
Is Oedipus Still Necessary in the Therapeutic Room? Sexuality and Love as Emerging at the Contact-Boundary in a Situational Field¹

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ABSTRACT

While sexuality has been amply studied in psychotherapy as a fact of relationship, and its ethical norms defined, love is a concept which, though taken for granted, proves difficult to define, whether for the therapist or for the patient. I begin by defining first the therapist's, then the patient's love, and go on to set these feelings within the reference framework of the co-created contact-boundary in a given situation. I then explain how the perspective of the contact-boundary implies the surmounting of that pillar of psychodynamic conceptualization that we call the Oedipus complex. In conclusion, in line with Gestalt epistemology, I introduce the concept of the



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triadic field as an epistemological frame for the experiences of love and sexuality in psychotherapy.²

The Therapist's Love

Is what we feel for our patients love? Patients often ask: "Do you love me?" They find it hard to believe – especially in the initial phases of therapy, when they are still surprised at what the therapist is able to see in them – that the professional to whom they have turned, and whom they are paying, can really love them. They are afraid that the support given by the therapist to their positive aspects (in which they actually profoundly recognize themselves) is a technique, a trick of the trade, and not a genuine feeling. The result is that our profession is sometimes seen as a sort of prostitution: "Do I have to pay to be loved?" the patient wonders. We can distinguish between two kinds of love the therapist may have for the patient: one linked to the role and one that springs spontaneously from the situation.

The love that is linked to the role of the therapist is an "institutional" love: the therapist is taking care of the patient. But to what extent is it possible to call this care "love"? The answer lies in the definition we give of our profession: is it a technique or an art? As Gestalt therapists, we answer without a shadow of a doubt that our profession is an art, and that therefore emotional involvement is an *intrinsic part* of the method of treatment. The therapist's involvement is *real*, her/his feelings toward the patient are genuine, and it is on this concreteness that our treatment method is based. But can this involvement of the therapist be called love? In my view, the most fascinating answer to this question was given by Erving Polster (1987) in his book *Every Person's Life is Worth a Novel*, when he defined the treatment attitude of the therapist as a search for the hidden fascination of the patient; the therapist's interest and curiosity regarding this concealed fascination revitalizes the patient's ability to be interested/interesting. Health, for us, is spontaneous vitality, whereas neurosis is the desensitization of the contact-boundary, the lulling of the senses that makes us bored and boring. Polster adopts a language that is definitely divergent from Goodman's: he translates in terms of fascination/interest/aesthetic attraction the concept of the vitality and spontaneity of contact between organism and environment, maintaining the hermeneutic reference to the concept of novelty, excitement, and growth in the human personality from the founding text (Perls, Hefferline, & Goodman, 1951/1994)

² Although I respect and have other times used the term "client" in my writings, I deliberately use here "patient" in order to define the context of a psychotherapeutic treatment. I am aware that this preference is in opposition to a development of the Humanistic value of the "client" as a peer partner.

This, for us Gestalt therapists, is a good way of defining the therapist's love: the task of the therapeutic intuition and "love" is to rediscover the fascination the patient has concealed. We may say that neurosis is the consequence of the lack of loving light projected by the significant other. The healing love is a sort of spotlight illuminating the other's beauty, a light that makes visible, in the relationship, the harmonic vitality inherent in the integrity with which the other is in the relationship, the intentionality of contact with which the other offers her/himself in order to adjust to the situation with all of her/his creativity and uniqueness. When the therapist wonders: "What really attracts me in this patient?" s/he is directing the spotlight of her/his therapeutic love in such a way that the patient can reawaken, as s/he looks at her/himself in this light, the sense of her/his own beauty, which implies the spontaneity of his/her being-there (Spagnuolo Lobb, 2003).

Ethics of Therapeutic Love

The therapist's curiosity about the fascination that the other has blotted out in her/himself places therapeutic love within the ethical boundaries of the treatment role: esthetics is our ethics (Bloom, 2003). In speaking of "beauty" and "fascination," we make reference to esthetic canons, those linked to sensory experience (Bloom, 2005).

Some decades ago the therapist's love for the patient recorded a certain confusion in the application of that human equality between therapist and patient upheld by the humanistic psychotherapies. The drive to go beyond the authoritarian mentality implicit in the concept of treatment which was then in force (and in psychoanalysis with the interpretative method) led many humanistic psychotherapists to cast off the incest taboo, which they saw as a rule imposed by an authoritarian system. The banning of sexual relationships in psychotherapy was confused with a rule that could be broken in the face of a different emotion. The problem was, of course, that whoever decided to break this rule – or any other – was still the therapist, who thus in turn became authoritarian, distorting the patient's request.

The fact is that the patient enters therapy in order to be treated, not in order to find a partner. At that time treatment was sometimes even identified, by both therapist and patient, with a narcissistic ostentation: the patient could be "the father's chosen one,"³ while the therapist might decide not to put her/his faith in an ethical rule *super partes*, taking the responsibility of guaranteeing her/himself for the treatment relationship, although involved in it. If the bemoaned observance of an imposed rule

³ I am not going into here the question of distinguishing the gender of the therapist and the patient, since this might lead us away from my objective.

created a split between the spontaneous feeling of therapist and patient and a "must-be" linked to the role of each, the absolute rejection of rules in the treatment relationship led to a confused anarchy, whose victims were the abused patients and the image of the model. The professionalization of psychotherapy in Europe in the 1980s and 1990s – with the general acceptance of an ethical code – drew attention to the ethical respect for the patient's request, and the use of sexuality in psychotherapy was finally banned in the psychotherapeutic relationship. The practice of Gestalt therapy has followed this evolution, to the great benefit of the patients and of the method itself.

That said, this question must be answered: "What is the specific way in which Gestalt therapy regards sexual feelings and feelings of love?" We set these feelings at the contact-boundary, hence seeing them as functional to the relationship, and to the situational field which patient and therapist create. This aspect will be treated in more detail below.

The Patient's Love

The patient's love obviously cannot be disputed: it is the form taken by *commitment* in the various therapeutic situations. The patient offers the therapist the access code to an intimate history, with an intentionality of contact that implies completing open gestalts with the other; integral self-fulfillment with the other. In this sense, we may also speak of the "institutional aspect" of the patient's love: it is the fact of being a patient, of putting her/himself in the therapist's hands that causes the loving attachment to arise. Entrusting oneself or not to the therapeutic relationship – and in consequence yielding to feelings of love and attachment – can also be used by the therapist as a diagnostic tool: excessive trust or reluctance to trust certainly give the therapist a key to read the patient's habitual relational patterns. The aim of the therapeutic relationship is that therapist and patient find a way of being at their contact-boundary, which enables the *commitment* and at the same time the independence of them both: meeting as an I with a You.

Thus far, our approach is not very different from the other psychotherapeutic models. What marks us is the concept of the unfolding of the self at the contact-boundary; that is to say, the idea that every emotion the patient feels for the therapist is not merely a repetition, a transference, a projecting on to the screen of the therapist emotions experienced in previous relationships, but a specific response, appropriately modulated for that therapist, within the frame of reference of the relational patterns that the patient intends to modify. Suppose that, in the course of therapy, a patient who habitually has an excessive *commitment* (which we might identify,

for instance, with a hysterical relational pattern) allows the spontaneity of a criticism to emerge, a deconstruction of parts of the environment. The patient will find a way of criticizing the therapeutic situation that the particular therapist can accept. For example, with her/his ability to be a good patient (typical of the hysterical relational pattern) s/he will anchor her/his criticism to something the therapist has previously said, so as to avoid possible anger on the part of the therapist. It is from the ability to adjust creatively to the current situation with this therapist that the possibility emerges for the patient to modify an unsatisfactory relational pattern.

Love in Therapy as an Emergent Event at the Contact-Boundary

The concept of spontaneity takes us back to the occurrence of another kind of love: the love that springs up in certain situations and not in others, and which may imply physical attraction, hence sexual feelings. The special nature of the therapeutic encounter may involve the profound desire for total intimacy, old and new at the same time, in both patient and therapist (Salonia, 1987). I hold that Gestalt therapy, with its hermeneutics of the contact-boundary, can offer a new perspective to the world of psychotherapy.

For Gestalt, the perception (and hence also the emotion) of the patient or the therapist is a process that occurs not "inside" the individual, but as co-creation in the space "between" in which their experiences are realized. The attraction that may be felt by the therapist and/or the patient – like any other feeling – has meaning in the relational pattern the patient her/himself triggers. For instance, the therapist who is attracted to a particular patient might discover that this patient is, so to speak, "used to" parental love. In fact, in this way the patient "shapes" the therapeutic situation, offering the therapist – who responds sensitively – the access key to an intimate experience, so that the therapist will create the conditions to fulfill the intentionalities of contact that have not been brought to completion. The attraction the aware therapist feels (s/he is present with all her/his senses at the contact-boundary) is a sensitive, specific response to the situational field created by this particular patient.

Let us take an example. A therapist comes for supervision because he is attracted to a young, good, intelligent patient. I ask him: "What attracts you?" "Her style of being a good girl," he says. "It really looks as if she wants to make me happy, as if she cares about me. She relaxes me." Obviously, we all think that the therapist's narcissism in this case is colluding with the patient's openness toward and admiration for a real or dreamed-of father. But these two aspects may be the ground of the situation, whereas the figure is the fulfillment of this type of contact, which responds to a

“suspended” intentionality on the girl’s part. The patient can experience old love in a new situation. The challenge for the therapist is to provide a clearer, more courageous love, so as to relocate the positive aspect of this love in a non-manipulative context, and cause the patient to experience her spontaneity on the ground of a clear relationship. Therefore, I ask this therapist: “If you imagine openly saying to this patient what you’ve just told me up to this point, what do you think would happen?” He says, “I don’t know. Oddly, I think all the tension I feel would be relaxed. Perhaps she’d tell me that she’s always wanted her father to say something of the sort to her. I think, too, that at that point my sexual attraction would calm down: I’d understand that the charge of attraction is actually determined by NOT saying these things. And maybe the patient would finally feel that she was seen in her affection for me, and her admiration would achieve its object. Maybe she could even become more independent of me.” The therapist has grasped an intentionality of contact that was still incomplete, and in stating explicitly what attracted him, he gives the patient the chance to achieve full contact in the here and now, in a new, real situation. The therapist’s sexual attraction to the patient – like that of the father to the daughter – is an out-of-context emotion, but the fact that it happens responds in a way to a self-regulation of the situation.

The patient’s attraction toward the therapist can be understood in the same way: the healing factor will not be the positive response of the therapist to this attraction (which instead would disorient her), but rather the fact that the patient *feels seen and appreciated by him in her intentionality of contact*. Only this can restore the spontaneity of the patient’s love. For example, the patient tells the therapist that she has had a dream about making love with him. The therapist listens to what she is telling him and how, and then he says: “I’m struck by the effort you’ve made to overcome your shyness and embarrassment. I appreciate the trust you have in me, and the courage with which you face your relationship with me.” This answer gives the patient the sense of being seen in the intentionality of contact, not just in the feeling of attraction, which is thus confined by the therapist to the context of treatment: the patient has the right to express the most disturbing of emotions, without such expression leading to a change in the setting she has personally chosen.

From the point of view of transference, the therapeutic situation is artificial and serves to analyze the external reality, to make conscious what is unconscious. We regard the therapeutic situation as real; the habitual relational patterns are fulfilled in it, in search of a new solution.

Procedural Relational Knowledge in Psychotherapy: An Overcoming of the Id/Ego Polarity

This phenomenological hermeneutics, which is characteristic of Gestalt therapy, brings about a radical revolution of Freud's assertion that "all that is Id must become Ego." In the cultural climate in which psychoanalysis was born, the idea of treatment was linked to bringing into reason all that is part of the disturbance. The novelty that Freud offered was not so much the idea of making rational all that was not rational, but rather proposing an unconscious irrational level that actually determines human behavior. Freud's statement cited above was based on what was at that time normal a faith in reason. Interpretation as a treatment mechanism is its consistent methodological application.

In the intervening century, despite the cultural changes psychotherapy has undergone, the idea of making conscious what is not conscious has generally remained the central core of psychotherapy. Some approaches speak of conscious and unconscious, others of rational and irrational, yet others of conscious and not-conscious, but in the final analysis the aim of psychotherapy seems to remain that of *making "sayable" what is "unsayable."* This basic idea has been put to the test recently by different scientific developments. Some new techniques used in psychotherapy, for instance, can be said, on the one hand, to have challenged the concept that the client needs to say and understand the experience related to his or her discomfort. EMDR has shown that trauma and other deep negative feelings can be resolved solely through certain eye movements and free storytelling; the patient does not need an understanding of symptoms to get better. On the other hand, neuroscientific discovery of mirror neurons (Gallese, 1995) has given psychotherapy and developmental research revolutionary support for the "magic" that happens between patient and therapist, or parent and child. Based on these kinds of neurological discoveries, as well as on infant research, Daniel Stern (Stern et al., 1998) states that the implicit relational knowledge is what is truly responsible for much therapeutic change, and many psychotherapists are debating this topic today (Spagnuolo Lobb, 2006). Implicit relational knowledge is defined as non-verbal, not conscious but not repressed (Stern et al., 1998); in other words, a new category of knowledge for psychoanalysis.

Gestalt therapy has been based on procedural knowledge since its birth: it mainly observes the relational patterns the patient comes into contact with together with the therapist, from breathing and bodily relational processes to the relational meaning of dreams told to the therapist (cf. Isadore From's theory in Müller, 1993). Despite having this "something more" compared with other approaches, Gestalt therapy has not sufficiently de-

veloped a praxis based on relational processes, but continues to identify the treatment method with making the procedural elements explicit: "Are you aware that...?"

There is a need for theoretical reflections and clinical perspectives better suited to the new challenges of post-modernity. Can we still say that psychological well-being depends on the control the person succeeds in exercising over her/his experiences ("All that is Id must become Ego"), or do we wish instead to attribute it to a kind of relational confirmation we look for in the other? Today, long after the humanist movement, we are part of a cultural movement centered on relationship, or rather on the experience of relationship. We have moved from a culture based on regulatory principles (first external and subsequently internalized) that were in force at the birth of psychoanalysis, to the paradigm of self-regulating subjectivity of the 1950s, and then to the paradigm of truth that is never external to a happening but arises from the relationship itself and belongs indissolubly to its texture. This trajectory allows us to move away from the intrapsychic perspective, which sees treatment as a process linked to the satisfaction (or sublimation) of needs, toward the postmodern viewpoint, where the "power of truth" has been replaced by the "truth of the relationship."

Intentionality of Contact: The Now-for-Next in Psychotherapy

In the 1970s, Erving and Miriam Polster used to teach that Gestalt therapy has to do with now-for-next rather than with here-and-now (Polster & Polster, 1973). In fact, what makes it possible to treat psychic disturbance is the *support of spontaneity*, of the proactive tension of the person toward the fulfillment of an intentionality of contact, not the sublimation of impulses. The use of the myth of Oedipus as a paradigm of the solipsistic search for the satisfaction of one's needs has thus had its day (cf. the way that Vernant [1972] demolishes the Freudian hypothesis in *Oedipus without Complex*). The experience and behavior of the child toward the mother is to be seen not so much as an intrapsychic need as from a relational viewpoint: the mother and father, together with the whole situational field, concur in this experience. Finally, *the implicit intentionality of contact in the field, and not the internal needs of single individuals, determines the meaning of the experiences.*

In a word, a radical change of perspective is being imposed not only on psychotherapy but also on culture in general and on the agencies of socialization: what treats the patient is not rational understanding and hence control of the disturbance, much less the acceptance—willy-nilly (*ob torto collo*)—of limits, but procedural and aesthetic issues. "Treatment" consists of helping the patient not to understand and control, but *to live fully*, re-

specting her/his natural ability to regulate her/himself in the situation, not only at the verbal level but above all at the level of spontaneous activation of the neuro-physiological structures that deal with daily relationship. We are a long way from a concept of spontaneity that is confused with that of impulsiveness (typical of Freudian anthropology) because, in contrast to impulsiveness, there is in spontaneity the ability to “see” the other. We are also far from a Rousseauesque idea of childlike spontaneity: the opposite of the art, learned throughout the years, of integrating all experiences, including the painful ones, into a harmonious, personal style, fully present to the senses; the physiological means by which we realize our being-in-relationship.

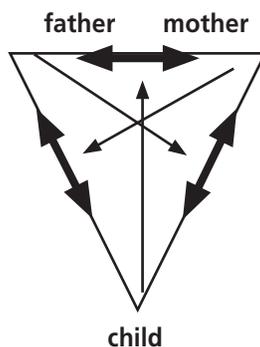
Sexuality and Love in a Situational Field

Our culture, which has developed the worship of individualism, does not make us accustomed to seeing the plurality of relationships. The word “relationship” generally summons up an individual who encounters another individual. We think of the mother-child relationship, for instance, rather than a field of relationships. What matters in the development of the child is the field of relationships in which s/he is inserted, where sometimes the mother, sometimes the father, or sometimes others represent emerging figures; it is a field where the various interweaving relationships of the ground influence the figure. The child experiences a field, a situation, which includes both the ground and the figure. For example, in the child’s perception of the father, the perception of what the father knows about the mother is included, as is what the child her/himself knows about the mother, so that the child knows what the father does not know about the mother (which s/he knows) and what the father knows about the mother that s/he does not know.

The intersubjective viewpoint (cf., among others, Mitchell, 2000; Stern, 2000; Beebe & Lachman, 2002) may be a valid tool to describe the perception at the contact-boundary. If the mother feels neglected by the father, the child (even though this feeling has not been communicated explicitly to her/him) notices the mother’s forced breathing, her sad face, her lowered eyes; s/he looks at the father and sees that the father is pensive and peeking at the mother. So the child knows that the father knows what is wrong with the mother. But if the child sees the father continuing to play with her/him or making the usual business calls, s/he understands that the father does not know that the mother feels neglected by him; therefore, the child has to decide whether or not to take action so that the father will realize this. The father’s awareness will depend on the child’s adjusting creatively to the situation. Hence, the child’s perception is oriented toward

the contact-boundary between mother and father, as well as, respectively, toward the contact-boundary between her/himself and the mother, and between her/himself and the father. This principle is also applied to the other people present in the field, constituting—in the case of the mother-father-child triangle—a phenomenological field whose vertex is triadic (Figure 1).

Figure 1. Perceptions in a triadic field.⁴



The child perceives not only the mother (or the father) but also what is happening at the contact-boundary between them, so s/he knows if the father knows that the mother is sad or not, etc. In line with the phenomenological principle of the experience as happening in the here and now at the contact-boundary in a field or situation (Robine, 2003), in Gestalt therapy we see intimate relationships (e.g., between family members, or between patient and therapist) as a figure that emerges from a relational field. In line with the triadic models thus far developed in the context of infant research (Fivaz-Depeursinge & Corboz-Warnery, 1998), Gestalt therapy can offer a view of the experience as a boundary event, rather than as an internalized relational pattern. This way of looking at the experience as a boundary event (rather than as a “mentalization”) puts trust in spontaneity and in the aesthetic aspect of the relationship. Therefore, the therapeutic relationship is experienced as a real event, happening in the here and now.

In a word, the relationship is always multiple and complex. The child who is aware of the “fog” at the contact-boundary between mother and father will develop a relational pattern that fulfils her/his intentionality of contact as a child (taking care of the disturbed parents) and adjust creatively to the situation; for instance, s/he will take steps to make the parents aware of

⁴ The perceptive principle represented in this figure was developed by Spagnuolo Lobb and Salonia (1986) in their model of co-therapy.

each other, or will take on the responsibility of cheering up the mother if s/he is the only one who can do so (Stern, 2006).

In summary, what happens at the contact-boundary is a figure supported by the perceptive ground of the situational field. In the therapeutic setting, the patient never sees the therapist in isolation but always as part of a relational field. It would be interesting to ask the patient: "If you think of someone alongside your therapist, whom do you imagine?" "What do you know about your therapist?" "What do you imagine that your therapist knows about this person?" "In your opinion, what do they both think of you?" As will be revealed in the clinical example below, this work brings to light a key aspect of "implicit relational knowledge" and gives the therapist a better-defined understanding of contact-making with the patient.

Oedipus and Descartes

The use of the Oedipus myth in Freudian theory is supported by the Cartesian principle of division that has been typical of Western individualistic culture. Oedipus must give up his own impulses if he wants to grow up. The incompatibility of the relationship between individual desires and impulses (the Freudian Id) and the demands of social living was decidedly called into question by the founders of Gestalt therapy. For instance, in the opening chapters of *Gestalt Therapy*, Perls, Hefferline, and Goodman define their aim as that of overcoming certain dichotomies (body-mind, self and outside world, conscious-unconscious, personal and social, etc.), "leading up to a theory of the self and its creative action" (Perls et al., 1951/1994, p. 17). Thus, the hermeneutics of our approach imposes on us the *logic of continuity* rather than that of fracture (Spagnuolo Lobb, Salonia, & Sichera, 1996). If we are to draw upon myth, we might consider the experience and behavior of Oedipus as a co-creation at the contact-boundary in terms of himself, Laius, and Jocasta (and many others). The use of the tragedy of Oedipus in psychotherapy is supported by his desire for a woman (who turns out to be his mother), by the (unwitting) non-acceptance of the father's power, and by his guilt and consequent need for expiation. At the contact-boundary, since the drama of Oedipus is based on blindness (Salonia, 2006), the desensitization at the contact-boundary in the triad hinders all three people – not only Oedipus – from seeing each other. The Oedipus myth, used and abused in psychological, sociological, and psychotherapeutic cultures as a paradigm of the individual drama in a society with rules to be respected, becomes the triadic drama, the collective drama arising from being blind to the situation. As evolutionist theories have shown, it is impossible to live and grow alone in life; one never exists only as a couple but rather as part of a social community – a shared situation. Let us repeat what we stated

above: *in the therapeutic setting, the patient does not see the therapist in isolation but as part of a relational field.*

A Clinical Example of the Triadic Perspective in a Dyadic Therapeutic Setting

The following clinical example is intended to make clear the movement from an Oedipal perspective to a field perspective. A male patient is madly in love with his female psychotherapist. The fervor of his feelings and the desire for physical contact increase with every session. The therapist, after trying to make explicit every possible reading of the patient's feeling, is embarrassed: she cannot meet the patient in a perceptive clarity. Whatever she says or does seems to increase the patient's desire; in addition, she finds him rather attractive.

After having supervision on the triadic method, she asks the patient: "Imagine there is somebody beside me. Whom do you see?" The patient's expression changes at once and he says, laughing: "I saw your husband (whom I don't know), or at least a man, your man. He's very different from you. I have a feeling he doesn't like me, and he's not too happy about my being with you. He doesn't think much of me. He impresses me: his presence attracts me more than yours now, though with unpleasant feelings. The experience of his glance is terrible for me. It strikes me very differently from yours. You're fond of me. You like me, don't you? It's just as well you like me!" The therapist asks: "What do I know about him? I mean, do I know that he puts you down?" The patient responds: "I guess so, that's precisely why you're kind to me!"

The triadic perspective brings out a new awareness in the therapeutic situation, which casts an interesting light on the sexual feelings between patient and therapist, redressing the balance of the therapeutic relationship in the direction of the patient's intentionality of contact. It is clear, in fact, that what is moving his organism is not the "desire" to win the therapist's favor (as a dyadic view would suggest) but to understand: (1) the relationship between the therapist and her partner; (2) why she appreciates him but her partner does not; (3) whether the therapist's liking of him derives from the fact that he is better than the other man or from the fact that he is "little," immature; (4) whether he can be independent of the therapist (i.e., be sure that she is still fond of him even if he does things she does not like); (5) whether he can reach the adult man and win the other man's regard; and (6) whether the therapist can intercede with her partner to bring this about. In sum, in the triadic perspective, what emerges is very different from what is seen in the dyadic context. Within the triadic perspective, the more complex dynamic emerges from the relationship between male and female, and between generations: the child always makes

reference in growing up, not so much to the dyadic relationship with one or the other parent, as to one (or more) couple relationship(s), to contact boundaries between couples.

The therapeutic intervention that is modulated from this perspective is much more effective especially in the advent of sexual feelings, whether on the part of therapist or patient. In the specific example given, the patient's answer made it possible to move the attention for contact on to what had previously remained in the ground; remaining in the shadow, it lit the fire of sexual attraction. Focusing attention on the patient's relationship with men made it possible to talk about his fear of not being up to the mark (with both men and women), about the compulsions that characterized his seductive behavior toward women (sexual attraction to a woman in a maternal role allowed him to avoid the anxiety brought about by comparing himself with men), and to understand that, basically, starting a sexual relationship with the therapist would have frightened and confused him, burdening him with a responsibility he did not want. The humiliation of comparing himself with other men enabled him to offer himself spontaneously to a woman on equal terms, with desire and the sense of risk.

Conclusion

The love of both therapist and patient is the context of the therapeutic situation. Feelings, including sexual feelings, are the figures emerging from a ground of complex perceptions in a triadic field. In this article, I have attempted to show that the use of the Oedipus complex is based on an individualistic vision of needs, and that the perspective offered by a triadic field can better direct the therapist toward supporting the patient's intentionality of contact. The fact that human perception is always in the direction of a contact-boundary, and not an isolated object, enables creative adjustment in the social community.

Integrating experiences of love and sexuality in psychotherapy cannot be reduced to a technical fact; rather, it requires the co-creation of a contact-boundary where the values, personalities, and ways of dealing with life of both patient and therapist play a fundamental part. They are two people who together find possibilities of fulfilling interrupted intentionalities (Spagnuolo Lobb, 2003). It is the dance that the therapist, with all of her/his scientific knowledge and humanity, and the patient, with all her/his pain and longing to be healed, create in order to (re-)build the ground on which daily life rests, the sense of security in the ground and in the other, and thus the surrender to intimacy.

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