort of free and faithful *diakonia* of the words of others. It is not about repeating, and maybe telling lies, and not about disconfirming by interpreting, but relying on the risk of the relationship, in order to give background and consistency to the fragments of truth of the 'divergent' language of the other, not asking for normalisation, but creative restitution. In other words, as the last analysis, poetry: «The

moon is made of cheese». Isadore's yellow, which connects and colours them, is nothing but the aesthetic space where words meet, renew and find themselves.
Bd pt feedback seems to include every therapist's task (and the desire of any bd pt): «Thanks. How did you understand, from what I said, what I meant and was unable to say?».

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WEBOGRAPHY

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Abstract

The code of clinical revolution used by gestalt therapy in the treatment with borderline patients lies in i from's acute response 'moon and cheese are yellow'. Do not deny, interpret, define their experience; do not compare it, but find out its sense. Starting from these teachings, the author systematically develops a treatment model for borderline patients, expressing new hermeneutics in his statement – "gestaltic translation of borderline language": approaching to the strange language of borderline like a foreign and not subordinated or strange language. With the help of neurosciences, places and levels of confusions are described, which – reread within the theory of the self and the contact cycle – represent the plot of the therapy. In a coherent and punctual comparison with verbatims of other approaches – gabbard, kernberg, mentalization, and empathy – new clinical declinations of the new hermeneutics are shown: gestaltic translation of borderline language.