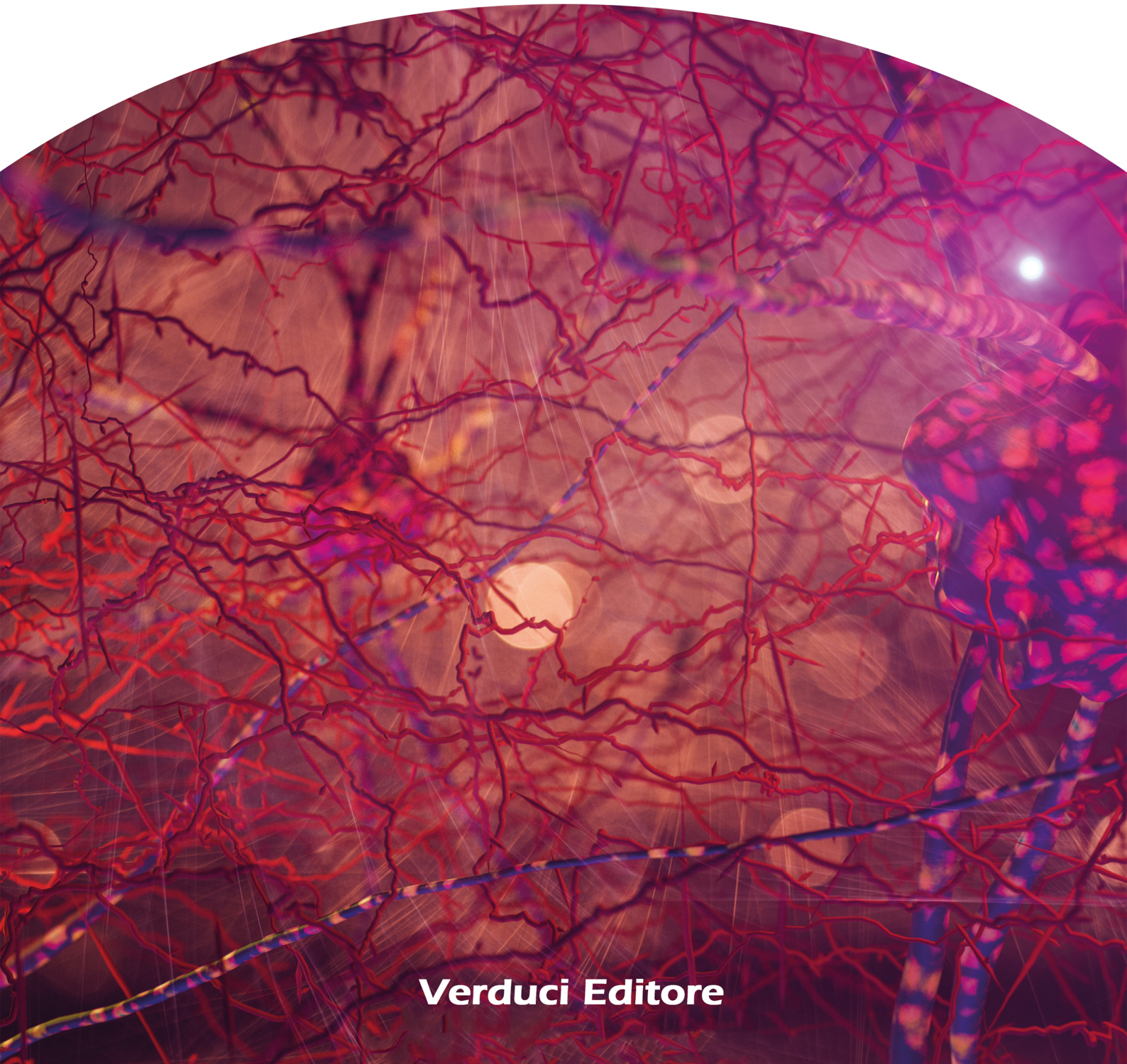
Vol. 8 No. 1, 2026

phenomenajournal

International Journal of Psycopathology, Neuroscience and Psycotherapy

Editor-in-chief: Raffaele Sperandeo, PhD, MD



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Single Case Study

In a child's time: the clinic as a space for restoring being – A phenomenological-Gestalt journey in co-therapy

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ABSTRACT

Background: This contribution presents a clinical case from the developmental age conducted in a public setting over six months of weekly co-led therapy sessions.

Case report: A five-year-old girl entered therapy with marked difficulties in affect regulation, premature role adultification, and an impaired ability to distinguish between reality and fantasy. The intervention was structured within a phenomenological-existential framework, integrated with elements from Gestalt therapy, transactional analysis, systemic-relational approaches, and affective neuroscience. Co-therapy, conceived not merely as an organizational structure but also as a clinical element, enabled the construction of a plural and regulatory therapeutic field, supporting the functions of mirroring, differentiation, and developmental triangulation. Moreover, the use of symbolic, narrative, and bodily tools—such as role-play, embodiment techniques, co-constructed stories, drawings, and dramatizations—facilitated the reappropriation of the child self, supported bottom-up emotional regulation, and promoted a profound transformation of internal relational models.

Conclusions: This case highlights the potential of a holistic, embodied approach in developmental care settings, offering an applied reflection on the clinical value of phenomenological presence as a healing space. The focus is on restoring the child's right to experience her own age, through a form of listening that does not seek to correct but to accompany, name, and give symbolic meaning to her experience. The therapeutic work thus supported the emergence of a new, more integrated and vital internal narrative in which play, the body, and the relationship restored the natural rhythm of development.

Keywords

Child psychotherapy, Phenomenological approach, Gestalt therapy, Co-therapy, Embodiment.

Citation: D'Aquino, R., & Napolitano, L. L. L. In a child's time: the clinic as a space for restoring being – A phenomenological-Gestalt journey in co-therapy. *Phenomena Journal - International Journal of Psychopathology, Neuroscience and Psychotherapy, 8*(1), 1–9.

Editor in Chief: Raffaele Sperandeo, PhD, MD

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Received: September 4, 2025

Accepted: February 3, 2026

Published: March 20, 2026

ABSTRACT in ITALIANO

Background: Il presente contributo presenta un caso clinico in età evolutiva, condotto in un contesto pubblico, nell'arco di sei mesi di sedute settimanali di co-terapia.

Presentazione del Caso: Una bambina di cinque anni ha intrapreso il percorso terapeutico presentando marcate difficoltà nella regolazione affettiva, una precoce adultizzazione del ruolo e una compromessa capacità di distinguere tra realtà e fantasia. L'intervento è stato strutturato all'interno di un quadro fenomenologico-esistenziale, integrato con elementi della terapia della Gestalt, dell'analisi transazionale, degli approcci sistemico-relazionali e delle neuroscienze affettive. La co-terapia, intesa non solo come assetto organizzativo ma come vero e proprio elemento clinico, ha consentito la costruzione di un campo terapeutico plurale e regolativo, sostenendo le funzioni di rispecchiamento, differenziazione e triangolazione evolutiva. Inoltre, l'utilizzo di strumenti simbolici, narrativi e corporei, quali il gioco di ruolo, le tecniche di embodiment, le storie co-costruite, il disegno e le drammatizzazioni, ha facilitato la riappropriazione del Sé infantile, ha sostenuto la regolazione emotiva bottom-up e ha promosso una profonda trasformazione dei modelli relazionali interni.

Conclusioni: Il caso evidenzia il potenziale di un approccio olistico e incarnato nei contesti di cura in età evolutiva, offrendo una riflessione applicativa sul valore clinico della presenza fenomenologica come spazio di cura. L'attenzione è posta sul ripristino del diritto del bambino a vivere la propria età, attraverso una forma di ascolto che non mira a correggere, ma ad accompagnare, nominare e simbolizzare l'esperienza. Il lavoro terapeutico ha così favorito l'emergere di una nuova narrazione interna, più integrata e vitale, nella quale il gioco, il corpo e la relazione hanno contribuito a ristabilire il ritmo naturale dello sviluppo.

Parole chiave

Psicoterapia infantile, Approccio fenomenologico, Terapia della Gestalt, Co-terapia, Embodiment.

INTRODUCTION

Childhood clinical practice, when approached through a phenomenological-Gestalt perspective, takes the shape of a landscape in constant motion—a terrain where every gesture, every suspended breath, and every unspoken syllable becomes a landing strip for mutual understanding.

A plural theoretical framework: orientations and references in clinical work

The patient was guided by a holistic perspective in which body, speech, and relational texture were treated as a single living organism [1. The phenomenological stance provided the space to inhabit the here-and-now of experience [2, 3], while the existential lens illuminated the irreducible tension between freedom and the need for rootedness that accompanies every growing subject [4].

On this phenomenological ground, Gestalt psychotherapy was interwoven: the concept of contact [5] and Laura Perls' organismic vision allowed us to read interruptions and emergent figures in Matilde's play. Body-oriented work, inspired by Kepner [6] and Francesetti [7], gave voice to those micro-movements that precede language and reveal its deeper truth.

The interpersonal dimension was informed by several theoretical contributions. Attachment Theory [8] and Fonagy's work on mentalization [9, 10] helped us understand the child's oscillation between fusional dependence and sudden bursts of autonomy. Berne's Transactional Analysis [11] clarified Matilde's rapid shifts between the "Child Ego State," a prematurely assumed "Parent Ego State" toward her mother, and an emerging "Adult Ego State." The systemic–relational perspective [12] allowed us to map porous boundaries and covert alliances within the family. Finally, Social Neuroscience [13] and bottom-up models of regulation [14] supported the clinical intuition that emotional modulation involves a continuous dialogue between cortex, limbic system, and embodied memory.

Theoretical framework – application to this case

Matilde entered therapy as a small tightrope walker suspended between two emotional poles: on one side a morbidly protective attachment to her mother, on the other a shy curiosity toward her father, shielded by oppositional outbursts. It was the five-year-old's body that spoke first: shoulders rigidly raised toward the neck, toes wavering in search of support, shallow breathing that tran-

sformed into a sigh of relief once the therapy room closed the door on the outside world. This is how the therapeutic journey began.

During the first month—conducted by the female therapist—the setting was conceived as a holding environment [15], a symbolic womb where Matilde could "take off" her armor of the prematurely adult child and recognize, without shame, her longing to be cared for. The male co-therapist's entrance opened a passage toward the otherness of the outside world and the otherness within herself. Initially wary, the child gradually experienced a male presence as consistent, reliable, and caring rather than ambiguous. The co-therapy setting offered two complementary perspectives, allowing Matilde to develop a more differentiated and integrated perception of herself and of others [16].

Methods

The therapeutic pathway with Matilde unfolded through weekly sessions, almost all conducted in co-therapy, delicately alternating the voices, silences, and gazes of two adults who together offered themselves as plural and differentiated mirrors. Only on rare occasions, for logistical or contingent reasons, was a session led by a single therapist, while still preserving the continuity of the process and the underlying relational structure. Sessions took place from September to March within a public setting, in a room that gradually became a "third space"—a womb and a boundary—where every object acquired meaning under the attentive gaze of the therapeutic relationship.

The presence of the parents, though limited, was significant. At the end of certain sessions, during the last 10-15 minutes, the parents were welcomed—sometimes together, sometimes separately—to observe their daughter from a protected distance, noticing possible changes in her gestures, her modes of contact, and the quality of her gaze. These moments, though brief, represented a liminal space between the inner world and the family sphere, between imagination and the restitution of reality.

At the beginning of the process, a qualitative psychodiagnostic assessment was carried out to understand the child's affective, symbolic, and cognitive organization and to orient the therapeutic intervention accordingly. The tools employed were selected based on Matilde's age and her predominantly symbolic and bodily communicative style. Specifically, we referred to:

- Human Figure Drawing Test and Family Drawing Test [17], useful for exploring self-perception, significant relationships, body image, and projective relational experiences;
- Tree Test, used as an exploratory tool for vital tone, ego structuring, and modes of identity rooting;
- Age-appropriate cognitive assessment scales, such as the WPPSI-IV [18] or equivalent measures, were administered in partial and targeted form to explore general cognitive abilities, receptive language, and visuospatial organization.

These tools were not used in a standardized manner, but within a phenomenological–experimental frame, in which data were integrated with clinical observation and relational resonance. Drawings, play, and responses were read as embodied expressions of lived experience rather than nosographic indicators, in line with the dialogical and non-labeling approach that guided the entire process.

On the experiential level, the work unfolded through a multiplicity of languages, always centered on the child's embodied, symbolic, and affective experience. Through role-play, co-constructed narratives, spontaneous postures, and bodily resonances, a dialogue among internal parts was activated: the child, the adult, the mother, the sister, the hidden daughter. The Gestalt method of the "empty chair dialogue [5]," adapted into a playful, embodied language, allowed the emergence and integration of split polarities and unacknowledged inner conflicts, offering the child the possibility of feeling herself in her wholeness. During several sessions, Matilde gave voice to objects, arranged them as families or conflicting groups, and moved them across the room. This spontaneous and meaningful practice evoked elements of sandplay therapy, even in the absence of the sandbox: the symbolic manipulation of figures enabled a re-narration of trauma, safeguarded by play.

The body, meanwhile, was never silent. Somatic focusing accompanied the discovery of sensations and boundaries, where spontaneous movements—sometimes contained, sometimes explosive—were welcomed and at times mirrored by the therapists in a subtle dance of emotional attunement and affective co-regulation. Within these gestu-

res, techniques based on embodiment were also integrated, such as non-directive creative movement, vocal play, and rhythm [19]. Oscillations, sounds, small jumps, or the request to be lifted were embodied signs of a need for tenderness and containment that had not yet found verbal expression.

Throughout the process, shared fairy tales and two-voiced stories emerged—often incomplete or interrupted—in which Matilde projected desires and fears: through games, characters, and Dixit cards, she shaped a child-queen who saves her mother, an invisible monster that steals her voice, a father-tree that cannot be touched. Co-constructed narratives, consistent with the transformative narrative approach [20], allowed the child to "re-story" her sense of self, recognizing and redefining her affective and relational role, gradually releasing herself from the parental function she had prematurely assumed.

Finally, through relational and symbolic drawings, family bonds were explored—sometimes represented as animals, other times as diverse plants, and still others as overlapping houses. Without the need for explanations, the child revealed emotional distance, conflicts, alliances, and a desire for reconnection.

Every technique employed, even the simplest, was grounded in a phenomenological attitude of listening, where nothing was forced, and every expression was granted meaning. The methodology thus became relational art, a sensitive and dynamic fabric in which play, voice, body, and imagination repaired ruptures, reshaped experience, and allowed the birth of new possibilities of existence [21].

Objectives and Foundations of the Therapeutic Process: A Complex and Layered Blooming

The core of the therapeutic process with Matilde unfolded as a slow blossoming, a circular movement that gradually embraced her inner world. A world composed of images, gestures, silences, and words borrowed from imagination, where the primary goal emerged over time: to support the child's neural, affective, and emotional development through a gentle restoration of the possibility of fully inhabiting her developmental stage, without disguises or premature demands.

In this sense, the clinical work aimed to:

- Restore Matilde to her own child experience, allowing her to inhabit her body and her own temporal rhythm;
- Provide spaces to distinguish the self from the other, recognizing the often blurred or confused boundaries between her emotions and those of the adults surrounding her;
- Support her capacity for symbolization and narration, fostering a transition from the unspoken bodily expression to storytelling, from confusion to articulation;
- Legitimize her inner experience, valuing its complexity with a non-judgmental yet deeply resonant perspective.

Within this framework, therapy became a place of relational holding [16], following Daniel Stern's perspective, where the child's experiences could emerge with their full intensity, without needing to be restrained or censored. Through symbolic play, dramatization, drawing, bodily expression, and words, themes such as birth, nourishment, love, solitude, and fear were explored in a constant dialogue between imagination and reality. The Gestalt framework guided the intervention in reclaiming the here and now, enhancing lived experience and sensory awareness [5], while body-based practices enabled Matilde to experience her body as a possible home, a locus of identity.

In parallel, the systemic-relational approach provided tools to interpret and integrate transgenerational [12] dynamics, ties with parental figures, alliances, and prematurely imposed roles. At the same time, transactional analysis shed light on the child's inner postures: the hypervigilant inner parent, the vulnerable child striving to survive, and the emergent adult struggling to find a voice [11].

Our task was to accompany her in differentiating reality from symbolic construction, helping her to grant each emotion, thought, or fantasy its own space, function, and dignity, without confusion or overlap. Thus, the therapeutic goal was not a fixed destination but a movement—a process of reclaiming herself, recognizing the other as both distinct and possible, and opening toward a world where being a child was no longer dangerous but instead a discovery.

This was particularly embodied in mother-child play and in the care of baby dolls, where the patient revealed her confusion between caring for and being cared for. We welcomed these enactments as gestures of exi-

stence, offering symbolic containers where they could be transformed. Supporting this process were body-based techniques such as diaphragmatic breathing, grounding, and micro-movements, which facilitated regulation, while metaphorical narration [22] opened spaces of meaning where fantasy and reality could recognize themselves as sisters, not as inseparable twins.

Matilde, once the "mother of her mother," gradually rediscovered the taste of play for its own sake. Her posture became more open, her breathing rounder; her boundaries, once fragile, acquired an elastic consistency—neither walls nor endless fields, but spaces into which the child could move in and out without fragmenting or becoming lost.

CLINICAL CASE PRESENTATION

The therapeutic process unfolded in clinically significant phases, each centered on the transformations that emerged over time and within the therapeutic relationship.

Initial Phase: Resistance and Field Construction

In our experience, co-therapy represented a multi-voiced therapeutic space, capable of mirroring and holding the multiple polarities of the child's internal world. The dynamic alternation of our roles allowed us to offer Matilde complementary yet coherent relational models: the female therapist, embodied a position more attuned to the child state, privileging play, emotional intimacy, and regression; the male therapist, provided a more structured and parental reference, emphasizing boundaries, safety, containment, and relational regularity [23]. This multifaceted articulation can be understood, in systemic-relational terms, as the effect of a double transferential matrix [12], where the relational field expands to hold both projective tensions and conflicting affective fantasies, offering a richer internal evolutionary stage.

In this ongoing oscillation between two therapeutic presences—one softer, childlike, embodied; the other steadier, defined, and reassuring—Matilde found an intersubjective space broad enough to sustain her processes of symbolization and growth. In the dual-therapist setting, the child's inner world unfolded across multiple levels: body, voice, affect, distance and closeness, truth and play, nostalgia and desire. Co-therapy thus functioned as a dialogical container, a therapeutic dyad supporting the construction of a regulatory relational environment [24].

From the earliest sessions, Matilde's relational ambivalence became clear. One part was hesitant, cautious, almost restrained, as though genuine connection carried the risk of loss or disintegration, a dangerous rupture. At the same time, there was a pulsating desire for connection, a powerful need to be seen, heard, and recognized. This overwhelming desire manifested in her insistent requests ("Can I come tomorrow too?" "Can we meet twice a week?"), signaling both the emergence of an affective alliance and a central therapeutic knot: her difficulty in tolerating separation, distance, and the passage of time, and the burden of hearing "no [15]."

Central Phase: Regressive Play, Role Redefinition, and Symbolization

A recurring symbolic theme in Matilde's therapeutic play was caregiving: she meticulously cared for a doll, often playing the maternal role and explicitly stating that, unlike her real mother, she was an adequate caregiver. This enactment was clearly an affective staging, in which Matilde inverted parental roles and enacted a relational system where it was she—not the adult—who contained, nurtured, and protected. Such dynamics suggest a precocious adultification, an early emotional burden often observed in family contexts where the child assumes responsibility for parental needs [25].

In parallel, she displayed surprisingly advanced knowledge of anatomy, female sexuality, and pregnancy—elements suggesting early and possibly inappropriate exposure to adult content, linked to fragile familial boundaries. Within this context, therapy provided an opportunity to regress toward developmental stages that had been skipped or lived in fragmented ways. Regression, expressed through gestures, voice, posture, and play, revealed its therapeutic and reparative potential, allowing Matilde to reclaim the legitimate need to be a child, free of roles she never had to bear [16].

The body served as the compass and central axis of the work. In early sessions, Matilde appeared disconnected from her body,

often suspended in an imaginative or narrative plane, as if living "outside herself." Over time, through motor play, sensory experiences, and our embodied presence, she began to feel, name, and recognize her sensations. The body thus became a vehicle of communication, a locus of identity and memory, and a ground of reality. In Gestalt terms, the Id function re-emerged, bringing forth authentic and vital needs that could finally be acknowledged and validated [5].

Advanced Phase: Distinguishing Reality from Fantasy, Truth from Imagination

The interplay between fantasy and reality was another central and deeply felt theme. Matilde often recounted invented stories involving non-existent siblings or events that had never occurred. The boundary between real and imaginary was blurred and confusing. Our therapeutic stance involved continuous validation of her inner world—not by denying or forcing, but by gently accompanying her toward a more stable reality-testing capacity. A pivotal moment came when, as her mother mistakenly attributed a drawing to her, Matilde firmly corrected her: "Lies are not okay. You did this, not me." This marked an ethical and relational turning point, a sign of integration and access to truth. [10].

Another key moment emerged around her mother's tears. Initially, Matilde repeated the adult's rationalizations ("I'm not crying, it's just allergies... it's makeup"), but gradually she learned to recognize the underlying emotion, eventually saying: "No, mom, you're crying because you are sad." This represented a developmental milestone in her affective maturation, reflecting growth in theory of mind and empathic understanding [26].

Among the narratives that permeated therapy, one in particular persisted with striking vitality: the story of Emily, an imaginary 8-month-old sister. Matilde described Emily with remarkable detail—feeding, changing, and soothing her—sometimes even reenacting sleepless nights with a toy stroller. This enactment was not mere play but embodied drama, expressing the heavy emotional burden Matilde felt responsible for regulating. Our role was not to expose Emily's unreality but to explore the deep meaning behind her presence. Gradually, Matilde acknowledged that Emily did not exist in the external world but persisted as a symbol of her need for reciprocity and emotional resonance [8]. From a theoretical standpoint, this process marked a significant step in reflective functioning and theory of mind development. From a Gestalt perspective, the imaginary sister emerged as a dominant affective figure within an impoverished relational field, which could only be reintegrated once safety and awareness were established.

Through the therapeutic bond with Luca, Matilde also re-explored her relationship with her father, initially perceived as absent or peripheral. Encountering a male figure who was affectionate, present, and consistent allowed her to rehabilitate the paternal role in her internal world, supporting her differentiation from maternal fusion and clarifying family dynamics [27].

The most delicate terrain emerged with the disclosure of a presumed sexual trauma, narrated in fragmented form and attributed to a family adult. Our task was not investigative but witnessing: to hold the narrative's affective and relational meaning, protecting her while naming and bearing the ambivalence. Treated like a dream laden with emotional truth, the disclosure was received without haste, denial, or the need for absolute definition. Over time, Matilde revisited and reworked the narrative, eventually reframing it as not factually real but emotionally true—an expression of boundary fragility, inner confusion, and an urgent search for meaning. This process represented not denial but transformation: distinguishing lived experience from fear, imagination, or symbolic response to relational and bodily disorganization [28].

In summary, the therapeutic process enabled Matilde to feel real—real in her body, real in her needs, real in her relationships. Co-therapy supported this journey, functioning as a double container, mirror, and anchor. The child reclaimed her childhood, relinquished adultified roles, explored complex emotions, told lies, and then chose truth, cried, and then laughed. In that shared time, her story began to be rewritten.

DISCUSSION

The therapeutic journey with Matilde was a sensitive reconstruction of the boundary between existing and feeling oneself to exist, between being seen and regaining a gaze capable of looking back at oneself. The process was not about correcting behaviors, nor merely providing emotional containment,

but about co-inhabiting an embodied transitional space, where the therapeutic relationship became flesh, rhythm, shared breath. Change occurred through experience, not through explanation. In phenomenological and embodied terms, this can be understood as an embodied insight, emerging through a relationship that supported affective co-regulation and the capacity to name experience starting from felt sense, before verbal elaboration.

Although nonlinear, the therapeutic process revealed several recognizable transformative stages. In the first two months, regression and ambivalence predominated. During the central phase (months three and four), symbolic and bodily work intensified. In the final stage, signs of integration emerged: recognition of emotions, differentiation between self and other, and an expansion of reflective functioning [5].

Matilde learned about the world through our way of being with her—through our present, nonjudgmental, permeable bodies. In this sense, the therapeutic relationship constituted an intersubjective field of presence, in which every gesture, gaze, and pause carried transformative value. Over time, we cultivated a quality of presence made of slowness and deep listening, where the body became the first therapeutic site, the first diagnostic tool, and the first pathway of care. Here, co-therapy represented a fundamental relational structure, not only for the quality of the dual relationship but also for the possibility of restoring to Matilde a differentiated and integrated relational matrix. The alternation of therapeutic roles facilitated the progressive construction of internal parental functions capable of containing and differentiating. The female therapist initially embodied a free, empathic, and playful space, strongly attuned to the child-self, while the male therapist gradually represented limit, regulation, and a firm parental stance, offering a solid and reliable base. This dual presence supported both internal and external triangulation. Within this context, Matilde could experience desire, jealousy, competition, and differentiation in a protected, real yet symbolic setting, capable of sustaining critical affective transitions in her development. In the interplay between our roles, she was able to reorganize her representation of the adult world, previously partial, collusive, and fused.

Symbolic play, in particular, emerged as one of the most powerful therapeutic contexts. Initially, her identification with the mother dominated; later, it gradually yielded, allowing her to be cared for. Through this, she could experience a reparative developmental regression, playing at being small, vulnerable, imperfect. In those scenes, it was her body that spoke most freely—when she allowed herself to be held, when she sought physical contact with one of the therapists, when she brought a toy to share. Transformation occurred there.

Work with the body was central—sometimes explicit, always present. Every movement, hesitation, and posture carried a story. Bodily awareness was supported through small gestures, such as sitting in a circle, creating protected spaces, using objects, and recognizing somatic tensions. We fostered the construction of an embodied self-awareness [8], restoring meaning to pre-verbal experiences that are too often denied or invisible. This shift allowed a movement from perceiving the self as function ("I am good because I serve") to perceiving the self as existence ("I am loved because I exist").

Another significant transformation concerned the relationship with truth. Matilde initially oscillated between fantastical narratives and organized lies, in an implicit attempt to protect her mother and herself from collapse. Yet through bodily awareness and the reliability of the therapeutic relationship, she gradually distinguished reality from fantasy, attributed mental states to self and other, and learned to tolerate the pain of truth not as fracture but as a pathway of growth. This marks a significant advance in the development of her reflective functioning [8, 24].

A decisive restructuring also occurred regarding the father, initially absent from her narrative and emotional experience. The encounter with the male therapist offered her a safe context in which to project, compare, and eventually differentiate. Within this space and attuned timeframe, the father—once absent or idealized—became real, fallible, possible. He took form as a significant figure, breaking the symbiotic duality with the mother and enabling the developmental Oedipal triangulation, supporting the construction of a separate yet connected sense of self.

From the early stages of therapy, as previously noted, Matilde exhibited a surprisingly advanced sexual knowledge: she used anatomical terms for female physiology, spoke in detail about conception and childbirth,

and engaged in age-inappropriate representations. Strikingly, these narratives were accompanied by somatic activation—a body already inhabited by an adult gaze, though devoid of actual sexual experience, as if narrated before being lived. In this context, precocious eroticization did not appear as seduction, but as the sign of a symbolic intrusion, where the child's body was narrated, exposed, and explained in an environment lacking emotional filters and appropriate contexts [29].

The therapeutic field sought to offer another possibility: a space where the body could return to play, movement, rhythm—not as an object of premature knowledge, but as a sensitive dwelling of lived experiences. Within this framework, the narration of alleged abuse could be held, listened to, and eventually returned to the child as an internal fragment, an affective metaphor, not as guilt or fact to be proven. "No, it never happened," said the child.

Here, the phenomenological and Gestalt approaches revealed their full clinical potential: not by interrogating facts but by attending to lived experience; not by investigating external reality but by supporting the construction of internal reality in its evolution and complexity [7].

Transformative processes emerging in therapy included:

- Transition from a precociously adultified self to a spontaneous child self;
- Development of bodily awareness as a foundation for selfhood;
- Construction of relational boundaries through co-therapy;
- Affective elaboration of the wish to care for others and identification with the mother;
- Recognition of the father as a separate and meaningful presence;
- Differentiation between fantasy and reality, supported by an embodied, reliable therapeutic relationship, consistent with reflective functioning and the cognitive-emotional decentering that characterizes the developmental emergence of an integrated theory of mind;
- Generalization of therapeutic learning into daily and family life.

It is important to emphasize that, while a single case cannot support generalizations nor capture the complexity of clinical work in a replicable way, it nonetheless offers a significant trace of the lived process. Though limited in empirical validation, this approach has a generative and transformative value residing in its capacity to illuminate lived experience, rendering it narratable and transformable within the therapeutic relationship.

CONCLUSIONS

Every encounter with a child is a threshold, a subtle passage where what has been, what is, and what may become overlap, blur, and reshape. In Matilde's therapy, that threshold became a world: a world where it was possible to play, regress, imagine, repair—but above all, to be. We traversed complex territories, barefoot in the phenomenological clinic, which never rushed to explain, but held, named, and accompanied.

Matilde showed us what happens when childhood is accelerated, when the world's gaze is overloaded with demands yet deprived of nourishment. She also showed us what happens when that gaze changes—when the other does not judge but receives, when the body becomes home again, when emotions need not be disguised or denied, but can finally be spoken.

Through symbolic and embodied play, new forms of contact were born. We witnessed the restoration of the child-self—not only as openness to spontaneity, but also as the reactivation of the Id function and the reintegration of internal polarities within a Gestalt framework. At the same time, we observed the unfolding of a process where reality and fantasy ceased to be enemies and began to dialogue. We explored the internal parts of Matilde—the internalized mother, the distant father, the lonely child, and the one struggling to exist—offering them a stage, a frame, a voice. This enabled a movement from an adapted self to an authentic self, capable of sustaining emotional life even when fragile, fractured, or imperfect.

Co-therapy proved to be the cornerstone of this work: two therapists, two presences, two ways of being with—one closer to the child state, one more rooted in the adult/parental self. Two positions that contained, amplified, protected, and symbolized. This co-presence allowed Matilde to explore, deconstruct, and reconstruct her internal representations within a relational field that enabled her to safely experiment with human multiplicity.

The body, the voice, the gesture, the gaze: each embodied aspect became language, and over time, that language became meaning,

and meaning, progressively, became story. A story we did not write in her place, but one that, together with her, we learned to listen to.

This case study, in its uniqueness, demonstrates how therapeutic work conducted with a holistic, embodied, and dialogical perspective can support deep growth processes even in children prematurely exposed to dysfunctional relational configurations. Although limited in its empirical generalizability, this approach illustrates the transformative power of therapeutic presence as a regulatory experience, confirming its effectiveness in developmental contexts of vulnerability. It fosters differentiation of self, recognition of the other, and the construction of healthy emotional and cognitive boundaries—opening pathways of care that transcend diagnosis and are rooted in encounter.

Informed Consent

All names and identifying details of the patient have been modified to preserve anonymity. Clinical material was shared with informed parental consent, in full accordance with ethical and professional standards.

Conflict of Interest

The authors have no conflict of interest to declare.

Authors' Contributions

Rossella D'Aquino conceived the clinical work, conducted the therapeutic process, and drafted the manuscript.
Luigi Lorenzo Luca Napolitano contributed to the theoretical framework, participated in the co-therapy process, and revised the manuscript.
Both authors read and approved the final version of the manuscript.

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phenomena journal

Mini review

Green prescriptions: an innovative approach to human health from a planetary health perspective

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ABSTRACT

Green prescriptions represent an innovative therapeutic approach that integrates contact with nature into care pathways, addressing the growing disconnection from natural environments in contemporary societies. This mini-review presents a mapping of green prescriptions within the One Health and Planetary Health paradigms, exploring their therapeutic potential in managing chronic diseases and promoting psychophysical well-being. The mini-review analyzes international scientific evidence on the benefits of green prescriptions, with particular focus on Italian experience and programs implemented across European, American, and Oceanic countries. Pilot projects, research initiatives, and clinical protocols are examined to evaluate the effectiveness, appropriateness, and sustainability of green prescriptions. International meta-analyses support the effectiveness of green prescriptions in managing chronic pathologies characterized by systemic chronic inflammation, including diabetes, obesity, hypertension, and mental disorders. Documented benefits include improvements in cardiometabolic health, stress reduction, decreased anxiety and depression, increased physical activity, and enhanced social well-being. The Italian experience, led by projects from the University of Valle d'Aosta and the TeFFIt Network, a multidisciplinary network focused on green prescriptions, demonstrates the feasibility of integrating green prescriptions into the National Health System. Green prescriptions represent a paradigmatic shift toward a holistic approach to health that recognizes the interconnection between human and environmental well-being. Their implementation requires specialized training for healthcare providers, standardization of practices, and interdisciplinary collaboration. The potential of green prescriptions extends beyond individual therapy, positioning them as a tool for promoting planetary health and healthcare system sustainability.

Keywords
Green prescriptions, One health, Planetary health, Integrative medicine, Therapeutic nature, Public health.

Citation: Orlando, S., Danon, M., Marino, F., Bucciarelli , F., Di Leva, A., Morelli, F., & Perrone, M. Green prescriptions: an innovative approach to human health from a planetary health perspective. *Phenomena Journal - International Journal of Psychopathology, Neuroscience and Psychotherapy, 8*(1), 10–17.

Editor in Chief: Raffaele Sperandeo, PhD, MD

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Received: September 29, 2025

Accepted: February 18, 2026

Published: March 20, 2026

ABSTRACT in ITALIANO

Le *green prescriptions* rappresentano un approccio terapeutico innovativo che integra il contatto con la natura nei percorsi di cura, rispondendo alla crescente disconnessione dagli ambienti naturali nelle società contemporanee. Questa mini-review propone una mappatura delle *green prescriptions* all'interno dei paradigmi One Health e Planetary Health, esplorandone il potenziale terapeutico nella gestione delle patologie croniche e nella promozione del benessere psicofisico. Questa mini-review analizza le evidenze scientifiche internazionali sui benefici delle *green prescriptions*, con particolare attenzione all'esperienza italiana e ai programmi implementati in Paesi europei, americani e oceanici. Vengono esaminati progetti pilota, iniziative di ricerca e protocolli clinici per valutarne efficacia, appropriatezza e sostenibilità. Le meta-analisi internazionali supportano l'efficacia delle *green prescriptions* nella gestione di patologie croniche caratterizzate da infiammazione sistemica cronica, tra cui diabete, obesità, ipertensione e disturbi mentali. Tra i benefici documentati si evidenziano miglioramenti della salute cardiometabolica, riduzione dello stress, diminuzione dell'ansia e della depressione, incremento dell'attività fisica e miglioramento del benessere sociale. L'esperienza italiana, guidata da progetti dell'Università della Valle d'Aosta e dalla rete TeFFIt, una rete multidisciplinare dedicata alle *green prescriptions*, dimostra la fattibilità dell'integrazione di tali interventi nel Servizio Sanitario Nazionale. Le *green prescriptions* rappresentano un cambiamento paradigmatico verso un approccio olistico alla salute che riconosce l'interconnessione tra benessere umano e ambientale. La loro implementazione richiede una formazione specialistica per i professionisti sanitari, la standardizzazione delle pratiche e la collaborazione interdisciplinare. Il potenziale delle *green prescriptions* va oltre la terapia individuale, configurandosi come uno strumento per promuovere la salute planetaria e la sostenibilità dei sistemi sanitari.

Parole chiave

Psicoterapia infantile, Approccio fenomenologico, Terapia della Gestalt, Co-terapia, Embodiment.

INTRODUCTION

In today's scientific landscape, the relationship between human health and natural ecosystems is receiving increasing attention, supported by innovative therapeutic tools such as "green prescriptions" that are integrated into modern approaches according to the One Health and Planetary Health paradigms [1, 2], and the growing awareness of the importance for psychophysical well-being of recovering the connection with natural environments from which contemporary society has progressively distanced itself in recent years [3-5]. Thanks to health professionals' ability to "prescribe" experiences in nature as part of a broader therapeutic path, we are witnessing a paradigm shift in the approach to treatment [6]. This research contribution aims to provide an initial mapping of green prescriptions, with a particular focus on the concept of nearby nature, understood as nature easily accessible and integrated into daily life, representing both an opportunity to improve individual health and a step toward a more integrated approach to global health [5], framed within a holistic perspective that encompasses physical, psychological, social, and spiritual dimensions, without forgetting its theoretical foundations. Indeed, the study of green prescriptions is grounded in the innate human connection with the natural world—what E.O. Wilson defined in 1984 as biophilia [4]—which continues to play a vital role in the psychophysical balance of human beings, even in highly urbanized societies [5]. Green prescriptions thus emerge not only as a novel therapeutic approach but also as a potential bridge toward a conception of health that fully acknowledges the bond between human beings and the ecological context in which they live [7].

METHODOLOGY

This contribution is a narrative mini-review of the scientific and grey literature on green prescriptions. Literature searches were conducted in PubMed, Scopus, and Google Scholar, using search terms including "green prescriptions," "nature prescriptions," "nature-based interventions," "social prescribing," "forest therapy," "One Health," and "Planetary Health," in both English and Italian, without date restrictions. Eligible sources included peer-reviewed original articles, systematic reviews, and meta-analyses. Additionally, non-peer-reviewed materials—such as institutional reports, national program documentation, conference proceedings, and project websites—were included when peer-reviewed evidence was limited or unavailable, given the emerging nature of this field and the substantial heterogeneity of green prescription implementation across

national contexts. Peer-reviewed sources were prioritized throughout the review; non-peer-reviewed materials were used to document ongoing programs, pilot projects, and policy developments not yet represented in the indexed scientific literature. The absence of a systematic protocol and the inclusion of grey literature constitute acknowledged limitations of the present review, discussed further in the Limitations.

GREEN PRESCRIPTIONS

Green Prescriptions, also known as ecological or natural prescriptions, represent an innovative approach to health that seeks to enhance an individual's psycho-physical well-being through contact with nature. Green Prescriptions are designed to address health and care needs, particularly those related to chronic diseases (e.g., diabetes, obesity, hypertension, depression, asthma, autoimmune disorders), which often stem from low-grade systemic chronic inflammation caused by environmental factors and lifestyle [8]. This lifestyle is frequently characterized by physical inactivity, poor diet, excessive hygiene, reduced contact with animals and natural soils, exposure to environmental and industrial toxins, nighttime exposure to blue light, and psychological stress [8, 9]. The physical benefits investigated to date in international studies on green prescriptions include cardiometabolic health, physical activity, and inflammation. The number of studies is insufficient to highlight benefits for orthopedic conditions, chronic pain, or burnout [10, 11]. Accessible local green spaces are associated with improved mental health, encourage active behaviors and social interaction, increase self-esteem, and reduce mental distress such as stress, depression, anxiety, and feelings of loneliness [10, 12]. The most recent international meta-analyses [11, 13] support the idea that incorporating nature-based social prescribing interventions into mental health care plans can be a fundamental and effective complement to traditional therapies. Italian research aligns with the international landscape, critically examining how green prescriptions may prove effective, appropriate, feasible, accessible, and sustainable in its context, both from the perspective of community well-being (people, animals, ecosystems) and in terms of diagnostic and treatment plans. The medical doctor plays an important role in becoming sensitive to and implementing green prescriptions, thereby effectively addressing patients' holistic needs while also contributing to the sustainability of National Health Service resources and products [9, 12]. The intriguing aspect of green prescriptions lies in their holistic nature, which makes them complementary to traditional therapeutic pathways. They do not aim to replace medical care, but to integrate it with a preventive and health-promoting approach. Ultimately, green prescriptions represent a paradigm shift in the understanding of health, highlighting the therapeutic power of nature and promoting a healthier, more sustainable lifestyle. In Italy, this practice is gaining increasing popularity, supported by various initiatives and pilot projects. Several research and practice groups are working to foster collaboration between medical doctors and green care practitioners for prescribing outdoor activities in natural settings. At the international level, green prescriptions are finding fertile ground in many countries as well.

GREEN PRESCRIPTIONS IN ITALY

In Italy, Green Prescriptions (GPs) are garnering increasing scholarly and clinical interest as an innovative framework for health promotion through nature-based contact [14, 15]. Numerous initiatives, professional networks, and research groups are contributing to the dissemination and implementation of this approach within the national healthcare landscape. A seminal development in this field is the project *"Green Prescriptions in a One Health/Planetary Health Perspective"*, a collaborative effort between GREEN LEAF (the Laboratory of Affective Ecology at the University of Valle d'Aosta) and the experimental observation center "Il Bosco di Puck" [14]. This initiative has fostered a community of practice involving healthcare professionals, researchers, and citizens, aimed at investigating and applying GPs through an integrated lens that encompasses human, animal, and environmental health. In October 2023, the Green Leaf Center, in partnership with ISDE (International Society of Doctors for the Environment) and the Medical Association of Valle d'Aosta, convened the symposium *"Approccio al concetto di salute planetaria e il potenziale delle Foreste Valdostane"* [16].

Concurrently, the TeFFIt Network (*Terapie Forestali in Foreste Italiane* – Forest Therapies in Italian Forests) has developed standardized protocols for nature-based interventions, including forest immersion, animal-assisted forest therapies, and physical activities in natural settings. TeFFIt has further contributed to the field by drafting clinical guidelines for medical prescriptions and by integrating nature-based interventions into community services, such as day centers, schools, and residential facilities. Notably, as early as 2022, TeFFIt launched a Continuing Medical Education (CME) course on forest immersion, accredited by the Medical Association of Arezzo [15, 16]. A further milestone in the standardization of Italian GPs is represented by the *Protocollo condiviso per le Prescrizioni Verdi* (Shared Protocol for Green Prescriptions), published on the prescrizioniverdi.it website in January 2026, which provides operational guidelines for healthcare professionals on how to prescribe, monitor, and evaluate nature-based interventions within clinical pathways [17, 18].

The modalities for prescribing GPs in Italy are heterogeneous and highly adaptable to patient-specific needs. Healthcare providers may prescribe structured or self-regulated interventions, delivered individually or in groups, with or without professional guidance, taking into account clinical conditions, patient preferences, and specific environmental characteristics. Crucially, prescriptions should incorporate activities designed to enhance nature connectedness—such as appreciation, stewardship, and ecological restoration—as the scientific literature underscores a robust correlation between the degree of nature connection and physical [19] and psychological [20] health outcomes. Research conducted in northeastern Italy further confirms that the naturalness of landscape structure positively influences children's connectedness to nature, suggesting that the qualitative characteristics of natural environments are a relevant variable in GP design [21]. A longitudinal study on green prescriptions in Italy has also demonstrated that ecosystem structure can significantly affect health outcomes, reinforcing the need for careful environmental selection in GP protocols [22, 23].

In the domain of sustainable architecture, the *Fabbrica dell'Aria* represents a pioneering project developed by PNAT—an academic spin-off of the University of Florence comprising plant scientists and architects, co-founded by neurobiologist Stefano Mancuso—that applies principles of plant neurobiology to devise design solutions to enhance indoor air quality. This approach leverages plant intelligence and biophilic design, aligning with the One Health vision to redefine the relationship between nature and the built environment, thereby promoting healthier, more symbiotic urban spaces [24]. Furthermore, the *"Spighe Verdi"* (Green Ears) program, promoted by FEE Italy (Foundation for Environmental Education), recognizes rural municipalities that implement sustainable development practices, incentivizing local administrations to integrate nature-based health promotion into territorial policies and fostering environments conducive to citizen well-being [25].

Despite burgeoning interest, the systematic adoption of GPs in Italy faces several challenges, including the need for specialized training for healthcare professionals, the standardization of clinical practices, and rigorous evaluation of intervention efficacy. Nevertheless, current Italian initiatives demonstrate a substantial commitment toward integrating nature-based solutions into the national healthcare system, promoting a holistic health paradigm that acknowledges the fundamental interdependence between humanity and the natural world.

GREEN PRESCRIPTIONS AROUND THE WORLD

In Scotland, the initiative "Medical Prescriptions for Nature" has been pioneering in the Shetland Islands since 2018, promoted by general practitioners in collaboration with the National Health Service (NHS) and the Royal Society for the Protection of Birds. Physicians prescribe activities such as walks, gardening, and outdoor group activities as an integral part of therapeutic plans for patients with anxiety, depression, and stress-related urban disorders [26]. Documented benefits include reduced stress, improved mood, stronger connection with nature, and greater social cohesion, along with a lower reliance on medication. The success of the initiative led to the program's expansion to Edinburgh in 2020 and to the Orkney Islands in 2024 [26, 27]. Program reports from Scotland showed that 74% of patients reported benefits from their prescriptions, and 91% of healthcare professionals stated they would continue prescribing natural remedies [28, 29].

Finland launched in 2021 the "Nature Step to Health" program as part of the Lahti Regional Health and Environment Programme 2022-2032, the result of collaboration between the Päijät-Häme Wellbeing Services, the city of Lahti (European Green Capital 2021), and the Lahti University Campus [30]. The program also involves the University of Helsinki, the Finnish Institute for Health and Welfare, the Finnish Environment Institute, the Natural Resources Institute Finland, and WWF Finland [30, 31]. The initiative pursues five macro-objectives: prevention of non-communicable diseases, improvement of biodiversity, climate change mitigation and adaptation, interdisciplinary collaboration, and cost-effectiveness [30]. These objectives are pursued through four transversal activities: healthy and sustainable diets; physical activity and active mobility; healthy living in a sustainable environment; and connection with natural settings [30, 31]. The program focuses on preventing obesity and chronic diseases through increased physical activity, balanced diets, and stronger contact with nature [30]. In 2022, the "Planetary Prescription" campaign monitored the well-being of five participants by providing personalized green prescriptions, including barefoot walks in forests, plant-based diets, and gardening. The campaign reached over three million people in Finland and millions worldwide [30, 31].

In Switzerland, the Pro Senectute Therapeutic Day Center in Balerna developed the "Sensory Garden," a therapeutic space specifically designed for elderly people with cognitive impairments such as Alzheimer's and mobility difficulties [32]. The garden integrates accessible pathways, safe ramps, rest areas, aromatic gardens, and targeted therapeutic elements. This approach fosters sensory stimulation, promotes autonomy and safety, improves emotional well-being, and enables specific therapeutic activities that reduce anxiety and aggression, facilitating integration with the natural environment.

In the United States, the non-profit Park Rx America promotes park visits as prescriptions to counter chronic diseases and improve quality of life [33]. The Children & Nature Network, founded by Richard Louv, is dedicated to connecting children with nature for both physical and mental benefits, offering resources, research, and programs to encourage families and communities to spend more time outdoors [33]. The program "Walk with a Doc" combines health and movement through free walks led by local medical doctors, with numerous active chapters across Ohio [34, 35].

Australia has developed the global concept of "Healthy Parks, Healthy People" (HPHP) through Parks Victoria, later adopted in Europe by the Europarc Federation [36-38]. This approach emphasizes that parks are essential to human health and well-being [15, 39]. Australia has created specific programs such as BrainLink for people with brain disorders, AMAZE for individuals with autism, and the Werribee Park Program for refugees and migrants [38-41]. Many European countries have adopted the HPHP approach as part of public health strategies [38]. In Italy, the project *"Natura è Benessere"* (NèB), supported by CURSA (University Consortium for Socio-Economic and Environmental Research), is based on HPHP principles and aims to spread awareness of nature's importance for children's health [42]. Similar experiences have been developed in Asia, Africa, and the United States [15, 36].

In Belgium, Dr. Ann Sterckx, ecopsychologist and Belgian representative of the International Ecopsychology Society, and director of the Earth Wise Education School of Ecopsychology, conducted her doctoral research on integrated nature-based interventions aimed at restoring biodiversity and beauty around healthcare facilities, so that patients could then be brought into these rehabilitated natural settings [43]. Her research was born from the realization that, in Belgium and beyond, incorporating nature into activities related to health and well-being gained popularity, particularly after COVID-19, when many psychologists and coaches started holding sessions outdoors, and some physicians began prescribing walks to their patients [15, 43]. Yet many of these professionals were not specifically trained to guide individuals in nature, nor did they have in-depth knowledge of selecting the most suitable environments for patients, the expected benefits, or the potential risks. In most cases, nature was simply "used" as a healthy backdrop, without fostering a deeper connection with the natural world [43]. To facilitate the implementation of such interventions, Dr. Sterckx interviewed a diverse sample of 16 healthcare professionals—8 general practitioners and 8 psychologists—about their self-care practices, their relationship with nature, and how they integrate these elements into their professional roles. The combined interview and questionnaire

approach deepened participants' awareness of nature's importance and could serve as a potential tool for increasing their "awareness of nature-connected care" [15, 43].

In Chile, Claudio Antonio Pereira Salazar – PhD in Communication, Social Change and Development, Chilean representative of the International Ecopsychology Society, and Director of the Ecopsychology Institute *Koru Transformación* – has described the developments in his country regarding green prescriptions and the involvement of the Chilean School of Ecopsychology in the project [44]. The National Program "Nature for Your Health" is a government initiative aimed at promoting emotional well-being and mental health through reconnection with the natural environment [12, 44]. Recently launched by the Ministries of Agriculture, Environment, and Health, the program focuses on sensory and experiential reconnection with nature in protected areas, urban and rural green spaces, health centers, educational institutions, and community spaces. It is addressed to the entire population, with particular attention to those seeking to improve their health, and it also aims to generate actions to care for ecosystems [2, 44]. The program draws inspiration from the experience of the National Forestry Corporation (CONAF) in implementing universal accessibility to nature and in creating forest bathing areas within the protected wilderness areas it manages [44]. Four interdisciplinary work areas are envisioned: democratizing access to nature with emphasis on vulnerable segments of the population; promoting forest bathing and land-connection practices inspired by Amerindian indigenous cultures; educating children and adolescents in full contact with nature to address Nature Deficit Disorder; and collaborating with public and private sectors to develop more sustainable urban centers. This project is supported by a cooperation agreement between *Koru Transformación*, CONAF, and the Corporation *Schools for Ecosocial Regeneration*, and will include training programs for facilitators of nature-based well-being experiences [2, 44].

Limitations

Several limitations of the present mini-review should be acknowledged. First, this work adopts a narrative rather than a systematic methodology, which introduces potential selection bias in the literature considered. Second, the inclusion of non-peer-reviewed materials—while necessary given the emerging and heterogeneous nature of green prescription programs internationally—limits the overall level of evidence. Third, the constructs central to the field, such as nature connectedness and biophilia, remain difficult to measure consistently, and the limited number of controlled trials makes it challenging to assess outcomes across different populations and settings. Fourth, the review does not include a formal quality assessment of included studies. Future research should prioritize randomized controlled trials, longitudinal designs, and cross-national comparative studies to strengthen the evidence base for green prescriptions as a public health intervention.

CONCLUSIONS

Green Prescriptions emerge as an innovative tool for therapeutic integration, connecting individual health, social bonds, and environmental sustainability. International literature and early Italian evidence confirm the potential of GPs to address chronic diseases and support mental health. Today, we can rethink healthcare models in a preventive and relational light. There is still a need to systematize practices, train professionals, and define shared guidelines to consolidate their effectiveness and safety—a direction now being actively pursued in Italy with the publication of the first shared national protocol for green prescriptions [18]. GPs do not replace traditional clinical pathways but enrich them with an ecological and experiential perspective, restoring nature to its role as co-therapist. In this sense, they represent a paradigm shift that, within the Planetary Health framework, redefines care as an interconnected process among individuals, communities, and ecosystems.

Conflict of interest

The authors have no conflict of interest to declare.

Authors' Contribution

Stefano Orlando: Conceptualization, Visualization, and Writing – original draft. Marcella Danon: Formal analysis and Subject Matter Expertise. Francesco Marino: Translation and Technical editing. Filippo Bucciarelli: Literature Search and Data Curation. Anna Di Leva: Critical Revision and Synthesis. Francesca Morelli: Validation and Table/Figure Preparation. Maura Perrone: Writing – review & editing.

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phenomena journal

Hypotheses and study methods

Studying through movement: motor activities to improve performance in children with ADHD – A psychoeducational protocol

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ABSTRACT

In the psychoeducational field, identifying effective strategies to support the learning and development of children with Attention-Deficit/Hyperactivity Disorder is a key priority. An emerging approach involves integrating structured motor activities into the educational routine. This article examines the effectiveness of such activities as pedagogical tools for improving academic performance in children with Attention-Deficit/Hyperactivity Disorder, using a clearly defined intervention protocol. The study explores how different forms of physical activity can be strategically incorporated into educational contexts to facilitate homework completion and reduce anxiety and frustration associated with these tasks. In addition, it investigates how exercise may enhance cognitive functioning and foster a more inclusive and supportive learning environment. Various types of motor activities and their impact on academic performance and behavior are analyzed. The implementation of this psychoeducational protocol may provide new perspectives for educators, parents, and special education professionals, promoting a more dynamic, individualized, and integrated approach to learning.

Keywords

ADHD, Hyperactivity, Neuropsychomotor intervention.

ABSTRACT in ITALIANO

Nel campo psicopedagogico, l'individuazione di strategie efficaci per sostenere l'apprendimento e lo sviluppo dei bambini con Disturbo da Deficit di Attenzione/Iperattività rappresenta una priorità fondamentale. Un approccio emergente prevede l'integrazione di attività motorie strutturate nella routine educativa. Il presente articolo esamina l'efficacia di tali attività come strumenti pedagogici per migliorare il rendimento scolastico nei bambini con Disturbo da Deficit di Attenzione/Iperattività, attraverso l'utilizzo di un protocollo di intervento chiaramente definito.

Citation: Perrone, L. V., Gambino, A., Imperiale, G., & Vangelista, G. Studying through movement: motor activities to improve performance in children with ADHD – A psychoeducational protocol. Phenomena Journal - *International Journal of Psychopathology, Neuroscience and Psychotherapy, 8*(1), 18–26.

Editor in Chief: Raffaele Sperandeo, PhD, MD

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Received: October 20, 2025

Accepted: March 3, 2026

Published: March 20, 2026

Lo studio esplora come diverse forme di attività fisica possano essere integrate strategicamente nei contesti educativi al fine di facilitare lo svolgimento dei compiti a casa e ridurre l'ansia e la frustrazione associate a tali attività. Inoltre, analizza come l'esercizio fisico possa potenziare il funzionamento cognitivo e favorire un ambiente di apprendimento più inclusivo e supportivo. Vengono esaminati diversi tipi di attività motorie e il loro impatto sul rendimento scolastico e sul comportamento.

L'implementazione di questo protocollo psicoeducativo può offrire nuove prospettive per insegnanti, genitori e professionisti dell'educazione speciale, promuovendo un approccio all'apprendimento più dinamico, individualizzato e integrato.

Parole chiave
ADHD, Iperattività, Intervento neuropsicomotorio.

INTRODUCTION

Attention-Deficit/Hyperactivity Disorder (ADHD) is a neurobiological disorder that affects a person's ability to focus, control impulses, and maintain organized behavior. ADHD often appears in childhood, although symptoms may persist into adolescence and adulthood. Scientific literature indicates that the disorder is more prevalent in males than in females, with a ratio of approximately 2:1 in children and 1.6:1 in adults [1].

DHD is a multifactorial neurodevelopmental disorder, involving neurological, psychological, and educational components. Addressing it requires an integrated approach that considers all these aspects. Specifically, regarding neurobiological components, ADHD is thought to involve differences in brain functioning. It is associated with an imbalance in neurotransmitters such as dopamine and norepinephrine, which are crucial for attention, self-regulation, and emotional regulation. Abnormalities have also been observed in the functioning of the prefrontal cortex, a brain region involved in self-control, planning, and decision-making. Individuals with ADHD often show reduced activation in this area, which may explain difficulties in planning and impulse control. Recent research suggests that individuals with ADHD may exhibit differences in connectivity between various brain regions, particularly those involved in attention and motor control [2].

ADHD also significantly impacts psychological components, affecting emotions, motivation, and behavior. Individuals with ADHD may experience difficulty managing their emotions, which can result in challenges with self-regulation and emotional control. This includes impulsivity and difficulties controlling emotions, such as frustration, anger, and anxiety. Such difficulties can create stress and tension in social interactions [3]. Due to the daily challenges associated with the disorder, individuals with ADHD may develop low self-esteem, particularly if they frequently feel incompetent or inadequate compared to peers or are often criticized. In addition to physical hyperactivity, many individuals with ADHD experience "mental hyperactivity," characterized by rapidly racing thoughts, difficulty sustaining attention on tasks, and constant distraction. ADHD is frequently associated with psychological comorbidities such as anxiety and depression, which may be exacerbated by difficulties in managing daily life [4].

The disorder also significantly affects school functioning, particularly with regard to learning and interactions with teachers and peers. Children with ADHD struggle to sustain attention for long periods, follow instructions, and complete tasks. These challenges can result in poor academic performance, even though intellectual potential is often normal or above average. They may experience difficulties with planning and time management, which can lead to disorganization in school activities, such as forgetting homework, failing to prepare necessary materials for lessons, or misplacing materials. Consequently, impulsivity may lead to inappropriate actions during school activities, such as responding without thinking or acting before reflecting, which can result in social or disciplinary difficulties. ADHD often requires specific educational support, including curriculum modifications or personalized teaching techniques. Students may benefit from an individualized instructional plan (IDP), which includes remedial measures and compensatory tools to support academic achievement [5].

NEUROPSYCHOMOTOR SKILLS AND NEUROPSYCHOMOTOR TREATMENT

Neuropsychomotor skills are a discipline that focuses on the study and rehabilitation of an individual's psychomotor functions, integrating neurological, psychological, and motor aspects. This field examines the relationship between mind, body, and movement, emphasizing how the nervous system regulates and influences motor behavior and cognitive abilities [6].

Creating an integrated model in which physical exercise becomes an integral part of school and homework routines may help improve body awareness and self-regulation, offering a dual benefit of physical and mental activation. Neuropsychomotor therapy is a structured intervention aimed at developing an individual's motor, cognitive, and emotional skills, particularly in children with neurological or psychomotor disorders. This type of treatment can be applied to various conditions, including ADHD, movement disorders, behavioral disorders, and other difficulties related to the integration of motor and cognitive functions. Neuropsychomotor therapy integrates multiple practices and techniques to promote proper development and functional integration between body and mind. It addresses motor skills, cognitive abilities, executive functions, and emotional functions such as emotional regulation, frustration management, self-esteem, and socialization. It also supports sensory integration, enhancing the processing of and response to sensory stimuli. Overall, it aims to foster better integration between motor and psychological components, thereby improving quality of life, communication, relationships, and learning skills [7].

The motor intervention protocol we intend to implement may provide numerous benefits for learning, as it aims to stimulate and enhance the child's cognitive, motor, and emotional abilities in an integrated manner. When the body and mind work synergistically, learning becomes more effective and fluid. Among the main benefits, we hypothesize a significant improvement in motor coordination. Good coordination is essential for learning tasks that require precise movements, such as writing, drawing, or using tools.

Neuropsychomotor activities help develop fine motor skills (small, precise movements) and gross motor skills (larger movements), promoting greater confidence in everyday tasks and academic activities. These activities also stimulate selective attention and concentration, which are critical for academic learning. They help children focus on a specific task, sustain attention for longer periods, and manage distractions. Furthermore, neuropsychomotor activities contribute to the development of executive functions, including planning, organization, working memory, and problem-solving. These skills are crucial for academic learning, as they enable children to tackle complex tasks, manage multiple steps of a process, and solve problems effectively. Among the expected outcomes, we also anticipate improved integration of sensory perception. Neuropsychomotor activities help children enhance body perception and spatial awareness, which are essential for many cognitive activities, such as reading and writing. Good sensory integration supports spatial orientation, shape and letter recognition, and the development of a sense of rhythm and sequence.

EVIDENCE FROM THE LITERATURE

The term ADHD has been used since the 1980s, although the characteristics of the disorder were previously described under various labels. The modern definition is based on diagnostic criteria established in manuals such as the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders) [8] and the ICD-10 (International Classification of Diseases) [9].

The etiology of ADHD is complex and multifactorial, involving genetic, neurological, environmental, and social factors. When discussing ADHD, it is important to consider different epistemological approaches [10]. The psychobiological approach seeks to understand ADHD through biological and neural mechanisms, emphasizing empirical evidence and providing a biological basis for the disorder. The behavioral approach focuses on observable behaviors and environmental factors that influence children with ADHD, emphasizing behavior modification techniques and cognitive-behavioral therapy. The sociocultural approach recognizes that cultural and social factors affect the perception and treatment of ADHD, as cultural norms and expectations may influence how the disorder is diagnosed and managed.

ADHD, as a neurodevelopmental disorder, may be influenced by genetic factors. Barkley [11] suggests that the disorder has a significant heritable component. Family members of children with ADHD are more likely to have the disorder, and genetic variants related to

neurotransmitters, particularly dopamine, have been associated with ADHD. Neurological factors and neuroimaging research have revealed differences in brain architecture and functioning in individuals with ADHD. Specific areas of the brain involved in regulating attention, behavior, and impulse control, such as the frontal lobe, may exhibit abnormalities. Environmental factors, including exposure to toxic substances (e.g., lead) during pregnancy or early life, psychosocial factors (e.g., adverse family conditions), and nutrition (some studies suggest a link between food additives and ADHD symptoms), may influence the development of the disorder. Prenatal factors, such as complications during pregnancy, premature birth, small birth size, and substance use during pregnancy (e.g., alcohol and nicotine), are also associated with a higher risk of developing ADHD [11].

Various methodologies are used to improve cognitive, social, and emotional skills in children with ADHD. Many children with ADHD experience difficulties processing and responding appropriately to sensory stimuli. Interventions based on sensory integration aim to improve their ability to process sensory information (visual, tactile, auditory) and respond more appropriately to the environment, thereby reducing hyperactive and disorganized behavior. Another methodology focuses on improving cognitive skills, such as working memory, planning, and attention. Cognitive enhancement interventions aim to strengthen executive functions. These include activities that support working memory, such as exercises requiring the maintenance and manipulation of information, including memory games, mental calculation exercises, or repeating number sequences. Activities that teach self-control, such as turn-taking games or "stimulus-response" exercises, require children to pause and think before acting. Games that stimulate cognitive flexibility, such as puzzles, logic games, role-playing, or activities in which the rules change during play, also promote adaptive cognitive strategies [12]. Behavioral approaches are commonly used to teach children strategies to manage impulsivity and improve attention. The ABA (Applied Behavior Analysis) methodology is based on analyzing and modifying behavior. Although primarily used for children with autism spectrum disorder (ASD), ABA may also be effective for children with ADHD. ABA focuses on behavior modification through reinforcement of desirable behaviors, which can be adapted to manage ADHD symptoms, including inattention, impulsivity, and hyperactivity. Positive reinforcement, a key tool of ABA, is particularly effective for children with ADHD, who may become easily demotivated or distracted. Immediate reinforcement after desirable behaviors encourages their repetition. ABA can improve attention management, self-control, motivation, and social skills. However, treatment should be personalized and combined with complementary therapeutic approaches to address ADHD comprehensively [13].

In recent years, mindfulness has become an increasingly popular therapeutic approach for children, particularly those with ADHD. It helps develop self-awareness and improve emotional and behavioral self-regulation, both of which are often challenging. Children with ADHD often struggle to maintain attention on tasks for prolonged periods. Mindfulness teaches them to focus on the present moment, whether it involves an activity, a sensory experience, or their own emotions. Regular mindfulness practice improves the ability to sustain attention and return to tasks when distracted. It also helps children observe emotions without being overwhelmed, learning to recognize anger, frustration, or anxiety as they arise and respond in a calm and deliberate manner. Mindfulness encourages children to pause before acting, reflect on their reactions, and consciously choose how to respond [14]. This approach can be particularly useful for reducing impulsive behaviors. Mindfulness can be taught through age-appropriate, playful methods, such as games that stimulate body and sensory awareness. Examples include "listening activities" or the "silence game," in which children remain still for a few minutes.

Neuropsychomotor skills

Neuropsychomotor sciences are an interdisciplinary field that studies the interaction between cognitive, emotional, and motor processes, with a particular focus on childhood development. The evolution of this field has been influenced by various epistemological perspectives and by research on the etiology of psychomotor disorders. The roots of the discipline can be traced to developmental psychology, psychomotor sciences, and neuroscience.

Neuropsychomotor sciences integrate knowledge from psychology, medicine, neurology, and pedagogy, allowing for a holistic view of childhood in which body, mind, and emotions are interconnected. Theoretical models, such as constructivism and the systems

approach, recognize that learning and development do not occur in isolation but result from dynamic interactions between individuals and their environment [15]. Neuropsychomotor therapy focuses on structured interventions that use movement as a therapeutic tool. Through play and physical activity, professionals help children develop motor, cognitive, and emotional skills [15]. This therapy addresses a range of developmental issues, including movement disorders, learning disabilities, attention deficit disorders, and behavioral disorders. These difficulties may have multifactorial etiologies, involving genetic, neurological, and environmental factors. A child's environment plays a crucial role in development. Stressful situations, emotional deprivation, or socioeconomic challenges may negatively impact neuropsychomotor development, whereas enriched or stimulating environments can foster the harmonious growth of motor and cognitive skills. Alterations in neurological processes can influence motor behavior and psychomotor development. Modern neuroscience suggests that early experiences may shape neural connections and influence cognitive and emotional development.

STUDY HYPOTHESIS

Creating a motor protocol for children with hyperactivity, such as those with Attention-Deficit/Hyperactivity Disorder (ADHD), is important for several reasons. One key reason is channeling energy, as hyperactive children often struggle to manage excess energy. A targeted motor protocol may help children direct this energy constructively, improving concentration and reducing impulsiveness. The development of motor skills is fundamental for children with hyperactivity, who may experience difficulties coordinating movements and developing fine and gross motor skills [16]. A structured motor protocol can improve coordination, balance, and overall motor control. Improving the management of impulsiveness through physical exercise and structured games helps children learn to respect rules, timing, and turn-taking. These activities also support the development of self-regulation by promoting control over impulsive behaviors. Physical exercise may enhance attention span and memory while stimulating neuroplasticity. A well-designed and targeted motor protocol can promote greater concentration, even during school activities [17].

Methodology

Integrating physical exercise into teaching strategies for children, particularly those with hyperactivity, may significantly improve learning outcomes and classroom behavior [18]. The combined movement-and-teaching approach allows children to harness their need for movement while enhancing their ability to concentrate. The protocol we propose includes two main components, each focused on improving specific aspects of children's behavior and learning. These components aim to help channel excess energy, improve concentration, reduce impulsivity, and promote emotional self-regulation [19]. Specifically, the first component involves physical exercises that stimulate motor coordination and behavior regulation. These exercises may improve self-control and help manage impulsive behaviors. The second component consists of movement strategies designed to enhance concentration and self-regulation, thereby promoting emotional self-regulation and increasing attention span.

Integrating Physical Exercise into Pedagogical Strategies with "Active Breaks"

Integrating physical exercise into pedagogical strategies through active breaks can be a highly effective method to improve learning, concentration, and students' psycho-physiological well-being.

Active breaks, or short periods during which a sedentary activity is interrupted to perform light but purposeful physical activity that stimulates both body and mind. These breaks may serve as pedagogical tools to increase student engagement, enhance attention, and promote positive classroom behavior [20].

Practical Example: Strategic "Active Breaks" during homework

Imagine a classroom or home environment where children with ADHD are completing homework. The teacher or parent introduces the concept of "active breaks," short periods dedicated to physical activity. These breaks are specifically designed to improve concentration and reduce restlessness. This approach may be implemented as follows.

Breaking tasks into blocks: Tasks are divided into 15-20 minute segments. After each block, the child takes a 5-minute active break.

Type of motor activity: Active breaks may include exercises that stimulate the vestibular system and increase alertness. Examples include jumping jacks, short runs along a defined path, ball games, or light obstacle courses. These exercises can help release excess energy and refocus attention.

Calm-down activities: After more intense exercises, a brief period of deep breathing or light stretching can help promote calm and prepare for the next study cycle.

Monitoring and adaptation: Each child can select from a range of activities during breaks, allowing the intervention to be tailored to their needs and interests. This personalization may increase motivation and engagement. Progress can be monitored through a diary or a shared feedback sheet among therapists, teachers, and parents.

Practical Exercise Examples

Coordinated Jumps

Equipment: Hoops on the floor or circles drawn with chalk.

Activity: Children are instructed to jump from one hoop to another, following a predetermined path. Variations may include hopping on one foot, performing two consecutive jumps within one hoop and one in the next, or jumping laterally.

Objective: To foster concentration, strengthen self-regulation through brief structured physical activities, and enhance motor coordination and attentional control by requiring the execution of precisely sequenced movements.

Pedagogical objective: This activity not only supports students' physical and psychophysiological well-being but also contributes to improved academic performance and enhanced learning quality. When structured physical activities are systematically integrated into the educational curriculum, students may benefit from increased energy levels, sustained attention, intrinsic motivation, and improved peer interaction, thereby fostering a more stimulating and productive learning environment [20].

Ball Throwing and Catching

Equipment: Soft or foam balls

Activity: Children perform the activity in pairs or individually against a wall. The child throws the ball and catches it. The type of throw can be varied (two-handed, one-handed, high, or low throws).

Objective: To improve hand-eye coordination and concentration. Gradually increase the complexity of the motor task to maintain engagement.

Pedagogical objective: This activity aims to improve attention span and task endurance while keeping children highly engaged. When integrated into the routine as an active break, it helps children with ADHD manage hyperactivity and sustain concentration [21].

Exercise Integration and Mind-Body Techniques Combination

The concept of "mind-body" refers to the connection between cognitive processes and physical well-being. The relationship between mind and body is a fundamental topic in many disciplines, including psychology, medicine, philosophy, and neuroscience. It is widely recognized that mental and physical health are closely interconnected: thoughts, emotions, and psychological experiences influence physical health, and vice versa.

The mind-body connection is particularly relevant in the treatment and management of ADHD [22]. Since ADHD primarily affects attention, self-control, and information processing, integrating strategies that engage both mind and body may be highly effective for improving symptoms and promoting better functioning across contexts. One possible example is "mindful movement" for academic tasks. This approach combines physical exercise with mindfulness practices, such as yoga or Tai Chi, to help children with ADHD develop greater awareness of their bodies and emotions. These activities can promote a balance between physical activation and mental regulation.

"Mindful Movement" routine

Before starting homework, the child participates in a short, 10–15-minute mindful movement session. This session may include the following components:

- Simple yoga poses: Such as Child's Pose (Balasana), Downward-Facing Dog (Adho Mukha Svanasana), and Tree Pose (Vrksasana), which combine balance, strength, and breath awareness [23].

- Breathing and coordination exercises: While holding yoga poses, children are guided to focus on their breathing, following a slow, deep rhythm. The teacher or parent may guide a count of four seconds for inhalation and four seconds for exhalation.
- Slow and controlled transitions: Exercises such as Tai Chi or slow stretching movements, in which the child moves deliberately from one pose to the next. The focus is on maintaining balance and sensing each movement.
- Visualization exercises: During these movements, the teacher may guide a brief visualization. For example, children imagine themselves as a tree rooted in the earth for stability, yet gently swaying in the wind for flexibility. This approach helps children connect with their bodies and achieve calm.
- Conclusion with a "resting pose": After the active and mindful movements, children conclude with a brief relaxation period in Savasana (corpse pose), focusing on their breathing and releasing tension [24].

Practical example of exercise

Start: Breathing exercises or light stretching (2-3 minutes).

Activity: After completing the circuit once, it is important to include an active break to recover. During the break, children can perform deep-breathing exercises (e.g., inhale for 4 seconds, hold for 4 seconds, and exhale for 4 seconds) or light stretching exercises.

Objective: To promote relaxation and emotional self-regulation, preparing children to resume their routine or engage in new activities.

Pedagogical objective: This approach supports the development of self-regulation and body awareness, may reduce stress, and may improve concentration and homework management. Mind-body techniques can provide children with practical tools to manage hyperactivity, impulsivity, and anxiety, making learning a more balanced and calm experience.

These examples demonstrate how physical exercise and mindfulness techniques can be creatively integrated into educational settings to support children with ADHD during homework [25].

Below is a summary table comparing the activities of the active break protocol and the mind-body approach for children with ADHD. Both protocols aim to enhance concentration, self-control, and psychophysiological well-being, but they employ different methods to achieve these outcomes.

Both modalities can be combined to create a pedagogical program that may enhance not only learning but also the child's overall psychophysiological well-being. Active breaks emphasize short physical activities, providing a quick "reset" that can improve concentration, energy levels, and behavioral regulation in children with ADHD. The mind-body approach focuses on the integration of mind and body. It can support children in developing self-awareness, reducing stress, and promoting more balanced emotional and energy regulation [26].

EXPECTED OUTCOMES AND DISCUSSION

The implementation of physical activity for educational purposes in hyperactive children, including those with Attention-Deficit/Hyperactivity Disorder (ADHD), may lead to significant outcomes across multiple domains. Applying the protocol can be expected to result in:

- Improved attention and concentration: Regular physical activity may enhance children's ability to maintain focus for longer periods, both in school and daily life.
- Reduction in impulsive and hyperactive behavior: Physical activity may help decrease excessively impulsive or hyperactive behaviors, supporting improved bodily and emotional self-regulation.
- Enhanced social skills: Through group games and structured activities, children may develop better peer interaction, cooperation, respect for rules, and conflict management skills.
- Increased motivation and well-being: Physical activity stimulates endorphin production, which may improve and reduce anxiety, potentially enhancing motivation in academic and social contexts.
- Improved motor skills: Alongside behavioral benefits, physical activity may enhance motor coordination, balance, and the development of fine and gross motor skills.
- Integration and inclusion: Group-based physical activity can promote social integration of children with ADHD, reducing potential exclusion and supporting inclusive educational environments [26].

This study supports the notion that physical activity provides not only physiological benefits but also educational and behavioral advantages. Movement can become a powerful tool to enhance learning outcomes and psychophysiological well-being in children with ADHD.

In summary, structured physical activity represents a highly promising educational

Table 1. **Overview of the activities included in the active break protocol and the mind–body approach for children with ADHD.**

PROTOCOLS/ ACTIVITIES	ACTIVE BREAKS	MIND-BODY
Main objective	Promote concentration and improve self-regulation through brief structured physical activities.	Promote mind-body integration by enhancing emotional regulation, body awareness, and stress management.
Duration	Approximately 5 minutes of physical activity, distributed throughout learning sessions.	Longer sessions, generally lasting 10 to 15 minutes and typically implemented prior to learning activities.
Type of activity	Brief, dynamic exercises such as jumping, walking, throwing a ball, and motor activities designed to stimulate energy levels.	Techniques combining slow, controlled movements with breathing and focused awareness, such as yoga, stretching, and meditation.
Methodology	Structured active breaks that promote physical movement as a form of cognitive “reset”.	Relaxation and mindful movement techniques, such as tai chi or guided breathing, to improve mind-body balance.
Tools used	Minimal equipment, such as free space in the classroom and small materials like balls or hoops.	Yoga mats, calming music, meditation guides or images to support relaxation and attentional focus.
Benefits used	Facilitates the release of excess energy, thereby improving concentration and reducing impulsivity.	Enhances body awareness and emotional regulation, contributing to reduced anxiety and improved self-regulation.
Psychological impact	May stimulate endorphin production, contributing to improved mood, reduced stress, and increased classroom engagement.	Reduces anxiety, supports emotional regulation and promotes inner calm and sustained self-regulation.

intervention for managing and supporting children with ADHD. It may improve both quality of life and academic achievement.

CONCLUSIONS

Physical exercise constitutes a valuable educational resource for supporting the development and learning of children and adolescents with ADHD. Incorporating targeted physical activities into school and family routines may improve attention, self-control, and executive functioning, while fostering social skills such as collaboration and respect for rules. Through structured exercise, children with ADHD can learn to manage energy and impulsivity in positive ways, transforming potentially disruptive behaviors into opportunities for active learning. Educators and families may integrate physical activity into daily routines as a supportive tool to strengthen self-esteem, resilience, and a sense of belonging, leveraging each child’s strengths. Physical activity can help release excess energy constructively, reduce hyperactive and impulsive behaviors, and improve attention management and motor control. Therefore, promoting the inclusion of physical exercise in educational programs not only strengthens cognitive and behavioral skills but also represents a holistic pedagogical approach. This approach considers the individual as a whole, encouraging balanced development and addressing each student’s specific needs with ADHD.

Conflict of Interest
The authors have no conflict of interest to declare.

Authors' Contribution

Lorena Vincenza Perrone: Conceptualization; Writing – original draft (abstract, study hypothesis); Writing – review & editing; Supervision; Integration of techniques and strategies. Antonietta Gambino: Writing – original draft (introduction; neuropsychomotricity; psychomotor treatment); Investigation. Giulia Imperiale: Methodology; Writing – original draft (pedagogical strategies); Formal analysis. Gaia Vangelista: Methodology; Writing – original draft (pedagogical strategies); Formal analysis.
All authors have read and agreed to the published version of the manuscript.

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phenomenajournal

Opinion Article

The phenomenon of frustration in Gestalt therapy and organizational development

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ABSTRACT

This article explores the concept of frustration as a potent catalyst for growth in Gestalt therapy and organizational development. The text examines how frustration, which is often perceived negatively, can serve as a vital tool for enhancing awareness, responsibility, and self-actualization. Drawing on Gestalt theory and practical examples, the authors define frustration as tension in the field arising from internal or external resistance that prevents need satisfaction. We analyzed how defense mechanisms inhibit this process and demonstrate how moderate, trust-based frustration can help to overcome them. Through comparative insights into psychoanalytic and Gestalt approaches and confrontational and relational tactics, the article emphasizes the importance of trust between therapists and clients or consultants and clients. A detailed organizational case study illustrates how awareness-based interventions can shift entrenched patterns and resolve paradoxes by facilitating a dialogical 'I-Thou' encounter. Ultimately, the article advocates a balanced approach to support and frustration to enable individuals and organizations to unlock deeper resources and co-create transformative outcomes.

Keywords
Frustration, Gestalt therapy, Organizational development, Awareness, Defense mechanisms, Responsibility, I-Thou relationship, Confrontation, Dilemma.

ABSTRACT in ITALIANO

Questo articolo parla di come la frustrazione possa essere un grande aiuto per crescere nella terapia della Gestalt e nello sviluppo organizzativo. Attraverso un bel dialogo tra gli autori, il testo guarda a come la frustrazione, che spesso viene vista in modo negativo, possa essere uno strumento importante per migliorare la consapevolezza, la responsabilità e la realizzazione personale. Basandosi sulla teoria della Gestalt e su esempi pratici, gli autori dicono che la frustrazione è una tensione causata da resistenze interne o esterne che non permettono di soddisfare i bisogni. Analizzano come i meccanismi di difesa blocchino questo processo e mostrano come una frustrazione moderata e basata sulla fiducia possa aiutare a superarli. Attraverso approfondimenti comparativi sugli approcci psicoanalitici e gestaltici e sulle tattiche conflittuali e

Citation: Nadirashvili, D., & Lassalle, J. The phenomenon of frustration in Gestalt therapy and organizational development. *Phenomena Journal - International Journal of Psychopathology, Neuroscience and Psychotherapy, 8*(1), 27–35.

Editor in Chief: Raffaele Sperandeo, PhD, MD

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Received: November 6, 2025

Accepted: February 4, 2025

Published: March 20, 2026

relazionali, l'articolo sottolinea l'importanza della fiducia tra terapeuti e clienti o consulenti e clienti. Un caso di studio organizzativo dettagliato mostra come gli interventi basati sulla consapevolezza possano cambiare modelli radicati e risolvere paradossi facilitando un incontro dialogico "Io-Tu". In definitiva, l'articolo sostiene l'applicazione equilibrata di sostegno e frustrazione per consentire agli individui e alle organizzazioni di sbloccare risorse più profonde e co-creare risultati trasformativi.

Parole chiave
Frustrazione, Terapia della Gestalt, Sviluppo organizzativo, Consapevolezza, Meccanismi di difesa, Responsabilità, Relazione Io-Tu, Confronto, Dilemma.

INTRODUCTION

This article emerged from a professional training session held at the Georgian National Gestalt Institute as part of the program "Gestalt in Organizations." During the training, a discussion arose concerning the role of frustration in therapeutic and organizational contexts. A clinical example presented during the session stimulated a deeper reflection on frustration as a deliberate and finely attuned intervention within Gestalt practice.

This exchange led to a more systematic exploration of the theoretical foundations and practical applications of frustration in both psychotherapy and organizational development, forming the basis of the present article.

THE PHENOMENON OF FRUSTRATION

Most people do not like feeling frustrated. However, from a Gestalt perspective, growth cannot occur without frustration. Thus, 'useful frustration' [1] is an important guidepost in therapeutic work and organizational development. Frustration can be defined as the tension that arises in the field when it strives to form a figure and find satisfaction. However, due to resistance from the field or defense mechanisms within the organism, this tension fails to form a clear figure and remains unresolved. Frustration serves as a therapeutic tool and a catalyst for personal growth [2]. In line with the SOS model [3], there are three levels of frustration within an organizational setting.

Individual level: A typical frustration within people arises from the need to be appreciated. An employee is frustrated because they feel their contributions are not recognized by their manager. Or a manager with a strong need for power feels frustrated because their career is progressing too slowly.

Group level: Unlike individual therapy, organizations often focus on groups. Typical groups within organizations include functional layers (e.g., purchasing, production, IT, marketing, sales, and finance), hierarchical layers (e.g., senior management, middle management, and employees), and special bodies (e.g., works councils and equal opportunities officers). Frustration typically arises between these groups due to conflicting goals. A common conflict arises from the tension between reducing costs to ensure profitability and investing in the workforce (e.g., employment, salary increases, development initiatives).

System or contextual level: The organization itself is an entity embedded within a market, as well as an economic, political, and social context [4]. This aligns with Kurt Lewin's field theory, which posits that organisms are interconnected with their environment [5]. From this perspective, frustration may arise at the system level when changes in the broader field — such as supply chain disruptions, shifts in consumer behavior, or rising global economic tensions — create resistance that impacts organizational functioning.

Frustration, when used as a therapeutic tool, is sometimes called a challenge. The process of frustration helps the client to recognize and take responsibility for their own actions. Typically, tension arising in the field is consciously perceived and thus easily recognized. However, this does not happen when defensive mechanisms, also known as contact interruption mechanisms, actively interfere with the process by preventing the experience of tension. In such cases, the therapist begins to work with these contact interruptions or defensive mechanisms. One aspect of this process may involve frustration, which is the main topic of this article. When the environment is not supportive, a person turns to their internal resources [2].

Defense Mechanisms

What are defense mechanisms, and how do we cope with them when they influence the quality of our lives and our sense of freedom? How is a defense mechanism defined in Gestalt therapy? It is the psyche's ability to adapt to existing realities, such as within the family or social institutions like kindergarten, school, or the neighborhood [2]. This adaptation is expressed through the psyche's ability to protect a person from unpleasant experiences and influences perceived as overwhelming, dominant, or even hostile, originating from the environment, other people, or society. Such emotions, sensations, and feelings are unpleasant for a person and can cause anxiety, distress, and suffering. Since anticipating such experiences is difficult, the psyche employs an unconscious strategy to prepare for these expectations. These strategies are referred to in Gestalt therapy as defense mechanisms, which are used chronically and stereotypically. However, they are also known by other names, such as avoidance mechanisms, resistance, or mechanisms of contact cycle interruption.

Gestalt theory identifies several core defense mechanisms — including introjection, projection, confluence, retroflection, deflection, and egotism — which have been extensively discussed in the literature [6–9]. Defense mechanisms may facilitate adaptation to routine or predictable situations. However, in novel or complex circumstances, rigid reliance on these mechanisms can limit flexibility and reduce the individual's capacity for authentic and context-sensitive responses. In Gestalt therapy, the alternative to such rigidity is described as "vital awareness" or "liveliness," referring to a dynamic and present-centered mode of engagement with experience.

What is Awareness?

According to Perls et al [2], awareness is a person's direct, lived experience and understanding of reality. It involves sensations, emotions, and intuition, and is not just intellectual or second-hand knowledge, but a deep, embodied sense of presence. Warmth, for example, whether physical or emotional in human relationships, is not understood solely through logic, but is felt and experienced. Awareness enables individuals to engage fully with the present moment, responding spontaneously and flexibly rather than relying on habitual or pre-learned reactions.

Those who lack awareness often feel disconnected, rigid, or unable to adapt to changing circumstances. In contrast, people with strong awareness navigate life with ease, much like a fish in water — naturally attuned to their environment. They are spontaneous and flexible in their reactions, unlike those who operate purely from intellect and always appear 'restrained' or 'held back'. There is a saying that illustrates this well: If a centipede starts thinking about which leg to move first while running, it will get tangled up, stumble, freeze, or lose the ability to move altogether. Creatures that live with awareness move through their environment as if they are 'at home', like fish in water. In contrast, a person guided by defense mechanisms is the opposite of someone living with awareness. A defense mechanism is like parental advice on how to behave in an unfamiliar environment or general instructions designed for average behavior in standard situations. In contrast, awareness-based behavior adapts to unique situations, considers specific needs, and is attuned to the present moment.

Awareness is a behavioral strategy that is unique to an individual. It considers the present moment, with all its unique external and internal realities, and is based on personal responsibility. Both behavioral styles are embodied by people around us, as those with awareness and those without. A person with awareness typically engages with the environment through sensations, emotions, experiences, and intellect. In contrast, a person without awareness lacks this sensory-emotional connection to their surroundings. These individuals are anesthetized and primarily interact with their surroundings through rational, cognitive processes, with all the pros and cons. The advantages include the ability to make logical judgements about what is useful, acceptable, harmful, or unnecessary in relation to the environment. However, this approach has one key disadvantage: it does not account for the nuances of the present moment, such as what one truly desires or does not desire, how the environment is being experienced in real time, how others feel here and now, and what alternative behaviors may emerge from a perspective of freedom.

When we talk about behaviors guided by awareness, we refer to a model fundamentally different from that of behaviors driven by defense mechanisms. Unlike automatic, unconscious reactions, awareness-based behavior is conscious and intentional. It considers the purpose of defensive behavior while offering an alternative free choice.

The Definition of Therapeutic Frustration

Therapeutic frustration is a deliberate intervention by the therapist designed to facilitate the fulfilment of a client's needs. This is employed when a client chronically avoids need-satisfaction despite the emergence of tension within the experiential field. By refusing to play into the client's habitual patterns of avoidance or manipulation, the therapist creates a vacuum that the client must fill with their own agency.

WORKING WITH FRUSTRATION IN THERAPY: CONFRONTATIONAL *VS*. RELATIONAL APPROACH

How do therapists work with defense mechanisms in psychoanalysis and Gestalt therapy, and are there fundamental differences between the two approaches? In psychoanalysis, resistance is associated with repressed content and serves as a force that hinders the process of becoming aware [10]. Rather than confronting resistance as an enemy, the psychoanalyst explores it thoroughly and weakens it through counterarguments in dialogue and collaboration with the patient. As the psychoanalysts' approach is intellectual, various methods of influence are employed to overcome resistance, which can sometimes resemble manipulation. These include stimulating the patient's curiosity and using rational arguments to diminish the power of resistance. Consequently, the patient engages in the struggle against their own resistance. In psychoanalysis, frustration is a technique the analyst uses to help the patient confront the problem.

However, Gestalt therapy makes even more use of this tactic. Compared to his contemporaries, Fritz Perls applied it in a more fundamental and prioritized way. In widely available video recordings of his individual and group therapy sessions, Perls can be seen confidently and intentionally using manipulation and frustration with participants. This approach directly challenges clients' hesitation and lack of initiative, helping them to become aware of these tendencies and take responsibility for what they chronically avoid. The Gestalt therapist works with the client in the present moment, and resistance is discovered here and now. Overcoming resistance is possible through the client's awareness, a process in which the Gestalt therapist provides support and frustration to facilitate growth.

Two Different Tactics of the Gestalt Therapist

Empathy is a powerful form of support and a serious means of coping with difficulties. Frustration affects clients in a specific and paradoxical way. People naturally try to avoid problems, escape, or turn a blind eye. This can become a life strategy, and in such situations, using frustration as a coping mechanism can be particularly effective. The goal is to help the client confront the problem rather than avoid or escape it.

To achieve this, the Gestalt therapist must not provide the client with an escape route, thereby encouraging them to face the problem directly. This is not easy and requires experience and skill. The applied frustration should be moderate, as overwhelming the client could be counterproductive. At the same time, the therapist should be supportive, encouraging the client to take the initiative and move forward [11]. For this to be successful, the therapist must earn the client's trust. Trust and frustration work well together. If the client does not trust the therapist, frustration will lead to avoidance of the problem rather than engagement with it. However, when there is trust, addressing a difficult topic can be a kind of joint endeavor. With the therapist standing by and offering support, the client cannot ignore the frustration. The therapist's ability to frustrate the client effectively can ensure that the client does not retreat from the 'front line' or flee the situation. Thus, the client may be led to respond and accept the 'duel' with the problem. When the client is left face-to-face with the issue, with the usual escape routes blocked, they require specific resources and support, both external — from the therapist, in this case — and internal.

When working with clients who exhibit chronic behavioral patterns, it is essential for the Gestalt therapist to create a sense of moderate frustration in the 'here and now' situation during the initial stage [12]. This enables the client to recognize the need to seek new ways to satisfy their needs and reassess ineffective strategies for solving problems. Without this awareness, a person may continue living life with the same inertia, feeling deeply discouraged and lacking in initiative, failing to seek alternative solutions. In such situations, frustration acts as a catalyst and motivator, suddenly and unexpectedly awakening unconscious potential when a decision is made and responsibility is taken.

Therefore, it is important to carefully prepare the conditions to create optimal circumstances for the client to confront and manage the problem effectively.

The East and West Coasts of American Gestalt Therapy

Gestalt therapists approach frustration — and the psychotherapy process itself — differently. While Fritz Perls actively used frustration, considering it essential for activating clients who were passive and inactive, the founders of Relational Gestalt, who represented the New York Gestalt School, were more cautious in its application. Instead, they placed greater therapeutic value on unconditional support.

It could be said that Gestalt therapists on the East Coast of the United States differ significantly from those on the West Coast. This fundamental division in Gestalt therapy proved so significant that the Esalen-based West Coast school expanded its influence on California, Spain, and South America, while the New York-based 'Relational Therapy' school developed in Europe.

The two schools — Esalen's West Coast school, associated with Fritz Perls, and the New York school, associated with Laura Perls — also differ in their ethical principles. This does not imply that one school is ethical while the other is not; rather, their ethical differences become particularly visible in their respective approaches to the use of frustration.

Techniques of the Relational Approach

In relational interaction, the most crucial aspect is the process characterized by the 'I-Thou' relationship, as described by Martin Buber [13]. Although many figures may exist in reality, the focus should be on these two phenomena. In this process, the therapist embodies an authentic 'I' and directs their sensory focus towards the 'Thou'. They observe the vibrations of the 'Thou' and facilitate processes that meet their needs. The therapist's technique centers on focusing their senses on the 'Thou'.

This differs from techniques oriented towards atmosphere-focused interaction. In that case, rather than focusing on the 'I-Thou' relationship, the therapist attunes to the overall atmosphere of the situation. Rather than concentrating on a specific sensory modality to engage with an object, the therapist becomes a whole-body perceiver of the environmental atmosphere in which the 'I' exists [14].

A useful metaphor for this complex process is that, in relational interaction, the 'I' should become a sensory membrane that perceives each vibration of the 'Thou'. In atmosphere-oriented therapy, the therapist should be like the reflective surface of a lake, where every falling leaf creates ripples. The calm surface of the lake reflects the surrounding landscape, mirroring it. Two metaphors emerge from these comparisons: 'I' as a membrane and 'I' as the calm surface of a lake.

Frustration and Support in Therapy

If the frustration procedure is applied adequately, as described above, it leads to rapid and meaningful change [15]. The problem is 'bitten into' and resolved through assimilation. Without this process, however, the problem continues in an endless cycle of exclusion. In Gestalt therapy, the therapist primarily supports the client through encouragement and, in certain situations, through frustration.

Methodology and Clinical Application

The application of frustration within a clinical setting follows a specific methodological framework:

- Indications for use: It is utilized when a client seeks professional intervention but remains stuck in chronic avoidance patterns.
- Informed consent: The therapist must explain the necessity of this technique to the client, ensuring they are consciously engaged in the process rather than feeling arbitrarily rejected.
- Therapist competency: Working with frustration requires specific clinical experience and self-regulation, as the therapist must remain present and supportive while simultaneously denying the client's immediate (and often regressive) demands.

Key concepts to remember:

- The field: The "space" or relationship between therapist and client where the tension occurs.

- Chronic avoidance: The repetitive ways a client deflects from their true goals or feelings (e.g., through humor, intellectualization, or seeking constant approval).
- Conscious involvement: The shift from a passive patient to an active participant who understands why the therapist is "difficult."
- Process markers in meetings (observable micro-behaviors): "Yes, but" spirals - proposals about efficiency measures were instantly negated.
- Contact boundary disturbances (how the system avoids clean contact): e.g., Blaming the leadership to be the problem, also see below ("Defense mechanisms in organizations").

WORKING WITH FRUSTRATION IN THE ORGANIZATIONAL FIELD: A CASE STUDY

One of the authors was asked to run a leadership development program for a medium-sized company. During the interviews we conducted to explore the organization's current challenges, it became clear that the company was in a difficult situation. Having experienced continuous growth since its foundation, the company was now facing a challenging economic environment. The company had always been very people-oriented, satisfying its employees' individual needs wherever possible. However, as the economy became more difficult, this became less possible. Consequently, many employees felt frustrated because their need for individual consideration was no longer met. During our work, we identified tensions between employees and management by using the following observational indicators:

- Figure/ground signals (what keeps trying to become "the topic"): The lack of employee orientation in the current situation was mentioned, even if other topics were officially addressed.
- Energy and arousal cues (too much, too little, or stuck): Energy used to drop when speaking about the business needs.

Dilemma as a Specific Form of Frustration

Many sources of frustration can be resolved by addressing the underlying need. For example, a manager could express appreciation to an employee, two groups could reach an agreement on how to collaborate on a certain matter, or an organization's supply chain could be restored. Johnson [16] refers to these types of frustration as 'problems'. However, we should be aware that most encounters involve polarities that can cause frustration if they are not integrated and balanced [17]. Unlike problems, polarities create paradoxical situations that lack straightforward solutions (Table 1). Instead, they require constant management of various goals. These goals appear to contradict one another in the same situation and therefore cannot be fully realized at the same time. For instance, on the one hand, employee involvement is an important managerial quality. However, when decisions must be made quickly, there may not be enough time for intensive participation.

It is important to understand that it is impossible to create a definitive solution to paradoxes. To do so would mean choosing one of the two sides. However, in doing so, we quickly realize that 'the other side' emerges again and

Table 1. Problem *vs.* paradox.

PROBLEM	PARADOX
· There is only one clear goal or task to overcome.	· There are several goals or tasks to overcome.
· There is an objectively best solution or optimal result.	· All sides are associated with advantages and disadvantages.
· One tries to maximize the advantages ('more is better') and minimize the disadvantages.	· If the advantages are maximized too much (exaggeration of one goal/task), disadvantages arise (neglect of the other goals/tasks).
· If a decision results in a solution, the problem has been overcome.	· Even when a decision results in a solution, it must be continuously managed, and new decisions have to be made.

demands to be heard. Paradoxes must therefore be managed and renegotiated repeatedly. A crisis is usually a clear indication that a paradoxical situation needs to be addressed, and that new, creative solutions must be found.

During the leadership development program, it became clear that the underlying challenge should not be viewed as a problem, but as a paradox. The unsatisfied need could not be easily addressed because it conflicted with requirements for standardization, cost savings, and even workforce reduction. Maximizing the advantages of one side (e.g., cutting costly benefits and standardizing HR guidelines) led to maximizing the disadvantages of the other side (e.g., lack of individual consideration and resulting frustration). At the same time, maximizing the advantages of the other side (i.e., maintaining the status quo and prioritizing employees' individual needs) also led to the maximization of its disadvantages (i.e., unleveraged savings potential, resulting in an increasingly difficult financial situation).

Unhealthy Ways to Deal with Frustration: Defense Mechanisms in Organizations

As mentioned above, frustration can result in healthy growth for individuals, teams, and organizations. However, if defense mechanisms cannot be overcome and people cannot connect with their current experience, they will remain stuck in the status quo [17]. In the case study, the frustration led to employees and middle management blaming top management, and vice versa. Both parties projected their fears and helplessness onto each other and acted upon these projections. This resulted in a great deal of anger. A second defense mechanism then came into play: retroflection. Neither party has openly expressed the accumulated anger. This resulted in a lack of contact. When talking to top management and the second leadership layer, there was a barrier between the two, leading to limited mutual understanding of each other's perspectives.

Confrontational vs. Relational Approach in Organizational Development

Once again, as in the therapeutic setting, both strategies for overcoming defense mechanisms apply to the process of organizational development. Unlike in one-to-one therapy, much of the interaction in organizations takes place in groups. Therefore, when using confrontational interventions, the consultant needs to be aware of group norms. In hierarchical organizations, upper management can easily feel put on the spot in front of middle management or their employees. To avoid this, confrontation with their own defense mechanisms should take place in personal, one-to-one conversations here as well. Top managers require a partner they trust to accept their own shortcomings and fears. A relationship based on the I-Thou paradigm [16], as described above, is fundamental to building this trust.

Dealing with Frustration: A Relational Approach

In our case study, we established common ground by highlighting the relational interconnectedness among all parties using the SOS model [3]. This model acknowledges our interconnectedness as human beings living together, and our increasing dependence on collaboration for survival. An organism (e.g., a person, team or organization) cannot satisfy its needs independently of its environment (e.g., other people, teams or organizations). As human beings, we need the love and appreciation of others. As a team, we need to collaborate with others to achieve our goals and feel part of something bigger. An organization needs customers to buy products to grow and nurture its employees. Therefore, dealing with frustration is never possible without connecting to others. This understanding paved the way for dialogue between the upper management, which represented the business perspective, and the second leadership layer, which represented the employee perspective. In the following section, we describe our approach to a workshop as our main intervention.

Integrating Both Sides of the Dilemma

For the workshop we decided to use Johnson's [16] model to address the dilemma. While Johnson's approach focuses more on cognitive and rational aspects, we added a relational perspective, which is required for each step. Without this, the approach risks being sabotaged by the complexity of human relationships. Once again, we would

like to emphasize that, from a Gestalt perspective, the relational process between the parties involved is much more important than the steps described. Meeting in a professional context like human beings is the opposite of most encounters observed in the business world, where the other person is seen merely to satisfy one's own needs.

Step 1: Raising Awareness as a Prerequisite to Overcome Defense Mechanisms

As described above in the therapeutic setting, awareness was key to addressing the organizational dilemma [18]. The author's main suggestion was for the client to organize a joint workshop between top management and the second-level leadership. A pivotal moment during the workshop occurred when the CEO recognized the dilemma and exclaimed, "Ah, now I understand why the tension exists!" It is important to note that the client fully embodied this realization or 'aha' moment, with sensations, emotions, posture and thoughts forming an integrated figure of the present moment. Acknowledging both the dilemma itself and the right of the other party to represent one side of the dilemma opened the situation to a new, more creative solution.

Step 2: Collecting Advantages & Disadvantages for Each Side

We naturally tend to overemphasize the advantages of one side of a dilemma. At the same time, we fail to recognize the other side's advantages. In our case study, for example, most people in the company did not recognize the advantages of standardization and cost savings. However, without a healthy financial situation, employees' well-being is fundamentally at risk. Recognizing both sides of an issue, even if we don't necessarily agree with them, enables us to be less judgmental and find more creative solutions.

Step 3: Defining a Higher Goal / Discussing Common Interests of Both Parties

Most dilemmas require short-term decisions and long-term management. Clearly, neither a happy workforce in a bankrupt company nor financial success without engagement is possible. Therefore, in the long term, both factors require equal consideration. In terms of dilemma management, this means defining a higher goal that encompasses both aspects of the dilemma. During the workshop, participants defined the goal as "a financially healthy company that enables us to take care of our employees' needs and support their personal growth". This did not solve all the problems, as some tough decisions remained. However, focusing on the bigger picture helped the company identify what was needed in the current situation and to achieve long-term satisfaction. From a relational perspective, this means widening the 'I-perspective' to a 'we-perspective'.

Step 4: Developing Creative Solutions to Manage the Dilemma

Based on considerations from previous steps, we have begun identifying solutions that support both short-term decision-making and long-term management of the dilemma, thereby alleviating the frustration. In any case, it is necessary to accept the reality of what is possible in each situation [1], which is often an inevitable part of adult life. Finding solutions often requires creativity to ensure both parties' needs are considered. At this stage, ongoing awareness is needed to avoid falling back into the unhealthy patterns described above. This can be prevented by reflecting on whether the needs of both parties have been sufficiently considered. As one means of managing the dilemma, the company decided to set up a sounding board composed of employees at various levels and in various functions. This board provides regular feedback on top management decisions to raise employees' awareness of their perspectives.

CONCLUSIONS

Frustration is often perceived as negative. However, in Gestalt therapy and organizational development, frustration serves as a catalyst for growth. This can apply to individuals, groups, or organizations. It facilitates the process of recognizing and taking personal responsibility for one's life. However, applying frustration as a therapeutic

process requires significant expertise and experience on the therapist's part; otherwise, it may resemble mere role-playing and could even be harmful. This process demands great tact and moderation in terms of intensity. When adequate external support is unavailable during frustration, an individual turns to their inner, hidden, and previously untapped resources. This enables deeper and fuller self-expression, fostering autonomy and individuality. Similar to working with individuals, organizational Gestalt work uses awareness as a key measure to facilitate contact between organizational members or groups and to overcome defense mechanisms. In the authors' view, this requires striking the right balance between confrontation and support. People can meet on an equal footing as human beings and jointly find creative solutions to the dilemma and dissolve the frustration only if they express and acknowledge each other's legitimate autonomy, interests, and goals.

Conflict of Interest

The authors have no conflict of interest to declare.

Authors' Contributions

Dimitri Nadirashvili: Frustration in therapy (Conceptualization, Methodology).
Julius Lassalle: Frustration in Organizations, Case Study.

Ethical Consideration

This article does not report empirical research involving human subjects. The organizational case is presented for illustrative purposes only and has been fully anonymized. No identifiable personal data is included.

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Brief narrative review

Problem behaviors, psychopathology, and respect for neurodivergence in gestalt therapy: A brief narrative review

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ABSTRACT

Scientific literature defines problem behavior as behavior that is destructive to the individual or to the environment and that compromises the person's quality of life. Such behaviors are frequently observed both in neurodivergent profiles, such as those within the autism spectrum, and in various psychopathological conditions.

The present work proposes a narrative mini-review of the literature on problem behaviors, with the aim of deepening the distinction between behaviors that represent expressions of neurodivergent functioning and behaviors that may instead be attributable to psychopathological conditions.

The discussion is developed within an integrated clinical perspective that considers behavior within the relational and environmental field in which it emerges. From this standpoint, understanding problem behaviors requires observing the person in their entirety, including not only symptoms but also individual resources, relational dynamics, and the broader life context.

The aim is to promote a multidisciplinary clinical approach that is respectful of neurodivergence and capable of distinguishing between psychopathological distress and differences in functioning, thereby avoiding processes of inappropriate pathologization.

Keywords
Problem behavior and autism, Psychopathology and problem behavior, Neurodivergence, Differential diagnosis, Autism.

Citation: Ciotola, V., Ammendola, A., Terracciano, R., Di Nardo , M. C., Giordano, S., Cesarano, S., & Morfini, F. Problem behaviors, psychopathology, and respect for neurodivergence in gestalt therapy: A brief narrative review. *Phenomena Journal - International Journal of Psychopathology, Neuroscience and Psychotherapy, 8*(1), 36–40.

Editor in Chief: Raffaele Sperandeo, PhD, MD

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Received: September 27, 2025

Accepted: March 13, 2026

Published: March 20, 2026

ABSTRACT in ITALIANO

La letteratura scientifica definisce il comportamento problema come un comportamento che risulta distruttivo per l'individuo o per l'ambiente e che compromette la qualità della vita della persona. Tali comportamenti sono frequentemente osservabili sia nei profili neurodivergenti, come nello spettro autistico, sia in diverse condizioni psicopatologiche.

Il presente lavoro propone una mini review narrativa della letteratura sul tema dei comportamenti problema con l'obiettivo di approfondire la distinzione tra comportamenti che rappresentano espressioni di un funzionamento neurodivergente e comportamenti che invece possono essere ricondotti a condizioni psico-patologiche.

La riflessione si sviluppa all'interno di una prospettiva clinica integrata che considera il comportamento nel contesto del campo relazionale e ambientale in cui emerge. In tale ottica, la comprensione dei comportamenti problema richiede di osservare la persona nella sua globalità, includendo non solo i sintomi, ma anche le risorse individuali, le dinamiche relazionali e il contesto di vita.

L'obiettivo è promuovere un approccio clinico multidisciplinare e rispettoso della neurodivergenza, capace di distinguere tra sofferenza psicopatologica e differenze di funzionamento, evitando processi di patologizzazione impropria.

Parole chiave

Comportamento problema e autismo, Psicopatologia e comportamento problema, Neurodivergenza, Diagnosi differenziale, Autismo.

INTRODUCTION

In recent decades, within clinical, educational, and social contexts, there has been increasing interest in so-called problem behaviors. At the same time, greater awareness has emerged regarding the need to reconsider the criteria through which such behaviors are observed and interpreted.

Scientific literature defines problem behavior as behavior that, due to its intensity, frequency, or duration, may place the physical safety of the individual or others at risk, or severely limit access to educational, social, and community settings, thereby interfering with adaptive functioning and compromising quality of life [1].

Problem behaviors are frequently observed in neurodevelopmental disorders, particularly within the autism spectrum, but they may also occur in various psychopathological conditions. This phenomenological overlap may generate diagnostic ambiguities and lead to reductive interpretations or to clinical interventions that are not adequately targeted.

In recent years, the scientific debate has increasingly questioned rigidly categorical diagnostic models, highlighting the need for dimensional and contextual perspectives in the understanding of human behavior. Within this framework, the concept of neurodivergence has emerged, referring to variations in neurological and cognitive functioning that diverge from statistically prevalent norms without necessarily constituting pathological conditions [2].

In the case of autism, numerous authors [3] have emphasized that certain behavioral characteristics may be understood as expressions of different modes of sensory, cognitive, and relational processing, rather than as mere deficits or dysfunctions.

However, the phenomenological overlap between some behavioral manifestations observed in neurodevelopmental disorders and those occurring in psychopathological conditions may make differential diagnosis particularly complex. Behaviors such as social isolation, difficulties in emotional regulation, relational withdrawal, or aggressive acting-out may emerge in both conditions, although they originate from profoundly different underlying dynamics [3].

This complexity therefore requires interpretative models capable of integrating biological, psychological, relational, and environmental dimensions. From this perspective, clinical approaches that consider the individual's subjective experience within the relational field may provide useful tools for a more nuanced understanding of problem behaviors [4].

METHODS

The present study was developed as a narrative mini-review of the literature addressing problem behaviors in relation to neurodivergence and psychopathology.

The authors conducted a survey of the available scientific literature by searching the PubMed and Google Scholar databases, focusing on contributions published primarily between 2015 and 2025.

The keywords used for the search included: problem behavior and autism, psychopathology and problem behavior, neurodivergence, differential diagnosis and autism, as well as the corresponding expressions in Italian.

Research articles, literature reviews, and theoretical-clinical contributions relevant to the understanding of problem behaviors and their interpretation within the contexts of neurodivergence and psychopathology were considered.

The aim of this narrative mini-review was not to produce a quantitative synthesis of the available studies, but rather to offer an integrated clinical-theoretical reflection on the main interpretative issues emerging from the scientific literature.

DISCUSSION

The literature reviewed highlights how problem behaviors may emerge both in contexts of neurodivergence and within psychopathological conditions, but with profoundly different meanings and functions [5].

In the case of autism spectrum disorders, numerous studies emphasize the role of neurobiological and genetic bases, as well as the presence of atypical developmental trajectories across several areas of functioning. Within this context, many behaviors considered problematic may represent attempts to communicate needs, strategies of sensory self-regulation, or ways of adapting to an environment perceived as overwhelming or insufficiently predictable [6].

In psychopathological conditions, by contrast, the same behaviors may more frequently be associated with processes of emotional dysregulation, intrapsychic conflicts, or traumatic experiences that have not been adequately integrated [7].

From a Gestalt perspective, behavior cannot be understood in isolation but must be observed within the relational field in which it emerges [6]. Gestalt psychotherapy, in fact, invites us to consider not only the form of the behavior but also the function it serves within the cycle of contact between organism and environment.

Within this framework, behaviors such as relational withdrawal, aggression, or certain forms of emotional dysregulation may be interpreted as forms of creative adjustment to a field perceived as insufficiently supportive [7].

The distinction between neurodivergence and psychopathology, therefore, becomes a central issue for clinical practice, as outwardly similar behaviors may derive from profoundly different internal dynamics.

This distinction has important clinical implications. Interventions aimed exclusively at behavioral normalization risk overlooking the relational and subjective meaning of the observed behaviors. Conversely, a clinical approach that takes into account the function of behavior within the relational field may foster interventions that are more respectful of the complexity of human experience and more attuned to the individual's needs [8].

Exemplary Clinical Vignette

The clinical vignette presented here is not intended to describe a clinical case in the strict sense, but rather to offer a phenomenological illustration that may facilitate reflection on the complexity of differential diagnosis between neurodivergence and psychopathology, as well as on the importance of considering not only the form of behavior but also its function and meaning within the relational context and the individual's life history [9].

To illustrate some of the dynamics discussed in the literature, we present a brief exemplary clinical vignette derived from the authors' clinical experience.

The case concerns an adolescent girl who displays problem behaviors characterized by sudden, out-of-context episodes of laughter, aggressive outbursts, and destructive behavior toward the surrounding environment. The variability of these behaviors appears closely related to the girl's emotional state and the quality of her relationships with the people present. In the presence of familiar or known figures, her behavior tends to be more regulated, whereas in contexts perceived as less predictable or less safe, more disorganized conduct tends to emerge.

From a cognitive and relational perspective, the girl demonstrates an adequate understanding of certain pragmatic aspects of communication, an element suggesting the presence of basic social competencies

that are not primarily impaired. A recurring theme in her subjective account is a sense of boredom, an internal experience characterized by emptiness and difficulty with emotional engagement. The girl reports this condition as a state of emotional immobility in which internal sensations are difficult to transform into narrative or symbolic experience. This sense of inner emptiness appears to be associated with moments of emotional disconnection and with difficulty in attributing meaning to subjective experience.

During interactions, a desire to connect with others and to build meaningful relationships emerges; however, this need is accompanied by marked relational vulnerability. The fear of being rejected or ridiculed appears to contribute to an alternation between attempts at closeness and sudden behaviors of withdrawal or aggression.

The school environment appears to be characterized by episodes of exclusion and bullying, which intensify the sense of isolation and the difficulty in establishing meaningful peer relationships. Within this context, the girl manifests increasing frustration and difficulty tolerating delayed gratification, which at times translates into impulsive or destructive acting out.

In some situations, self-injurious behaviors also emerge, such as scratching herself or hitting her head against the wall, particularly during moments of intense frustration or difficulties in emotional regulation. These behaviors seem to occur especially when emotional experience becomes difficult to mentalize and does not find space for elaboration within significant relationships.

It is important to emphasize that a similar behavioral presentation—characterized by aggressive acting out, emotional dysregulation, relational withdrawal, or self-injurious behaviors—may also be observed in contexts of neurodivergence. However, in such conditions, the genesis and function of these behaviors are often different. In neurodivergent conditions, apparently disorganized behaviors may represent attempts at self-regulation in response to environmental conditions perceived as overwhelming or difficult to decode, or they may constitute forms of communication of needs that are not adequately expressed through socially shared channels. Furthermore, the presence of social competencies that are not severely compromised appears particularly relevant from the perspective of differential diagnosis, since in neurodivergent conditions—and particularly within the autism spectrum—pragmatic and social decoding difficulties often represent a structural aspect of functioning [10].

In the case described, however, several elements orient the interpretation toward a psychopathological reading rather than toward a neurodivergent pattern of functioning. In particular, the experience of emotional emptiness, the difficulty in symbolizing internal experience, the presence of self-injurious behaviors, and the marked emotional dysregulation suggest the presence of significant psychological distress associated with processes of internal disorganization and difficulties in affect regulation [11].

CONCLUSIONS

The present work highlights the need, in future clinical research, to develop observation and assessment tools that are more sensitive to the processes involved in the differential diagnosis between neurodivergence and psychopathology. In particular, it appears increasingly important to design clinical instruments capable of capturing not only the form of behavior but also the function it serves within the relational field and in the organization of subjective experience. In this regard, the integration of phenomenological, clinical, and dimensional perspectives may contribute to the development of diagnostic models that are both more accurate and more respectful of the complexity of human functioning [12].

Conflict of Interest

The authors declare no conflict of interest.

Authors' Contributions

Valeria Ciotola: Conceptualization; Formal analysis; Writing – original draft; Writing – review & editing; Angela Ammendola: Conceptualization; Methodology; Formal analysis; Writing – original draft; Writing – review & editing; Roberta Terracciano: Investigation; Data curation; Maria Carmela Di Nardo: Investi-gation; Data curation; Stefania Giordano: Investigation; Formal analysis; Sebastian Cesarano: Investiga-tion; Formal analysis; Flavia Morfini: Supervision; Project administration.

Ethics Statement

The vignette represents a composite clinical illustration derived from multiple clinical experiences and does not correspond to any identifiable individual

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