

13. *The forms of aggression*¹

1. Respiratory aggression

Perls' criticism of Freud's libido theory was based on the observation that sexuality could not be the most basic energy of the human being, because before sex came hunger, the need to eat. Hence, the definition of dental aggression as basic and fundamental aggression for the adult human being. In the last years of his life, however, Perls considered it a mistake to place dental aggression at the basis of the individual's vital drive, recognizing that even before eating, the human being needs to breathe. He therefore left to future generations the investigation of this phenomenon.

Breathing is actually the first aggressive act of the being towards the environment. Until the moment of the first breath, the infant has no need for aggression. All the aggressive work towards the environment to satisfy his/her needs is done by the mother. The foetus lives immersed in a continuous flow of warmth, contact, nourishment, oxygen, fluids, without any need to 'do' anything, i.e. without the need to attack the environment to get what he/she needs.

When the umbilical cord is cut, for the first time the child is definitely separated from the environment of the maternal womb and, at the same time, experiences a new environment from which he/she will no longer leave until the moment of his/her death. He/she discovers that this new environment is capable of supporting his/her needs but that he/she must do something to take what he/she needs. The first act of appropriation, and thus of aggression, is breathing.

Respiratory aggression is the basis for all other forms of aggression.

It has a distinctive feature that distinguishes it and makes it unique. In all the other forms of aggression that we will discuss later, the human being is able to exert total control. We can prevent ourselves from eating until we die of hunger or thirst. We can prevent ourselves from defecating and urinating to the point of death. We can prevent ourselves from having sexual intercourse. But we cannot prevent ourselves from breathing. We can hold our breath even for a few minutes but we are not able to kill ourselves by stopping breathing. Through breathing we discover that this world is the right place for us and that we are right for this world.

We are saying that breathing is the fundamental experience for the development of faith in the terms in which Goodman talks about it. He gave a beautiful definition of faith, saying that it is the experience that when we take the next step the earth is there to support us.

Goodman, like Perls, had not considered 'breathing' either. We believe it is correct to update his definition of faith by saying that: "*Faith is the experience that with every breath we take the air is always there for us*". This is why panic attacks and anxiety signal a loss of faith in our right to exist in this world and are always linked to a blockage of breathing.

Anxiety, in fact, from a physiological point of view, is always a choking anxiety.

A characteristic trait of a person who has lost his/her sense of his/her own dignity, his/her right to exist and to feel adequate in the environment is his/her breathing: shallow, contracted, controlled.

Another distinctive feature of breathing is that it is only partially involuntary. We are not able to prevent it but we are able to control and modify it at will. This is what makes it rightfully one of the forms of aggression and what makes it so important. Breathing provides us with a continuous link between us and our environment and, at the same time, allows us to maintain a continuous dialogue between the Ego and the Id.

Any action or emotion is preceded by a change in breathing and is supported by an adequate breathing. In Gestalt we pay close attention to breathing because we are aware that each change in the breathing rhythm signals a break of the contact with one process and the establishment of a new contact with another.

Deep breathing, if not caused by an increased physical exertion, requires awareness and keeps us in touch with the present moment.

All Indo-Chinese/Tibetan meditation practices, which are based on breath awareness, know this well.

To detach ourselves from the present moment, to lose ourselves in our thoughts that take us everywhere and to times other than the present moment, we must not be aware of our breath which invariably becomes shallow.

¹ This chapter on the forms of aggression was largely taken from the book *Aggressività e Sessualità* (Pizzimenti, 2015) already cited several times. However, the discussion has been expanded, deepened and, above all, the connections with sexual dysfunctions have been developed.

In order to disconnect from our body and thus from our environment, we need a shallow, unconscious breath. Any phenomenon of arousal which necessitates bodily sensations, also needs an increase in oxygen in the blood, thus an increase in respiratory aggression and thus in awareness.

However, Gestalt teaches us that awareness is not usually needed to change the situation (PHG, 1951). Unless to the concept of awareness, that is the immediate consciousness, we also add the action that supports the contact process and decide that it is only at this point that the person is aware.

If the person inhibits his or her ability to breathe more, e.g. through a chronic contraction of the diaphragm of the solar plexus, the thoracic muscles, the abdominal and pelvic muscles or the throat, he/she will consequently inhibit his/her ability to become aroused. All those experiences such as joy, happiness, anger and sexuality which require a high degree of arousal will be difficult if not impossible.

Even orgasm is impossible without proper breathing.

Working on one's breathing is the basis of any mindfulness intervention that supports the person to get back into contact with unresolved situations and re-establish those connections that he/she tried to break in order to escape painful experiences.

In all sexual disorders we find controlled and often shallow breathing. The blockage of the pelvis prevents the spontaneous, even if small, anteversion movement during inhalation and retroversion during exhalation. This stiffening may depend on a chronic contraction or, conversely, on a loss of tone in the pelvic, abdominal and lumbar muscles acting in coordination.

Let us not fall into the functionalistic error of thinking that by restoring correct movements and breathing, we can solve sexual disorders.

Breathing is a form of aggression towards the environment and, as such, is charged with experience and is always contextual and situational.

If I experience the environment as dangerous and feel inadequate, I will tend to reduce the exchange, to be less aggressive and therefore to breathe less and/or in a shallow way. If I experience the environment as overpowering, I will completely block my aggression and go into apnoea. If I perceive the environment as nourishing and cozy, I will go towards it with more desire and determination, so the breathing will be full and deep.

These changes are spontaneous and healthy.

That is why in Gestalt we do not 'teach' people to breathe differently but through exercises and experiences we help them to become aware of their breath: through it they can recover the emotions and experiences with which they have lost their connections and only then experience and 'risk' full breathing.

If I encourage people to sit down so that they feel they are resting on their anus, perineum and genitals and then I invite them to contract this area plus the abdominal muscles when they exhale, or to relax and expand them when they inhale deeply, they will easily experience a sense of increased strength, while their back will straighten as a result of the expansion of the abdomen and not of the tightening of the muscles of the spine and/or shoulders. This is not an idealistic type of teaching, i.e. it does not aim to give the person a model to follow but to experience a different possible support for his/her being in the world, linked to the aggressive-bodily movement towards his or her environment.

The same applies if I let them try out various breathing techniques that disciplines such as yoga, martial arts or Reichian studies have developed, such as the dog breathing which acts on the tension of the solar plexus. Other examples are the jellyfish breathing which fluidly increases oxygenation in all organs, or the holotropic breathing which promotes the experience of altered states of consciousness and has cathartic effects, and many others.

The aim is never to intervene as an expert and change something that is wrong with the other person. The aim is always to experience that today he/she is able to co-construct, together with the people around him/her, situations in which spontaneous and contextual aggression can be allowed, feeling that he/she has the capacity to live the consequences.

First of all we breathe the world, the environment, the other person, in a continuous and unstoppable exchange. This is why breathing aggression is the aggression we cannot give up.

2. Oral aggression

By this term I mean a form of aggression in which I transform the environment in me without any prior deconstruction work. The term 'oral' refers to the Freudian expression of 'oral passivity', i.e. to the first time when, according to Freud, we experience aggression towards and from the environment: the developmental

phase in which the child sucks at the mother's breast before the appearance of teeth. During this experience the child does not operate any conscious form of deconstruction of the food before swallowing it, nourishment comes to him/her in a form that he/she can directly swallow. It is not true, however, that the child does not operate any form of deconstruction of the external environment. The infant's cry is a powerful instrument of action on the environment. No non-pathological adult is able to remain indifferent to the crying of an infant. As documented by certain strands of research, such as *Infant Research* (Beebe and Lachmann, 2003), the newborn baby is not powerless in the face of the environment. On the contrary, he/she is perfectly structured to provoke the environment to take aggressive action against him/her, i.e. to make the environment take care of his/her needs. We can therefore extend the concept of oral aggression to all those behaviours that lead the environment to satisfy our needs, without any direct transformative action on our part on the object of our need. In adult relational life, this form of aggression is found in many forms of manipulation in which we bring the environment to give us what we want without our own transformative action on the desired object. I remember that when I was a kid, the word 'want' was absolutely forbidden. If, while walking around with my father, I had said: "Daddy, I want an ice cream", not only would I never have gotten it but I would also have been severely scolded. That's when I learnt to 'talk' about ice cream. I could, for example, make general comments like: "You know, I've been told that fruit ice creams are made with water". Whereupon my father would invariably give me an explanation on the subject and then conclude: "Would you like an ice cream?" Victory! The ice cream came to me with no 'aggressive' action towards the ice cream on my behalf. Interestingly, in the example given, I had already developed other forms of aggression, such as dental aggression, which I will soon discuss, so this is an example of a conscious return to the use of oral aggression. One of the reasons why we decide to use oral aggression, even in adulthood, is when we feel we do not have enough power over our environment.

However, there are also unconscious forms in which oral aggression is acted out by adults, for example in expectations. When I 'expect' something from the others, I believe that I do not have to do anything for it to happen. Expectation is different from wanting or desiring something. If I 'want' you to buy me the newspaper on the way home, I will implement a series of actions to 'try' to get it from you, knowing that I may or may not succeed. But if I 'expect' you to buy the newspaper, I will do absolutely nothing and will be disappointed and/or surprised if you do not bring it to me. Other expressions of verbal aggression are complaints. In a complaint there is no responsible action to get what I want. There is only an expression of pain, in the hope that someone will do what is necessary, so that I can be satisfied. Uncritical learning, i.e. devoid of that form of aggression that Perls called 'dental', is another form of oral aggression. School education supports young people in using oral aggression whenever it forces them to learn concepts they do not understand or in which they cannot develop an interest. In this case, young people are encouraged to use oral aggression to 'introject' concepts that are alien to them and will remain so within them.

I do not want to give the impression that oral aggression is a form of aggression that should disappear in adulthood and that it always denotes, when acted upon, a lack of power and a retreat to a less evolved stage. To receive without asking or to be fed without making the effort to transform can be very pleasurable and, at times, worth running the risk of disappointment, in the same way a lover expects his/her beloved to remember his/her birthday. The important thing is to realize that I am building an expectation and not that it is the 'right' thing for the other person to remember my birthday. In reality, the lover is acting out a kind of test to see if the other's way of loving is similar to his/her own. If I am aware of this, then it is OK.

In sexual disorders, oral aggression is found in the expectations that the other person will take care of me.

"I need sex, can't you understand that?". *"To turn me on I need him/her to take care of me, can't he/she understand that?"*.

When oral aggression appears in sexuality not as a shared game but as an expectation of a way out of a difficulty, it becomes a way of blaming the other person for my discomfort and hiding my experience of powerlessness in being able to influence the environment to get what I want.

In oral aggression my desire has no dignity, unless the other fulfils it '*because he/she wants to*'. I can complain, I can feel bad but I do not feel I have the power to go and take what I want.

3. Dental aggression

This term was developed by Fritz Perls in opposition to what Freud said about oral aggression. With the term oral aggression Freud referred to the act of biting the nipple which a child does when he/she is teething. According to Freud, this was a sign of destructive aggression towards the object of love, i.e. the mother's

breast; conversely, for Perls, the act of breast-biting only signals the transition to a new form of aggression that the child begins to experience but does not yet know nor knows how to use correctly: dental aggression. With the appearance of teeth, the child begins to acquire the ability to destroy food in order to swallow it and so the panorama of foodstuffs at his/her disposal widens enormously. He/She learns that even if the external environment presents itself in a form that cannot be directly assimilated, he/she can, however, thanks to his/her teeth, destroy it so that he/she can then swallow and assimilate it.

Stating that every living organism constantly strives for growth, Perls postulated that the assimilation of the environment is the primary goal we all pursue and that dental aggression is therefore the most important form of aggression for us to develop, also consciously.

When we talk about assimilating the environment, we are not only referring to that part of the environment composed of plants and animals which we feed on, but to everything in the environment that is nourishment for us. We are nourished by beauty, affection, intellectual stimulation, art, love, work and much more. Our environment is an inexhaustible source of nourishment and thus of possibilities for growth. A nourishment that is often present in forms that are not directly assimilable to us but which we have to be able to deconstruct in order to be able to combine them with other parts of ourselves, be they gastric juices, enzymes, hormones or thoughts, intuitions, prior knowledge, existing affections or more. Teeth are the first part of the body we use for this task, then come hands and then thought.

If we leave the view of developmental stages and enter the view of contact process, we find “the *awareness of assimilable novelty and the operations necessary to assimilate or reject it*”. We need assimilable novelty to continue our growth but it is not enough for our environment to contain it: we must be aware of it and perform operations to assimilate or reject it. *That is awareness plus dental aggression.*

If, when reading this book, you encounter familiar and taken for granted concepts, you will surf over them like on ice, you will need very little awareness and no dental aggression. But when you encounter something new, everything changes.

In sexual disorders as well as in the suffering of many paraphilias we almost always find a lack of dental aggression.

The lack of dental aggression leads us to be compliant and to try to accept the other as he/she is, for fear of losing him/her, for inadequacy introjections, for conformity with implicit and explicit cultural assumptions, for religious introjections.

The lack of dental aggression in the sexual field, as we shall see, results in the impossibility of sustaining the necessary evolution of our relationship.

No relationship, not even the most satisfying one, can remain unchanged over time. Changes are inevitable but they must be attacked to make them assimilable, otherwise the consequences will be a frustrating compromise or a painful abandonment.

Dental aggression is an important complement to sexuality, as long as it is not confused with anal aggression, which is often present in delinquent and criminal behaviour, it supports all creative processes and thus sexuality.

A sexuality that has a good dental aggression in its background will be able to afford moments of fusion with the other without losing its ability to differentiate itself. It will be able to sustain love without losing its autonomy, to get aroused and experience pleasure without losing its critical capacities.

A dental aggression that has sexuality as its background, will know how to contain its own destructiveness to avoid hurting the other fruitlessly; it will sustain the discussions by feeling the pleasure of building together with the other but neither to win nor dominate. Such dental aggression will always have clear that destructiveness is only a passage to creativity and growth.

4. Anal aggression

This term was also used by Freud to describe a stage in the child's development, namely the stage during which the child begins to acquire sphincter control and thus to exercise control over the ability to get rid of something inside his/her body. During this period, the child also develops its oppositional capabilities in relation to the world, the ability to say no. In adult relational terms, we use the term anal aggression to refer to the action of directing something that we no longer want towards the environment or of sending something back to the environment that comes from it to us and that we reject. It is the aggressiveness we need in order to separate from a partner with whom we had a love affair, but whom we no longer love; to quit a job that no longer satisfies our needs; to leave the city in which we were born, but which we now feel

too cramped for our plans; to distance ourselves from the family of origin which is so protective, but which frustrates our need to fly. It is the aggression we need to reject an overly insistent suitor, to defend ourselves from a person who tries to subdue us, to get a friend out of our house whom we no longer feel like talking to at that moment. Like all forms of aggression, it cannot only arise inside the child's body, but always in the interaction between the inside and the outside where each determines the other. Anal aggression has first and foremost the task of ridding us of what we do not need or no longer need. In this sense it also has a deconstructing function, since it is a matter of eliminating what we 'then' find out we do not need, i.e. once we have ingested it. From this point of view, it fulfils a very important task which is to remove what may intoxicate us. No matter how much we deconstruct the external world, it will never be completely assimilable, there will always be toxic components to be eliminated. By extension we define as anal aggression the rejecting of what comes from the environment which we experience as toxic, be it a thought, an experience, a relationship. It is a form of aggression that expresses not so much destructiveness, typical of the dental aggression, but annihilation, i.e. eliminating, making 'nothing'. It is the 'going-towards-to-reject'. It is important to be aware that in all relationships there are toxic aspects that cannot be assimilated but that one must be able to eliminate, i.e. reduce to nothing, otherwise these pile up in the relationship until the whole relationship will become toxic. This also applies to the therapeutic relationship which does not mean that there are toxic 'parts' of the patient to be annihilated, but that the relationship will also develop toxins that both patient and therapist will have to recognize and eliminate.

Compared to the two forms of aggression mentioned earlier, this one has an opposite algebraic sign. Both oral and dental aggression comply with the intentionality of appropriating something of the environment, so the direction is from the environment towards us. In anal aggression, the direction is from us to the environment, because the expressed intentionality is to give back to the environment something that had been directed towards us or that until recently actually belonged to us. Respiratory aggression is characterised by a rapid and incessant succession of these algebraic signs. However, all four of these forms of aggression obey an intentionality of appropriation, expressed with a plus sign (I want it to be mine) or a minus sign (I want it not to be mine).

Anal aggression is of great importance, for example, in order to deal with situations of powerlessness in which we have the impression that we have no tools to counteract an oppressive environment. I remember working a few years ago with a patient who was in a situation of great frustration with a vexatious and intrusive landlord (she was renting), in respect of whom she felt absolutely powerless, unless she accepted the idea of moving house, which she would not have wanted. I worked on the possibility of performing a *woodoo* rite, i.e. modelling a wax figure representing this hated man and then sticking pins in it, wishing him all sorts of misfortunes. After overcoming the feelings of guilt linked to the fear of magical omnipotence, the patient gradually recovered the sense of being able to use her discomfort and came out of her sense of powerlessness, to the point of being able to change her relationship with this person. The point is that, if you are in contact with aggression, you can decide how to use it and how to distance the other when it invades your boundaries. This is an example of what Freud would have called anal sadism, functional in order to get out of a powerless dynamic. When the person dignifies his/her experiences of hatred, he/she can objectively return to the border and regain his/her grounding and sense of personal strength. Being able to accept to desire the evil of a person who makes us suffer requires the development of this form of aggression. This happens in order to dignify even those aspects of ourselves that we judge as 'ugly, dirty and bad' and to find a form of 'contained' expression that does not block us in the dyad of 'being stuck, powerless and enduring' or 'performing socially untenable actions'.

An excess of anal aggression results in the attitude of 'throwing shit'. We find it in people who tend to criticise proposals or positions brought by others without ever making proposals in the current moment but only saying what should have been done before.

This form could sometimes be confused with dental aggression which however tends to deconstruct in order to assimilate and/or construct, while anal aggression wants to annihilate in order to make things disappear.

A strong anal aggression fosters delinquent and criminal behaviours in which, when the other becomes an enemy, one wants to 'wipe him/her off the face of the earth'. Whether it is by dissolving him/her in acid or embedding him/her in a concrete pour, as in the worst criminal traditions, or less drastically humiliating him/her by expelling this person from the community, as it happens in criminal circles.

In sexual, emotional and friendship relationships, it is a form of aggression that must be used with care, precisely because it tends to humiliate the other person and make him/her feel ashamed. Sexual disorders often develop in areas where anal aggression is frequently present, where people feel that they are being 'shat on' and that they have to go through all the trouble to get something constructive out of the other

person's aggression.

5. Genital aggression

Genitality is a component of sexuality, yet it is important to separate one from the other.

Normally, we recognise to have sexual sensations when we start having genital sensations. When talking to a colleague, I may realise that I am looking at her/his mouth and that this creates pleasurable sensations in me. However, I rarely relate these sensations to sexuality. On the contrary, if I notice that I experience genital sensations, or develop fantasies resulting in genital sensations, I come to the conclusion that I have a sexual attraction to that colleague. This difference is more or less consciously used in many modern companies where it is considered important to have a gender mix within the work team: it is proven that this increases creativity and makes work less tiring. However, it is strictly forbidden to create couple relationships and therefore to let genitality break in, as this is considered detrimental to the smooth functioning of the team.

Sexuality in human beings is no longer simply an instinct but a complex phenomenon composed of pleasurable sensations that involve all the senses to varying degrees, genital stimulations, emotions such as joy, surprise, satisfaction, shame or passions such as desire, pleasure, jealousy, needs such as affection and intimacy. It also plays a primary function in the realisation of creativity, both biological and social. Genitality is only one component of sexuality that we may or may not identify with, whereas genital aggression is a form of aggression that we develop when we choose to identify with our genital feelings.

The confusion between genitality and sexuality is responsible for misunderstandings and even very serious suffering. A father who gets frightened because he ends up having an erection while playing wrestling or bathing with his children, or is disturbed by his teenage daughter's body, falls into such confusion. Feeling pleasure is part of sexuality but if I do not develop genital fantasies and thus do not identify with my genitals, this pleasure will sustain an affective, emotional but not genital intimacy. In other words, I will have no desire to make love.

This view of sexuality is consistent with the phenomenology of 'sexual' experiences that have nothing to do with sexual coupling. For example, breast-feeding in which women report how the oral stimulation of the nipples causes genital arousal. Or we can think of the masturbation experiences of children who, already in childhood, discover genital pleasure within intimate relationships (with parental relations, friends, cousins, etc.). Freud in the *Three Essays* (1905) describes nappy changing as an exciting situation for both child and mother. Genital sensations of pleasure are present throughout life and are part of the contact.

On the other hand, we often find a lack of genital aggression in sexual disorders, such as erectile and lubricatory impotence or in vaginismus.

Genital aggression is what sustains us to 'take' the other person, to possess him/her, to penetrate him/her or to vaginate him/her.

If these experiences frighten us or seem wrong or impossible, we will not identify with our genitals and will not develop this form of aggression.

It is important to realize that we may not identify with genitals without alienating from our sexuality. Genitality has a specific purpose and is linked to specific contexts and situations. Sexuality is a much more complex phenomenon and can develop different intentions which are possible in very different contexts and situations. A good example is a therapy or counselling session which professionally, ethically and legally are not suitable contexts for a genital encounter between patient and therapist, whereas they are often the right context for sexually charged encounters. In the clinical setting, Eros is a presence that sooner or later will emerge, as both the patient and the therapist are sexual human beings. It may emerge as an issue brought by the patient in his or her relationships, or it may pass implicitly or explicitly through the relationship with the therapist.

During a session, the therapist can sense the patient's arousal and treat it as an opportunity for work. For example, he/she can make it clear to the patient that he/she, the therapist, will take responsibility for the boundaries and thus invite the patient to explore his/her desires, excitement and fears without being blocked by the risk of unintended consequences. Making this clear serves to clear the field of unshared introjections or fears that may complicate the therapeutic progress.

If the therapist decides to work and enter into the experience of sexuality, he/she can invite the patient not to identify with the genitals, but to also feel the rest of the body and what is happening in the contact. For example, the need to be welcomed by the therapist and to be able to be himself/herself in a spontaneous way, allowing himself/herself personal sensations and expressions of that he/she cannot experience in the world.

Working on the awareness of sensations by distinguishing between genital and sexual sensations not only gives clarity to the therapy but also supports the patient in feeling and orienting himself/herself when experiencing sexual arousal.

In narcissistic experiences, the patient may quickly identify with genitals and sexual performance in order to avoid creating situations of intimacy. Genital aggression is often a movement in which the patient, starting with genital sensations, quickly identifies with a genitalised intention and does not allow himself/herself to feel widespread sensations of pleasure which may connote relationships that are not necessarily genital or amorous.

The images with sexual content that the media expose in all channels are strong stimuli with respect to genital aggression: yet, these have nothing to do with the richness and depth of sexuality but more with pornography in which the other is only present as an object.

If the therapist does not feel his/her own sexuality first and foremost and cuts it off from the contact with the patient, he/she will confirm precisely his/her patient's fears of allowing himself/herself an intimate and intense experience.

Otherwise, the therapist may decide to work on genital awareness by distinguishing the 'genital feelings' from the 'genital aggression'. This key is useful in borderline experiences where naming the different experiences in an exact way helps to relax the boundary. The clarity of the words we use reflects a cleaning of boundaries that is therapeutically necessary when the sexual experience is in the foreground. Erection (or vaginal lubrication) may reflect a bodily tension that is not oriented to the sexual intercourse but to a clear interpersonal intimacy involving the whole body, including the genitals.

The most complicated situation is when the therapist identifies with the genital feelings and this identification is the prevailing figure with the patient. The Code of Ethics expresses the risk of abuse for the patient.

Every power relationship can potentially involve some form of abuse by those in the dominant position. The psychotherapeutic relationship is no exception. It is an asymmetrical and unequal relationship: one of the two relies on the other to deal with and solve a problem of a personal nature.

According to the Code of Ethics, one of the ways in which the relationship can go beyond certain boundaries of propriety is when it takes the form of a sexual relationship between therapist and patient.

The codes of ethics of the health professions have always prohibited sexual behaviours with patients, ever since the Hippocratic oath.

First and foremost, the therapist has an obligation to be clear and honest with himself/herself.

Genitality is, in fact, linked to intimacy and thus to the patient's – but also the therapist's – deepest needs. Therefore, experiencing genital sensations and, above all, identifying with them, may be the consequence of the fact that the therapist is putting his or her own unmet needs into the relationship with the patient which often happens unconsciously.

The patient often senses the therapist's needs just as the child senses the parents' needs. In this sense, Isha Bloomberg, provocatively, spoke of the abuse of the therapist by the patient. The patient 'uses' the therapist for his/her own treatment needs and the therapist agrees to be 'used', i.e. to become deeply involved. But while the patient has nothing to lose in terms of social reputation, the therapist risks losing his/her profession and being disbarred.

Once the therapist makes contact with the experiences he/she is bringing into the setting (e.g. his/her own love needs) and feels sexual feelings and desires (Id function), once he/she decides he/she no longer wants to carry on with the therapy but wants a personal relationship (Ego function), once he/she no longer identifies with the therapeutic situation and his/her role as therapist (Personality function), then he/she can always terminate the therapeutic contract. The Code of Ethics for Psychologists regulates certain aspects of this issue, e.g. the time that must elapse before the psychologist can have relations of a different nature with the patient. Regulating such delicate aspects is inevitably reductive with respect to the protection of the patient; there can be no one-size-fits-all treatment and therefore the therapist's attention must be maximised.